HEALTHYTOGETHER™

2014 Benefits Open Enrollment

October 28 – November 15, 2013

PFG Performance Food Group

What's New in 2014

Keeping you and PFG *Healthy Together* is the focus of our benefits program. Towards that goal, we're always looking for new ways to offer quality, competitive, and affordable benefit plans for you and your family.

After careful evaluation, we're making some additions and changes for 2014:

- New Consumer Driven Health Plan (CDHP) Medical Plan option
- New Health Savings Account (HSA) and Limited Purpose Flexible Spending Account (LPFSA)
- Changes to premiums, deductibles and out-of-pocket maximums for UHC Choice Plus Medical Plans 1 and 2
- Changes to coinsurance amounts for UHC Choice Plus Medical Plan 1
- Consolidation of Medical Plan coverage tiers from twelve to four
- New Decision Support Tool
- Changes to the Wellness Program and Wellness Credits
- Expanded coverage for same-sex spouses, domestic partners, and their children
- Spousal/domestic partner surcharge
- Consolidation of Dental Plan options
- Changes to Short-Term Disability benefits
- New *Healthy Together* website

Please be sure to read more about these changes on the following pages of this guide, so you'll have the information to make the best choices for your needs. Then, go online to ADP Self Service, at https://portal.adp.com or call the Benefits Center at 1-888-MYHWBEN (1-888-694-9236), and make your elections for 2014 no later than November 15th.

Active Open Enrollment

Open Enrollment for 2014 is an "active" enrollment for Medical and Flexible Spending Accounts. That means you must go online and make elections—even if you want your current coverage to continue in 2014. If you do not enroll and you currently have medical coverage with PFG, you and your covered dependents will be defaulted to the Consumer Driven Health Plan (CDHP) option and you will *not* have an FSA in 2014.

Announcing 2014 Benefits Open Enrollment

October 28 – November 15, 2013

Open Enrollment for the 2014 plan year is here!

This year brings some important changes. We're taking a new approach to health and wellness, aimed at keeping both you and PFG *Healthy Together* while at the same time complying with all aspects of Health Care Reform.

Due to the significance of these changes, we urge all associates to carefully review the information in this guide. You are required to actively participate in the enrollment process. Otherwise, you and your currently covered dependents will be defaulted to the Consumer Driven Health Plan (CDHP) option, and you will ***not*** have a Flexible Spending Account (FSA) for health or dependent care in 2014. Other benefits for which you and your dependents are currently enrolled will carry over to 2014.

Open Enrollment is your only opportunity to make changes for 2014, unless you experience a qualifying family status change. It is also an opportunity to review and update your dependent and beneficiary information. Keep in mind that your beneficiaries can be updated at any time.

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 pages 26-27 for more details.

WHAT'S INSIDE

New Benefits Website

Communication plays an important role in helping you participate in the benefits and programs that best fit your needs. That's why we've recently launched our new *Healthy Together* benefits brand and website. When you see *Healthy Together* on any of PFG's communications, you'll know this is important information pertaining to your PFG benefits. The *Healthy Together* website replaces PFG Smart Choices as your benefits information resource—available at your convenience.

PFG Performance Food Group

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. Effective with the 2014 plan year, the definition of eligible dependents for PFG benefit plans has been expanded.

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 or civil union partner's child,
- 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.

To add a same-sex spouse to coverage, designate the relationship as a *domestic partner* online, but identify him or her as a same-sex spouse on the Domestic Partner affidavit. Coverage for a same-sex spouse is not subject to federal taxation, but it may be subject to state tax.

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.

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).

Spousal Surcharge in 2014

If your spouse or domestic partner has medical coverage available through another employer, **and** you cover your spouse or domestic partner under PFG's Medical Plan, a $500 annual surcharge (prorated over a per-pay-period basis) will be added to your medical premiums in 2014. You'll need to certify whether your spouse or domestic partner has other employer-sponsored medical coverage available.

Qualifying Family Status Change Events

After Open Enrollment, if you experience a qualifying family status change event, you may be eligible to change elections consistent with the qualifying event, provided you do so 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 include (but are not limited to):

- 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 can also change your coverage under your "Special Enrollment Rights." See page 23 for more information.

