2019 Benefits Open Enrollment

October 29 - November 9, 2018

PFG Performance Food Group

HEALTHY TOGETHER

What's Inside

Welcome to 2019 Benefits Open Enrollment

October 29 – November 9, 2018

Maintaining your health and well-being is important to you and your family–and that's important to us. At Performance Food Group we continue to evaluate and enhance our benefits and more – your Total Rewards.

We strive to keep our offerings competitive and meaningful while delivering quality and affordability for you and for PFG. We remain committed to being "Healthy Together."

Due to federal regulations, Open Enrollment is typically your only opportunity to make certain elections and changes to your benefits and covered dependents–unless you experience a qualifying family status change during the year. It is also a good opportunity to review and update your dependent and beneficiary information, where applicable.

We hope you will take time to familiarize yourself with the benefits PFG is offering for 2019. Please consider your benefit needs, the options available, and the associated costs for each plan, then actively participate in the 2019 Open Enrollment process so you will have the coverage best suited to your needs and budget.

For further assistance call the Benefits Center at 1-888-MYHWBEN (1-888-694-9236 option 1) Monday – Friday 10 am – 8 pm ET and Saturday 8 am – 5 pm ET. Spanish-speaking representatives are also available.

2019 Benefits Open Enrollment Highlights At-a-Glance

PFG has a personal interest in the health and well-being of all our associates and their families. That is why we'll continue to focus on staying *Healthy Together* in 2019. Below are some highlights of our 2019 benefits strategy toward meeting that goal:

For 2019, **you must actively enroll** in medical benefits, or to make contributions to a Flexible Spending Account (FSA) for health or dependent care, limited purpose, and/or a Health Savings Account (HSA), if eligible (please see pages 8, 19-21 for details about the different plans available and their eligibility requirements).

- **If you do not actively enroll in medical,** you will be defaulted to the CDHP plan at the same coverage level you currently have for 2018. If you waived coverage for 2018, you will continue to waive coverage in 2019 if no action is taken.
- **If you do not actively enroll in an FSA,** for health or dependent care, and/or limited purpose, you will not be able to contribute to these accounts unless you experience a qualifying event.
- **If you do not actively enroll in an HSA,** you will not be able to contribute to this account until you make an election. With an HSA, you can make changes to your contributions at any time.

There will be three medical plans for you to choose from in 2019:

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

Payroll deductions are also changing. Take this opportunity to evaluate which of the medical plans is the best option for you in order to decide whether to continue your current coverage or make a change.

When making your medical election for 2019, you will be prompted to answer a question regarding nicotine usage. If you have used nicotine in the past 12 months, you will be charged a nicotine surcharge in the amount of $600 annually. **If you do not make an election but have coverage under PFG's medical plans, you will automatically be defaulted to a nicotine user status and charged the nicotine surcharge.**

PFG's wellness program will now be a participation-based program instead of an incentive-based program. Meaning, regardless of your results, you have the opportunity to earn a wellness contribution to an HSA or a Health Reimbursement Arrangement (HRA) depending on the medical plan you enroll in. Your spouse/ domestic partner (DP) can also participate this year. In order to qualify for any wellness contributions, you and/or your spouse/ domestic partner must complete a biometric screening and an annual physical. See page 10 for more details.

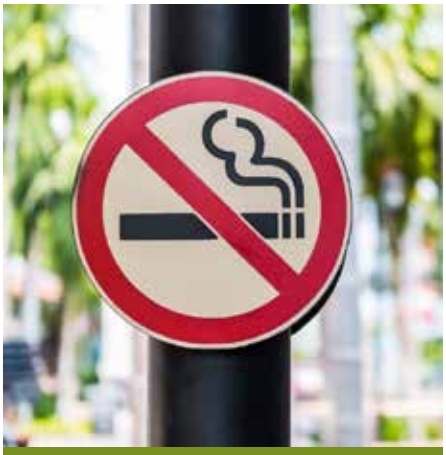
If you participate in the CDHP, PFG will contribute to your HSA. Contributions are (pro-rated, on a pay period basis) $250 if you have coverage for yourself, and $500 if you have coverage for yourself and at least one other dependent. If you wish to add your own contributions, refer to page 8 for the 2019 annual contribution limits. You are *not* eligible for an HSA if you elect the HDHP or the PPO.

In 2019, UnitedHealthcare (UHC) will be the new administrator for all FSAs and HRAs, while Optum Financial Services (Optum) will administer HSAs. You will still receive a debit card to use when seeking reimbursement for eligible expenses. See pages 8, 19 and 20 for more information.

We encourage you to review the information provided by the online Decision Support Tool (see page 9) as part of the enrollment process. This tool can help you forecast the "big picture" of your overall out-of-pocket costs (per-pay-period premiums, deductibles, copayments, etc.) under each plan option and also show how funding an FSA or HSA with pre-tax dollars might help you cover some of your out-of-pocket costs.

Learn about your medical plan options. In the newly redesigned enrollment site (my.adp.com), you will be able to view a plan comparison to decide which plan will provide the best value for your situation. The information provided can help you forecast costs related to paying for and using your coverage.

Additional information on the full menu of PFG Benefits is available on the following pages of this guide. You may also view a recorded presentation at **https://www.pfgcbenefits.com/2019OEPresentation** to learn more about changes for 2019. When you are ready to make your 2019 elections, please go online to ADP Self Service at **https://my.adp.com** (click on Benefits) or call the Benefits Service Center at 1-888-MYHWBEN (1-888-694-9236 option 1).



Nicotine Surcharge

An annual nicotine surcharge of $600 (prorated per-pay-period) will be added to your 2019 medical premiums if:

You have used any nicotine product within the last 12 months (this includes but is not limited to those delivered through: e-cigarettes, vaporizers and other electronic delivery systems, as well as cigarettes, cigars, pipes, smokeless tobacco products, hookahs, patches, gum and lozenges.

