# Your 2018 PFG Benefits

PFG Performance Food Group

HEALTHY TOGETHER

## What's Inside


Welcome to PFG! ..... 1
Benefits Eligibility ..... 2
Qualifying Family Status Change Events ..... 3
Enrolling Online ..... 3
Our Approach to Health Care ..... 4
Medical Plans ..... 5
Health Savings Account ..... 8
Diabetes Health Plan ..... 9
Prescription Drug Coverage ..... 10
Wellness Credits ..... 11
Medical and Prescription Plan Highlights ..... 12
Medical Plan Usage Comparisons ..... 14
Decision Support Tool ..... 15
Dental Coverage ..... 16
Vision Coverage. ..... 18
Health Care Flexible Spending Account (FSA) ..... 19
Dependent Care Flexible Spending Account (FSA) ..... 20
Employee Assistance Program ..... 20
Life and Accident Benefits ..... 21
Disability Benefits ..... 23
Other Voluntary Benefits ..... 23
Contact Information ..... 24
Choose to Receive Future Benefits Information Electronically ..... 25


# Healthy Together in 2018!

As an associate at PFG, you have many benefit choices. This guide provides a summary of your choices and the tools available to help you:

- Learn about your benefits
- Take an active role and make smart choices about using your health care, and
- Enroll in your 2018 benefits.

**If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see your Legal Notices booklet for more details.**

## *PFG Keeps You Covered*

Detach this wallet card and keep it with you for important benefits contact information. You will not receive a Vision ID card, so please use the Group ID number listed on this card when you visit your provider.

# Welcome to PFG!

We are pleased to offer you a comprehensive and flexible benefits package designed to meet a wide variety of personal needs. At PFG, we take pride in ensuring that our benefits package is competitive within the industry while providing choice and value for you and your family. This is your opportunity to enroll in the PFG Benefits Plan for 2018.

**All associates must enroll in order to receive 2018 benefits.** If you don't enroll, the only coverage you will have for the remainder of the 2018 plan year is the company-provided coverage, which includes the Employee Assistance Program, Basic Life and Accidental Death and Dismemberment (AD&D), Short-Term Disability, and Basic Long-Term Disability. Refer to page 3 to learn more about how to enroll in your benefits.

You must enroll by the deadline shown in the Important Enrollment Deadlines chart below. If you miss the enrollment deadline, you will not be able to enroll until the next annual Open Enrollment period (unless you have a qualified change in family status; refer to page 3 for more information). Open Enrollment is typically held in November, with changes in coverage effective the following January 1.

In addition to our health and welfare programs, we are pleased to offer a Wellness Program that provides the opportunity to earn cost savings on your medical premiums in the form of Wellness Credits. By participating in our Wellness Program, you can earn up to $600 in annual credits. Refer to page 11 to learn more.

If you are **adding dependents to coverage**, you must add them as dependents first, then add them to your coverage for the applicable benefit. Whether you enroll for coverage as a new hire or make changes due to a subsequent change in family status event, you will receive a letter from PFG Dependent Verification Services requesting the required documentation for both the event (if due to a change in status) and the eligibility of your dependents, as applicable. 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.

While making your elections, we encourage you to take time to designate your beneficiary(ies). You can do this through **ADP Self Service**. Click on Benefits, Health & Welfare, and then Manage Beneficiary Information.

**If you have questions about this enrollment guide or your PFG benefits, please contact the Benefits Center at 1-888-MYHWBEN (1-888-694-9236) Monday – Friday between 10 am – 8 pm ET, and Saturday between 8 am – 5 pm ET.**

Additional information on the full menu of PFG Benefits is available on the following pages of this guide. When you are ready to make your 2018 elections, please go online to ADP Self Service at **https://portal.adp.com** (Benefits tab, then Health & Welfare) or call the Benefits Service Center at 1-888-MYHWBEN (1-888-694-9236), and make your elections for 2018 no later than the deadlines listed below.

## *Important Enrollment Deadlines*

| If your hire date is: | Coverage for most PFG benefits will be effective* | You must enroll by: |
|---|---|---|
| 10/04 – 11/03/2017 | 01/01/2018 | 12/31/2017 |
| 11/04 – 12/04/2017 | 02/01/2018 | 01/31/2018 |
| 12/05/2017 – 01/01/2018 | 03/01/2018 | 02/28/2018 |
| 01/02 - 02/01/2018 | 04/01/2018 | 03/31/2018 |
| 02/02 - 03/03/2018 | 05/01/2018 | 04/30/2018 |
| 03/04 - 04/03/2018 | 06/01/2018 | 05/31/2018 |
| 04/04 - 05/03/2018 | 07/01/2018 | 06/30/2018 |
| 05/04 - 06/03/2018 | 08/01/2018 | 07/31/2018 |
| 06/04 - 07/04/2018 | 09/01/2018 | 08/31/2018 |
| 07/05 - 08/03/2018 | 10/01/2018 | 09/30/2018 |
| 08/04 - 09/03/2018 | 11/01/2018 | 10/31/2018 |
| 09/04 - 10/03/2018 | 12/01/2018 | 11/30/2018 |

*Coverage for Supplemental Term Life Insurance in excess of certain amounts will become effective upon approval of your Evidence of Insurability by the insurance company. Disability coverage will become effective first of the month coinciding with or following six (6) months continuous full-time employment.

### *Spousal Surcharge*

An annual spousal surcharge of $550 (prorated over each per-pay-period) will be added to your 2018 medical premiums if:

- Your spouse or domestic partner has medical coverage available through his/her employer, *and*
- Your spouse or domestic partner waives coverage through that employer, *and*
- You elect to cover your spouse or domestic partner under one of PFG's medical plans.

You will need to certify whether your spouse or domestic partner has other employer-sponsored medical coverage available. The above **does not** apply if your spouse or domestic partner is also a PFG associate or if they are covered under Medicare or another employer's medical plan.

# Benefits Eligibility

If you are a regular, full-time associate working at least 30 hours per week, you are eligible to enroll in the PFG Benefits Program. You may also enroll your eligible dependents in plans offering dependent coverage. The definition of eligible dependents for PFG benefit plans is explained below.

If a plan offers a spouse coverage option, 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 civil union partners.

If a plan offers a child(ren) coverage option, 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 s/he would otherwise become ineligible for coverage as your dependent.

Anytime you enroll or change your medical, dental or vision benefits, you will be required to provide supporting documentation when requested. The date that you make the change effective 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 coverage may still be subject to both federal and state taxation (known as imputed income). This is applicable to medical, dental and vision.

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

For more information, visit **https://portal.adp.com** on the Benefits tab, then Health & Welfare, and click on the link to the Document Library. You may also call the Benefits Center at 1-888-MYHWBEN (1-888-694-9236).

# Qualifying Family Status Change Events

If you experience a qualifying family status change event in 2018, you may be eligible to change elections consistent with the qualifying event, provided you do so by contacting 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 and when the change in coverage takes effect. Qualifying family status change events may occur when:

- 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/domestic partner, 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 less than 30 hours per week and elect coverage under another qualifying plan which is effective no later than the first day of the 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.

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

# Enrolling Online

**If you're registering for the first time:**

1. Go to: **https://portal.adp.com** and under Need an Account, click on Sign Up.
2. **Enter** the *Registration Pass Code* PFGC-1234.
3. **Click** on *Yes* when asked, "Do you want to setup an account with Performance Food Group?"
4. **Fill out** the required information. You will need to enter your legal first and last name (nicknames are not accepted), Social Security Number and the month and day of your birthdate.
5. **Verify** your information and click on *Register Now*.
6. **Enter** your *Contact Information*. You must have a valid e-mail address to register.
7. **Enter** your *Security Information*. Create a password that is at least eight characters long with at least one letter and one number. You will receive an e-mail confirmation of your registration, along with your user ID that you will use to log into the Employee Self Service Portal. Then, follow the instructions in the next column.

**Once you're registered, log on to the ADP Self Service website:**

1. **Go to https://portal.adp.com**
2. **Click** *User Sign In*
3. **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)
4. When the PFG ADP Self Service Home Page appears, **go to** the *Benefits* tab, then *Health & Welfare*
5. **Click** *Enroll Today!* and follow the instructions
6. **Check** your enrollment summary under the *Benefits Overview* section
7. **Click** *Confirm Elections* to save your elections

**Not Online?**

If you are not able to enroll online, you can call and speak with a live representative at 1-888-MYHWBEN (1-888-694-9236) between 10 am – 8 pm ET, Monday – Friday and 8 am – 5 pm ET, Saturday.