Enrolling Online

Go to https://portal.adp.com

If you're registering for the first time:

1. **Click** *First Time Users Register Here*
2. **Click** the *Register Now* button
3. **Enter** the *Registration Pass Code* PFGC-1234
4. **Fill in** the required information
5. **Enter** your *Personal and Business information*
6. **Enter** your *Security* information

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

1. **Go to** https://portal.adp.com
2. **Click** *User Login*
3. **Enter** your User Name and Password (your User Name is the user ID your 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 and 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

A New Approach to Health Care

PFG recognizes that the health and well being of our associates directly impacts the health of our company over the long term. Meeting the needs of our associates and company remains our top priority as we face the challenges of rising health care costs and compliance with the Patient Protection and Affordable Care Act (PPACA). Keeping these realities in mind, we actively manage our health care plans and continuously look for new ways to maintain quality and affordability so that we can be *Healthy Together*.

We self fund our medical plan. This 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.

We are pleased to announce the addition of a **Consumer Driven Health Plan (CDHP)** option with a **Health Savings Account (HSA)** to our health plans for 2014. We've also added a new Decision Support Tool to help you decide if the CDHP and HSA are the best fit for your needs. This new approach to health care encourages you to take a more proactive role in deciding how health care dollars are spent.

To help our medical plans stay affordable, we encourage spouses/domestic partners to take advantage of medical coverage that is available to them through employment or other sources. That is why we are implementing a spousal surcharge as part of our new approach to health care. We are also consolidating our medical plan tiers from twelve down to four.

This new approach will better leverage the money we (both you and PFG) spend on health care. Due to the scope and potential financial impact of these changes, it's important for everyone to actively participate in the 2014 Open Enrollment process. Otherwise, you may not have the coverage that best fits your needs in 2014.

Another component of our *Healthy Together* initiative is our wellness program. The program was recently enhanced and changes were announced in our summer 2013 newsletter. You can read more about this program and wellness incentives on page 11.

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.

Medical Plans

You may choose from the following medical plans for 2014:

Medical Plan Options
UHC Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA)
UHC Choice Plus Medical Plan 1 or UHC Out-of-Area Medical Plan 1*
UHC Choice Plus Medical Plan 2 or UHC Out-of-Area Medical Plan 2*

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

All of these plans are designed to cover the same services; however your total costs (including your payroll deductions) may vary according to the plan and providers you select.

Consumer Driven Health Plan

Consumer Driven Health Plans (CDHPs) are increasing in popularity as we all seek new ways to contain costs while maintaining quality and choice. By design, 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 new CDHP, administered by United Healthcare (UHC), has a lower per-pay-period premium deduction than the other plans. However, there is a trade off: a higher deductible and a higher out-of-pocket maximum.

Under this plan, you'll be 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 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.

Certain routine preventive services, such as annual physical exams and immunizations, are covered 100% without meeting the deductible or paying coinsurance. If you're used to paying a copayment for services such as office visits and prescription drugs under your current plan, please be aware that those will now be subject to the deductible and coinsurance under the CDHP. However, you'll pay a discounted rate on prescription drugs at CVS/Caremark pharmacies.

With the CDHP as well as PFG's Network 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 7).

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 those of Medical Plans 1 and 2, please see the charts on pages 8-9.

Insurance Definitions

Copayment: A pre-determined amount you pay to your provider at the time of service.
Deductible: The annual amount you are responsible to pay for services before your insurance covers any expenses.
Coinsurance: The percentage of cost you share with the insurance provider after your deductible is met.
Out-of-Pocket Maximum: The annual limit on how much you are required to pay out of your own pocket for copayments, deductibles and coinsurance.

Health Savings Account (HSA)

A Health Savings Account (HSA) is a companion feature administered through PayFlex, and an important key to cost savings under the CDHP. You *must* enroll in the CDHP in order to have the HSA. 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), and PFG will make contributions to your account ($250 pro-rated annually if you have coverage for yourself only, and $500 pro-rated annually 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 before-tax dollars to cover certain unreimbursed health care expenses. However, the HSA has some big advantages over the health 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 for longer term growth using a combination of investment funds, once your account balance is at least $1,000.
- You own the account if you retire or leave PFG.

You are not allowed to use your HSA to cover eligible medical 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 past expenses, as long as those expenses were incurred after your account was established. You can still enroll in a Limited Purpose FSA for dental and vision expenses. See page 15 for more information.

You are eligible to participate in an HSA if you are enrolled for the CDHP and you are not covered under any other health plan that's not a qualifying High Deductible Health Plan (HDHP), such as your spouse's plan, a general-purpose health FSA, Medicare, nor are you 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.

