HEALTHYTOGETHER

2021

PFG BENEFITS GUIDE

PFG Performance Food Group

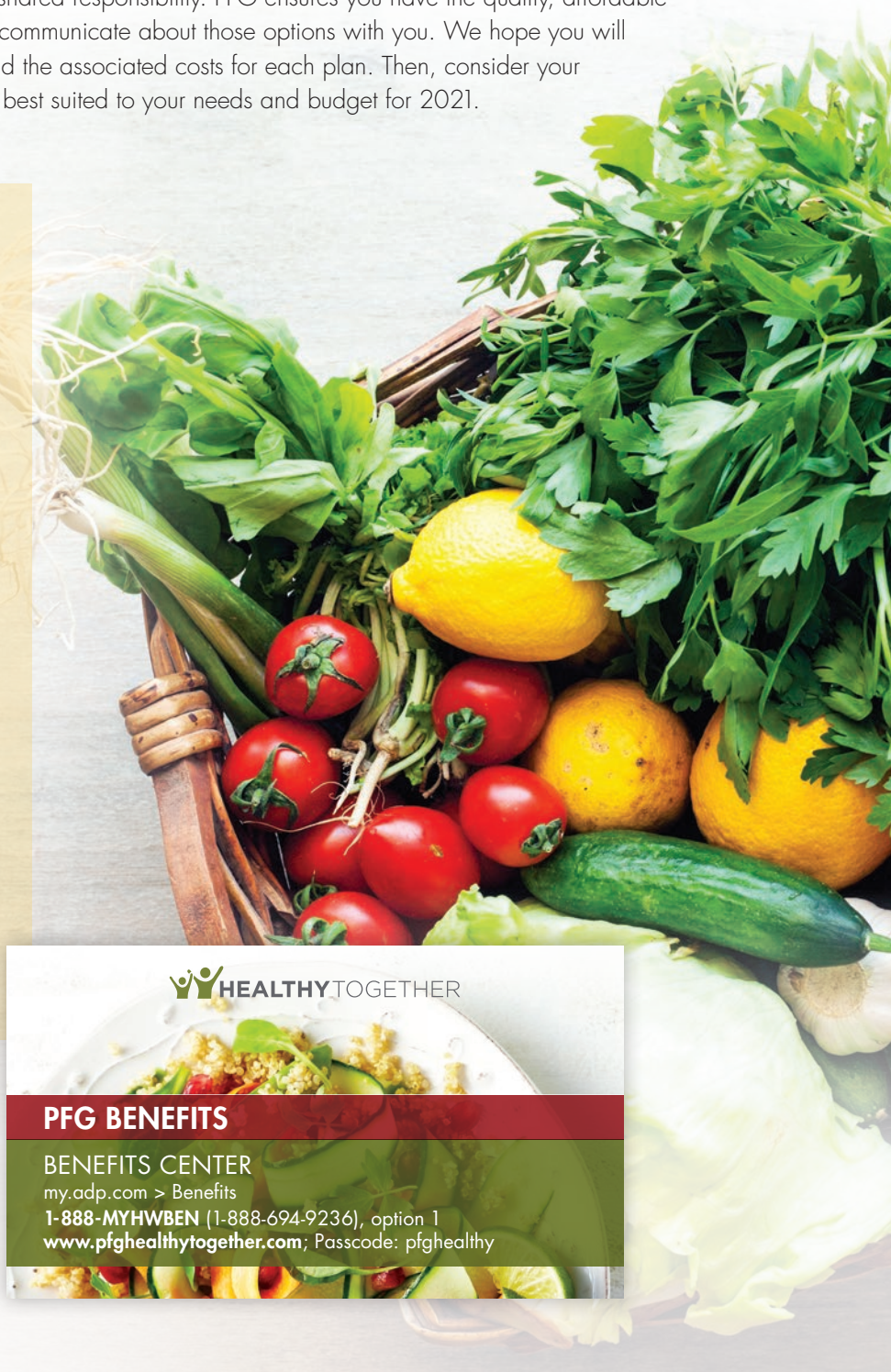
2021 PFG BENEFITS

Benefits are an important part of your PFG Total Rewards. We know that when you are happy and feeling well in your day-to-day life, it is reflected in the work you do as a PFG associate. We all win when we are *Healthy Together!*

For 2021, PFG is continuing our tradition of offering benefits that balance quality and affordability. There are a variety of benefit options — for health, life insurance, disability income and more — allowing you to select coverage that is best for you and your eligible family members.

Making sure your benefits work well for you is a shared responsibility. PFG ensures you have the quality, affordable options described inside, and we do our best to communicate about those options with you. We hope you will take time to learn about your options for 2021 and the associated costs for each plan. Then, consider your benefit needs and actively enroll in the coverage best suited to your needs and budget for 2021.

WHAT'S INSIDE



HEALTHYTOGETHER

PFG BENEFITS

BENEFITS CENTER
my.adp.com > Benefits
1-888-MYHWBEN (1-888-694-9236), option 1
www.pfghealthytogether.com; Passcode: pfghealthy

See the back cover for your wallet card – a quick reference to your PFG benefits contacts.

BENEFITS ELIGIBILITY

You are eligible to enroll in the PFG benefits program if you are a regular, full-time associate working at least 30 hours per week. You may also enroll your eligible dependents in plans offering dependent coverage.

If a plan offers coverage to your spouse, you may enroll:

- Your legal spouse as defined by federal law (unless you are legally separated) who resides in the same country of residence as you, including a same-sex spouse; or
- Your same- or opposite-sex domestic partner, which includes your civil union partner.

If a plan offers coverage to your child(ren), you may enroll:

- Your child(ren) under age 26, including your biological child, step-child, foster child, child who has been legally adopted or placed for adoption with you, or a child for whom you have been designated as the legal guardian.
- Your domestic partner's child(ren).
- Your child, age 26 or older, who is incapable of self-support due to a mental or physical disability which commenced prior to age 26 or the time they would otherwise have become ineligible for coverage as your dependent.

Anytime you enroll or change your medical, dental or vision benefits, you may be required to provide supporting documentation when requested. The date you indicate as the effective date of the change must match the date on your supporting documentation. If you do not provide this documentation by the deadline listed in the letter requesting it, your changes will not remain in effect after the deadline has passed.

To add a domestic partner (and if applicable, child(ren) of a domestic partner) to your coverage, you must meet certain legal requirements. The portion of your contribution that is for your domestic partner and/or your domestic partner's child(ren) will be taken from your paycheck after taxes are applied, unless they otherwise qualify for tax-free status. Also, any contribution that PFG makes toward your medical, dental or vision coverage may still be subject to both federal and state taxes (known as imputed income).

Coverage for a same-sex spouse is not subject to federal taxes or imputed income, but it may be subject to taxes and imputed income under state law.

For more information, visit **my.adp.com > *Benefits > Forms & Plan Documents*, or contact the Benefits Center at 1-888-MYHWBEN (1-888-694-9236, option 1).**

ELECT GREENER BENEFITS

By selecting "electronic" PFG benefit communications, you'll help reduce the environmental impact, control the costs of communicating about benefits and receive benefits information faster.

Visit **www.pfgcbenefits.com** to ensure your delivery preference is "electronic."

Note: Salaried associates, other than drivers, automatically receive benefits information electronically.

QUALIFYING FAMILY STATUS CHANGE EVENTS

If you experience a qualifying family status change event during the year, you may be eligible to change elections consistent with the qualifying event. However, **you must contact the Benefits Center within 31 days of the event.**

Your benefit elections will be effective the first of the month following the date of the change in your family status. The only exceptions are if you experience a birth or adoption; benefits will begin on the date of the birth or adoption. The type of qualifying event will determine the type of change you are allowed to make. Qualifying family status change events may occur when:

You can also change your coverage under the terms of your "Special Enrollment Rights." See ***PFG Legal Notices*** for more information.