### *Using Network Providers = Cost Savings*

With the HDHP, CDHP, and PPO Plans, you'll pay lower deductibles, coinsurance, copayments, and less out-of-pocket when you use In-Network providers. Choice Plus is the UHC network for all medical plans.

In-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, known as the "maximum allowable amount."

You'll pay higher deductibles, coinsurance, and more out-of-pocket if you use Out-of-Network providers. Since there is no maximum allowable amount with an Out-of-Network provider, you may also end up paying charges billed over and above the allowable amount. You may also be required to pay up front and submit the insurance claim yourself for reimbursement. Finally, you are responsible for meeting any pre-authorization requirements.

***Tip: Look for the UnitedHealthcare Premium Tier 1 designation. These providers may save you even more as they have been recognized for quality and cost efficiency.***

**How to Find an In-Network Provider:**

Log on to **www.myuhc.com** and select *Find a Physician, Laboratory, or Facility* or call 1-877-769-7001.

# Our Approach to Health Care

Meeting the health care needs of our associates, while carrying out our company's healthy initiatives, remains our top priority as we continue to face the challenges of rising health care costs and compliance with regulations, particularly the Patient Protection and Affordable Care Act (PPACA). Keeping these realities in mind, we actively manage our plans and continuously look for new ways to maintain quality and affordability so that we can all be *Healthy Together*.

PFG is self-funded for medical, which means that PFG, not the insurance company, pays for medical claims. Self-funding our medical plans allows us to directly manage administrative costs, which in turn allows a bigger share of premium contributions to go towards the actual cost of providing health care for you and your family. Another way we help our medical plans stay affordable is by encouraging spouses/domestic partners to take advantage of medical coverage that is available to them through employment or other sources.

For 2018, we're offering associates a choice between three plans (plus an "out-of-area" alternative for those outside of the Choice Plus network for the PPO), which are all administered by UnitedHealthcare (UHC):

- **UHC HDHP with Unfunded HSA**
- **UHC CDHP with PFG Funded HSA**
- **UHC PPO (or UHC Out-of-Area Plan for associates residing outside PPO service areas)**

As you'll see on the following pages, the difference between these plans is in their cost-sharing structure. In short, that can be summarized by what you and PFG pay for premiums, plus *what* and *how* the plan pays when you receive services.

Our goal is for you to have the coverage that best suits you and your family's needs for 2018, while enabling both you and PFG to stretch each dollar spent on health care to its full potential. By keeping you informed about your health options (with their associated benefits, providers, costs, and other requirements) *plus* additional opportunities for cost savings such as FSAs and the Wellness Program, we hope that goal is met.

It is to your advantage to carefully evaluate your options and costs. To help you make the best choices and leverage money you spend on medical and prescriptions, please check out the Decision Support Tool (see page 15) and also consider cost savings strategies such as FSAs or the HDHP or CDHP with an HSA.

# Medical Plans

You may choose from the following medical plan options for 2018:

- **UHC High Deductible Health Plan (HDHP) with Unfunded HSA**
- **UHC Consumer Driven Health Plan (CDHP) with PFG Funded HSA**
- **UHC Preferred Provider Option (PPO)***
- **UHC Out-of-Area Plan ****

* Log on to **www.myuhc.com** and select *Find a Physician, Laboratory, or Facility,* then enter your home zip code. If your zip code is not serviced by the UHC Choice Plus Provider Network, you will only be able to enroll in the Out-of-Area Plan, the CDHP or the HDHP.

**Offered only to those associates who live in a geographical area that is not serviced by UHC Choice Plus network providers.

All of PFG's medical plans are designed to cover the same services. The main difference between them is their cost sharing structure. Cost sharing refers to what you pay (including your payroll deductions), what PFG pays to provide coverage, and what the medical plan pays when you receive services. Your total out-of-pocket costs may vary according to the plan's cost sharing structure and the providers you select.

**Cost sharing components**

- **Premium cost:** this refers to the pre-tax deductions taken from your paychecks, as well as the portion of premiums that PFG pays to provide coverage.
- **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 satisfied your deductible; usually expressed as a percentage of the cost (e.g., you pay 30% and the medical plan covers the rest).
- **Copayment:** a pre-determined dollar amount paid to your provider when you receive services under the PPO plan (e.g., $25 per office visit to a primary care physician).
- **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 a "safety net" protecting you against catastrophic costs that you might incur in the event of a serious illness or injury. The amounts you have paid in deductibles, coinsurance, and copayments all count towards satisfying this limit.
- **Preventive care:** includes routine annual physical exams and screenings, well-child care, and age-appropriate immunizations that are covered 100% by the plan and do not require you to meet a deductible or pay a copayment or coinsurance.

Insurance coverage is all about risk management. That's true whether you are insuring belongings such as your home or automobile, or something of even greater value—your life, health, and financial well-being. Having coverage won't protect you from things going wrong, but it can help protect against financial losses that might result if/when you or your loved ones experience accidents, illness, disability, or death.

Most medical plans are developed under the assumption that you will share some portion of the cost, then the plan will cover the rest. If you are willing to assume a greater share of the cost, along with the associated risks, the cost of coverage is proportionately less.

All of the PFG medical plans have deductibles, otherwise known as the amount you pay up front for the medical expenses. The PPO plan also includes copayments that make the cost of the coverage more predictable and manageable.

Medical and prescription costs have escalated at an alarming rate in recent years, and plans with deductibles have become the most popular. This causes consumers to experience the real cost of health care services up front, and potentially consider other options when receiving care. However, since all medical plans now cover certain preventive services at 100% without having to meet the deductible, consumers can take a more proactive approach to managing their health through prevention and early detection.

All of our medical plans cover the same services. The Decision Support Tool (see page 15) helps you determine what cost-sharing arrangement for receiving those services is the best for you. If we all choose the most appropriate place for the type of care we need, we control both our own out-of-pocket costs and keep premiums lower for everyone in the future. An example is applying home treatment and waiting to be checked out by a primary care physician during office hours or using a telemedicine provider instead of going to an urgent care center. If it is a condition that cannot wait, you may want to go to the nearest urgent care center instead of the emergency room over the weekend (if the condition is not serious or life-threatening), as that could save you thousands of dollars. Shopping around for lower cost prescription drugs, using generics, or even opting for over-the-counter alternatives, when appropriate, can save you hundreds of dollars in your medical spending.

## *UHC High Deductible Health Plan (HDHP) with Unfunded HSA*

This plan is designed to offer associates a minimal safety net against high, unanticipated medical costs. Of the three plan options PFG offers, this plan has the highest annual deductibles ($3,000 per individual; $6,000 if covering one or more dependents). As a trade-off, it has the lowest per-pay-period payroll deductions. When weighing affordability, you'll want to factor in more than the deductible and per-pay-period costs.

Under this medical plan, you are responsible to pay for most health care services until your annual deductible is met, then the coinsurance rate applies. With coinsurance, you share a percentage of the cost with the plan until your annual out-of-pocket limit is reached; then the plan pays 100% of additional medical costs incurred within the same year. The covered expenses you pay under both the medical and prescription benefits count towards the deductible and out-of-pocket maximum. Plus, the deductible is included in the out-of-pocket maximum.

The deductible and out-of-pocket maximum work differently based on coverage level. If any covered member or more than one member of the family incur services, the family deductible must be met. Conversely, if any covered member of the family reaches the individual maximum out-of-pocket, you will not have to pay anything further for covered expenses for the remainder of the 2018 calendar year for that covered member.

Certain routine preventive services, such as annual physical exams and immunizations, are covered 100% without meeting the deductible or paying coinsurance. If you are used to paying a copayment for services such as office visits and prescription drugs under other plans, please be aware that those services will be subject to the deductible and coinsurance under the HDHP.

Preventive medications are subject to coinsurance, but you do not have to meet the deductible first. Check Caremark's website (**www.caremark.com**) for a list of preventive medications to confirm if your prescriptions are considered preventive or not.