2014 Annual Health Savings Account Contribution Summary

CDHP Coverage Level	2014 Contribution Limit	PFG Contribution*	Associate's Contribution Maximum
Associate Only	$3,250	$250	$3,000
Associate + Spouse Associate + Child(ren) Family	$6,500	$500	$6,000
Catch Up (if turning age 55+ in 2014)**	+$1,000	N/A	+$1,000

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

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 24 or older.

Network and Out-of-Area Plans

We will continue offering our existing medical plans in 2014:

Network Plans	Out-of-Area Plans
UHC Choice Plus Medical Plan 1	UHC Out-of-Area Medical Plan 1
UHC Choice Plus Medical Plan 2	UHC Out-of-Area Medical Plan 2

For both Network and Out-of-Area Plans, Medical Plan 1 will have lower payroll premium deductions than Medical Plan 2, but it will also have higher deductibles, copayments and coinsurance. Services covered under each plan will remain the same. However, please be aware *there will be cost increases under all of these plans*. These cost increases apply to:

- Per-pay-period premium deductions
- Deductibles
- Coinsurance percentage (Plan 1 only)
- Out-of-pocket maximums
- Mail order prescription coinsurance minimums and maximums

These plans will continue to cover certain preventive services, such as routine physical exams and immunizations, at 100%. You'll pay a copayment for services such as office visits to your primary care physician and for prescription drugs. You'll have a deductible and coinsurance for other services, such as non-routine lab work, x-rays, and outpatient hospital services.

For more details about these plans and the cost changes, please refer to the premium deduction and plan comparison charts on pages 8-9.

Medical ID Cards

You will **not** receive new Medical ID cards from UHC if you are electing the same medical plan for 2014. Please keep your current cards and continue to use them. If you are enrolling in a different medical plan for 2014, UHC will send you new medical cards before January 1, 2014.

The Out-of-Area Plans are offered only to associates who live outside the Network Plans' service area. With the Out-of-Area Plans, the benefit allowance is the same regardless of the provider you use, because you generally don't have access to In-Network providers.

With all of these plans, you are automatically enrolled in prescription drug coverage through CVS/Caremark.

Using Network Providers = Cost Savings

With the **Network Plans** and the **CDHP**, 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, copayments, 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.

How to Find an In-Network Provider:

Log on to www.myuhc.com and select *Find a Doctor/Hospital* or call 1-877-769-7001.

Medical and Prescription Plan Highlights

	UHC CDHP w/HSA		UHC Choice Plus Medical Plan 1	
Features	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible • Individual • Family (Associate + 1 or more)	 $ 1,500 $ 3,000	 $ 3,000 $ 6,000	 $ 1,000 $ 2,000	 $ 2,000 $ 4,000
Annual Out-of-Pocket Maximum (includes deductible) • Individual • Family (Associate + 1 or more)	 $ 6,000 $12,000	 $12,000 $24,000	 $ 5,000 $10,000	 $10,000 $20,000
Coinsurance (percentage you pay)	30%	50%	30%	50%
PCP Office Visit (no charge for routine physicals, immunizations)	30% after deductible	50% after deductible	$25 copay (no deductible)	50% after deductible
Specialist Office Visit	30% after deductible	50% after deductible	$45 copay (no deductible)	50% after deductible
Hospital Services • Inpatient • Outpatient	 30% after deductible 30% after deductible	 50% after deductible 50% after deductible	 $400 copay, then 30% 30% after deductible	 $400 copay, then 50% 50% after deductible
Emergency Services • Hospital ER • Ambulance	 30% after deductible 30% after deductible	 50% after deductible 50% after deductible	 $250 copay (waived if admitted) 30% (no deductible)	 $250 copay (waived if admitted) 30% (no deductible)
Urgent Care Facility (freestanding)	30% after deductible	50% after deductible	$45 copay (no deductible)	50% after deductible
Non-Routine Lab/X-rays (no charge for preventive/routine lab/X-rays)	30% after deductible	50% after deductible	30% after deductible $100 copay for MRI, MRA, CT & PET Scan	50% after deductible
Mental Health & Substance Abuse • Inpatient • Outpatient	 30% after deductible 30% after deductible	 50% after deductible 50% after deductible	 $400 copay, then 30% $25 copay (no deductible)	 $400 copay, then 50% 50% after deductible
Durable Medical Equipment	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Prescription Drugs, Retail Pharmacy (30-day supply)* • Generic • Brand-name, preferred • Brand-name, non-preferred	After Ded. & 30% Coinsurance: $25 max $25 min; $50 max $50 min; $100 max	Not Covered	$10 20% ($25 min; $50 max) 30% ($50 min; $100 max)	Not Covered
Prescription Drugs, Mail Order (90-day supply or CVS Pharmacy)* • Generic • Brand-name, preferred • Brand-name, non-preferred	After Ded. & 30% Coinsurance: $50 max $50 min; $100 max $100 min; $200 max	Not Covered	$20 20% ($50 min; $100 max) 30% ($100 min; $200 max)	Not Covered

