myKeHE™ 2015 - 2016

Your BENEFITS Your CHOICES

KeHE

Be **Well** & Well **Informed!**

Table of Contents

Stay Posted on Benefits

Important Contacts

Please contact the individual company/provider listed below to learn more about a specific benefit plan. Additional information is available on the KeHEInsider under the MyKeHe tab.

When You Have Questions About	Contact	Phone Number	Website
Medical Insurance* Health Care Account (HCA) Health Savings Account (HSA) Value Plan (HSA)	Blue Cross Blue Shield of Illinois (BCBSIL)	1-888-409-7144	www.bcbsil.com
24/7 Nurse Hotline	Blue Card Access (BCBS)	1-800-299-0274	N/A
Pharmaceuticals	Prime Therapeutics	1-800-423-1973	www.myprime.com
Dental Insurance*	Delta Dental	1-800-323-1743	www.deltadentalil.com
Vision Insurance*	EyeMed	1-866-800-5457	www.eyemedvisioncare.com
Life and AD&D Insurance	Cigna Customer Service	1-800-221-6036	www.mycigna.com
Disability Insurance	Cigna Claims	1-800-36-CIGNA	www.mycigna.com
401(k) Plan*	Prudential	1-877-778-2100	www.prudential.com/online/retirement
Employee Stock Ownership Plan (ESOP)	N/A	N/A	www.croweesopadvantage.com
Flexible Spending Accounts*	PayFlex	1-800-284-4885	www.healthhub.com
COBRA*	PayFlex	1-800-359-3921	www.healthhub.com
Employee Assistance Program*	Bensigner, Dupont & Associates (BDA)	1-800-272-2727	www.bdaeap.com
Accident Insurance*	Allstate	1-800-521-3535	www.allstateatwork.com/mybenefits
Critical Illness*	Allstate	1-800-521-3535	www.allstateatwork.com/mybenefits
Universal Life*	Allstate	1-800-521-3535	www.allstateatwork.com/mybenefits
Health Savings Account*	HSA Bank	1-800-357-6246	www.hsabank.com
Benefits Concierge*	Health Advocate	1-866-695-8622	HealthAdvocate.com/members
Wellness*	Virgin Pulse	1-866-852-6898	www.virginhealthmiles.com
Long Term Care	LifeSecure*	Existing Policy Holders: 1-866-582-7701 New Hires: 1-855-549-8913	www.yourlifesecure.com
Care Partners	Marketplace Chaplains USA	1-800-757-7657	N/A

*Mobile application available for download on your smart phone.

Dear KeHE Employee:

KeHE's annual benefit Open Enrollment is scheduled to begin on March 4, 2015. Each year we review our benefit offerings and compare them to what is offered in the marketplace. Our objective is to provide our employees with a comprehensive benefit program at a reasonable cost. While balancing cost control with providing affordable health care benefits, KeHE absorbs a large portion of the total cost of our health insurance and pays more than 75% of the actual cost.

In FY16, KeHE has a budget of close to $30.6 million dollars in medical costs, which represents the 4th largest single expense KeHE experiences in operating our business. Additionally, this past year, KeHE experienced greater than expected healthcare costs making it more difficult to mitigate cost increases within our own programs. Because of these increases, we are now faced with having to make some difficult financial decisions. In this guide you will see that, unlike last year when rates remained constant, we have made some adjustments to the premiums and maximum out-of-pocket amounts. This was not an easy decision; however, you are being provided information to help you make educated decisions on various healthcare coverage options available to you, whether they are through KeHE or another avenue.

To be proactive in managing rising costs, we are also committed to offering programs that promote wellness and overall well-being. Our Wellness Program provides the support and resources for you to maintain a healthier lifestyle and to stay actively engaged in your own wellbeing. Employees that live healthier lifestyles, like not smoking and understanding and managing vital health metrics will see discounted premiums in the future. This is just one of the many enhancements that will be coming to the Wellness Program. Over time, the key to reducing your costs is to be healthier—by exercising, making wise nutritional decisions and understanding where your personal health risks are so you can manage them.

This guide is provided to each of you to help outline the many benefits that are available. I encourage you to take the opportunity to review and evaluate all of the options that may be right for you and your family and learn about the new features of our plans.