This plan might be your best value if you typically have low medical costs and you are willing to assume the higher risk of paying the high deductible (and possibly your out-of-pocket maximum) in the event that you have unexpected medical expenses. Before selecting this plan, you'll want to consider not only your costs, but also those of family dependents (if applicable), plus medical coverage that might be available through a spouse's employment, Medicare/Medicaid, CHIP, etc.

Under this plan, you are eligible to make contributions to a Health Savings Account (HSA), but PFG will not be making a contribution on your behalf.

### *Summary of Benefits and Coverage (SBC)*

Summaries of Benefits and Coverage (SBCs) provided by UnitedHealthcare are available at **www.pfghealthytogether.com** (passcode: pfghealthy) to help you:

- Compare health coverage options before you enroll.
- Understand your coverage once you enroll.

A free paper copy is available by calling UHC at 1-877-769-7001.

## *Consumer Driven Health Plan (CDHP) with Funded HSA*

A CDHP encourages consumers to carefully consider quality of care, cost, and other factors as they choose health care providers and services to address health care needs. Our CDHP, administered by UnitedHealthcare (UHC), has a lower per-pay-period premium deduction than the PPO plans. While the trade-off is a higher deductible and out-of-pocket maximum, PFG will fund a Health Savings Account (HSA) for you and you may be able to add funds with your premium savings to help cover your deductible and other out-of-pocket costs. This may save you money in the long run.

Under this medical plan, you are responsible to pay for most health care services until your annual deductible is met, then the coinsurance rate applies. With coinsurance, you share a percentage of the cost with the plan until your annual out-of-pocket limit is reached, then the plan pays 100% of additional medical costs incurred within the same year. The covered expenses you pay under both the medical and prescription benefits count towards the deductible and out-of-pocket maximum. Plus, the deductible is included in the out-of-pocket maximum.

The deductible and out-of-pocket maximum work differently based on coverage level. If any covered member or more than one member of the family incur services, the family deductible must be met. Conversely, if any covered member of the family reaches the individual maximum out-of-pocket, you will not have to pay anything further for covered expenses for the remainder of the 2018 calendar year for that covered member.

Certain routine preventive services, such as annual physical exams and immunizations, are covered at 100% without meeting the deductible or paying coinsurance. If you are used to paying a copayment for services such as office visits and prescription drugs under other plans, please be aware that those services will be subject to the deductible and coinsurance under the CDHP. Preventive medications are subject to coinsurance, but you do not have to meet the deductible first. Check Caremark's website (**www.caremark.com**) for a list of preventive medications to confirm if your prescriptions are considered preventive or not.

Depending on your utilization and needs, the CDHP's cost structure could save you money in the long run. To compare the CDHP's benefits and costs with the HDHP and PPO Plans, please see the charts on pages 12–15.

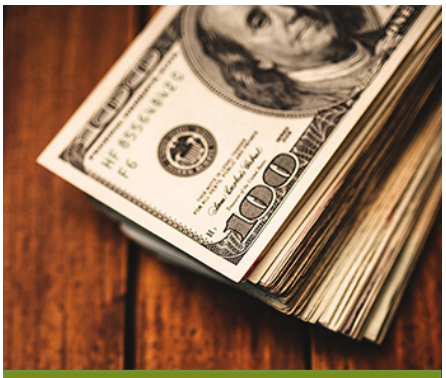
With the HDHP, CDHP as well as the PPO Plans, your deductibles, coinsurance percentages, and out-of-pocket maximums are lower if you receive services from UHC network providers (for more information on In-Network and Out-of-Network providers, please see page 4).

### *Did You Know?*

Some financial experts say HSAs are a good strategy for long-term financial planning because they have a "triple-tax advantage."

The premiums go in pre-tax, so you don't pay taxes on the money you set aside in your account. You don't pay taxes on any investment earnings or interest while funds are accumulating in your account. Finally, you pay no tax on funds withdrawn from your account if they are used to cover qualifying health care expenses before or after retirement.

HSA funds remaining in your account after age 65 can be used for other purposes besides health care, without paying a tax penalty —although they would be taxed as "ordinary income," similar to withdrawing funds from a tax-advantaged retirement account such as an IRA or 401(k).



While the Patient Protection and Affordable Care Act (PPACA) allows parents to add their adult children (up to age 26) to their health plans, the IRS has not changed its definition of a dependent for health savings accounts. This means you cannot be reimbursed for expenses for your child who is age 24 or older.

## Health Savings Account (HSA)

A Health Savings Account (HSA) is a companion feature to the UHC HDHP and CDHP, and is administered through PayFlex. The HSA is an important key to your cost savings. In order to have an HSA, you must enroll in the HDHP or CDHP. An HSA allows you to contribute pre-tax dollars that can be used to pay certain out-of-pocket health care costs, such as deductibles and coinsurance. You choose how much you wish to contribute (subject to plan limits). If you are enrolled in the UHC CDHP Plan, PFG will also make contributions (pro-rated, on a per pay period basis) to your account: $250 if you have coverage for yourself only, and $500 if you have coverage for yourself and at least one other dependent.

The HSA has some similarities to a Health Care Flexible Spending Account (FSA). They both allow you to set aside pre-tax dollars to cover certain unreimbursed medical, dental and vision expenses. However, the HSA has some big advantages over the health care FSA. These include:

- No use-it-or-lose-it requirement. Your account balance can grow over time to cover future expenses, since any unused funds in your account roll over from year-to-year.
- You may invest part of your account balance using a combination of investment funds, once your account balance is at least $1,000.
- You own the account if you leave PFG.

You are not allowed to use your HSA to cover eligible medical, dental or vision 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 on PayFlex's website (**www.payflex.com**). You can still enroll in a Limited Purpose FSA for dental and vision expenses. See page 19 for more information.

You are eligible to participate in an HSA if you are enrolled in the HDHP or the CDHP unless you are covered under another health plan that is not considered a qualifying High Deductible Health Plan (such as your spouse's plan), *or* if you are covered under a general-purpose health FSA, Medicare, TriCare, *or* if you are eligible to be claimed as a dependent on someone else's tax return.

There are complicated rules associated with an HSA. Please consult your tax advisor to determine if an HSA fits your needs.

## 2018 Annual Health Savings Account Contribution Summary

| Coverage Level | If you are enrolled in the HDHP | | | If you are enrolled in the CDHP | | |
|---|---|---|---|---|---|---|
| | 2018 Contribution Limit | PFG Contribution | Associate's Contribution Maximum | 2018 Contribution Limit | PFG Contribution | Associate's Contribution Maximum |
| Associate Only | $3,450 | $0 | $3,450 | $3,450 | $250* | $3,200 |
| Associate + Spouse<br>Associate + Children<br>Family | $6,900 | $0 | $6,900 | $6,900 | $500* | $6,400 |
| Catch Up (if turning age 55+ in 2018)** | +$1,000 | N/A | +$1,000 | +$1,000 | N/A | +$1,000 |

* PFG's contributions are pro-rated and paid on a per-pay-period basis for associates enrolled in the CDHP.
**You cannot make contributions, including catch up contributions, if you are enrolled in Medicare.

## *UHC PPO and Out-of-Area Plans*

PPO or "Preferred Provider Organization" plans provide you with the convenience of paying a specified copayment (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. However, the tradeoff for this convenience is a higher per-paycheck premium deduction than the HDHP or CDHP.

For more details about the UHC PPO Plan and the UHC Out-of-Area Plan, please refer to the charts on pages 12–15.

## *Diabetes Health Plan*

UnitedHealthcare's Diabetes Health Plan is designed to help associates and their eligible dependents who are enrolled in one of PFG's medical plans and who have been diagnosed with prediabetes or diabetes. Enrollment is automatic and determined by either the results of your biometric screening or from health claims submitted by health providers. Participation in the Diabetes Health Plan will remain confidential and be reviewed only by professionals within UHC. Information will not be shared with PFG. You have the option to waive participation in the program. If you choose not to participate, you will not be eligible for the savings associated with the program.

By actively participating in the program and performing certain health actions, you will receive the following cost savings:

| If you are enrolled in PFG's: | Your diabetes-related doctor visits, prescriptions and supplies will: |
|---|---|
| HDHP or CDHP | Be paid at 80%<br>(deductible does not need to be met) |
| UHC Choice Plus PPO Plan or<br>the UHC Out-of-Area Plan | Have a $0 copay |

Additional details, including a list of required health actions are located at **www.pfghealthytogether.com** (passcode: pfghealthy).