- You marry, divorce or become legally separated, or your marriage is annulled.
- You have a new, eligible dependent child — by birth, adoption, placement for adoption or for whom you have been designated as the legal guardian.
- Your spouse/domestic partner or your dependent child dies.
- You, your spouse/domestic partner or your dependent child starts or stops working.
- You, your spouse/domestic partner or your dependent child has a change in employment status or work schedule.
- You, your spouse/domestic partner or your dependent child has a significant increase in the cost of employer-sponsored health care coverage or that person's employer-sponsored health care coverage significantly changes or ends (this includes COBRA coverage).
- You, your spouse/domestic partner or your dependent child becomes eligible or ineligible for Medicare or Medicaid.
- Your dependent child becomes eligible for — or is no longer eligible for — health care coverage due to age.
- Your spouse's/domestic partner's or your dependent child's coverage changes under their employer's plan because of a change-in-status event, eligibility requirements or an Open Enrollment.
- You, your spouse/domestic partner or your dependent move to a new residence or change jobs and it affects access to care within your current plan.
- Your domestic partnership ends.
- You work fewer than 30 hours per week and elect coverage under another qualifying plan which is effective no later than the first day of month following the month in which you lost coverage.
- You are eligible for a special enrollment period through the Health Insurance Marketplace or if you enroll in a plan through the Health Insurance Marketplace's open enrollment period. Your new coverage must be effective no later than the day immediately following the last day of coverage under PFG's group health plan.

HOW TO ENROLL

Register for or sign in to MyADP to start the enrollment process.

TO REGISTER ON MYADP

Visit **my.adp.com** > Click on the ***Register Now*** button.

- Click on ***I have a Registration Code***.
- Enter the Registration Pass Code: PFGC-1234.
- Complete the required information — enter your legal first and last name (nicknames are not accepted), Social Security number and the month and day of your birthdate.
- Verify your information, and click ***Register Now***.
- Enter your contact information. You must have a valid email address.
- Enter your security information. Create a password that is at least eight characters with one letter and one number.

You will receive an email confirmation of your registration, along with your user ID needed to log in to MyADP.

ONCE REGISTERED ON MYADP

If you've already registered on MyADP, visit **my.adp.com**.

- Click ***User Sign In***.
- Enter your user name and password. Your user name is the user ID you received when you completed your registration; your password is the password you created.
- When the PFG MyADP home page appears, choose ***Benefits***.
- Click ***Enroll Now!*** and follow the instructions.

When finished, click ***Complete Enrollment*** and then ***Confirm Enrollment***.

IF YOU DON'T ENROLL

If you do not actively enroll, your coverage for 2021 will default as follows:

NEW HIRE OR NEWLY-ELIGIBLE FOR BENEFITS

You will have only the following company-paid benefits:

- Employee Assistance Program
- Basic Life
- Basic Accidental Death & Dismemberment (AD&D)
- Short-Term Disability
- Long-Term Disability

DURING BENEFITS OPEN ENROLLMENT

Flexible Spending Accounts (FSAs): If you do not actively enroll in a Health Care FSA, Limited Purpose Health Care FSA or Dependent Care FSA, you will not contribute to these accounts in 2021. An annual election is required.

Health Savings Account (HSA): If you do not actively enroll, you will not contribute to your HSA. An annual election is required. However, you may make changes to your contributions at any time and for any reason.

All other current coverage will continue for 2021.

NICOTINE SURCHARGE

If you are enrolled or plan on enrolling in medical coverage, you must certify whether you and your enrolled spouse/domestic partner have used nicotine products within the last 12 months.

For 2021:

- The associate annual nicotine surcharge is $600 (prorated per pay period).
- The spouse/domestic partner annual nicotine surcharge is $300 (prorated per pay period).

Nicotine products include, but are not limited to, e-cigarettes, vaporizers and other electronic delivery systems, cigarettes, cigars, pipes, smokeless tobacco products, hookahs, patches, gum and lozenges.

Recertification is required every year. If you do not certify your and your spouse's/domestic partner's nicotine user status and you enroll in a PFG medical plan, you will automatically default to nicotine user status and the surcharges will apply.

If you or your spouse/domestic partner is a nicotine user, the surcharge can be removed by completing the Quit 4 Life program, offered as part of PFG's wellness program. To enroll, call 1-866-QUIT-4-LIFE (1-866-784-8454) or visit **quitnow.net** (company identifier: PFG).

MEDICAL

PFG offers you medical plan options, administered by UnitedHealthcare (UHC), that encourage preventive care and help protect you and your family from costs associated with illness or injury. The following medical plan options are available:

- High Deductible Health Plan (HDHP)
- Consumer Driven Health Plan with an HSA (CDHP)
- PPO Plan (or the Out-of-Area Plan for associates residing outside PPO service areas)

Log on to **www.myuhc.com** and select *Find a Doctor* (or, if you are newly enrolling, go to **www.welcometouhc.com/pfg** and select ***Find a Doctor*** under the ***Benefits*** menu item). Enter your home zip code, and if your zip code is not serviced by the UHC Choice Plus Provider Network, you will be able to enroll in the Out-of-Area Plan, HDHP or the CDHP, but the PPO Plan will not be available to you. If you enroll in one of PFG's medical plans, you are automatically enrolled in prescription coverage through Caremark/CVS Health. See page 14 for more details.

To compare your options, consider the following factors:

- **Your premium cost:** This is the pre-tax deduction taken from your paychecks.
- **Deductible:** The dollar amount you are required to pay for services before your medical plan covers any portion of the cost.
- **Coinsurance:** Your share of the cost after you have met your deductible; usually a percentage of the cost.
- **Copay:** A pre-determined dollar amount paid to your provider when you receive services under the PPO Plan.
- **Annual out-of-pocket limit:** The maximum dollar amount you are required to pay for covered services in the plan year. Once you reach this limit, the medical plan covers 100% of any additional covered expenses for the year. Think of this as your safety net — protecting you from catastrophic costs you could incur from a serious illness or injury. The amounts you pay in deductibles, coinsurance and copays all count toward this limit.

Keep in mind, all PFG medical plans cover in-network preventive care services at 100% without having to meet the deductible, pay coinsurance or a copay. Preventive care includes routine annual physical exams and screenings, well-child care and age-appropriate immunizations.

If you are newly enrolling or making a change, you will receive a new medical ID card from UHC.

NETWORK PROVIDERS = COST SAVINGS

You'll pay lower deductibles, coinsurance, copays and less out of pocket when you use network providers. Choice Plus is the UHC network for all PFG medical plans. Network providers have service agreements with UHC — so your share of the cost is based on a rate agreed upon between UHC and the provider.

TIP! Look for the UnitedHealthcare Premium Tier 1 designation when searching for a provider. These providers may save you even more as they have been recognized for quality and cost efficiency.

To find a network provider, log on to **www.myuhc.com** and select *Find a Doctor* (or, if you are newly enrolling, go to **www.welcometouhc.com/pfg** and select *Find a Doctor* under the *Benefits* menu item), or call 1-877-769-7001.

HOW THE PLANS WORK

The medical plan options cover the same services, and you are automatically enrolled in prescription drug coverage through Caremark/CVS Health.

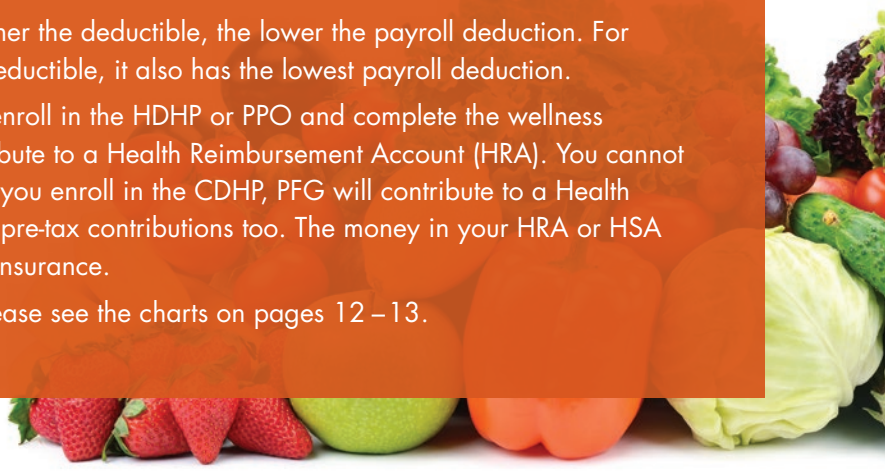
IN-NETWORK PREVENTIVE CARE IS COVERED AT 100%	In-network preventive care is covered at 100% with no deductible.	
YOU PAY COPAYS	Depending on your plan, for certain services and supplies you may be subject to a copay for an item (such as $25 for a PCP visit under the HDHP or PPO Plans, $40 for an in-network urgent care facility visit under the PPO Plan, etc.).	
OR		
YOU PAY THE DEDUCTIBLE	For most other categories of services, you pay out of your pocket until you have reached the deductible.	**If you enroll in the HDHP or PPO,** your deductible and coinsurance can be paid with funds from your Health Reimbursement Account. (The HRA is available if you complete the wellness requirements. See page 10.) **If you enroll in the CDHP,** your deductible and coinsurance can be paid with funds from your Health Savings Account. (See page 8.)
YOU PAY COINSURANCE	After reaching the deductible, you pay a percentage of covered costs as your coinsurance (such as 20% for non-routine lab work).	
YOU REACH THE MAXIMUM OUT-OF-POCKET	If you meet the annual out-of-pocket limit, the plan pays 100% of eligible charges for the remainder of the calendar year.	