Together, let's work to improve our total personal wellness and successfully manage our health care costs.

Sincerely,

Brandon Barnholt—President and CEO

How Your Benefits Work

Benefits are high on everyone's priority list. That's why KeHE offers a complete benefits package to help simplify and enrich our employees' lives.

Open Enrollment

Open Enrollment is the time of year in which you can make changes to your benefits. If you do not make changes at this time, you must wait until the next Open Enrollment, or you experience a Qualifying Life Event.

Eligibility Information

Once the eligibility waiting period has been met, all regular full-time employees are eligible to enroll in the benefits described in this guide. Full-time is defined as 30 hours or more per week over a 12 month period. Your spouse and/or eligible dependents up to age 26 can receive some benefits, too.

Making Changes During the Year

Generally, you can only change your benefit elections during the Open Enrollment period, unless you experience a Qualifying Life Event (QLE) such as marriage, divorce, birth or adoption, or a change in your or your spouse's employment status that affects benefits eligibility. Make your choices within 31 days of the QLE.

Please note: KeHE's plan year begins May 1 and end April 30.

COBRA Continuing Coverage

Under certain circumstances, you and your dependents may continue to participate in some benefit plans after you terminate employment through COBRA Insurance. Complete COBRA details are included in the insurance contracts and booklets that govern each benefit.

Qualified Dependents

A dependent is defined under the KeHE plan as a legal spouse, as determined under the law of the state or jurisdiction in which the marriage was entered into, and children younger than 26.

Note: See your tax advisor for implications of enrolling dependents on your plan.

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for other coverage (or if the employer stops contributing toward your or your dependent's other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Important Note

You need to submit proper documentation to your HR representative. To request special enrollment or obtain more information, contact HR.

How Your Benefits Work

Choose Benefits Wisely

We are proud of our comprehensive benefits package—one that protects you and your family. Some benefits are provided automatically at no cost to you. Other benefits are available if you choose them.

Keep in mind, the following benefits are an important part of your total rewards package, which includes pay, benefits, and career opportunities. Below is a quick summary of your 2015-2016 benefit options.

2015-2016 Benefits-at-a-Glance

Plan Provisions	Who Pays
Health Care Insurance	
Medical Plan	You and KeHE
Dental Plan	You and KeHE
Vision Plan	You
Life and Accident Insurance	
Basic Life and AD&D	KeHE
Supplemental Life and AD&D	You
Dependent Life Insurance	You
Disability Insurance	
Short-Term Disability Base Plan	KeHE
Buy-Up Short-Term Disability	You
Long-Term Disability Base Plan	KeHE
Buy-Up Long-Term Disability	You
Savings and Investment Options	
401(k) Plan	You
Employee Stock Ownership Plan (ESOP)	KeHE
Managing Expenses	
Flexible Spending Accounts	You
Health Care Account	KeHE*
Health Savings Account	You and KeHE*
Additional Benefits	
Employee Assistance Program	KeHE
Wellness Program	KeHE*
Critical Illness	You
Accident Insurance	You
Universal Life	You
Long-Term Care	You
Health Care Advocate	KeHE
Care Partners	KeHE

*KeHE will deposit funds into your accounts upon completion of certain wellness activities.

Enrolling in Your Benefits

2015-2016 Benefits-at-a-Glance

It's time to decide which benefits are right for you and your family. Keep in mind, newly eligible employees have 31 days from their eligibility date to enroll in benefits. Enrolling in your benefits is as easy as … 1—2—3.

Opportunities to Enroll:

You are eligible to enroll in benefits:

- At annual Open Enrollment
- As a new hire
- During a Qualifying Life Event — can enroll or make changes to current benefits. See page 5 "Special Enrollment" section

Annual Open Enrollment

Each year KeHE designates an Open Enrollment period, generally in March, when employees are able to make enrollment and coverage changes to their plan elections. Unless an employee experiences a Qualified Life Event (QLE) this is the only time that an employee may make changes to the benefits they are enrolled in and the dependents they cover. Benefit elections will be effective on May 1, and will stay in affect until April 30 of the following year.

Annual open enrollment changes will be made through Ulti-Pro. See below for login information.