*Not covered if you use a non-participating pharmacy

2014 Medical Plan Payroll Deductions

	UHC CDHP w/HSA		UHC Choice Plus Medical Plan 1	
Coverage Level	**Pre-Tax Weekly Cost**	**Pre-Tax Bi-Weekly Cost**	**Pre-Tax Weekly Cost**	**Pre-Tax Bi-Weekly Cost**
Associate Only	$20.99	$ 41.98	$29.32	$ 58.64
Associate + Spouse	$39.84	$ 79.68	$56.20	$112.41
Associate + Child(ren)	$37.65	$ 75.30	$52.62	$105.23
Family	$53.94	$107.87	$79.29	$158.59

	UHC Choice Plus Medical Plan 2		UHC Out-of-Area Plan 1	UHC Out-of-Area Plan 2
Features	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**
Annual Deductible • Individual • Family (Associate + 1 or more)	$ 500 $1,000	$ 1,000 $ 2,000	$ 1,000 $ 2,000	$ 500 $1,000
Annual Out-of-Pocket Maximum (includes deductible) • Individual • Family (Associate + 1 or more)	$2,500 $5,000	$ 5,000 $10,000	$ 5,000 $10,000	$2,500 $5,000
Coinsurance (percentage you pay)	10%	50%	30%	10%
PCP Office Visit (no charge for routine physicals, immunizations)	$20 copay (no deductible)	50% after deductible	$25 copay (no deductible)	$20 copay (no deductible)
Specialist Office Visit	$40 copay (no deductible)	50% after deductible	$45 copay (no deductible)	$40 copay (no deductible)
Hospital Services • Inpatient • Outpatient	$200 copay, then 10% 10% after deductible	$200 copay, then 50% 50% after deductible	$400 copay, then 30% 30% after deductible	$200 copay, then 10% 10% after deductible
Emergency Services • Hospital ER • Ambulance	$250 copay (waived if admitted) 10% (no deductible)	$250 copay (waived if admitted) 10% (no deductible)	$250 copay (waived if admitted) 30% (no deductible)	$250 copay (waived if admitted) 10% (no deductible)
Urgent Care Facility (freestanding)	$40 copay (no deductible)	50% after deductible	$45 copay (no deductible)	$40 copay (no deductible)
Non-Routine Lab/X-rays (no charge for preventive/routine lab/X-rays)	10% after deductible $100 copay for MRI, MRA, CT & PET Scan	50% after deductible	30% after deductible $100 copay for MRI, MRA, CT & PET Scan	10% after deductible $100 copay for MRI, MRA, CT & PET Scan
Mental Health & Substance Abuse • Inpatient • Outpatient	$200 copay, then 10% $20 copay, (no deductible)	$200 copay, then 50% 50% after deductible	$400 copay, then 30% $25 copay (no deductible)	$200 copay, then 10% $20 copay, (no deductible)
Durable Medical Equipment	10% after deductible	50% after deductible	30% after deductible	10% after deductible
Prescription Drugs, Retail Pharmacy (30-day supply)* • Generic • Brand-name, preferred • Brand-name, non-preferred	$10 20% ($25 min; $50 max) 30% ($50 min; $100 max)	Not Covered	$10 20% ($25 min; $50 max) 30% ($50 min; $100 max)	
Prescription Drugs, Mail Order (90-day supply or CVS Pharmacy)* • Generic • Brand-name, preferred • Brand-name, non- preferred	$20 20% ($50 min; $100 max) 30% ($100 min; $200 max)	Not Covered	$10 20% ($25 min; $50 max) 30% ($50 min; $100 max)	

	UHC Choice Plus Medical Plan 2		UHC Out-of-Area Plan 1		UHC Out-of-Area Plan 2	
Coverage Level	**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	$ 39.99	$ 79.98	$29.32	$ 58.64	$ 39.99	$ 79.98
Associate + Spouse	$ 79.29	$158.58	$56.20	$112.41	$ 79.29	$158.58
Associate + Child(ren)	$ 73.73	$147.45	$52.62	$105.23	$ 73.73	$147.45
Family	$115.07	$230.14	$79.29	$158.59	$115.07	$230.14