### *Medical ID Cards*

You will receive Medical ID cards from UHC at your home address. Please present your card when you visit your medical service provider.

With all of PFG's medical plans, you are automatically enrolled in prescription drug coverage through Caremark (CVS Health).

# 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 (see page 12). Your medical plan's design will determine how you pay for prescriptions. For example, if you are enrolled in the PPO Plan or the Out-of-Area Plan, you'll pay a prescription copayment (generic only) or coinsurance at a participating pharmacy. If you are enrolled in the HDHP or CDHP, the deductible and coinsurance rules apply. Caremark 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 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 ID card. Visit **www.caremark.com** or call Caremark Customer Care at 1-888-790-4260 to find a participating retail pharmacy. If your doctor has authorized refills, contact your pharmacy when you've used about 70% of your supply (e.g., 21 days of a 30-day supply).

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 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. Refills are available when you've used about 60% of your supply, and can be ordered online or by phone with a credit card once you're registered and your prescription is on file. For even greater convenience, you may register for automatic refills with a credit card. Please allow 10-14 days for mail order prescriptions to arrive at your home.

## *Step Therapy*

Step therapy is a process targeted at providing the most cost-effective prescription drugs for your needs. 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.

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.

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. Brand-name non-preferred 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.

### ***Prescription ID Cards***

You will receive Prescription ID cards from Caremark at your home address. Please keep your cards and present them at your pharmacy when filling prescriptions.

### ***HDHP or CDHP Preventive Medications***

Under the HDHP or CDHP, preventive medications are not subject to the deductible. A list of preventive medications is available in the Document Library located in ADP Self Service under Benefits, Health and Welfare or by calling Caremark at 1-888-790-4260.

***Rally Challenge***
For more information about these programs, visit **www.pfghealthytogether.com** (passcode: pfghealthy) or call 1-888-MYHWBEN (1-888-694-9236).

# Wellness Credits

Regardless of which medical plan you choose, you have the opportunity to earn cost savings on your medical premiums in the form of wellness credits. By participating in the enhanced Wellness Program, you can earn up to $600 in annual credits. However, in order to qualify for any wellness credits, you **must** first complete a health survey and biometric screening.

You can complete the biometric screening at a participating Quest facility or your physician's office. To schedule an appointment for a Biometric Screening:

- Go to **https://my.questforhealth.com** and create an account. The Registration Key is PFG2017 or
- Call 1-855-623-9355, Monday - Friday, from 8 am - 9:30 pm ET and Saturday 8:30 am - 5 pm ET.

| PROGRAM | CREDIT* |
|---|---|
| **Health Survey and Biometric Screening (required)** | $150<br>You must complete both the health survey and biometric screening in order to receive any other credits in 2018, including the credits for non-nicotine use and weight loss goals. |
| **Glucose & Total Cholesterol****<br>• Glucose < 100 md/dl<br>• Total Cholesterol ≤ 200 mg/dl<br>• Blood Pressure** ≤ 140/90 | $75 per test |
| **Body Mass Index (BMI) ≤ 27 or Weight Loss ≥ 5%**** | $100 total (only one credit) |
| **Non-Nicotine User Status**** | $100 |
| **Wellness Programs**<br>• Quit4Life®<br>• Healthy Weight<br>• Real Appeal (weight loss program) | $200 per program if completed between 10/1/17 and 9/30/18 |
| **Rally Challenge** | $100 total (only one credit) if you complete a challenge between 10/1/17 and 9/30/18 |
| **Preventive Services*****<br>• Routine physical/annual exam<br>• Colorectal Cancer Screening (age 50 or older)<br>• Mammography (females age 40 or older)<br>• Dental cleaning<br>• Eye exam | $50 per service between 10/1/17 and 9/30/18<br>(max of $150 total) |
| **Total Savings** | **$600 Maximum** |

*All Wellness Credits are applied on a per-pay-period basis. You will start receiving credits for the programs you complete as soon as administratively possible after PFG receives official notification of completion.
**Determined from Biometric Screening.
***Must be covered under PFG's medical plan to receive any wellness credits, as well as dental and/or vision plans to receive credit for the respective preventive service.

## *Medical and Prescription Plan Highlights*

| | UHC HDHP with Unfunded HSA | | UHC CDHP with PFG Funded HSA | | UHC PPO | | UHC Out-of-Area Plan |
|---|---|---|---|---|---|---|---|
| **Features** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** |
| Annual Deductible<br>• Individual<br>• Family (Associate + 1 or more) | $ 3,000<br>$ 6,000 | $ 6,000<br>$12,000 | $ 1,500<br>$ 3,000 | $ 3,000<br>$ 6,000 | $ 900<br>$ 1,800 | $ 1,800<br>$ 3,600 | $ 900<br>$ 1,800 |
| Annual Out-of-Pocket Maximum (includes deductible)<br>• Individual<br>• Family (Associate + 1 or more) | $ 6,550<br>$13,100 | $13,100<br>$26,200 | $ 6,550<br>$13,100 | $13,100<br>$26,200 | $ 6,000<br>$12,000 | $12,000<br>$24,000 | $ 6,000<br>$12,000 |
| Coinsurance (percentage you pay) | 30% | 50% | 30% | 50% | 20% | 50% | 20% |
| PCP Office Visit (no charge for routine physicals, immunizations) | 30% after deductible | 50% after deductible | 30% after deductible | 50% after deductible | $25 copay | 50% after deductible | $25 copay |
| Specialist Office Visit | 30% after deductible | 50% after deductible | 30% after deductible | 50% after deductible | $40 copay | 50% after deductible | $40 copay |
| Hospital Services<br>• Inpatient<br>• Outpatient | 30% after deductible<br>30% after deductible | 50% after deductible<br>50% after deductible | 30% after deductible<br>30% after deductible | 50% after deductible<br>50% after deductible | $150 copay per day (5 day max), 20% after deductible<br>20% after deductible | 50% after deductible<br>50% after deductible | $150 copay per day (5 day max), 20% after deductible<br>20% after deductible |
| Emergency Services<br>• Hospital ER<br>• Ambulance | 30% after deductible<br>30% after deductible | 50% after deductible if not emergency<br>30% after deductible | 30% after deductible<br>30% after deductible | 50% after deductible if not emergency<br>30% after deductible | $250 copay (waived if admitted), 20% after deductible<br>20% (no deductible) | 50% after deductible if not emergency<br>20% (no deductible) | $250 copay (waived if admitted), 20% after deductible<br>20% (no deductible) |
| Urgent Care Facility (freestanding) | 30% after deductible | 50% after deductible | 30% after deductible | 50% after deductible | $40 copay | 50% after deductible | $40 copay |
| Non-Routine Lab/X-rays (no charge for preventive/routine lab/X-rays) | 30% after deductible | 50% after deductible | 30% after deductible | 50% after deductible | 20% after deductible<br>$100 copay for MRI, MRA, CT & PET Scan | 50% after deductible | 20% after deductible<br>$100 copay for MRI, MRA, CT & PET Scan |
| Mental Health & Substance Abuse<br>• Inpatient<br>• Outpatient | 30% after deductible<br>30% after deductible | 50% after deductible<br>50% after deductible | 30% after deductible<br>30% after deductible | 50% after deductible<br>50% after deductible | $150 copay per day (5 day max), 20% after deductible<br>$25 copay | 50% after deductible<br>50% after deductible | $150 copay per day (5 day max), 20% after deductible<br>$25 copay |
| Durable Medical Equipment | 30% after deductible | 50% after deductible | 30% after deductible | 50% after deductible | 20% after deductible | 50% after deductible | 20% after deductible |
| Prescription Drugs, Retail Pharmacy (30-day supply)*<br>• Generic<br>• Brand-name, preferred<br>• Brand-name, non-preferred | After Ded.† then 30%<br>$25 max<br>$25 min; $50 max<br>$50 min; $100 max | Not Covered | After Ded.† then 30%<br>$25 max<br>$25 min; $50 max<br>$50 min; $100 max | Not Covered | $10<br>20% ($50 min; $75 max)<br>30% ($75 min; $125 max) | Not Covered | $10<br>20% ($50 min; $75 max)<br>30% ($75 min; $125 max) |
| Prescription Drugs, Mail Order (90-day supply or CVS Pharmacy)*<br>• Generic<br>• Brand-name, preferred<br>• Brand-name, non-preferred | After Ded.† then 30%<br>$50 max<br>$50 min; $100 max<br>$100 min; $200 max | Not Covered | After Ded.† then 30%<br>$50 max<br>$50 min; $100 max<br>$100 min; $200 max | Not Covered | $20<br>20% ($75 min; $125 max)<br>30% ($125 min; $225 max) | Not Covered | $20<br>20% ($75 min; $125 max)<br>30% ($125 min; $225 max) |

* Not covered if you use a non-participating pharmacy.
† Preventive drugs do not require the deductible to be met prior to paying the coinsurance. A list of preventive drugs is available in the Document Library located on ADP Self Service.