When electing your medical coverage, you will need to certify whether you have or have not used nicotine products. **If you do not make a medical plan election, you will automatically default to a nicotine user status and have the surcharge.**

If you are a nicotine user, you can have the surcharge removed by completing the Quit 4 Life program offered as part of PFG's wellness program.

To enroll in Quit 4 Life, call 1-866-QUIT-4-LIFE (1-866-784-8454) or go online to QUITNOW.NET (company identifier: PFG).

Benefits Eligibility

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

If a plan offers a spouse coverage option, you may enroll:

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

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

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

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

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

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

For more information, visit **https://my.adp.com** and click on Benefits, then click on Forms & Plan Documents. You may also call the Benefits Center at 1-888-MYHWBEN (1-888-694-9236 option 1).

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 by contacting the Benefits Center within 31 days of the event. Your benefit elections will be effective the first of the month following the date of the change in your family status. The only exceptions are if you experience a birth or adoption; benefits will begin on the date of the birth or adoption. The type of qualifying event will determine the type of change you are allowed to make and when the change in coverage takes effect. Qualifying family status change events may occur when:

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

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

Enrolling Online

Already registered? Follow the instructions in the right-hand column below.

If you're registering for the first time:

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

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

1. **Go to https://my.adp.com**
2. **Click** *User Sign In*
3. **Enter** your User Name and Password (your User Name is the user ID you received when you completed your registration; your password is the password you created)
4. When the PFG ADP Self Service Home Page appears, **go to** *Benefits*
5. **Click** *Enroll Now!* and follow the instructions
6. When finished, **Click** *Complete Enrollment,* then *Confirm Enrollments*

Using Network Providers = Cost Savings

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

In-Network providers have service agreements with UHC, so your share of the cost is based on a rate agreed upon between UHC and the provider, known as the "maximum allowable amount."

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

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

How to Find an In-Network Provider:

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

Our Approach to Health Care

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

Maintaining quality and affordability are key components of the overall design. Self-funding our medical plans allows us to directly manage administrative costs, which in turn allows a bigger share of premium contributions to go towards the actual cost of providing health care for you and your family. Another way we help our medical plans stay affordable is by encouraging spouses/domestic partners to take advantage of medical coverage that is available to them through employment or other sources.

For 2019, we're offering associates a choice between three plans (plus an "out-of-area" alternative for those outside of the Choice Plus network for the PPO), which are all administered by UnitedHealthcare (UHC):

- **UHC HDHP**
- **UHC CDHP**
- **UHC PPO (or UHC Out-of-Area Plan for associates residing outside PPO service areas)**

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

Our goal is for you to have the coverage that best suits you and your family's needs for 2019, while enabling both you and PFG to stretch each dollar spent on health care to its full potential. By keeping you informed about your health options (with their associated benefits, providers, costs, and other requirements) *plus* additional opportunities for cost savings such as FSAs, we hope that goal is met.

You are required to make a medical election during the 2019 Open Enrollment. If you do not make an election, you will be defaulted to the CDHP plan at the same level of coverage you have for 2018. If you waive coverage, you will continue to waive coverage in 2019. It is to your advantage to carefully evaluate your options and costs to determine if your current coverage still provides the best fit, because plan designs and payroll deductions can change from year to year. To help you make the best choices and leverage money you spend on medical and prescriptions, please check out the Decision Support Tool (see page 9) and also consider cost savings strategies such as FSAs or CDHP with an HSA (you must make active elections each year to contribute to the FSAs or an HSA).

Medical Plans

You may choose from the following medical plan options for 2019:

- **UHC HDHP**
- **UHC CDHP**
- **UHC PPO (UHC Out-of-Area Plan for associates residing outside PPO service areas)**

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

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

Cost sharing components

- **Premium cost:** this refers to the pre-tax deductions taken from your paychecks, as well as the portion of premiums that PFG pays to provide coverage.
- **Deductible:** the dollar amount you are required to pay for services before your medical plan covers any portion of the cost.
- **Coinsurance:** your share of the cost after you have satisfied your deductible; usually expressed as a percentage of the cost (e.g., you pay 20 percent and the medical plan covers the rest).
- **Copayment:** a pre-determined dollar amount paid to your provider when you receive services under the PPO plan (e.g., $25 per office visit to a primary care physician).
- **Annual out-of-pocket limit:** the maximum dollar amount you are required to pay for covered services in the plan year. Once you reach this limit, the medical plan covers 100% of any additional covered expenses for the year. Think of this as a "safety net" protecting you against catastrophic costs that you might incur in the event of a serious illness or injury. The amounts you have paid in deductibles, coinsurance, and copayments all count towards satisfying this limit.
- **Preventive care:** includes routine annual physical exams and screenings, well-child care, and age-appropriate immunizations that are covered 100 percent by the plan and do not require you to meet a deductible or pay a co-payment or coinsurance.

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

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

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

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

All of our medical plans cover the same services. The Decision Support Tool (see page 9) helps you figure out what cost-sharing arrangement for receiving those services is the best for you. If we all choose the most appropriate place for the type of care we need, we control both our own out-of-pocket costs and keep premiums lower for everyone in the future. An example is applying home treatment and waiting to be checked out by a primary care physician during office hours or using a virtual visit provider instead of going to an urgent care center. If it is a condition that cannot wait, you may want to go to the nearest urgent care center instead of the emergency room over the weekend (if the condition is not serious or life-threatening), as that could save you thousands of dollars. Shopping around for lower cost prescription drugs, using generics, or even opting for over-the-counter alternatives, when appropriate, can save you hundreds of dollars in your medical spending.