Prescription Drug Coverage

When you enroll in medical coverage, you are automatically enrolled in prescription drug coverage through CVS/Caremark. The cost of this coverage is included with your medical premiums (see pages 8-9). Your medical plan's design will determine how you pay for prescriptions. For example, if you are enrolled in one of the Network Plans, you'll pay a prescription copayment (generic only) or coinsurance at a participating pharmacy. If you are enrolled in the CDHP, the deductible and coinsurance rules apply; however, you may receive a discount on prescriptions filled by participating CVS/Caremark pharmacies. Caremark has a preferred arrangement with many independent pharmacies as well as nationwide chains, including CVS, Rite-Aid, Walgreens, and WalMart.

Prescription ID Cards

You will **not** receive new Prescription ID cards from CVS/Caremark unless you previously waived coverage and are now electing for 2014. Please keep your current cards and continue to use them.

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/pfg 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 pharmacy. The first time you use mail order, register with Caremark by visiting www.caremark.com/pfg 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 (e.g., if you've tried the generic without success or if your doctor has deemed it unsuitable for treating you due to allergy 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.

Exceptions to Step Therapy

For certain exceptions to the Step Therapy program, such as an allergic reaction to an ingredient in a generic drug or if you have already tried a generic medication without success, your physician may request prior authorization for the use of a brand-name drug by calling 1-877-203-0003.

Decision Support Tool

To help you determine if the new CDHP/HSA or one of the other plans is the best fit for your health care needs, we are also rolling out a 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 if the CDHP/HSA or another 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.

You can access this tool from ADP Self Service https://portal.adp.com any time by going to the *Benefits* tab, then *Health & Welfare*. Simply click the link on the Medical election page and follow the prompts.

Wellness Credits

Whether you choose the new CDHP with the HSA or one of the other medical plans, 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 $500 in annual credits, as follows:

Program	Wellness Credit*
Complete Health Assessment & Biometric Screening by October 31, 2013	$100
Achieve BMI and/or Weight Loss Goals as determined through Screening	$250
Confirm Non-Tobacco User Status Through New Nicotine Screening	$150
Complete a Wellness Program • QuitPower® (tobacco/nicotine cessation) • Healthy Weight • Diabetes Prevention and Control	$250 per program
Total Savings	**$500 Maximum**

*All wellness credits are applied on a per-pay-period basis.

Elect to Receive Benefits Information Electronically

You may elect to receive future benefit communications electronically. Simply log on to ADP Self Service at **https://portal.adp.com** with your user ID and password, select the *Personal Information* tab, then click *Addresses*. If your current email address is not on file, click the *Edit* button, then update your email address and click *Save*. Return to the home page, select the *Go Green* link under *Benefit News*, and follow the instructions for giving your consent for electronic delivery of benefits information.

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.

In 2014, dental coverage will be consolidated into one plan.

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	Benefit
Calendar Year Deductible (applies to basic and major services) • Individual • Family	 $ 50 $150
Orthodontic Lifetime Deductible (Per covered member – coverage for children up to age 26 only)	$ 50
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 (2 per calendar year) Bitewing X-rays (1 set per calendar year) Full Mouth X-rays (1 every 3 calendar years) Routine cleaning (every 6 months/2 per calendar year) Fluoride treatments (1 per calendar year, up to age 19) Space maintainers (up to age 14) Sealants (1 application per tooth on unrestored, noncarious permanent molars, 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 planning, gingival curettage, root canal therapy, pulpal therapy, pulp capping)	20% after deductible
Major Services 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 Diagnosis, occlusal adjustment, orthodontic appliance and orthognathic surgery.	50% after deductible
Orthodontia Complete orthodontic exam (including X-rays), active orthodontic treatment.	50% after deductible

Dental ID Cards

You will **not** receive a Dental ID card from Delta Dental for 2014. When you visit your provider, give them the Group ID number listed under "Contact Information" at the back of this guide.

2014 Dental Plan Payroll Deductions

Coverage Level	Pre-Tax Weekly Cost	Pre-Tax Bi-Weekly Cost
Associate Only	$ 4.80	$ 9.59
Associate + Spouse	$ 9.54	$19.07
Associate + Child(ren)	$11.78	$23.55
Family	$16.35	$32.70

PPO and Premier Networks

You may use providers in the Delta Dental PPO and Delta Dental Premier Networks. You'll generally pay less out of pocket if you use the PPO, but using the Premier Network will still cost you less than going out of the network.