## *2018 Medical Plan Payroll Deductions*

| Coverage Level | UHC HDHP with Unfunded HSA | | UHC CDHP with PFG Funded HSA | | UHC PPO Plan | | UHC Out-of-Area Plan | |
|---|---|---|---|---|---|---|---|---|
| | Pre-Tax Weekly Cost | Pre-Tax Bi-Weekly Cost | Pre-Tax Weekly Cost | Pre-Tax Bi-Weekly Cost | Pre-Tax Weekly Cost | Pre-Tax Bi-Weekly Cost | Pre-Tax Weekly Cost | Pre-Tax Bi-Weekly Cost |
| Associate Only | $ 17.82 | $ 35.64 | $ 23.10 | $ 46.20 | $ 45.15 | $ 90.31 | $ 45.15 | $ 90.31 |
| Associate + Spouse/DP | $ 39.31 | $ 78.62 | $ 49.17 | $ 98.35 | $111.39 | $222.79 | $111.39 | $222.79 |
| Associate + Child(ren) | $ 37.34 | $ 74.69 | $ 47.15 | $ 94.30 | $105.41 | $210.83 | $105.41 | $210.83 |
| Family | $ 64.45 | $128.90 | $ 79.21 | $158.42 | $179.53 | $359.07 | $179.53 | $359.07 |



### *Fitting It All Together*

Review the comparison chart and premiums on this page, along with the hypothetical plan usage examples on the following pages, to see how the pieces fit together for each of PFG's medical and prescription drug plans—and some bottom-line cost comparisons.

## *Medical Plan Usage Comparisons*

**Meet Linda and Gary**

- Active family, two children, Jill and Tom
- Linda takes blood pressure medication, but no chronic conditions
- No anticipated surgeries or hospitalizations
- Low-to-medium utilization of health care services

*Assumptions:*

- *In-Network providers used*
- *PCP = Primary Care Physician*
- *HSA contribution applied to out-of-pocket costs*

| | | HDHP | | | CDHP | | | PPO | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Description of Services Received** | **Covered Charges** | **Applied to $6,000 Deductible** | **PFG Pays** | **Member Pays** | **Applied to $3,000 Deductible** | **PFG Pays** | **Member Pays** | **Applied to $1,800 Deductible** | **PFG Pays** | **Member Pays** |
| ***Linda's expenses*** | | | | | | | | | | |
| Well visit | $ 120 | $ 0 | $ 120 | $ 0 | $ 0 | $ 120 | $ 0 | $ 0 | $ 120 | $ 0 |
| 2 specialist visits | 560 | 560 | 0 | 560 | 560 | 0 | 560 | 0 | 480 | 80[2] |
| 2 lab tests | 66 | 66 | 0 | 66 | 66 | 0 | 66 | 66 | 0 | 66 |
| Mail-order drug[1] | 760 | 760 | 0 | 760 | 760 | 0 | 760 | 0 | 680 | 80 |
| ***Gary's expenses*** | | | | | | | | | | |
| Well visit | 120 | 0 | 120 | 0 | 0 | 120 | 0 | 0 | 120 | 0 |
| 2 specialist visits | 560 | 560 | 0 | 560 | 560 | 0 | 560 | 0 | 480 | 80 |
| 2 lab tests | 497 | 497 | 0 | 497 | 497 | 0 | 497 | 497 | 0 | 497 |
| ***Jill and Tom's expenses*** | | | | | | | | | | |
| 2 well visits | 400 | 0 | 400 | 0 | 0 | 400 | 0 | 0 | 400 | 0 |
| Sick visit | 200 | 200 | 0 | 200 | 200 | 0 | 200 | 0 | 175 | 25 |
| Prescription | 25 | 25 | 0 | 25 | 25 | 0 | 25 | 0 | 15 | 10 |
| Covered Charges and Payments | $3,308 | $2,668 | $ 640 | $2,668 | $2,668 | $ 640 | $2,668 | $563 | $ 2,470 | $ 838 |
| HSA Contribution | | | $ 0 | $ 0 | | $ 500 | $ (500) | | Not Eligible | |
| Premiums for Family Coverage | | | $11,952 | $3,352 | | $11,990 | $4,119 | | $14,602 | $9,336 |
| Wellness Credits Applied | | | $ 450 | $ (450) | | $ 450 | $ (450) | | $ 450 | $ (450) |
| **Total Premiums and Out-of-Pocket Costs** | | | **$13,042** | **$5,570** | | **$13,580** | **$5,837** | | **$17,522** | **$9,724** |

[1]3-month supply of generic prescription, filled 4 times
[2]$40 copay per specialist visit
All dollar figures are rounded.

Linda and Gary may have gone into enrollment thinking that the PPO would be best for them since they are a family of four who uses medical care during the year. But looking closer at each option, they realize they would pay approximately $4,000 more for the PPO and may not utilize the plan enough to make up for that cost difference. Although their total out-of-pocket spending would be a bit lower under the HDHP, they like the CDHP's lower deductible and out-of-pocket maximum, plus the Health Savings Account feature. They decide to enroll in the CDHP and use their cost savings to invest in their future by making pre-tax contributions to both a Health Savings Account and a 401(k).

**Meet Becca and Paul**

- In their mid-fifties, no children at home
- Becca has an ongoing medical condition that required surgery and inpatient care in the past ($26,500 cost), and she sees a specialist two times
- Paul receives preventive care from his primary care physician and also sees a specialist three times
- Medium-to-high utilization of health care services

*Assumptions:*

- *In-Network providers used*
- *PCP = Primary Care Physician*
- *HSA contribution applied to out-of-pocket costs*

| | | HDHP | | | CDHP | | | PPO | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Description of Services Received** | **Covered Charges** | **Applied to $6,000 Deductible** | **PFG Pays** | **Member Pays** | **Applied to $3,000 Deductible** | **PFG Pays** | **Member Pays** | **Applied to $1,800 Deductible** | **PFG Pays** | **Member Pays** |
| ***Becca's annual expenses*** | | | | | | | | | | |
| Well visit | $ 120 | $ 0 | $ 120 | $ 0 | $ 0 | $ 120 | $ 0 | $ 0 | $ 120 | $ 0 |
| 2 specialist visits | 560 | 560 | 0 | 560 | 560 | 0 | 560 | 0 | 480 | 80[2] |
| 2 lab tests | 66 | 66 | 0 | 66 | 66 | 0 | 66 | 66 | 0 | 66 |
| Minor outpatient surgery | 385 | 385 | 0 | 385 | 385 | 0 | 385 | 385 | 0 | 385 |
| Mail-order drug[1] | 380 | 380 | 0 | 380 | 380 | 0 | 380 | 0 | 340 | 40 |
| Surgery requiring inpatient hospitalization for 8 days | 26,500 | 4,609 | 21,341 | 5,159 | 1,609 | 21,341 | 5,159 | 1,349 | 21,071 | 5,429 |
| Lab tests while hospitalized | 800 | 0 | 800 | 0 | 0 | 800 | 0 | 0 | 800 | 0 |
| Mail-order drug[1] | 380 | 0 | 380 | 0 | 0 | 380 | 0 | 0 | 380 | 0 |
| ***Paul's annual expenses*** | | | | | | | | | | |
| Well visit | 120 | 0 | 120 | 0 | 0 | 120 | 0 | 0 | 120 | 0 |
| 3 specialist visits | 840 | 0 | 588 | 252 | 0 | 588 | 252 | 0 | 720 | 120 |
| MRI and lab tests | 5,000 | 0 | 3,500 | 1,500 | 0 | 3,500 | 1,500 | 0 | 4,400 | 600 |
| Sick visit | 200 | 0 | 140 | 60 | 0 | 140 | 60 | 0 | 175 | 25 |
| Retail prescription | 25 | 0 | 18 | 7 | 0 | 18 | 7 | 0 | 15 | 10 |
| Covered Charges and Payments | $35,376 | $6,000 | $27,007 | $ 8,369 | $3,000 | $27,007 | $ 8,369 | $1,800 | $28,621 | $ 6,755 |
| HSA Contribution | | | $ 0 | $ 0 | | $ 500 | $ (500) | | Not Eligible | |
| Premiums for Associate + Spouse/DP Coverage | | | $ 7,831 | $ 2,044 | | $ 7,838 | $ 2,557 | | $ 9,654 | $ 5,793 |
| Wellness Credits Applied | | | $ 350 | $ (350) | | $ 350 | $ (350) | | $ 350 | $ (350) |
| **Total Premiums and Out-of-Pocket Costs** | | | **$35,188** | **$10,063** | | **$35,695** | **$10,076** | | **$38,625** | **$12,198** |

[1]3-month supply of generic prescription, filled 4 times
[2]$40 copay per specialist visit
All dollar figures are rounded.