UHC High Deductible Health Plan (HDHP)

This plan is designed to offer associates a minimal safety net against high, unanticipated medical costs. Of the three plan options PFG offers, this plan has the highest annual deductibles ($5,000 per individual; $10,000 if covering one or more dependents). However as a trade-off, it has the lowest per-pay-period payroll deductions. When weighing affordability, you'll want to factor in more than the deductible and per-pay-period costs.

Under this medical plan, you are responsible to pay for most health care services, with the exception of a Primary Care Physician (PCP) visit, until your annual deductible is met, then the coinsurance rate applies. With coinsurance, you share a percentage of the cost with the plan until your annual out-of-pocket limit is reached; then the plan pays 100% of additional medical costs incurred within the same year. The covered expenses you pay under the medical benefits count towards the deductible and medical & prescription costs count towards the 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 are used to paying a copayment for services such as specialist office visits, please be aware that those services will be subject to the deductible and coinsurance under the HDHP.

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

Summary of Benefits and Coverage (SBC)

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

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

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

Consumer Driven Health Plan (CDHP)

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

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

The deductible and out-of-pocket maximum work differently based on coverage level. If any covered member or more than one member of the family incur services, the family deductible must be met. Conversely, if any covered member of the family reaches the individual maximum out-of-pocket, for that covered member you will not have to pay anything further for covered expenses for the remainder of the 2019 calendar year.

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

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

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

Did You Know?

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

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

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

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

Health Savings Account (HSA)

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

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

- No use-it-or-lose-it requirement. Your account balance can grow over time to cover future expenses, since any unused funds in your account roll over from year-to-year.
- You may invest part of your account balance for longer term growth using a combination of investment funds, once your account balance is at least $2,000.
- You own the account if you 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 expenses that were incurred after your account was established. A complete list of eligible expenses can be found online at **myuhc.com**. You can still enroll in a Limited Purpose FSA for dental and vision expenses. See page 19 for more information.

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

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

2019 Annual Health Savings Account Contribution Summary

Coverage Level	2019 Contribution Limit	PFG Contributions[1]		Your Contribution Limit
		Automatic	Potential Wellness	
Associate Only	$3,500	$250	$400	$2,850
Associate + Spouse Associate + Children Family	$7,000	$500	$600	$5,900
Catch Up (if turning age 55+ in 2019)[2]	$1,000	N/A	N/A	$1,000

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

UHC PPO and Out-of-Area Plans

PPO or "Preferred Provider Organization" plans provide you with the convenience of paying a specified copayment (or sometimes a deductible) up front—at the time you receive medical services or fill prescriptions using one of the plan's designated ("preferred" or "network") providers. In that way, a PPO can alleviate some of the concern and guesswork because you generally know how much you will have to pay out of your own pocket for routine medical services and prescriptions. However, the tradeoff for this convenience is a higher per-paycheck premium deduction than the HDHP or CDHP.

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

Decision Support Tool

To help you determine if the HDHP, CDHP, or the PPO plan is the best fit for your medical and prescription plan needs, we encourage you to utilize the Decision Support Tool. This tool allows you to input your typical or expected medical expenses and rank your preferred plan features, you may want to input your 2018 expenses if they represent your typical year, then compare your hypothetical bottom line under each PFG medical plan. While there is no way to know for certain which plan will have the lowest out-of-pocket cost overall, the Decision Support Tool can take some of the guesswork out of your decision-making.

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

You can access this tool from ADP Self Service at **https://my.adp.com** (click on Benefits).

Simply click the link on the Medical tile and follow the prompts. This tool is only accessible on the medical page during your enrollment period.

Medical ID Cards

You will receive new Medical ID cards from UHC.

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

Elect to Receive Benefits Information Electronically

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

***Going Green* is easy, follow the steps below:**

1. Log on to **www.pfgcbenefits.com**
2. Ensure Delivery Preference is **"Electronic."**

Wellness Contributions

Regardless of which medical plan you choose, you have the opportunity to earn cost savings by participating in PFG's Wellness Program, and PFG has made it even easier for you to earn additional cost savings. PFG's Wellness Program is changing from incentive-based to a participation-based program. In other words, regardless of your results, you will be rewarded with a contribution to an HSA or HRA depending on the medical plan you have elected. All you need to do is complete a biometric screening and annual physical between October 1, 2018 and September 30, 2019.

Your spouse/domestic partner (DP) can earn an additional contribution to an HSA or HRA if they are covered under your medical plan and also complete a biometric screening and annual physical between October 1, 2018 and September 30, 2019. You do not have to participate to receive any contribution your spouse/DP may earn.

If you and/or your spouse/DP were unable to participate in an onsite biometric screening, you can still do so at a participating Quest facility or your physician's office. To schedule an appointment for a biometric screening:

- Go to **https://my.questforhealth** and create an account if you do not already have one. The Registration Key is PFG2018. Enter the required information, or;
- Call 1-855-623-9355, Monday - Friday, from 8 am - 9:30 pm ET and Saturday 8:30 am - 5 pm ET.

By completing a biometric screening and annual physical	Enrolled in HDHP or PPO	Enrolled in CDHP
You can earn:	$400 contribution to an HRA	$400 contribution to an HSA
Your Spouse/DP can earn:	$200 contribution to an HRA	$200 contribution to an HSA

Employee Assistance Program (EAP)

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

Confidential assistance is available 24/7 by calling OPTUM® at 1-866-248-4094, or you can access a variety of online and interactive resources by logging on to **www.liveandworkwell.com**.

The program is designed to help you and your eligible dependents cope with a variety of issues. Whether you need support through a personal or family crisis, financial or legal advice, stress management tips, or help finding resources to deal with substance abuse and recovery, the EAP is a good place to start. When needed, the EAP will connect you with licensed professionals who provide short-term counseling services and referrals. You and your eligible dependents are each entitled to five face-to-face counseling sessions with an OPTUM® provider. Your personal records are never shared with PFG, or anyone else, without your permission.