Choosing an In-Network dentist:

When you see an In-Network provider, there are many advantages for you:

- Most importantly, yours 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.
- All you are responsible for is your deductible and coinsurance (if applicable)—PFG pays the rest, up to the annual plan maximum.

If you choose an Out-of-Network dentist:

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

You may have to file your own claim with Delta Dental, by:

- U.S. mail to Delta Dental of Virginia, 4818 Starkey Road, Roanoke, VA 24018, or
- Fax to 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 in addition to your coinsurance.
- 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.

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[3]	Out-of-Network
Eye Exams Once every 12 months[1]	Covered 100%	Reimbursed up to $35
Lenses[2] One pair every 12 months[1] • Single Vision • Bifocal • Trifocal	Covered 100%	Reimbursed up to: $25 $40 $55
Frames One pair every 24 months[1]	Up to a $120 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 • Standard • Premium	Up to $55 copay 10% discount off retail amount	N/A N/A
Contact Lenses[2] In lieu of all other lens benefits, every 12 months[1]	**Conventional:** $0 copay, $115 allowance; 15% discount on difference. **Disposable:** $0 copay, $115 allowance (member pays difference) **Medically Necessary:** $0 copay; paid in full	**Conventional:** Reimbursed up to $110 **Disposable:** Reimbursed up to $110 **Medically Necessary:** 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,[4] including contact lens fitting and follow up exam[4]	
Diabetic Care	Eye exam and diagnostic testing every six months with optional copays and member eye exam reminders.	

[1]Measured from date of last service/purchase
[2]You may select either eyeglasses or contact lenses, but not both, during the same coverage period
[3]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.
[4]Within same benefit year.

2014 Vision Plan Payroll Deductions

Coverage Level	Pre-Tax Weekly Cost	Pre-Tax Bi-Weekly Cost
Associate Only	$ 1.37	$ 2.74
Associate + Spouse	$ 2.60	$ 5.20
Associate + Child(ren)	$ 2.74	$ 5.49
Family	$ 4.03	$ 8.06

Vision ID Cards

You will **not** receive a new Vision ID card from EyeMed for 2014. When you visit your provider, give them the Group ID number listed under "Contact Information" at the back of this guide.

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.

Limited Purpose Health Care FSA (LPFSA)

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

> Remember to use the new Decision Support Tool from ADP to determine if the new CDHP with HSA will save you more money than one of the other medical plans. Regardless, you may be able to save even more money by enrolling in the Health Care FSA or the Limited Purpose Health Care FSA, as applicable, for 2014.

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 $2,500 (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 2014 may only be used to pay for eligible expenses you incur in 2014. After the claims submission deadline (the earlier of 90 days after your coverage ends or March 31, 2015), 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.

For example, if you elect to contribute $650 in 2014 ($25 bi-weekly) and incur $650 or more in eligible, out-of-pocket expenses after you've contributed only $25, you will be reimbursed for the full $650. You'll continue to have $25 deducted from each paycheck for the remainder of the year until you've contributed the full $650.

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.healthhub.com.

PayFlex Debit Cards

Your PayFlex HealthHub debit card provides you convenient access to the money in your Flexible Spending Account(s). If you were enrolled in an FSA for 2013, please keep your card and continue using it if you re-enroll in 2014 (you will **not** receive a new card unless this is your first time enrolling). 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.healthhub.com** to access your account information and to learn more about claims reimbursement options.

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.

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.healthhub.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.healthhub.com.

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 United Behavioral Health 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 a United Behavioral Health 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!

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. Open Enrollment is a good time to review your coverage needs. If you find your existing coverage is not enough, you may be able to add or increase your coverage (subject to Evidence of Insurability requirements, where applicable).

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 have 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 18 for more information about EOI).

Your monthly cost per $1,000 of coverage:

Age on December 31, 2013	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 same-sex spouse or domestic partner starting in 2014), 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

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

Your Beneficiary Information

Please verify that your beneficiary information is correct and up-to-date. In the event of your death, policy proceeds will be paid according to your most recent beneficiary designation. You may name primary and contingent (secondary) beneficiaries. You are the beneficiary for Supplemental Dependent Term Life and Supplemental AD&D coverage on your dependents.

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).

Effective with disability leaves beginning on or after January 1, 2014, the 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 $1,000 per week.
- Two or more years of service: 60% of weekly basic earnings, capped at $1,000 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 $0.43 for each $100 of monthly basic earnings.