WHAT'S THE DIFFERENCE?

The main differences among the plans are the payroll deductions, deductibles and the accounts associated with each plan.

- **Payroll deductions and deductibles.** The higher the deductible, the lower the payroll deduction. For example, while the HDHP has the highest deductible, it also has the lowest payroll deduction.
- **Accounts associated with each plan.** If you enroll in the HDHP or PPO and complete the wellness requirements (see page 10), PFG will contribute to a Health Reimbursement Account (HRA). You cannot make your own contributions to an HRA. If you enroll in the CDHP, PFG will contribute to a Health Savings Account (HSA), and you can make pre-tax contributions too. The money in your HRA or HSA can be used to pay your deductible and coinsurance.

To compare medical plan benefits and costs, please see the charts on pages 12 – 13.



HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Of the three plan options PFG offers, this plan has the highest annual deductibles for most medical services ($5,000 for individual coverage; $10,000 if covering one or more dependents). As a trade-off, it has the lowest per-pay-period payroll deductions.

While there is a copay for primary care office visits, if you are used to paying a copay for services such as specialist office visits, please be aware that under the HDHP, those services will be subject to the deductible and coinsurance rather than a copay. The HDHP also offers copay/coinsurance coverage on your prescriptions before meeting your deductible. Refer to the medical comparison chart on pages 12-13 for more details.

CONSUMER DRIVEN HEALTH PLAN (CDHP)

This plan is designed to encourage participants to carefully consider quality of care, cost and other factors as they choose health care providers and services to address their health care needs. The CDHP has a lower per-pay-period premium deduction than the PPO. The trade-off is that the deductible and out-of-pocket maximum are higher than the PPO and lower than the HDHP. PFG will fund a Health Savings Account (HSA) for you, and you may also elect to add your own tax-free funds to help cover your deductible and other out-of-pocket costs, as well as save for future years. The CDHP may save you money overall.

Under the CDHP, prescription drugs are treated as any other medical expense. You pay for all expenses, medical services and/or prescriptions (that are not considered preventive), until you've met the plan deductible.

If you cover any dependents, you must meet the family annual deductible before the plan starts to pay coinsurance. The expenses of one person alone, or any combination of your family members, counts toward the family deductible.

If you cover dependents, an individual can meet the annual out-of-pocket limit in one of two ways:

1. Covered expenses for one person reach the individual out-of-pocket limit. Once the individual limit has been met by one person, the plan will start to pay at 100% for that person.

   OR

2. Covered expenses for all covered family members reach the family out-of-pocket limit. Once the family limit has been met, the plan will start to pay at 100% for all covered family members.

If you are used to paying a copay for services such as office visits under other plans, please be aware that under the CDHP, those services will be subject to the deductible and coinsurance rather than a copay. See page 8 for additional details.

If you enroll in the CDHP, preventive medications are not subject to the deductible. A list of preventive drugs is available on **MyADP > Benefits > Forms & Plan Documents**.

HEALTH SAVINGS ACCOUNT — FOR CDHP PARTICIPANTS

A Health Savings Account (HSA) works much like your own personal checking or savings account, but it is designed to be used for qualified medical, dental, vision or prescription expenses. If you enroll in the CDHP, PFG will contribute to your HSA:

- $250 if you have coverage for yourself only (prorated per pay period), or
- $500 if you have coverage for yourself and at least one other dependent (prorated per pay period).

If you enroll in the CDHP, you can make tax-free contributions to your HSA too — up to the IRS limit. For 2021, total contributions can be up to:

- $3,600 for associate only coverage, or
- $7,200 for associate + 1 or more coverage.

If you're age 55 or older, you can make an additional catch-up contribution of $1,000.

If you and/or your spouse/domestic partner participate in PFG's wellness program, you will need to reduce your annual contributions by the amount you earn in wellness contributions.

AN HSA OFFERS THESE ADVANTAGES:

- **Your account is triple tax-free.** Your contributions are tax-free, any investment earnings are tax-free and your withdrawals are tax-free (if you use the money for a qualified health care expense).
- **Use the money now or later.** Each time you have a qualified health care expense, you can decide to pay for it with funds from your HSA or out of your own pocket. To access your HSA funds, use your Optum HSA debit card, submit a claim or make payments by electronic check.
- **There are NO "use it or lose it" rules.** Any balance left in your account at the end of the year rolls over to the next year — even if you change your medical coverage, retire or leave PFG. This makes HSAs particularly useful to support your health needs in retirement. Because HSA dollars used for qualified health care expenses are tax-free, these funds are much more tax-efficient than using your 401(k) assets for health care expenses in retirement.

You are not allowed to use your HSA to cover qualified health care expenses incurred before your account is established. Also, your HSA will not reimburse expenses greater than your account balance. However, as contributions go into your account, they can be withdrawn to cover any eligible expenses that were incurred after your account was established. A complete list of eligible expenses can be found online at **www.myuhc.com**. You are also eligible to enroll in a Limited Purpose Health Care FSA for dental and vision expenses; see page 19 for more information.

HSA CONTRIBUTIONS

COVERAGE LEVEL	2021 TOTAL CONTRIBUTION LIMIT (your contribution + PFG's combined)	PFG CONTRIBUTIONS		YOUR 2021 CONTRIBUTION LIMIT (if you maximize your wellness contributions)
		AUTOMATIC[1]	POTENTIAL WELLNESS[2]	
Associate Only	$3,600	$250	$550	$2,800
Associate + Spouse/ Domestic Partner	$7,200	$500	$750	$5,950
Associate + Children				
Family				
Catch Up (if turning age 55+ in 2021)[3]	$1,000	N/A	N/A	$1,000

[1] *PFG's contributions are prorated and paid on a per-pay-period basis for associates enrolled in the CDHP.*
[2] *Wellness contributions are paid in a lump sum upon completion.*
[3] *You cannot make contributions, including catch-up contributions, if you are enrolled in Medicare.*

UHC PPO AND OUT-OF-AREA PLANS

The PPO (Preferred Provider Organization) provides the convenience of paying a specified copay (or sometimes a deductible) up front — at the time you receive medical services or fill prescriptions using one of the plan's designated (preferred or network) providers. In that way, a PPO can alleviate some of the concern and guesswork because you generally know how much you will have to pay out of your own pocket for routine medical services and prescriptions. The tradeoff for this convenience is the highest per-paycheck premium deduction of all PFG medical plans. If your zip code is not serviced by the UHC Choice Plus Provider Network, instead of being able to enroll in the PPO Plan, you will be able to enroll in the Out-of-Area Plan, which mirrors the PPO Plan design.

DECISION SUPPORT TOOL

Help Choosing the Right Plan for Your Situation

To help you choose the right plan for your situation, use the Decision Support Tool. Simply enter your expected medical expenses and rank your preferred plan features. Then compare your bottom line under each medical plan. While there is no way to know for certain which plan will have the lowest out-of-pocket cost for you, the Decision Support Tool can take some of the guesswork out of your decision.

To access the Decision Support Tool, log on to **MyADP** at **my.adp.com > Benefits.** To see the Tool, you must be on the medical page of your enrollment session.

WELLNESS CONTRIBUTIONS

Regardless of the medical plan you choose, you have the opportunity to earn money for your Health Reimbursement Account (HRA) or Health Savings Account (HSA). Plus, there are many ways to earn it.

Complete a biometric screening or an annual physical between January 1 – December 31, 2021. Regardless of your results, you (and your spouse/domestic partner who is also enrolled in a PFG medical plan) will be rewarded with a PFG contribution to your HRA or HSA, depending on the medical plan in which you enroll.