After taking a closer look at their expected spending, Becca and Paul realize that the PPO option will end up costing them slightly more than the CDHP. They now need to decide: do they prefer the convenience of the office visit and prescription copays with the security of a slightly lower out-of-pocket maximum? Or, could they maximize potential savings by enrolling in the CDHP and making pre-tax contributions to the Health Savings Account?



**Meet Robbie**

- Single
- No significant health issues
- Sees his primary care physician once or twice a year
- May see an orthopedic specialist for heel pain
- Low medical plan utilization

*Assumptions:*

- *In-Network providers used*
- *PCP = Primary Care Physician*
- *HSA contribution applied to out-of-pocket costs*

| **Description of Services Received** | | HDHP | | | CDHP | | | PPO | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Description of Services Received** | **Covered Charges** | **Applied to $3,000 Deductible** | **PFG Pays** | **Member Pays** | **Applied to $1,500 Deductible** | **PFG Pays** | **Member Pays** | **Applied to $900 Deductible** | **PFG Pays** | **Member Pays** |
| ***Robbie's expenses:*** | | | | | | | | | | |
| Well visit | $120 | $ 0 | $ 120 | $ 0 | $ 0 | $ 120 | $ 0 | $0 | $ 120 | $ 0 |
| 2 specialist visits | 560 | 560 | 0 | 560 | 560 | 0 | 560 | 0 | 480 | 80[1] |
| Sick visit | 190 | 190 | 0 | 190 | 190 | 0 | 190 | 0 | 165 | 25 |
| Prescription | 10 | 10 | 0 | 10 | 10 | 0 | 10 | 0 | 0 | 10 |
| Covered Charges and Payments | $880 | $760 | $ 120 | $ 760 | $760 | $ 120 | $ 760 | $0 | $ 765 | $ 115 |
| HSA Contribution | | | $ 0 | $ 0 | | $ 250 | $ (250) | | Not Eligible | |
| Premiums for Associate Only Coverage | | | $3,706 | $ 927 | | $3,676 | $1,201 | | $4,899 | $2,348 |
| Wellness Credits Applied | | | $ 600 | $ (600) | | $ 600 | $ (600) | | $ 600 | $ (600) |
| **Total Premiums and Out-of-Pocket Costs** | | | **$4,426** | **$1,087** | | **$4,646** | **$1,111** | | **$6,264** | **$1,863** |

[1]$40 copay per specialist visit
All dollar figures are rounded.

Robbie is excited about the new HDHP option. Knowing that he is in a stage of life where he seldom uses his medical plan benefits, he enrolls in the new HDHP, opens a Health Savings Account, and even decides to increase his 401(k) contribution with the amount he saves.

## Decision Support Tool

To help you determine if the HDHP with an unfunded HSA, CDHP with the PFG funded HSA, or the PPO plan is the best fit for your medical and prescription plan needs, we encourage you to utilize the Decision Support Tool. This tool allows you to input your typical or expected medical expenses and rank your preferred plan features, then compare your hypothetical bottom line under each PFG medical plan. While there is no way to know for certain which plan will have the lowest out-of-pocket cost overall, the Decision Support Tool can take some of the guesswork out of your decision-making.

For example, if you're a minimal or even moderate user of health care, the tool may show the PPO Plan may cost you more overall than the CDHP. The premium costs you would save by enrolling in the CDHP could go into an HSA, along with PFG's contribution, to help offset unexpected out-of-pocket costs. If you anticipate higher health care usage, it may show that you get your money's worth by paying the PPO's higher premium costs.

You can access this tool on the medical election page through ADP Self Service at **https://portal.adp.com.** Simply click the link on the Medical election page on the Benefits tab, then Health & Welfare, and follow the prompts.

# Dental Coverage

PFG knows that good dental care contributes to your health and well being. That's why we offer dental coverage, administered through Delta Dental of Virginia.

The chart below lists some highlights of the plan, assuming use of In-Network providers. If you choose an Out-of-Network provider, benefits may be limited and your out-of-pocket costs may be higher. To find an In-Network provider, log on to **www.deltadentalva.com**.

| Dental Plan Features | Your Responsibility |
|---|---|
| **Calendar Year Deductible** (applies to basic, major services, and orthodontia)<br>• Individual<br>• Family | <br>$ 50<br>$ 150 |
| **Maximums**<br>• Calendar Year Maximum Benefit<br>• Orthodontic Lifetime Maximum Benefit (per eligible child only)<br>• Temporomandibular Joint Disorder (TMJ) Lifetime Maximum Benefit | <br>$1,500<br>$2,000<br>$1,000 |
| **Preventive and Diagnostic Services** (does not apply toward the annual maximum)<br>Oral exams (2 per calendar year)<br>Bitewing X-rays (1 set per calendar year)<br>Full Mouth X-rays (1 every 3 calendar years)<br>Routine cleaning (every 6 months/2 per calendar year)<br>Fluoride treatments (1 per calendar year, up to age 19)<br>Space maintainers (up to age 14)<br>Sealants (1 application per tooth on unrestored, noncarious permanent molars, up to age 16) | No charge, no deductible |
| **Basic Services**<br>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**<br>Crowns, 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**<br>Diagnosis, occlusal adjustment, orthodontic appliance and orthognathic surgery | 50% after deductible |
| **Orthodontia (coverage for children up to age 26 only)**<br>Complete orthodontic exam (including X-rays), active orthodontic treatment | 50% after deductible |

### *Dental ID Cards*

You will receive a Dental ID card from Delta Dental at your home address. Please present your card when you visit your dental provider.

**Tip:** You'll generally pay less out of pocket if you use the PPO Network, but using the Premier Network will still cost less than going out of network.

## *PPO and Premier Networks*

You may use providers in the Delta Dental PPO and Delta Dental Premier Networks.

| PPO or Premier dentist: | Out-of-Network dentist: |
|---|---|
| **When you see an In-Network provider, there are many advantages for you:**<br>• Most importantly, your and the company's costs are lower.<br>• There are no claim forms to file.<br>• The provider will submit pre-approval for treatment upon your request.<br>• All you are responsible for is your deductible and coinsurance (if applicable)—PFG pays the rest, up to the annual plan maximum. | **Your benefits may be limited. You must pay the dentist in full when services are received.**<br>You may have to file your own claim with Delta Dental, by:<br>• U.S. mail to Delta Dental of Virginia, 4818 Starkey Road, Roanoke, VA 24018, or<br>• Fax to 1-540-725-3880.<br>• 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 in addition to your coinsurance.<br>• Delta Dental does not require pre-authorization for services; however, some Out-of-Network providers will submit predetermination forms on behalf of their patients. It is your responsibility to submit this if your provider does not. |

## *2018 Dental Plan Payroll Deductions*

| Coverage Level | Pre-Tax Weekly Cost | Pre-Tax Bi-Weekly Cost |
|---|---|---|
| Associate Only | $ 5.42 | $10.84 |
| Associate + Spouse | $10.77 | $21.55 |
| Associate + Child(ren) | $13.30 | $26.61 |
| Family | $18.47 | $36.95 |

# Vision Coverage

Taking care of your eyes is another key component of good health. That's why we offer a vision plan, administered by EyeMed Vision Care.