EAP services are easy to use and are completely confidential!

Medical and Prescription Plan Highlights

	UHC HDHP with Unfunded HSA		UHC CDHP with PFG Funded HSA		UHC PPO		UHC Out-of-Area Plan
Features	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**
Annual Deductible • Individual • Family (Associate + 1 or more)	$ 5,000 $10,000	$10,000 $20,000	$ 1,500 $ 3,000	$ 3,000 $ 6,000	$ 1,250 $ 2,250	$ 2,500 $ 4,500	$ 1,250 $ 2,250
Annual Out-of-Pocket Maximum (includes deductible) • Individual • Family (Associate + 1 or more)	$ 6,550 $13,100	$13,100 $26,200	$ 6,550 $13,100	$13,100 $26,200	$ 6,000 $12,000	$12,000 $24,000	$ 6,000 $12,000
Coinsurance (percentage you pay)	30%	50%	20%	50%	20%	50%	20%
PCP Office Visit (no charge for routine physicals, immunizations)	$25 copay	50% after deductible	20% after deductible	50% after deductible	$25 copay	50% after deductible	$25 copay
Specialist Office Visit	30% after deductible	50% after deductible	20% after deductible	50% after deductible	$40 copay	50% after deductible	$40 copay
Virtual Visit (Telemedicine)	$25 copay	50% after deductible	20% after deductible, up to $49	50% after deductible	$25 copay	50% after deductible	$25 copay
Hospital Services • Inpatient • Outpatient	30% after deductible 30% after deductible	50% after deductible 50% after deductible	20% after deductible 20% after deductible	50% after deductible 50% after deductible	$150 copay per day (5 day max), 20% after deductible 20% after deductible	50% after deductible 50% after deductible	$150 copay per day (5 day max), 20% after deductible 20% after deductible
Emergency Services • Hospital ER • Ambulance	30% after deductible 30% after deductible	50% after deductible if not emergency 30% after deductible	20% after deductible 20% after deductible	50% after deductible if not emergency 30% after deductible	$250 copay (waived if admitted), 20% after deductible 20% (no deductible)	50% after deductible if not emergency 20% (no deductible)	$250 copay (waived if admitted), 20% after deductible 20% (no deductible)
Urgent Care Facility (freestanding)	30% after deductible	50% after deductible	20% after deductible	50% after deductible	$40 copay	50% after deductible	$40 copay
Non-Routine Lab/X-rays (no charge for preventive/routine l lab/X-rays)	30% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible $100 copay for MRI, MRA, CT & PET Scan	50% after deductible	20% after deductible $100 copay for MRI, MRA, CT & PET Scan
Mental Health & Substance Abuse • Inpatient • Outpatient	30% after deductible 30% after deductible	50% after deductible 50% after deductible	20% after deductible 20% after deductible	50% after deductible 50% after deductible	$150 copay per day (5 day max), 20% after deductible $25 copay	50% after deductible 50% after deductible	$150 copay per day (5 day max), 20% after deductible $25 copay
Durable Medical Equipment	30% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible
Prescription Drugs, Retail Pharmacy (30-day supply)* • Generic • Brand-name, preferred • Brand-name, non-preferred • Specialty	$25 max 30% ($50 min; $100 max) 50% ($75 min; $150 max) 50% ($100 min; $150 max)	Not Covered	After Ded.† $25 max 30% ($50 min; $100 max) 50% ($75 min; $150 max) 50% ($100 min; $150 max)	Not Covered	$25 max 30% ($50 min; $100 max) 50% ($75 min; $150 max) 50% ($100 min; $150 max)	Not Covered	$25 max 30% ($50 min; $100 max) 50% ($75 min; $150 max) 50% ($100 min; $150 max)
Prescription Drugs, Mail Order (90-day supply or CVS Pharmacy)* • Generic • Brand name, formulary • Brand name, non-formulary • Specialty	$50 max 30% ($100 min; $200 max) 50% ($150 min; $300 max) 50% ($200 min; $300 max)	Not Covered	After Ded.† $50 max 30% ($100 min; $200 max) 50% ($150 min; $300 max) 50% ($200 min, $300 max)	Not Covered	$50 max 30% ($100 min; $200 max) 50% ($150 min; $300 max) 50% ($200 min; $300 max)	Not Covered	$50 max 30% ($100 min; $200 max) 50% ($150 min; $300 max) 50% ($200 min; $300 max)

* Not covered if you use a non-participating pharmacy
† Preventive Drugs do not require the deductible be met prior to paying the coinsurance. A list of preventive drugs is available in the Benefits section, under Forms & Plan Documents, located on ADP Self-Service.

2019 Medical Plan Payroll Deductions

Coverage Level	UHC HDHP with Unfunded HSA		UHC CDHP with PFG Funded HSA		UHC PPO Plan		UHC Out-of-Area Plan	
	Pre-Tax Weekly Cost	Pre-Tax Bi-Weekly Cost	Pre-Tax Weekly Cost	Pre-Tax Bi-Weekly Cost	Pre-Tax Weekly Cost	Pre-Tax Bi-Weekly Cost	Pre-Tax Weekly Cost	Pre-Tax Bi-Weekly Cost
Associate Only	$ 17.82	$ 35.64	$ 23.10	$ 46.20	$ 45.15	$ 90.31	$ 45.15	$ 90.31
Associate + Spouse/DP	$ 43.53	$ 87.07	$ 52.08	$ 104.15	$120.72	$241.44	$120.72	$241.44
Associate + Child(ren)	$ 39.82	$ 79.63	$ 47.15	$ 94.30	$110.41	$220.82	$110.41	$220.82
Family	$ 70.23	$140.46	$ 83.28	$166.56	$191.88	$383.75	$191.88	$383.75