Other Voluntary Benefits

Through Marsh at Work, 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.

Home Mortgage: Expert advice and assistance when you finance or refinance a home mortgage.

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 1-800-928-7129 or visiting www.personal-plans.com/pfgbenefits.

Legal Notices

Notice of Privacy Practices

This Notice is effective as of September 23, 2013 and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information the following plan (referred to herein as the "Plan") creates or receives about you:

- **Performance Food Group, Inc. Employee Benefits Plan**

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). Since their initial publication, the Privacy Regulations were amended by the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), and by modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, as published in the Federal Register on January 25, 2013. As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information, including "genetic information" (as defined in Section 105 of GINA), that is created or received by the Plan (your "Protected Health Information" or "PHI"). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS") and the office to contact for further information about the Plan's privacy practices.

How the Plan Will Use or Disclose Your PHI

Other than the uses or disclosures discussed below, any use or disclosure of your PHI will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself provides such right.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. Effective for uses and disclosures on or after February 17, 2010 until the date the Secretary of HHS issues guidance on what constitutes the "minimum necessary" for purposes of the privacy requirements, the Plan shall limit the use, disclosure or request of PHI (1) to the extent practicable, to the limited data set or (2) if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to HHS;
- uses or disclosures that are required by law;
- uses or disclosures that are required for the Plan's compliance with legal regulations; and
- uses and disclosures made pursuant to a valid authorization.

The following uses and disclosures of your PHI may be made by the Plan:

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above. Uses and disclosures of PHI for payment purposes are limited by the minimum necessary standard.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you. One example would be if your doctor requests information on what other drugs you are currently receiving during the course of treating you.

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances. The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes. Uses and disclosures of PHI for health care operations are limited by the minimum necessary standard.

The following use and disclosure of your PHI may only be made by the Plan with your written authorization or by providing you with an opportunity to agree or object to the disclosure:

To Individuals Involved in Your Care. The Plan is permitted to disclose your PHI to your family members, other relatives and your close personal friends involved in your health care or the payment for your health care if:

- the PHI is directly relevant to the family or friend's involvement with your care or payment for that care;
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected; and
- the PHI is needed for notification purposes, or, if you are deceased, the PHI is relevant to such person's involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

For Appointment Reminders. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that this PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require reporting of certain types of wounds or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

For Workers' Compensation. The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

For Public Health Activities. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

To Report Abuse, Neglect or Domestic Violence. When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.

For School Records. The Plan may disclose immunization records for a student or prospective student to the school to comply with a state or other law requiring the student to provide proof of immunization prior to admitting the student to school.

For Public Health Oversight Activities. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

For Judicial or Administrative Proceedings. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

For Other Law Enforcement Purposes. The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

To a Coroner or Medical Examiner. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

For Research. The Plan may use or disclose PHI for research, subject to certain conditions.

To Prevent or Lessen a Serious and Imminent Threat. When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

State Privacy Laws. Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

Your Privacy Rights With Respect to PHI

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person.

A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

Right to Amend

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make requests for amendments in writing and provide a reason to support your requested amendment.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2004. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Notwithstanding the foregoing, if your Plan maintained electronic PHI as of January 1, 2009, you can request an accounting of all disclosures of your electronic PHI made by the Plan during the three years prior to the date of your request (but on and after January 1, 2014).

Right to Receive Confidential Communications

You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan's Duties With Respect to Your PHI

The Plan has the following duties with respect to your PHI:

- The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect to the PHI.
- The Plan is required to abide by the terms of the notice that are currently in effect.
- The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. In the event of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice, the Plan will post the change or the revised Notice on its customer service and benefits web site by the effective date of the material change to the Notice, and a copy of the revised Notice, or, alternatively, information about the change to the Notice and the means to obtain the revised Notice, will be provided to you in the Plan's next annual benefits (or similar) mailing.
- The Plan is required to notify you of any "breach" (as defined in 45 CFR 164.402 of the Privacy Regulations) of you unsecured PHI.

Your Right to File a Complaint

You have the right to file a complaint with the Plan or HHS if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Complaint Official, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

Contact Information

If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI, or your rights under HIPAA, you should contact the Privacy Official and Complaint Official for the Plan. The Privacy Official is the Chief Human Resources Officer, Performance Food Group, Inc., 12500 West Creek Parkway, Richmond, VA 23238, 1-804-484-7700. The Complaint Official is the Vice President, Compensation, Benefits & HRIS, Performance Food Group, Inc., 12500 West Creek Parkway, Richmond, VA 23238, 1-804-484-7700.