The EyeMed Network offers a broad range of independent providers as well as larger retail chains such as LensCrafters, Pearle Vision, and optical shops at Sears, Target, and JC Penney. To find an In-Network provider, visit **www.eyemedvisioncare.com** or call 1-866-723-0513. You'll receive the maximum benefit allowance and other discounts by utilizing EyeMed's network of providers.

The chart below highlights your EyeMed Vision Care benefits.

| Plan Feature | In-Network[2] | Out-of-Network |
|---|---|---|
| **Eye Exams**<br>Once every 12 months | Covered 100% | Reimbursed up to $35 |
| **Lenses**[1]<br>One pair every 12 months<br>• Single Vision<br>• Bifocal<br>• Trifocal | Covered 100% | Reimbursed up to:<br>$25<br>$40<br>$55 |
| **Frames**<br>One pair every **12** months | Up to a **$140** allowance with no copay. If your frames exceed the allowance, you will receive a 20% discount on the difference. | Reimbursed up to $50 allowance |
| **Contact Lens Fitting & Follow Up**<br>• Standard<br>• Premium | <br>Up to $55 copay<br>10% discount off retail amount | <br>N/A<br>N/A |
| **Contact Lenses**[2]<br>In lieu of all other lens benefits, every 12 months[1] | **Conventional:**<br>$0 copay, $115 allowance; 15% discount on difference<br>**Disposable:**<br>$0 copay, $115 allowance (member pays difference)<br>**Medically Necessary:**<br>$0 copay; paid in full | **Conventional:**<br>Reimbursed up to $110<br>**Disposable:**<br>Reimbursed up to $110<br>**Medically Necessary:**<br>Reimbursed up to $200 |
| **Additional Benefits** | | |
| **Retinal Imaging Discount** (offered by provider) | Copay will not exceed $39 for a retinal exam | |
| **Kids Benefit** (dependent children under age 19) | Two exams and one prescription change if vision changes,[3] including contact lens fitting and follow up exam[3] | |
| **Diabetic Care** | Eye exam and diagnostic testing is covered at 100% twice a year. Services must be six months apart. Members also receive eye exam reminders from EyeMed. | |

[1]You may select either eyeglasses or contact lenses, but not both, during the same coverage period
[2]After you've utilized your annual benefit, you'll receive a 40% discount on additional eyeglasses or a 15% discount on additional conventional contact lenses.
[3]Within same benefit year.

## *2018 Vision Plan Payroll Deductions*

| Coverage Level | Pre-Tax Weekly Cost | Pre-Tax Bi-Weekly Cost |
|---|---|---|
| Associate Only | $ 1.67 | $ 3.34 |
| Associate + Spouse/DP | $ 3.17 | $ 6.35 |
| Associate + Child(ren) | $ 3.35 | $ 6.70 |
| Family | $ 4.92 | $ 9.84 |

### *Vision ID Cards*

You will not receive a Vision ID card from EyeMed. When you visit your provider, give them the Group ID number listed under "Contact Information" at the back of this guide.

For more information about the Health Care and Limited Purpose Health Care FSAs, including who qualifies, eligible expenses, and a worksheet for estimating your expenses and cost savings, visit **www.payflex.com**.

### *PayFlex Debit Cards*

Your PayFlex HealthHub debit card provides you convenient access to the money in your Flexible Spending Account(s). Once enrolled, you will receive a debit card at your home address.

Be sure to keep all receipts and itemized statements so you'll be able to prove, if necessary, that your debit card purchases were for eligible expenses. Visit **www.payflex.com** to access your account information and to learn more about claims reimbursement options.

# Health Care Flexible Spending Account (FSA)

## *Health Care FSA*

A Health Care Flexible Spending Account (FSA) allows you to set aside pre-tax dollars to pay for eligible, out-of-pocket health care expenses such as deductibles, copayments, and other health care expenses that are not reimbursed by insurance. These can include certain out-of-pocket medical, dental, vision, and prescription drug expenses. You do not need to be enrolled in a PFG medical plan to have an FSA.

## *Limited Purpose Health Care FSA (LPFSA)*

If you elect the HDHP or the CDHP, you are not eligible for a regular Health Care FSA. However, you are eligible for a special ***Limited Purpose FSA*** that can be used to cover eligible out-of-pocket **dental and vision expenses only**.

## General Rules for Health Care and Limited Purpose Health Care FSAs

With a Health Care FSA (general or Limited Purpose):

- You must *actively enroll* each year and elect how much money to set aside from your pay—the annual minimum under PFG's plan is $100, and the annual maximum is $2,650 (the annual amount you elect will be divided over the number of pay periods in the year).
- Once you enroll, you are not allowed to change your election until the next Open Enrollment period, unless you have a qualifying family status change.
- You may *not* transfer money between accounts.
- If you have both a Health Savings Account (HSA) and a Limited Purpose Health Care FSA, you may choose which account to use for reimbursing eligible dental and vision expenses, but you cannot be reimbursed from both accounts for the same expenses.

It's true that you assume some risk with a Health Care FSA (general or Limited Purpose) because it is subject to a "use-it-or-lose-it" rule. Money you set aside in 2018 may only be used to pay for eligible expenses you incur in 2018. After the claims submission deadline (the earlier of 90 days after your coverage ends or March 31, 2019), any unused funds in your account will be forfeited. You'll want to keep this in mind as you decide how much to contribute.

In exchange for your risk, a Health Care FSA allows you the advantage of being reimbursed in advance—up to your full annual contribution election—as soon as you incur an eligible expense. In other words, you have access to the full amount of your elected amount regardless of the amount you have actually contributed to your account.

# Dependent Care Flexible Spending Account (FSA)

A Dependent Care Flexible Spending Account (FSA) allows you to set aside pre-tax dollars to cover the cost of caring for your eligible dependents while you work. Your Dependent Care FSA may be used for day care, pre-school, before-school and after-school care, day camps, elder care, and in-home care (e.g., provided by nannies or housekeepers whose primary responsibility is dependent care).

As with a Health Care FSA, you must actively enroll each year to participate. You may contribute from $100 up to $5,000 each year ($2,500 if you are married and file separate tax returns). A Dependent Care FSA is also subject to the use-it-or-lose-it rule, so you'll want to carefully estimate your dependent care expenses before you enroll. Be sure to consider vacations and foreseeable changes, such as when a child starts school and no longer requires full-time daycare.

Unlike the Health Care FSA, you cannot receive reimbursement for dependent care expenses that exceed your account balance. For example, if you file a claim for $500 when there is only $400 in your account, you will be reimbursed $400. The other $100 can be reimbursed as additional deposits are made to your account during the same plan year.

# Employee Assistance Program (EAP)

PFG's Employee Assistance Program (EAP) can help you navigate life's ups and downs more effectively.

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. Whether you need support through a personal or family crisis, financial or legal advice, stress management tips, or help finding resources to deal with substance abuse and recovery, the EAP is a good place to start. When needed, the EAP will connect you with licensed professionals who provide short-term counseling services and referrals. You and your eligible dependents are entitled 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.

EAP services are easy to use and are completely confidential!

**A Dependent Care FSA may save you money if you meet the following criteria:**

- You and your spouse (if applicable) are employed, looking for work, or attending school full time.
- You will have qualifying dependent care expenses for:
  - Your child under age 13, or
  - Any person (regardless of age) whom you claim on taxes as a dependent, and who is incapable of self-care due to physical or mental incapacity.
- Your income level and tax filing status do not qualify you to receive a dependent care tax credit greater than what you would save using the Dependent Care FSA.

For more information about the Dependent Care FSA, including who qualifies, eligible expenses, and a worksheet for estimating your expenses, visit **www.payflex.com**.

An interactive calculator is available to help you estimate out-of-pocket expenses and the annual tax savings you could realize by participating in FSAs. To access the calculator, log on to **www.payflex.com**.

**Your Beneficiary Information**

Please designate primary and contingent (secondary) beneficiaries. In the event of your death, policy proceeds will be paid according to your designation. You are the beneficiary, as the default designation, for Supplemental Dependent Term Life and Supplemental AD&D coverage on your dependents.