Fitting It All Together

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

Medical Plan Usage Comparisons

Meet Beth and Leonard

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

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

Description of Services Received		HDHP			CDHP			PPO		
Medical/Prescription	**Covered Charges**	**Applied to $10,000 Deductible**	**PFG Pays**	**Member Pays**	**Applied to $3,000 Deductible**	**PFG Pays**	**Member Pays**	**Applied to $2,250 Deductible**	**PFG Pays**	**Member Pays**
Beth's expenses										
Well visit	$ 120	$ 0	$ 120	$ 0	$ 0	$ 120	$ 0	$ 0	$ 120	$ 0
2 specialist visits	560	560	0	560	560	0	560	0	480	80[2]
2 lab tests	66	66	0	66	66	0	66	66	0	66
Mail-order drug[1]	760	0	532	228	760	0	760	0	532	228
Leonard's expenses										
Well visit	120	0	120	0	0	120	0	0	120	0
2 specialist visits	560	560	0	560	560	0	560	0	480	80[2]
2 lab tests	497	497	0	497	497	0	497	497	0	497
Virtual Visit (Telemedicine)	100	0	75	25	49	51	49	0	75	25
Jill and Tom's expenses										
2 well visits	400	0	400	0	0	400	0	0	400	0
2 sick visit	200	0	150	50[3]	200	0	200	0	150	50[3]
Retail Generic Prescription	18	0	0	18	18	0	18	0	0	18
Covered Charges and Payments	$ 3,401	$ 1,683	$ 1,397	$ 2,004	$2,701	$ 691	$ 2,710	$ 563	$ 2,357	$ 1,044
HSA Contribution			Not Eligible			$ 500	$ (500)		Not Eligible	
Premiums for Family Coverage			$12,295	$3,652		$12,455	$4,331		$14,966	$9,978
Wellness Contribution[4]			$ 600	$ (600)		$ 600	$ (600)		$ 600	$ (600)
Total Premiums and Out-of-Pocket Costs			**$14,292**	**$5,056**		**$14,246**	**$5,941**		**$17,923**	**$10,422**

[1]3-month supply of brand name prescription, filled 4 times
[2]$40 copay per specialist visit
[3]$25 copay per Primary Care Physician (PCP) visit
[4]Wellness Contributions are deposited into an HSA if enrolled in the CDHP and an HRA if enrolled in the HDHP or PPO

All dollar figures are rounded

Beth and Leonard may have gone into Open Enrollment thinking that the PPO would be best for them since they are a family of four who uses medical care during the year. But looking closer at each option, they realize they would pay approximately $4,480 more for the PPO and may not utilize the plan enough to make up for that cost difference. Although their total out-of-pocket spending would be lower under the HDHP, they like the CDHP's lower deductible and out-of-pocket maximum, plus the Health Savings Account feature. They decide to enroll in the CDHP and use their cost savings to invest in their future by making pre-tax contributions to both a Health Savings Account and a 401(k).

Meet Sue and Rick

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

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

Description of Services Received		HDHP			CDHP			PPO		
Medical/Prescription	**Covered Charges**	**Applied to $10,000 Deductible**	**PFG Pays**	**Member Pays**	**Applied to $3,000 Deductible**	**PFG Pays**	**Member Pays**	**Applied to $2,250 Deductible**	**PFG Pays**	**Member Pays**
Sue's annual expenses										
Well visit	$ 120	$ 0	$ 120	$ 0	$ 0	$ 120	$ 0	$ 0	$ 120	$ 0
2 specialist visits	560	560	0	560	560	0	560	0	480	80[2]
2 lab tests	66	66	0	66	66	0	66	66	0	66
Minor outpatient surgery	385	385	0	385	385	0	385	385	0	385
Mail-order drug[1]	380	0	266	114	380	0	380	0	266	114
Surgery requiring inpatient hospitalization for 8 days	26,500	3,989	20,961	5,539	1,609	21,341	5,159	799	21,031	5,469
Lab tests while hospitalized	800	0	800	0	0	800	0	0	800	0
Mail-order drug[1]	380	0	380	0	0	380	0	0	380	0
Rick's annual expenses										
Well visit	120	0	120	0	0	120	0	0	120	0
3 specialist visits	840	840	0	840	0	672	168	0	720	120[2]
MRI and lab tests	5,000	2,610	1,673	3,327	0	4,000	1,000	500	4,400	600
Sick visit PCP	200	0	175	25[3]	0	160	40	0	175	25[3]
Retail Generic prescription	18	0	0	18	0	0	18	0	0	18
Virtual Visit (Telemedicine)	100	0	75	25	0	80	20	0	75	25
Covered Charges and Payments	$35,469	$8,450	$24,570	$10,899	$3,000	$27,673	$ 7,796	$1,750	$28,567	$ 6,902
HSA Contribution			Not Eligible			$ 500	$ (500)		Not Eligible	
Premiums for Associate + Spouse/DP Coverage			$ 8,026	$ 2,264		$ 8,124	$ 2,708		$ 9,818	$ 6,277
Wellness Contribution[4]			$ 400	$ (400)		$ 400	$ (400)		$ 400	$ (400)
Total Premiums and Out-of-Pocket Costs			**$32,996**	**$12,763**		**$36,697**	**$9,604**		**$38,625**	**$12,779**

[1]3-month supply of generic prescription, filled 4 times
[2]$40 copay per specialist visit
[3]$25 copay per Primary Care Physician (PCP) visit
[4]Wellness Contributions are deposited into an HSA if enrolled in the CDHP and an HRA if enrolled in the HDHP or PPO