You'll find all the ways to earn money for your HRA or HSA in the following chart.

WAYS TO EARN MONEY FOR YOUR HRA OR HSA	COMPLETED BY YOU	COMPLETED BY YOUR ENROLLED SPOUSE / DOMESTIC PARTNER
Complete a biometric screening or annual physical	$300	$150
Get a free preventive dental or vision exam, cancer screening or prenatal visit	Up to $150 (up to three screenings allowed; $50 each)	$50
Register for Rx Savings Solutions*	$50	N/A
Complete a virtual visit with a UHC provider	$100	N/A
Participate in personal coaching or Real Appeal	$150 each	$100 each
Maximum amount you each can earn	**$550**	**$200**
Total possible wellness contribution	**Up to $750** **If you're enrolled in the HDHP or PPO**, the amount earned by you (and your enrolled spouse/domestic partner, if applicable) will be added to your HRA. **If you're enrolled in the CDHP**, the amount earned by you (and your enrolled spouse/domestic partner, if applicable) will be added to your HSA.	

**If you previously registered for Rx Savings Solutions, you are not eligible; only new registrants will receive a wellness contribution.*

If you and/or your spouse/domestic partner are unable to participate in an onsite biometric screening, visit a Quest Diagnostics lab or your physician's office. To schedule an appointment with a Quest Diagnostics lab after January 1, 2021, visit my.questforhealth.com. If you haven't already done so, create an account and enter the required information. (The registration key is PFG2021.) Or contact Quest Labs at 1-855-623-9355, Monday – Friday, 8 a.m. – 9:30 p.m. ET and Saturday, 8:30 a.m. – 5 p.m. ET.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

An HRA allows PFG to contribute to an account on your behalf to help cover the cost of out-of-pocket medical and prescription expenses, such as deductibles, coinsurance, copays and other such expenses that are not reimbursed by insurance.

To be eligible for an HRA, you must be enrolled in either the HDHP or PPO and have completed the wellness requirements. Reimbursements are tax-free. As a PFG associate, your HRA balance rolls over year after year, as long as you remain in an HRA-eligible medical plan.

HRAs have an auto substantiation feature which means when UHC processes your claims, they will automatically reimburse either you or your provider. UHC will pay your provider directly for any deductibles and/or coinsurance until you no longer have a balance in your HRA, and you will automatically be reimbursed for any copays until you no longer have a balance in your HRA. If you wish to discontinue this feature, you can do so by logging on to **www.myuhc.com**.

CONTRIBUTIONS TO JENNA'S HRA OR HSA

If Jenna enrolls in the HDHP or PPO, by completing the wellness requirements she can earn up to $550 as a contribution to her HRA.

If Jenna enrolls in the CDHP, PFG will automatically contribute $500 to her HSA. Plus, by completing the wellness requirements she can earn up to an additional $550 contribution. Jenna can also contribute to her HSA with pre-tax money, up to the IRS limit, which lowers her taxable income.

PREVENTIVE CARE

Every year, Jenna and her son visit their in-network primary care physician for an annual physical.

Good news for Jenna: Under all PFG medical plans, in-network preventive care is covered at 100%! And when she gets her annual physical, she will earn $300 in wellness contributions (see page 10).

OTHER SERVICES

During the year, Jenna sees her doctor when she's sick, has lab work and fills three generic prescriptions. Jenna's son sees his doctor twice when he's sick and Jenna fills four generic prescriptions for him.

For the HDHP or PPO: Primary care physician office visit copays and prescription coinsurance apply (no deductible applies, other than for lab work). Jenna can use the money in her HRA to cover those out-of-pocket expenses.

For the CDHP: Jenna pays for the expenses as they are subject to the deductible. Based on Jenna's and her son's expenses, they would only have to pay a small portion of the deductible. She has the option to use money in her HSA — from PFG contributions and her own tax-free contributions — or she can save that HSA money for future health expenses.

USING HRA/HSA MONEY

If Jenna uses all of the money in her account (HRA or HSA), she must pay her remaining health care expenses out of her own pocket, up to the deductible, as applicable. After she meets the deductible, she pays coinsurance until she meets the out-of-pocket maximum.

For the HDHP or PPO: If she does not use all of the money in her HRA, the balance will carry over to the next year — provided she remains in the same plan or enrolls in another PFG plan that has an HRA.

For the CDHP: If she does not use all of the money in her HSA, the balance will carry over to the next year, and it's her money to keep — even if she retires or otherwise leaves PFG.

MEET JENNA

Jenna is deciding among the medical plan options. She intends to cover herself, plus her son. Besides payroll deductions, she considers the differences shown at left.

MEDICAL AND PRESCRIPTION DRUG PLAN COSTS AND HIGHLIGHTS

COVERAGE LEVEL	HDHP		CDHP
	PRE-TAX WEEKLY COST	PRE-TAX BI-WEEKLY COST	PRE-TAX WEEKLY COST
Associate Only	$18.23	$36.46	$23.63
Associate + Spouse/Domestic Partner	$44.52	$89.05	$53.27
Associate + Child(ren)	$40.73	$81.47	$48.23
Family	$71.84	$143.69	$85.20
FEATURES	**IN-NETWORK**	**OUT-OF-NETWORK[1]**	**IN-NETWORK**
Annual Deductible • Individual • Family (Associate +1 or more)	 $5,000 $10,000	 $10,000 $20,000	 $1,500 $3,000
Annual Out-of-Pocket Maximum *(includes deductible)* • Individual • Family (Associate +1 or more)	 $6,550 $13,100	 $13,100 $26,200	 $6,550 $13,100
Coinsurance *(percentage you pay)*	30%	50%	20%
Preventive Care Services	Plan pays 100%, no deductible	50% after deductible	Plan pays 100%, no deductible
PCP Office Visit	$25 copay	50% after deductible	20% after deductible
Specialist Office Visit	30% after deductible	50% after deductible	20% after deductible
Virtual Visit *(Telemedicine)*	$25 copay	50% after deductible	20% after deductible, up to $49
Hospital Services • Inpatient • Outpatient	 30% after deductible 30% after deductible	 50% after deductible 50% after deductible	 20% after deductible 20% after deductible
Emergency Services • Hospital ER • Ambulance	 30% after deductible 30% after deductible	 50% after deductible *if not emergency* 30% after deductible	 20% after deductible 20% after deductible
Urgent Care Facility *(freestanding)*	30% after deductible	50% after deductible	20% after deductible
Non-Routine Lab/X-rays	30% after deductible	50% after deductible	20% after deductible
Mental Health & Substance Abuse • Inpatient • Outpatient	 30% after deductible $25 copay	 50% after deductible 50% after deductible	 20% after deductible 20% after deductible
Durable Medical Equipment	30% after deductible	50% after deductible	20% after deductible
Prescription Drugs – Retail Pharmacy[2] (30-day supply) • Generic • Brand-name, preferred • Brand-name, non-preferred • Specialty	 $25 max 30% ($50 min/$100 max) 50% ($75 min/$150 max) 50% ($100 min/$150 max)	 Not Covered	 After deductible:[3] 20% ($25 max) 30% ($50 min/$100 max) 50% ($75 min/$150 max) 50% ($100 min/$150 max)
Prescription Drugs – Mail Order[2] (90-day supply or CVS Pharmacy) • Generic • Brand-name, preferred • Brand-name, non-preferred • Specialty	 $50 max 30% ($100 min/$200 max) 50% ($150 min/$300 max) 50% ($200 min/$300 max)	 Not Covered	 After deductible:[3] 20% ($50 max) 30% ($100 min/$200 max) 50% ($150 min/$300 max) 50% ($200 min/$300 max)

1. If you choose out-of-network providers, you'll pay higher deductibles, coinsurance and more out-of-pocket. There is no maximum allowable amount, and you may also pay charges billed over and above the allowable amount. Additionally, you may be required to pay for services up front and submit the insurance claim form for reimbursement. You are also responsible for meeting any pre-authorization requirements.

2. Not covered if you use a non-participating pharmacy.

3. Preventive drugs do not require the deductible to be met prior to paying coinsurance. A list of preventive drugs is available on MyADP > Benefits > Forms & Plan Documents.