Special Enrollment Rights

HIPAA Special Enrollment Rules

If you have declined enrollment in PFG's medical plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in health coverage under this plan without waiting for the next Annual Enrollment period, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Children's Health Insurance Program Reauthorization Act of 2009

PFG will allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these new enrollment opportunities, you will have 60 days instead of 31 – from the date of the Medicaid /CHIP eligibility change to request enrollment in the PFG health plan. Note that this new 60 day extension does not apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility.

ALABAMA- Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

ALASKA- Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage):1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA- CHIP
Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

COLORADO- Medicaid
Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA- Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA- Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO - Medicaid and CHIP
Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA - Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA - Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS - Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY - Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA - Medicaid
Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE - Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY 1-800-977-6741

MASSACHUSETTS - Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA - Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA - Medicaid
Medicaid Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084

NEBRASKA - Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-800-383-4278

NEVADA - Medicaid
Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY - Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK - Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA - Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA - Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON - Medicaid and CHIP
Website: http://www.oregonhealthykids.gov; http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND - Medicaid
Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA - Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS - Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH - Medicaid and CHIP
Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

VERMONT - Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP
Medicaid Website: http://www.dmas.virginia.gov/
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

WASHINGTON - Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA - Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN - Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of I998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under this Plan. Therefore, the deductibles and coinsurance shown in the medical section of this guide apply. If you would like more information on WHCRA benefits, call your Plan Administrator at **1-804-484-7700**.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Notice from PFG about Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Performance Food Group, Inc. Employee Benefits Plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2014. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2014 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty - as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Notice of Creditable Coverage

Please read this notice carefully. It has information about prescription drug coverage with PFG and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the PFG prescription drug plans listed below, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2014. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

- Consumer Driven Health Plan
- Medical Plans 1 & 2
- Medical Out-of-Area Plans 1 & 2

If you decide to enroll in a Medicare prescription drug plan and you are an active associate or family member of an active associate, you also may continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop PFG coverage, Medicare will be your only payer. You can re-enroll in the employer plan at Open Enrollment or if you have a special enrollment event for the Performance Food Group, Inc. Employee Benefits Plan.

You should know that if you waive or leave coverage with PFG and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this PFG coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You also may be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help
- Call your State Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number)
- Call **1-800-MEDICARE (1-800-633-4227).** TTY users should call **1-877-486-2048**

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For information, contact the Social Security Administration (SSA) online at www.socialsecurity.gov or call **1-800-772-1213** (TTY **1-800-325-0778**).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Chief Human Resources Officer
Performance Food Group
12500 West Creek Parkway
Richmond, VA 23238
1-804-484-7700

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 Passcode: pfghealthy	
General Benefits Questions	Benefits Center	ADP Self Service at https://portal.adp.com, then Benefits tab.	1-888-MYHWBEN (1-888-694-9236) 10 am – 8 pm ET, Monday- Friday.
Verification of Dependents and Qualified Changes in Status	Dependent Verification Services (DVS)		1-800-847-8531 1-866-400-1686 (fax)
Medical	United Healthcare Group Number: 742781	www.myuhc.com	1-877-769-7001 1-877-440-9935 NurseLine®
Prescription Drug	Caremark Group Number: PFGRX	www.caremark.com/pfg	1-888-790-4260
Dental	Delta Dental Group Number: 700065	www.deltadentalva.com	1-800-237-6060
Vision	EyeMed Group Number: 9659616	www.eyemedvisioncare.com	1-866-723-0513
Employee Assistance Program (EAP)	United Behavioral Health	www.liveandworkwell.com Access code: PFG	1-866-248-4094
Health Savings Account (HSA) and Flexible Spending Accounts (FSAs)	PayFlex Group Number: 119232	www.healthhub.com	1-800-284-4885
Disability	Contact your supervisor first, then Aetna Disability Services Group Number: 809843	www.wkabsystem.com Company Identifier: PFG	1-800-688-6820
401(k)	Fidelity	www.401k.com	1-800-835-5095
Wellness Programs • QuitPower® (Tobacco Cessation Program) • Healthy Weight • Healthy Pregnancy			1-877-784-8797 Company Identifer: PFG 1-800-478-1057 1-800-411-7984
Voluntary Benefits	Marsh at Work	www.personal-plans.com/pfgbenefits	1-800-928-7129

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.

PFG Performance Food Group

12500 West Creek Parkway
Richmond, VA 23238