All dollar figures are rounded

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

Meet Frankie

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

Description of Services Received		HDHP			CDHP			PPO		
Medical/Prescription	**Covered Charges**	**Applied to $5,000 Deductible**	**PFG Pays**	**Member Pays**	**Applied to $1,500 Deductible**	**PFG Pays**	**Member Pays**	**Applied to $1,250 Deductible**	**PFG Pays**	**Member Pays**
Robbie's expenses:										
Well visit	$ 120	$ 0	$ 120	$ 0	$ 0	$ 120	$ 0	0	$ 120	$ 0
2 specialist visits	560	560	0	560	560	0	560	0	480	80[1]
Sick visit	190	0	165	25[2]	190	0	190	0	165	25[2]
Generic Prescription	10	10	0	10	10	0	10	0	0	10
Virtual Visit (Telemedicine)	100	0	75	25	49	51	49	0	75	25
Covered Charges and Payments	$980	$570	$360	$620	$809	$171	$809	$0	$840	$140
HSA Contribution			Not Eligible			$250	$(250)		Not Eligible	
Premiums for Associate Only Coverage			$3,901	$927		$3,881	$1,201		$5,204	$2,348
Wellness Contributions[3]			$400	$(400)		$400	$(400)		$400	$(400)
Total Premiums and Out-of-Pocket Costs			**$4,661**	**$1,147**		**$4,702**	**$1,360**		**$6,443**	**$2,088**

[1]$40 copay per specialist visit
[2]$25 copay per Primary Care Physician (PCP) visit
[3]Wellness Contributions are deposited into an HSA if enrolled in the CDHP and an HRA if enrolled in the HDHP or PPO

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

Prescription Drug Coverage

When you enroll in medical coverage, you are automatically enrolled in prescription drug coverage through Caremark (CVS Health). The cost of this coverage is included with your medical premiums (see page 14).

Determine how you pay for prescriptions. For example, if you are enrolled in the CDHP, the deductible and coinsurance rules apply. For the HDHP & PPO plans, only coinsurance applies. Caremark has a preferred arrangement with many independent pharmacies as well as nationwide chains, including CVS, Rite-Aid, Walgreens, Target and Walmart.

Filling and Refilling Prescriptions

You have access to both retail and mail order prescriptions. For prescriptions you need to fill immediately, go to any participating retail pharmacy and present your Caremark ID card. Visit **www.caremark.com** or call Caremark Customer Care at 1-888-790-4260 to find a participating retail pharmacy. If your doctor has authorized refills, contact your pharmacy when you've used about 70% of your supply (e.g., 21 days of a 30-day supply).

For maintenance drugs (those you take on a long-term basis), you are required to use the Mail Order Program or a local CVS or Target pharmacy. The first time you use mail order, register with Caremark by visiting **www.caremark.com** or by calling 1-888-790-4260. Then complete and return your mail service order form along with your prescription (request a duplicate from your doctor) and payment. Refills are available when you've used about 60% of your supply, and can be ordered online or by phone with a credit card once you're registered and your prescription is on file. For even greater convenience, you may register for automatic refills with a credit card. Please allow 10-14 days for mail order prescriptions to arrive at your home.

Step Therapy

Step therapy is a process targeted at providing the most cost-effective prescription drugs for your needs. The first step requires you to use a *generic equivalent* of a drug that is commonly prescribed for your condition, when a suitable generic is available. Generic drugs will cost the least.

If a generic equivalent is not available or suitable (for example, if you've tried the generic medication without success or if your doctor has deemed it unsuitable for treating you because of allergic reaction or possible drug interaction), the next step uses a *brand-name preferred* drug. Your doctor may need pre-authorization to use a brand-name drug (call 1-877-203-0003 for more information). Brand-name drugs will cost you more.

If no suitable generic or brand-name preferred drugs can be found under the first two steps, the last step is a *brand-name non-preferred drug or specialty drug*. Brand-name non-preferred and specialty drugs will cost you the most.

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

Prescription ID Cards

You will not receive new Prescription ID cards from Caremark unless you previously waived coverage and are now electing for 2019. Please keep your current cards and continue to use them.

CDHP Preventive Medications

Under the CDHP, preventive medications are not subject to the deductible. A list of preventive medications is available in the Forms & Plan Documents Section located in ADP Self Service (click on Benefits), or by calling Caremark at 1-888-790-4260.

Dental Coverage

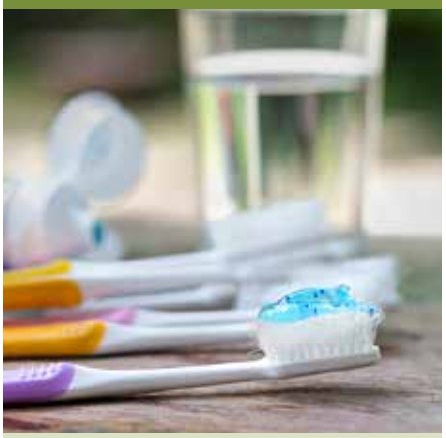
PFG knows that good dental care contributes to your health and well being. That's why we offer dental coverage, administered through Delta Dental of Virginia.

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

Dental Plan Features	Your Responsibility
Calendar Year Deductible (applies to basic and major services) • Individual • Family	 $ 50 $ 150
Maximums • Calendar Year Maximum Benefit • Orthodontic Lifetime Maximum Benefit (per eligible child only) • Temporomandibular Joint Disorder (TMJ) Lifetime Maximum Benefit	 $1,500 $2,000 $1,000
Preventive and Diagnostic Services (does not apply toward the annual maximum) Oral exams (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 planing, 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 (coverage for children up to age 26 only) Complete orthodontic exam (including X-rays), active orthodontic treatment	50%

Dental ID Cards

You will not receive a Dental ID card from Delta Dental for 2019 unless you are changing coverage levels or are enrolling for the first time.