# Life, Accident, and Disability Benefits

PFG offers some benefit plans we hope you'll never have to use. However, we *do* hope you'll have peace of mind knowing there's a financial safety net in the event you and/or your family must cope with death, accident, or disability. Please review your coverage options carefully and elect the coverage that best meets your needs based on your family status, financial obligations, and other considerations (such as private policies that you may currently carry).

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

PFG provides company-paid Basic Life and Accident insurance to all associates who work at least 30 hours per week. In the event of your death, the Basic Life coverage would pay your beneficiary(ies) a benefit equal to one times your annual basic earnings, up to $1 million. In the event of accidental death, your beneficiary(ies) would receive an additional benefit equal to one times your annual basic earnings (the combined Basic Life and Basic AD&D benefits cannot exceed $1 million).

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 the AD&D plan. These are determined according to the extent of injury.

## *Supplemental Term Life*

Supplemental Term Life insurance is available in increments ranging from one to six times your annual basic earnings. Combined with your basic coverage, you can elect life insurance coverage up to a maximum of seven times your annual basic earnings. The combined coverage total cannot exceed $1.5 million. You will be required to furnish Evidence of Insurability (EOI) if you previously waived coverage or if you're applying for coverage exceeding certain limits (see page 22 for more information about EOI).

### *Your monthly cost per $1,000 of coverage:*

| Age on December 31, 2017 | 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.

## *Supplemental Dependent Term Life*

Life insurance is available for your spouse (including a domestic partner), plus your children by birth, marriage, adoption, or domestic partnership. Evidence of Insurability (EOI) will be required to add spouse coverage if it was previously waived or if you are increasing the coverage level by more than one level. The chart below shows the coverage options and cost amounts.

| 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 |

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

## *Supplemental Accidental Death and Dismemberment (AD&D) Insurance*

Supplemental AD&D coverage is available for associates and dependents (as defined above) in the same increments as Supplemental Life Insurance and Supplemental Dependent Life. Refer to the chart below for coverage levels and costs. EOI is not required to add or increase this coverage, even if you previously waived it.

| Coverage Level | Monthly Rate per $1,000 of Coverage |
|---|---|
| Associate – 1x to 6x 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 |

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

- You are newly eligible and you are applying for Supplemental Term Life coverage exceeding 2x your annual basic earnings or $500,000 (whichever is less).
- You are applying to increase your current Supplemental Term Life coverage by more than 1x annual basic earnings.
- You previously waived coverage for yourself or your spouse when initially eligible.
- You are applying to increase your spouse's coverage from $10,000 to $50,000.*

* No EOI is required to increase your spouse's coverage from $10,000 to $25,000 or from $25,000 to $50,000. No EOI is required to add or increase coverage for dependent children. EOI forms will be mailed to your home address by Aetna Life Insurance.

## *Disability Insurance*

Disability insurance is designed to replace a portion of your income in the event you become unable to work due to illness or injury. PFG associates who work at least 30 hours per week are automatically enrolled in Basic Short-Term Disability (STD) and Basic Long-Term Disability (LTD) coverage after satisfying a six-month waiting period. You do not have to pay for basic coverage, but you may be able to purchase Supplemental Long-Term Disability coverage to increase your potential income replacement benefit.

### Basic Short-Term Disability (STD)

If you become disabled, you may be eligible for STD benefits after a waiting period of 7 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:

- Between six months and two years of service: 50% of weekly basic earnings, capped at $1,500 per week.
- Two or more years of service: 60% of weekly basic earnings, capped at $1,500 per week.

### Basic Long-Term Disability (LTD)

If you remain disabled after 26 weeks, you may be eligible for continued benefits under the Basic LTD plan. Basic LTD provides up to 50% of your basic *monthly* earnings, capped at $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 LTD Benefits

Supplemental LTD works in conjunction with Basic LTD. Supplemental LTD increases your potential benefit from 50% to 66 2/3% of 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 first become eligible, Evidence of Insurability (EOI) must be provided and approved before you can be enrolled in this coverage at a later date. The EOI form will be mailed to your home address by Aetna Disability Services. Your monthly cost for Supplemental LTD is $0.36 for each $100 of monthly basic earnings.

# Other Voluntary Benefits

Through Voluntary Benefits, you may enroll in additional voluntary benefits. These are not directly sponsored by PFG, but your premiums can be deducted from your paycheck if you enroll. These benefits include:

**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 can also build up 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:** Credit monitoring and fraud restoration through the ID TheftSmart program.

**Legal Plan:** 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.

Choose the coverage you need, and enjoy the added convenience of having your premiums deducted through payroll. Learn more and get instant rate quotes by calling Enrollment Resources Group (ERG) at 1-866-747-8679 or visiting **www.voluntarybenefits.com**.

# Contact Information

Refer to the information below when you need assistance with benefits-related questions.

| Benefit | Vendor | Website | Phone Number |
|---|---|---|---|
| Healthy Together | | www.pfghealthytogether.com<br>Passcode: pfghealthy | |
| General Benefits Questions | Benefits Center | ADP Self Service at https://portal.adp.com, then Benefits tab | 1-888-MYHWBEN<br>(1-888-694-9236)<br>10 am – 8 pm ET,<br>Monday – Friday<br>8 am – 5 pm ET, Saturday |
| Verification of Dependents and Qualified Changes in Status | Dependent Verification Services (DVS) | | 1-800-847-8531<br>1-866-400-1686 (fax) |
| Medical | UnitedHealthcare Concierge<br>Group Number: 742781 | www.myuhc.com | 1-877-769-7001 |
| Prescription Drug | Caremark (CVS Health)<br>Group Number: PFGRX | www.caremark.com | 1-888-790-4260 |
| Dental | Delta Dental<br>Group Number: 700065 | www.deltadentalva.com | 1-800-237-6060 |
| Vision | EyeMed<br>Group Number: 9659616 | www.eyemedvisioncare.com | 1-866-723-0513 |
| Employee Assistance Program (EAP) | Optum® | www.liveandworkwell.com<br>Access code: PFG | 1-866-248-4094 |
| Health Savings Account (HSA) and Flexible Spending Accounts (FSAs) | PayFlex<br>Group Number: 119232 | www.payflex.com | 1-844-PAYFLEX<br>(1-844-729-3539) |
| Disability and Leaves of Absence | Contact your supervisor first, then Reed Group | pfg.leavepro.com | 1-844-556-6376 |
| 401(k) | Fidelity | www.401k.com | 1-800-835-5095 |
| Wellness Programs<br>• Quit For Life® (Tobacco Cessation Program)<br>• Wellness Coaching<br>• Healthy Pregnancy | | QUITNOW.NET<br>Company Identifer: PFG<br>More information on these programs can be found on www.myuhc.com | 1-866-QUIT-4-LIFE<br>(1-866-784-8454)<br>1-800-478-1057<br>1-800-411-7984 |
| Voluntary Benefits | | www.pfghealthytogether.com<br>Click on “Benefits” | |

# Choose to Receive Future Benefits Information Electronically

At PFG, we realize that our carbon footprint matters. That's why salaried associates (other than drivers) automatically receive benefits information electronically. We encourage hourly associates and salaried drivers to help us minimize our impact by consenting to receive all benefits information electronically. By *Going Green*, you will receive email versions of all **important information PFG sends about benefits**. *Your email address will be maintained as a part of your other confidential associate information and will be used for PFG business-related purposes only.* ***Going Green*** **is easy; just follow the steps below**.

**Step One: Update your Email Address**

To complete these requirements for future benefit communications, start by updating your email address:

1. Go to **ADP Self Service** at **https://portal.adp.com**, and enter your User ID and Password.
2. On the *Home* page, select the *Personal Information* tab from the top navigation menu and click on *Addresses*.
3. Click the *Edit* button at the bottom of the screen. This will take you to the *Update Addresses* page. Here, you can update your emergency contacts, mailing address, **email address**, and phone numbers.
4. Enter your email address.
5. Hit the Save button to submit your changes.

**Step Two: Provide Consent to Receive Benefits Information Electronically**

1. **Log on** to ADP Self Service at: https://portal.adp.com and click on the *Go Green* link on the home page under *Benefits News*.
2. **Supply** the first letter of your legal first name (e.g., J for John), your last name, the month and day of your birth, and the last four digits of your Social Security Number (SSN).
3. **Consent** to electronic delivery to access the benefit documents. You will get a confirmation of your election.

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.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