CDHP	PPO		OUT-OF-AREA PLAN	
PRE-TAX BI-WEEKLY COST	PRE-TAX WEEKLY COST	PRE-TAX BI-WEEKLY COST	PRE-TAX WEEKLY COST	PRE-TAX BI-WEEKLY COST
$47.26	$46.19	$92.39	$46.19	$92.39
$106.55	$123.49	$246.99	$123.49	$246.99
$96.47	$112.95	$225.90	$112.95	$225.90
$170.40	$196.29	$392.58	$196.29	$392.58
OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	
$3,000 $6,000	$1,250 $2,250	$2,500 $4,500	$1,250 $2,250	
$13,100 $26,200	$6,000 $12,000	$12,000 $24,000	$6,000 $12,000	
50%	20%	50%	20%	
50% after deductible	Plan pays 100%, no deductible	50% after deductible	Plan pays 100%, no deductible	
50% after deductible	$25 copay	50% after deductible	$25 copay	
50% after deductible	$40 copay	50% after deductible	$40 copay	
50% after deductible	$25 copay	50% after deductible	$25 copay	
50% after deductible 50% after deductible	$150 copay per day (5 day max), 20% after deductible 20% after deductible	50% after deductible 50% after deductible	$150 copay per day (5 day max), 20% after deductible 20% after deductible	
50% after deductible *if not emergency* 20% after deductible	$250 copay (waived if admitted), 20% after deductible 20%, no deductible	50% after deductible 50% after deductible	$250 copay (waived if admitted), 20% after deductible 20%, no deductible	
50% after deductible	$40 copay	50% after deductible	$40 copay	
50% after deductible	20% after deductible $100 copay for MRI, MRA, CT & PET Scan	50% after deductible	20% after deductible $100 copay for MRI, MRA, CT & PET Scan	
50% after deductible 50% after deductible	$150 copay per day (5 day max), 20% after deductible $25 copay	50% after deductible 50% after deductible	$150 copay per day (5 day max), 20% after deductible $25 copay	
50% after deductible	20% after deductible	50% after deductible	20% after deductible	
Not Covered	$25 max 30% ($50 min/$100 max) 50% ($75 min/$150 max) 50% ($100 min/$150 max)	Not Covered	$25 max 30% ($50 min/$100 max) 50% ($75 min/$150 max) 50% ($100 min/$150 max)	
Not Covered	$50 max 30% ($100 min/$200 max) 50% ($150 min/$300 max) 50% ($200 min/$300 max)	Not Covered	$50 max 30% ($100 min/$200 max) 50% ($150 min/$300 max) 50% ($200 min/$300 max)	

LIVONGO – DIABETES HEALTH PLAN

Diabetes is a serious health condition and can lead to health problems when it is not well managed. PFG offers a diabetes health plan administered by Livongo to all associates and dependents who have been diagnosed with Type 1 or Type 2 diabetes and are covered under one of PFG's medical plans.

Registration can be completed online at **welcome.livongo.com/PFG** (registration key — PFG) or by calling customer support 1-800-945-4355, which is available 24/7 once you are active on the medical plan.

Participants will receive:

- A connected meter that automatically uploads your blood glucose readings to your secure online account and provides real-time personalized tips.
- Online access to your blood glucose readings, along with graphs and insights through the website and Livongo mobile app.
- Support from coaches when you need it. Communicate with a coach anytime about diabetes questions on nutrition or lifestyle changes via phone, text messages and the Livongo mobile app.
- Unlimited strips and lancets at no cost to you. When you are about to run out, Livongo will ship more supplies right to your door.

In addition, registered participants who use the free Livongo meter will receive a discount on diabetes-related prescriptions and supplies through Caremark/CVS Health, as shown below.

Note: If you and/or a covered family member uses a Continuous Glucose Monitoring System (CGMS), you can continue to use your CGMS and still participate in the Livongo program, as shown below.

IF YOU ARE ENROLLED IN:	DIABETES-RELATED PRESCRIPTIONS AND SUPPLIES WILL BE:	LIVONGO-ISSUED GLUCOMETER, LANCETS AND TESTING STRIPS WILL BE:	CGMS OR GLUCOMETERS NOT ISSUED BY LIVONGO (IN-NETWORK) WILL BE:
HDHP	Paid at 100%	Paid at 100%	Paid at 70% (deductible waived)
CDHP	Paid at 90% (deductible waived)	Paid at 100%	Paid at 80% (deductible waived)
PPO or Out-of-Area Plan	Paid at 100%	Paid at 100%	Paid at 80% (deductible waived)

PRESCRIPTION DRUG COVERAGE

When you enroll in medical coverage, you are automatically enrolled in prescription drug coverage through Caremark/CVS Health. The cost of this coverage is included with your medical premiums.

When choosing your medical plan, consider how you pay for prescriptions.

- If you enroll in the CDHP, the deductible and coinsurance rules apply to non-preventive medications; only coinsurance applies for preventive medications.
- For the HDHP and PPO, only coinsurance applies.

Caremark/CVS Health has a preferred arrangement with many independent pharmacies as well as nationwide chains, including CVS, Rite-Aid, Walgreens, Target and Walmart.

FILLING AND REFILLING PRESCRIPTIONS

You will not receive new prescription ID cards from Caremark/CVS Health unless you are newly electing coverage for 2021.

You have access to both retail and mail-order prescriptions. For prescriptions you need to fill immediately, go to any participating retail pharmacy and present your Caremark/CVS Health ID card. Visit **www.caremark.com** or call Caremark/CVS Health Customer Care at 1-888-790-4260 to find a participating retail pharmacy.

For maintenance drugs (those you take on a long-term basis), you are required to use the Mail Order Program or a local CVS or Target pharmacy. The first time you use mail order, register with Caremark/CVS Health by visiting **www.caremark.com** or by calling 1-888-790-4260. Then complete and return your mail service order form along with your prescription (request a duplicate from your doctor) and payment.

PRESCRIPTION PROGRAMS TO HELP KEEP YOUR COSTS DOWN

PFG is continuously looking for ways to get the most from our benefit dollars and help you save money.

RX SAVINGS SOLUTIONS – LOWER YOUR PRESCRIPTION COSTS

Rx Savings Solutions is available to help you and your dependents enrolled in a PFG medical plan lower your prescription costs. The online tool can help you with:

- **Selection** – Discover all the options available to treat your condition and compare them to your current prescription(s);
- **Price** – Know exactly what a medication costs at every pharmacy, if your plan covers it, and the impact on your deductible; and
- **Convenience** – Never miss a savings opportunity, even in the doctor's office, and request a lower-cost prescription in just a few clicks.

Rx Savings Solutions will automatically notify you by text, email or mail when there is a prescription savings opportunity, such as the availability of a generic or a lower-cost medication that treats the same condition. At your direction, Rx Savings Solutions will even contact your provider for you and ask your provider to call your new prescription into the pharmacy of your choice.

Sign Up for Rx Savings Solutions to Earn $50 in Wellness Contributions!

Sign up on or after January 1, 2021 to get $50 in wellness contributions! To create an account, visit **www.rxsavingssolutions.com**, download their mobile app or call 1-800-268-4476.

Note: If you previously registered for Rx Savings Solutions, you are not eligible; only new registrants will receive a wellness contribution.

STEP THERAPY

The Step Therapy Program covers specified classes of drugs and is designed to help provide the most cost-effective prescription drugs for your needs.

1. **Generic drug.** The first step requires you to use a generic equivalent of a drug that is commonly prescribed for your condition, when a suitable generic is available. Generic drugs will cost the least.
2. **Brand-name preferred drug.** If a generic equivalent is not available or suitable (for example, if you've tried the generic medication without success or if your doctor has deemed it unsuitable for treating you because of allergic reaction or possible drug interaction), the next step uses a brand-name preferred drug. Your doctor may need pre-authorization to use a brand-name drug (call 1-877-203-0003 for more information). Brand-name drugs will cost you more.
3. **Brand-name, non-preferred drug or specialty drug.** If no suitable generic or brand-name preferred drugs can be found under the first two steps, the last step is a brand-name, non-preferred drug or specialty drug. Brand-name, non-preferred and specialty drugs will cost you the most.

For certain exceptions to the Step Therapy Program, your physician may request prior authorization for the use of a brand-name drug by calling 1-877-203-0003.