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

PPO and Premier Networks

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

PPO or Premier dentist:	Out-of-Network dentist:
When you see an In-Network provider, there are many advantages for you: • Most importantly, your 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.	**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.

2019 Dental Plan Payroll Deductions

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

Vision Coverage

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

The EyeMed Network offers a broad range of independent providers as well as larger retail chains such as LensCrafters, Pearle Vision, and optical shops at Sears, Target, and JCPenney. 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	Covered 100%	Reimbursed up to $35
Lenses[1] One pair every 12 months • Single Vision • Bifocal • Trifocal	Covered 100%	Reimbursed up to: $25 $40 $55
Frames One pair every **12** months	Up to a **$140** allowance with no copay. If your frames exceed the allowance, you will receive a 20% discount on the difference.	Reimbursed up to $50 allowance
Contact Lens Fitting & Follow Up • 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,[3] including contact lens fitting and follow up exam[3]	
Diabetic Care	Eye exam and diagnostic testing is covered at 100% twice a year. Services must be six months apart. Members also receive eye exam reminders from EyeMed.	

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

2019 Vision Plan Payroll Deductions

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

Vision ID Cards

You will not receive a Vision ID card from EyeMed for 2019. When you visit your provider, give them the Group ID number listed under "Contact Information" at the back of this guide.

Remember to use the Decision Support Tool from ADP to determine if the HDHP or CDHP will save you more money than the PPO medical plan. 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 2019.

United Healthcare (UHC) Debit Cards

Your UHC debit card provides you convenient access to the money in your Flexible Spending Account(s). If you enroll in a Flexible Spending Account for 2019, you will receive a new debit card.

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 **myuhc.com** to access your account information and to learn more about claims reimbursement options.

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 **myuhc.com.**

Health Care Flexible Spending Account (FSA)

Health Care FSA

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

Limited Purpose Health Care FSA (LPFSA)

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

General Rules for Health Care and Limited Purpose Health Care FSAs

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

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

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 2019 may only be used to pay for eligible expenses you incur in 2019. After the claims submission deadline (the earlier of 90 days after your coverage ends or March 31, 2019), any unused funds in your account will be forfeited. You'll want to keep this in mind as you decide how much to contribute.

In exchange for your risk, a Health Care FSA allows you the advantage of being reimbursed in advance—up to your full annual contribution election—as soon as you incur an eligible expense.

For example, if you elect to contribute $650 in 2019 ($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 will continue to have $25 deducted from each paycheck for the remainder of the year until you've contributed the full $650.

Dependent Care Flexible Spending Account (FSA)

A Dependent Care 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 daycare, 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.

Health Reimbursement Arrangement (HRA)

An HRA allows PFG to contribute to an account on your behalf to help cover the cost of out-of-pocket health care expenses such as deductibles, coinsurance, copayments and other health care expenses that are not reimbursed by insurance. To be eligible for an HRA, you must be enrolled in either the HDHP or the PPO Plan and have completed the wellness requirements. Reimbursements are pre-tax and you can elect to have a Health Care FSA in addition to an HRA.

As a PFG associate, your HRA balance rolls over year after year, as long as you remain in an HRA-eligible medical plan.

What's the Difference?

Learn the differences between an HSA, LPFSA, Health Care FSA, Dependent Care FSA and HRA to get the greatest cost savings from your medical plan.

	HSA	Limited Purpose FSA	Health Care FSA	Dependent Care FSA	HRA
What is it?	It's a personal bank account to help you save and pay for covered health care services and qualified medical expenses on a pre-tax basis.	It's an account to help you pay for covered health care services and eligible dental and vision expenses on a pre-tax basis.	It's an account to help you pay for covered health care services and eligible medical expenses on a pre-tax basis.	It's an account to help you pay for eligible day care and elder care services on a pre-tax basis.	It's an account to help you pay for covered health care services and eligible medical expenses on a pre-tax basis.
Do I have to be enrolled in a certain medical plan?	Yes, you need to be enrolled in the CDHP.	Yes, you need to be enrolled in the CDHP.	Yes, you need to be enrolled in the HDHP or PPO or waive PFG's medical coverage.	No	Yes, you need to be enrolled in the HDHP or PPO and have completed the wellness requirements.
Who contributes to the account?	You and PFG.	You	You	You	PFG but only if you complete the wellness requirements.
Is there a limit on how much I can put in it?	Yes. The IRS sets a limit on how much you can put into it each year. Refer to page 8.	Yes. The IRS sets a limit on how much you can put into it each year. Refer to page 19.	Yes. The IRS sets a limit on how much you can put into it each year. Refer to page 19.	Yes. The IRS sets a limit on how much you can put into it each year. Refer to page 20.	No. You can't put your own money into an HRA.
If I don't spend it all this year, can I use it next year?	Yes. Since you own the account, the money will stay in it until you choose to spend it. You can save and use it into retirement.	No	No	No	Yes, if you are still enrolled in the PPO or HDHP Plan for 2020.
Can I keep it if I leave PFG?	Yes. You own the account.	No	No	No	No
Do I have to pay taxes on it?	No, unless you withdraw money for an ineligible expense.	No	No	No	No
What expenses can I use the account for?	Eligible medical, dental, vision, and prescription drug expenses. Refer to **myuhc.com** for a complete list.	Eligible dental and vision expenses. Refer to **myuhc.com** for a complete list.	Eligible medical, dental, vision, and prescription drug expenses. Refer to **myuhc.com** for a complete list.	Eligible day care and elder care services. Refer to **myuhc.com** for a complete list.	Eligible medical, dental, vision and prescription drug expenses. Refer to **myuhc.com** for a complete list.
Can I have any other accounts?	Yes. You can have a limited purpose FSA. You can also have a dependent care FSA.	Yes. You can have an HSA and a dependent care FSA.	Yes. You can have an HRA and a dependent care FSA.	Yes. You can have an HSA, a limited purpose FSA, a health care FSA and a HRA.	Yes. You can have a health care FSA and a dependent care FSA.