DENTAL

Dental care contributes to your health and well-being. The dental plan, administered through Delta Dental of Virginia, encourages preventive dental care and provides coverage for a wide variety of dental services. The following chart highlights the dental plan features with in-network providers. To find an in-network provider, visit **www.deltadentalva.com**. If you choose an out-of-network provider, benefits may be limited and your out-of-pocket costs may be higher.

DENTAL PLAN COSTS AND HIGHLIGHTS

COVERAGE LEVEL	PRE-TAX WEEKLY COST	PRE-TAX BI-WEEKLY COST
Associate Only	$5.42	$10.84
Associate + Spouse/Domestic Partner	$10.77	$21.55
Associate + Child(ren)	$13.30	$26.61
Family	$18.47	$36.95

DENTAL PLAN FEATURES	YOUR COSTS IN-NETWORK SERVICES
Calendar Year Deductible (applies to basic and major services) • Individual • Family	 $50 $150
Maximums • Calendar year maximum benefit • Orthodontic lifetime maximum benefit (per eligible child only) • Temporomandibular Joint Disorder (TMJ) lifetime maximum benefit	 $1,500 $2,000 $1,000
Preventive and Diagnostic Services (does not apply toward the annual maximum) Oral exams – two per calendar year Bitewing x-rays – one set per calendar year Full mouth x-rays – one every three calendar years Routine cleaning – every six months/two per calendar year Fluoride treatments – one per calendar year, up to age 19 Space maintainers – up to age 14 Sealants – one application per tooth on unrestored, noncarious permanent molar, up to age 16	No charge, no deductible
Basic Services Composite (tooth colored) and amalgam (silver colored) fillings, resin fillings, simple extractions, general anesthesia, periodontal surgery, scaling and root planing, gingival curettage, root canal therapy, pulpal therapy, pulp capping	20% after deductible
Major Services Crowns, implants, inlays, onlays (when teeth cannot be restored with regular fillings), bridges, partials, dentures, bridge or denture repair, rebase or reline of dentures, re-cementing of crowns	50% after deductible
TMJ Diagnosis and Treatment Diagnosis, occlusal adjustment, orthodontic appliance and orthognathic surgery	50% after deductible
Orthodontia (coverage for children up to age 26 only; $2,000 maximum per eligible child) Complete orthodontic exam, including x-rays, and active orthodontic treatment	50%

CHOOSING A DENTAL PROVIDER

You may use a dental provider in the Delta Dental PPO Network, Delta Dental Premier Network or an out-of-network provider. However, there are some important differences in coverage and how your benefits are processed:

DENTAL PPO OR DELTA DENTAL PREMIER NETWORK PROVIDERS

There are many advantages to using an in-network provider:

- Your costs (and the company's costs) are lower.
- There are no claim forms to file.
- The provider will submit pre-approval for treatment upon your request.
- You pay your deductible and co-insurance, and PFG pays the rest, up to the calendar year maximum benefit.

SAVINGS TIP! You'll generally pay less out of pocket if you use a provider in the Delta Dental PPO Network. However, using a provider in the Delta Dental Premier Network will still cost you less than an out-of-network provider.

You will not receive a dental ID card, unless you are changing coverage levels or enrolling in dental coverage for the first time.

OUT-OF-NETWORK PROVIDERS

Your benefits may be limited, and you must pay the dentist in full when services are received.

You will have to file your own dental claim with Delta Dental, as follows:

By U.S. Mail:
Delta Dental of Virginia
4818 Starkey Rd.
Roanoke, VA 24018

By Fax:
1-540-725-3880

Delta Dental will reimburse you for "allowable charges" only, based on Delta Dental's criteria. If your dentist charges more than Delta Dental's allowable charges, you are responsible to pay the extra amount your dentist charges, plus your coinsurance.

Delta Dental does not require pre-authorization for services. However, some out-of-network providers will submit predetermination forms on your behalf. It is your responsibility to submit this if your provider does not.

VISION

The vision plan, administered by VSP, helps you pay a portion of a wide range of vision expenses. Plus, you can take advantage of exclusive member extras for additional savings.

The following chart highlights the vision plan features with in-network providers. To locate an in-network provider, visit **pfgc.vspforme.com**. For out-of-network plan details, contact VSP at 1-800-877-7195.

When you make an appointment, tell them you have VSP vision coverage. There's no ID card, but if you would like a card as a reference, print one from **pfgc.vspforme.com**.

VISION PLAN COSTS AND HIGHLIGHTS

COVERAGE LEVEL	PRE-TAX WEEKLY COST	PRE-TAX BI-WEEKLY COST
Associate Only	$1.53	$3.06
Associate + Spouse/Domestic Partner	$2.91	$5.81
Associate + Child(ren)	$3.07	$6.13
Family	$4.50	$9.01

VISION PLAN FEATURES	YOUR COSTS FOR IN-NETWORK SERVICES
Eye Exam one every calendar year	Covered 100%
Prescription Glasses You may select either prescription glasses or contact lenses, but not both, during the same coverage period.	
Lenses one pair every calendar year Single vision, bifocal or trifocal	Covered 100%
Lens Enhancements on one pair every calendar year	
• Standard progressive lenses	Covered 100%
• Premium progressive lenses	$95 – $105 copay
• Custom progressive lenses	$150 – $175 copay
Frames one pair every calendar year	Up to a $150 allowance for a wide selection of frames. If your frames exceed the allowance, you will receive a 20% discount on the difference.
Contacts You may select either prescription glasses or contact lenses, but not both, during the same coverage period.	
Contact Lens Fitting & Follow Up	Up to $55 copay
Contact Lenses once every calendar year	Up to $120 allowance

ADDITIONAL SAVINGS FROM IN-NETWORK PROVIDERS

Diabetic Eyecare Plus Program – Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD) are covered 100%.

Glasses and Sunglasses
- Receive an extra $50 allowance for featured frame brands.
- Receive 20% off of additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last eye exam.

Retinal Screening – An enhancement to your eye exam.
- Up to $39 copay.

Laser Vision Correction – From contracted facilities only.
- Receive 15% off the regular price or 5% off the promotional price.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs), administered by UHC, allow you to use pre-tax dollars to pay for certain health care or dependent care out-of-pocket expenses. You save money because you don't pay taxes on the amount that you put into the FSAs.

There are two FSAs — a Health Care FSA (standard or limited purpose) and a Dependent Care FSA. You make pre-tax contributions to your account(s) through payroll deductions throughout the year. Then, use those tax-free dollars to either pay your providers or reimburse yourself for eligible out-of-pocket expenses you incur during the plan year. Keep in mind, you do not have to enroll in a PFG medical plan to have an FSA.

HOW FSAs WORK	HEALTH CARE FSA	DEPENDENT CARE FSA
Estimate Your Expenses: See examples of eligible expenses below.	Consider your medical, prescription, dental and vision expenses not covered by a health plan.	Consider your annual dependent care expenses.
Enroll and Save on Taxes: Contribute pre-tax dollars, up to the IRS limits, to an FSA. Your contributions will be deducted in equal amounts during the year. Once enrolled, you are not allowed to change your election until the next Open Enrollment period, unless you have a qualifying family status change.	Contribute $100 – $2,750 per year.	Contribute $100 up to: • $5,000 if you are single, or married and filing a joint return; or • $2,500 if you are married and filing separately.
Pay Your Eligible Expenses: Use your FSA dollars throughout the year to help pay for certain eligible expenses. See the complete list of eligible expenses on **www.myuhc.com**.	Examples of eligible expenses: • Medical, dental, vision and prescription expenses; • Eye exams, glasses and contacts; • Hearing aids; • Laboratory fees; and • Mental health counseling.	Examples of eligible expenses: • Work-related child or elder care; • Tuition for nursery school and licensed day care centers that provide care while you work; • Day care expenses, including elder care, for the care of disabled dependents while you work; and • Before- and after-school programs while you work.
Get Reimbursed: Get reimbursed for expenses incurred from January 1– December 31.	Eligible expenses are reimbursed up to the full amount of your annual contribution as of January 1.	Request reimbursement for expenses you've incurred, up to the actual balance available in your FSA.
Unused Amounts: Plan carefully. Money cannot be transferred between accounts.	**If you have money left in your Health Care FSA at the end of the calendar year,** up to $550 will automatically carry over to your Health Care FSA for the next calendar year. Any leftover amount greater than $550 will be forfeited after the claims submission deadline. If you do not enroll in a Health Care FSA for the next calendar year, the leftover money will be forfeited after the claims submission deadline.	**If you have money left in your Dependent Care FSA after the claims submission deadline**, it cannot be carried over to the next year, nor can it be returned to you.
Claims Submission Deadline:	The claims submission deadline is the earlier of 90 days after your coverage ends or March 31, 2022.	

LIMITED PURPOSE HEALTH CARE FSA

If you enroll in the CDHP, the standard Health Care FSA is not available to you. However, you are eligible for a Limited Purpose Health Care FSA which has the same rules as the standard Health Care FSA, except it can only be used to cover eligible out-of-pocket **dental and vision expenses.** You may contribute $100–$2,750 per year.

UNITEDHEALTHCARE DEBIT CARDS

If you newly enroll in an FSA for 2021, you will receive a new debit card for convenient access to the money in your FSA.

Visit **www.myuhc.com** to access your account information, claims reimbursement options, find eligible expenses and a worksheet to estimate your expenses and cost savings. **TIP! Be sure to keep all receipts and itemized statements so you'll be able to prove, if necessary, that your purchases were for eligible expenses.**

COMPARING SPENDING & SAVINGS ACCOUNTS

For the greatest cost savings, learn the differences between the Health Savings Account (HSA), Limited Purpose Health Care Flexible Spending Account (FSA), Health Care FSA, Dependent Care FSA and Health Reimbursement Account (HRA).

	HSA	LIMITED PURPOSE HEALTH CARE FSA	HEALTH CARE FSA	DEPENDENT CARE FSA	HRA
What is it?	It's a personal bank account to help you save and pay for covered and eligible medical, dental, vision, and prescription expenses on a pre-tax basis.	It's an account to help you pay for covered and eligible dental and vision expenses on a pre-tax basis.	It's an account to help you pay for covered and eligible medical, dental, vision, and prescription expenses on a pre-tax basis.	It's an account to help you pay for eligible day care and elder care services on a pre-tax basis.	It's an account to help you pay for covered and eligible medical and prescription expenses on a pre-tax basis.
Do I have to be enrolled in a certain medical plan?	Yes, you need to enroll in the CDHP.	Yes, you need to enroll in the CDHP.	Yes, you need to enroll in the HDHP, PPO or waive PFG's medical coverage.	No.	Yes, you need to enroll in the HDHP or PPO and have completed the wellness requirements.
Who contributes to the account?	You and PFG.	You.	You.	You.	PFG, but only if you complete the wellness requirements.
Is there a limit on how much I can contribute?	Yes. The IRS sets a limit on how much you can contribute each year. See page 19.				You can't add your own money.
If I don't spend it all this year, can I use it next year?	Yes. The money will stay in your account until you spend it – even if you choose to save it to use during retirement.	Yes, you can carry over up to $550 to use in the following year. Any amounts over $550 will be forfeited.	Yes, you can carry over up to $550 to use in the following year. Any amounts over $550 will be forfeited.	No.	Yes, if you are still enrolled in the HDHP or PPO in 2022.
Can I keep it if I leave PFG?	Yes.	No.	No.	No.	No.
Do I have to pay taxes on it?	No, unless you withdraw money for an ineligible expense.	No.	No.	No.	No.
What expenses are eligible?	Eligible medical, dental, vision, and prescription drug expenses.	Eligible dental and vision expenses.	Eligible medical, dental, vision, and prescription drug expenses.	Eligible day care and elder care expenses.	Eligible medical and prescription drug expenses.
	Refer to **www.myuhc.com** for a complete list of eligible expenses.				
Can I have any other accounts?	Yes, you can have a Limited Purpose Health Care FSA. You can also have a Dependent Care FSA.	Yes, you can have an HSA and a Dependent Care FSA.	Yes, you can have an HRA and a Dependent Care FSA.	Yes, you can have an HSA, a Limited Purpose Health Care FSA or a Health Care FSA, and an HRA.	Yes, you can have a Health Care FSA and a Dependent Care FSA.

LIFE AND ACCIDENT INSURANCE

Life and accident insurance coverage is available to offer you and your family financial protection if you suffer a loss.

BASIC LIFE AND BASIC ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

PFG automatically provides company-paid Basic Life and Accidental Death & Dismemberment (AD&D) Insurance to all associates who work at least 30 hours per week.

- In the event of your death, Basic Life Insurance would pay your beneficiary an amount equal to one times your annual basic earnings, up to $1 million.
- In the event of your accidental death, Basic AD&D Insurance would pay your beneficiary an additional benefit equal to one times your annual basic earnings, up to $1 million of Basic Life and AD&D Insurance combined.

If you lose a limb or suffer other permanent disability as the result of an accident, you may be eligible for other benefit payments under Basic AD&D Insurance, determined by the extent of the injury.

SUPPLEMENTAL TERM LIFE INSURANCE

Supplemental Term Life Insurance is available in increments from one to six times your annual basic earnings. When combined with your Basic Life and AD&D Insurance coverage, you may elect Supplemental Term Life Insurance up to a maximum of seven times your annual basic earnings. The combined coverage total cannot exceed $1.5 million.

Evidence of Insurability (EOI) will be required if you previously waived coverage or if you're applying for coverage exceeding certain limits. See page 22 for more information.

YOUR MONTHLY COST PER $1,000 OF COVERAGE		
YOUR AGE ON DEC. 31, 2020	**NON-NICOTINE USER***	**NICOTINE USER***
Under 25 years old	$0.05	$0.07
25 – 29 years old	$0.06	$0.07
30 – 34 years old	$0.08	$0.08
35 – 39 years old	$0.09	$0.09
40 – 44 years old	$0.10	$0.12
45 – 49 years old	$0.15	$0.19
50 – 54 years old	$0.35	$0.38
55 – 59 years old	$0.54	$0.60
60 – 64 years old	$0.86	$0.92
65 – 69 years old	$1.32	$1.44
70 years old and above	$2.06	$2.06

**You are considered a nicotine user if you have used any nicotine products in the last 12 months.*

KEEP YOUR BENEFICIARY UP-TO-DATE IN MYADP

In the event of your death, any Life and/or AD&D Insurance proceeds will be paid according to your most recent beneficiary designation. You may name primary and contingent (secondary) beneficiaries.

For Supplemental Dependent Term Life and/or Supplemental AD&D Insurance on your dependents, you are automatically the beneficiary.

SUPPLEMENTAL DEPENDENT TERM LIFE INSURANCE

Supplemental Dependent Term Life Insurance is available for your spouse/domestic partner and your children by birth, marriage, adoption or domestic partnership. Evidence of Insurability (EOI) will be required to add spouse/domestic partner coverage if it was previously waived or if you are increasing the coverage level by more than one level. The following chart shows the coverage options and costs.

COVERAGE LEVEL	POST-TAX WEEKLY COST	POST-TAX BI-WEEKLY COST
Spouse – $10,000*	$0.37	$0.74
Spouse – $25,000*	$0.93	$1.86
Spouse – $50,000*	$1.86	$3.72
Child(ren) – $5,000 per child	$0.09	$0.18
Child(ren) – $12,500 per child	$0.22	$0.45
Child(ren) – $25,000 per child	$0.45	$0.90

**The spouse coverage level cannot exceed 100% of your Supplemental Life Insurance coverage.*

SUPPLEMENTAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Supplemental Accidental Death & Dismemberment (AD&D) Insurance is available for you, your spouse/domestic partner and your children by birth, marriage, adoption or domestic partnership. The following chart shows the coverage options and costs.

COVERAGE LEVEL	MONTHLY RATE PER $1,000 OF COVERAGE
You – one to six times your annual basic earnings	$0.03
Spouse – $10,000, $25,000 or $50,000	$0.03
Child(ren) – $5,000, $12,500 or $25,000 per child	$0.02

REQUIREMENTS FOR EVIDENCE OF INSURABILITY

Evidence of Insurability (EOI) is required for Supplemental Term Life or Dependent Term Life Insurance if:

- You are newly eligible and you are applying for Supplemental Term Life coverage exceeding two times your annual basic earnings or $500,000, whichever is less.
- You are applying to increase your current Supplemental Term Life coverage by more than one times your annual basic earnings or to a level exceeding $500,000.
- You are applying to increase your spouse's coverage from $10,000 to $50,000.