Your Beneficiary Information

Please verify that your beneficiary information is correct and up-to-date in ADP Self Service. 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.

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 (EOI) 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 elect life insurance coverage up to a maximum of seven times your annual basic earnings. The combined coverage total cannot exceed $1.5 million. You will be required to furnish EOI if you previously waived coverage or if you're applying for coverage exceeding certain limits (see page 23 for more information about EOI).

Your monthly cost per $1,000 of coverage:

Age on December 31, 2018	Non-Nicotine User*	Nicotine User*
Under 25 years old	$0.05	$0.07
25 – 29 years old	$0.06	$0.07
30 – 34 years old	$0.08	$0.08
35 – 39 years old	$0.09	$0.09
40 – 44 years old	$0.10	$0.12
45 – 49 years old	$0.15	$0.19
50 – 54 years old	$0.35	$0.38
55 – 59 years old	$0.54	$0.60
60 – 64 years old	$0.86	$0.92
65 – 69 years old	$1.32	$1.44
70 years old and above	$2.06	$2.06

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

Supplemental Dependent Term Life

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

Coverage Level	Post-Tax Weekly Cost	Post-Tax Bi-Weekly Cost
Spouse - $10,000*	$0.37	$0.74
Spouse - $25,000*	$0.93	$1.86
Spouse - $50,000*	$1.86	$3.72
Child(ren) - $5,000 per child	$0.09	$0.18
Child(ren) - $12,500 per child	$0.22	$0.45
Child(ren) - $25,000 per child	$0.45	$0.90

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

Supplemental Accidental Death and Dismemberment (AD&D) Insurance

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

Coverage Level	Monthly Rate per $1,000 of Coverage
Associate – 1x to 6x annual basic earnings	$0.03
Spouse – $10,000, $25,000, or $50,000	$0.03
Child(ren) – $5,000, $12,500, or $25,000 per child	$0.02

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

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

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

Disability Insurance

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

Basic Short-Term Disability (STD)

If you become disabled, you may be eligible for STD benefits after a waiting period of 7 consecutive calendar days. STD benefits are based on a percentage of your weekly basic earnings and can continue for up to 26 weeks (including the waiting period).

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

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

Basic Long-Term Disability (LTD)

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

Supplemental LTD Benefits

Supplemental LTD works in conjunction with Basic LTD. Supplemental LTD increases your potential benefit from 50% to 66 2/3% of monthly basic earnings. The maximum combined LTD benefit is $10,000 per month, minus any disability income you receive from other sources, such as Workers' Compensation or Social Security. If you do not elect Supplemental LTD when you first become eligible, Evidence of Insurability (EOI) must be provided and approved before you can be enrolled in this coverage at a later date. The EOI form will be mailed to your home address by Aetna Disability Services. Your monthly cost for Supplemental LTD is $0.36 for each $100 of monthly basic earnings.

Other Voluntary Benefits

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

Critical Care Insurance: Offers additional protection for critical illness such as cancer, heart attack, stroke, or other specified illnesses.

Life Plan: Offers additional Whole Life insurance protection, which can also build up a cash value over time.

Accident Plan: Covers out-of-pocket medical expenses associated with treating accidental injury.

Group Auto & Home Insurance: Offers special group rates to PFG associates with the convenience of payroll deduction.

Individual Long-Term Care Insurance: Pays a monthly allowance for long-term care in a nursing home, assisted living facility, or at home.

Identity Theft: Credit monitoring and fraud restoration through the ID TheftSmart program.

Legal Plan: Access to legal advice from trusted law firms.

Pet Insurance: Covers veterinary expenses.

Computer Purchase Program: Offers the convenience of payroll deductions when purchasing a computer.

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

Contact Information

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

Benefit	Vendor	Website	Phone Number
Healthy Together		www.pfghealthytogether.com Passcode: pfghealthy	
General Benefits Questions	Benefits Center	ADP Self Service at https://my.adp.com, then click on Benefits	1-888-MYHWBEN (1-888-694-9236) option 1 10 am – 8 pm ET, Monday – Friday 8 am – 5 pm ET Saturday
Verification of Dependents and Qualified Changes in Status	Dependent Verification Services (DVS)		1-800-847-8531 1-866-400-1686 (fax)
Medical, Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs)	UnitedHealthcare Group Number: 742781 (medical only)	www.myuhc.com	1-877-769-7001
Prescription Drug	Caremark (CVS Health) Group Number: PFGRX	www.caremark.com	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)	Optum®	www.liveandworkwell.com Access code: PFG	1-866-248-4094
Health Savings Account (HSA)	Optum Financial Services (Optum)	www.myuhc.com	1-800-791-9361
Disability	Contact your supervisor first, then Sedgwick	www.claimlookup.com/pfg	1-888-694-9236 option 2
401(k)	Fidelity	www.401k.com	1-888-694-9236 option 3
Wellness Programs • Quit for Life® (Tobacco Cessation Program) • Wellness Coaching • Healthy Pregnancy		More information on these programs can be found on www.myuhc.com	1-866-QUIT-4-LIFE (1-866-784-8454) 1-800-478-1057 1-800-411-7984
Voluntary Benefits	Enrollment Resources Group (ERG)	www.voluntarybenefitsatpfg.com	1-866-747-8679

12500 West Creek Parkway
Richmond, VA 23238