EOI is not required to add or increase coverage for your dependent children. EOI forms will be mailed to your home address by The Hartford.

DISABILITY INSURANCE

If you are unable to work due to an illness or injury, disability coverage can replace a portion of your income. PFG associates who work at least 30 hours per week automatically receive company-paid Basic Short-Term Disability (STD) and Basic Long-Term Disability (LTD) coverage, after a six-month waiting period. You may purchase Supplemental LTD to increase your potential income replacement benefit.

BASIC SHORT-TERM DISABILITY

If you become disabled, you may be eligible for Short-Term Disability (STD) benefits after a waiting period of seven consecutive calendar days. STD benefits are based on a percentage of your weekly basic earnings and can continue for up to 26 weeks (including the waiting period).

Your STD income benefit will be based on your years of service with PFG, as follows:

- If you have between six months and two years of service, your STD benefit is 50% of your weekly basic earnings, up to $1,500 per week.
- If you have two or more years of service, your STD benefit is 60% of your weekly basic earnings, up to $1,500 per week.
- If you become disabled for a pregnancy-related disability, your STD benefit is 100% of your weekly basic earnings for up to six weeks from your first day out.

BASIC LONG-TERM DISABILITY

If you remain disabled after 26 weeks, you may be eligible for continued benefits under Basic Long-Term Disability (LTD). Basic LTD provides up to 50% of your basic monthly earnings, up to $10,000 per month. The benefit amount you are eligible to receive is reduced by any disability benefits you receive from other sources such as Social Security or Workers' Compensation.

SUPPLEMENTAL LONG-TERM DISABILITY

Supplemental Long-Term Disability (LTD) works with Basic LTD. Supplemental LTD increases your potential benefit from 50% to 66⅔% of your monthly basic earnings. The maximum combined LTD benefit is $10,000 per month, minus any disability income you receive from other sources, such as Workers' Compensation or Social Security.

If you do not elect Supplemental LTD when you are first eligible, Evidence of Insurability (EOI) will be required and must be approved before you can be enrolled in this coverage. Your monthly cost for Supplemental LTD is $0.36 per $100 of monthly basic earnings.

OTHER VOLUNTARY BENEFITS

The following Voluntary Benefits are available:

- **Critical Care Insurance** offers additional protection for critical illness such as cancer, heart attack, stroke or other specified illnesses.
- **Life Plan** offers additional whole life insurance protection, which lasts for your entire lifetime (provided you pay the premiums) and can build a cash value over time.
- **Accident Plan** covers out-of-pocket medical expenses associated with treating accidental injury.
- **Group Auto & Home Insurance** offers special group rates to PFG associates with the convenience of payroll deduction.
- **Individual Long-Term Care Insurance** pays a monthly allowance for long-term care in a nursing home, assisted living facility or at home.
- **Identity Theft Protection** offers credit monitoring and fraud restoration through the ID TheftSmart program.
- **Legal Plan** provides access to legal advice from trusted law firms.
- **Pet Insurance** covers veterinary expenses.
- **Computer Purchase Program** offers the convenience of payroll deductions when purchasing a computer.

Voluntary Benefits are not directly sponsored by PFG, but your premiums can be deducted from your paycheck if you enroll. Learn more and get instant rate quotes by calling Enrollment Resources Group (ERG) at 1-866-747-8679 or by visiting **www.voluntarybenefitsatpfg.com**.

EMPLOYEE ASSISTANCE PROGRAM

PFG's Employee Assistance Program (EAP) can help you effectively navigate life's ups and downs. Free and confidential assistance is available 24/7 by calling Optum at 1-866-248-4094, or you can access a variety of online and interactive resources by logging on to **www.liveandworkwell.com**.

The program is designed to help you and your eligible dependents cope with a variety of issues, such as:

- A personal or family crisis;
- Financial or legal issues;
- Stress management; or
- Help finding resources to deal with substance abuse and recovery.

When needed, the EAP will connect you with licensed professionals who provide counseling services and referrals. **You and your eligible dependents may each receive up to five face-to-face counseling sessions with an Optum provider.**

Your personal records are never shared with PFG, or anyone else, without your permission — it's completely confidential.

CONTACTS

BENEFIT	VENDOR	WEBSITE	PHONE NUMBER
General Benefit Questions	Benefits Center	MyADP at **my.adp.com > Benefits**	1-888-MYHWBEN, option 1 (1-888-694-9236) Monday – Friday, 10 a.m. – 8 p.m. ET, Saturday, 8 a.m. – 5 p.m. ET
Healthy Together		**www.pfghealthytogether.com** Passcode: pfghealthy	
Verification of Dependents and Qualified Changes in Status	Dependent Verification Services (DVS)	MyADP at **my.adp.com > Benefits > View Verification Status**	1-800-847-8531 1-866-400-1686 (fax)
Medical, Flexible Spending Accounts (FSAs) and Health Reimbursement Accounts (HRAs)	UnitedHealthcare Group Number: 742781 (medical only)	**www.myuhc.com**	1-877-769-7001
Prescription Drugs	Caremark/CVS Health Group Number: PFGRX	**www.caremark.com**	1-888-790-4260
Prescription Drug Savings Program	Rx Savings Solutions	**www.rxsavingssolutions.com**	1-800-268-4476
Dental	Delta Dental Group Number: 700065	**www.deltadentalva.com**	1-800-237-6060
Vision	VSP Group Number: 30092545	**pfgc.vspforme.com**	1-800-877-7195
Employee Assistance Program (EAP)	Optum	**www.liveandworkwell.com** Access Code: PFG	1-866-248-4094
Health Savings Account (HSA)	Optum Financial Services (Optum)	**www.myuhc.com**	1-800-791-9361
Disability	Contact your supervisor first, then Sedgwick	**www.claimlookup.com/pfg**	1-888-694-9236, option 2
401(k)	Fidelity	**www.401k.com**	1-888-694-9236, option 3
Wellness Programs • Quest Diagnostics (biometric screening)		**my.questforhealth.com** (Registration Key: PFG2021)	1-855-623-9355
• Quit for Life® Tobacco Cessation Program		More information on these programs can be found on **www.myuhc.com**.	1-866-QUIT-4-LIFE (1-866-784-8454)
• Wellness Coaching			1-800-478-1057
• Healthy Pregnancy			1-800-411-7984
• Real Appeal (weight loss)		**pfg.realappeal.com**	
• Livingo		**welcome.livongo.com/pfg**	1-800-945-4355
Voluntary Benefits	Enrollment Resources Group (ERG)	**www.voluntarybenefitsatpfg.com**	1-866-747-8679

Medical (UHC Medical Group #: 742781) **AND Flexible Spending and Health Reimbursement Accounts (FSA/HRA)**
UnitedHealthcare
1-877-769-7001 • www.myuhc.com

Wellness Programs
Quit for Life: 1-866-784-8454
Wellness Coaching: 1-800-478-1057
Healthy Pregnancy: 1-800-411-7984
Real Appeal (weight loss): pfg.realappeal.com
Livongo: 1-800-945-4355

Prescriptions
Caremark/CVS Health
Group #: PFGRX • 1-888-790-4260
www.caremark.com

Prescription Savings Program
Rx Savings Solutions
1-800-268-4476
www.rxsavingssolutions.com

Health Savings Account (HSA)
Optum Financial Services
1-800-791-9361
www.myuhc.com

Employee Assistance Program (EAP)
Optum • 1-866-248-4094
www.liveandworkwell.com
Access Code: PFG

Dental Plan
Delta Dental • Group #: 700065
1-800-237-6060
www.deltadentalva.com

Vision Plan
VSP • Group #: 30092545
1-800-877-7195
pfgc.vspforme.com

401(k)
Fidelity
1-888-694-9236, option 3
www.401k.com

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www.claimlookup.com/pfg

Voluntary Benefits
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www.voluntarybenefitsatpfg.com

Here is your wallet card – a quick reference to your PFG benefits contacts.

PFG Performance Food Group

12500 West Creek Parkway
Richmond, VA 23238

This brochure is intended as an overview of the benefits offered under the Performance Food Group, Inc. Employee Benefit Plan. Information presented here does not include a comprehensive list of definitions, exclusions, limitations, and other policy provisions that are contained in the official, legal plan documents. Therefore, this brochure does not replace the legal plan documents, and in case of conflict, the legal plan documents will determine your actual benefits.