New Hire Enrollment

You will enroll through Ulti-Pro. To log in, go to Ulti-Pro's website: **https://n12.ultipro.com**

Your user name for the site is your last name, with the first letter in uppercase, and the last four digits of your social security number. The password for your account is your birth date in 8 digit format. For example, if your birth date was on December 3, 1980 then your password would be 12031980

Example: Doe234
Password: 12031980

Note: Please click "Forgot Your Password?" before contacting HR.

Think Healthy, Live Well

KeHE is pleased to provide you with a choice of health care plans at an affordable price through Blue Cross Blue Shield of Illinois. All of the following plans are considered Consumer-Directed Health Plans (CDHPs). CDHPs often involve pairing a high deductible medical plan with a tax-advantaged savings account, such as a Health Savings Account (HSA). The funds in these accounts are set aside specifically for medical expenses and can help with your annual deductible. KeHE will even contribute to your HCA or HSA if you participate in certain wellness activities. These products are popular because they cover many preventive services at 100% and provide flexibility in how a person spends his or her medical dollars.

You can choose from the following CDHPs:

- Health Care Account (HCA)
- Health Savings Account (HSA)
- Value Plan (HSA)

Health Care Account (HCA) Plan

It takes two components that work together to create the HCA Plan:

- A Consumer-Directed Health Plan (CDHP)
- A Health Care Account (HCA)

This Plan features a lower deductible than the other two plans offered with a slightly higher premium. The HCA is an account that's 100% employer-funded and designed to reimburse you for qualified medical expenses. You can't make contributions to the account. For the 2015-2016 plan year, KeHE will only contribute money into an account for you when you participate in the Wellness Program (see page 14 for amounts). This money doesn't count toward taxable income, which helps you save valuable tax dollars—complete with Uncle Sam's stamp of approval.

How does the HCA Plan work?

HCA funds can be used tax-free to pay for any "qualified medical expenses." In general, expenses are paid from your HCA as long as the expense is primarily to prevent or alleviate an illness. One advantage of an HCA is that funds are used to pay for qualified medical expenses for yourself, your spouse, or a dependent up to a maximum dollar amount determined by the employer (your dependent must be on the KeHE HCA plan. The funds are managed by BCBS. The account is updated when claims are filed. Please login to Blue Access for members (BAM) **www.bcbsil.com/member** to view your account balance.

For a partial list of expenses allowed by the IRS, check out **www.irs.gov/publications/p502/index.html**

Health Savings Account (HSA) Plan

The HSA Plan Features a higher deductible, but lower premium than the HCA plan. This high deductible plan is coupled with an HSA that houses employee contributions, as well as, earned wellness dollars. Through convenient payroll deductions you can add to it during the year, spend the funds when you see fit or save them for future use. You may even be able to use them for Medicare premiums.

It takes two components that work together to create the HSA Plan:

- A Consumer-Directed Health Plan (CDHP) (see page 8)
- A Health Savings Account (HSA)

How does the HSA Plan work?

An HSA is a personal account in which you can place tax-deferred money to help pay qualified expenses not covered by your health insurance plan, including copays, and deductibles. For the 2015-2016 plan year, KeHE will only contribute money into an account when you participate in the Wellness Program (see page 14 for amounts). The money in your HSA is yours to keep, even if you leave the company. You own the HSA, and any money in that account will roll over each year just like a traditional bank account. You can access those funds on a tax-free basis at any time to pay for a qualified health care expense. This money does not count toward taxable income. Think of this as your personal savings account for your current and future medical needs.

Value Plan (HSA) Plan

The Value Plan offers basic coverage at the lowest monthly premium cost. Because paycheck deductions are lower, you should expect to pay more of your health expenses out-of-pocket. This plan includes 60% coinsurance for most services, which means you pay the remaining 40% after meeting a $2,000 in-network individual deductible or a $4,000 family deductible.

Note: If you cancel your Consumer-Directed Health Plan later in the year, you may have to withdraw some of the contributions from the HSA account. If you don't withdraw excess contributions, you may have to pay additional taxes at a higher rate at tax time.

How Will I Save With an HSA?

A Health Savings Account can help you:

- Save money on your income taxes. Deposits made to your HSA are 100% tax deductible. Interest that accrues on the money in the account is tax-deferred.
- Save money tax-free for health expenses.
- **Withdrawals from your HSA for qualified medical expenses are always tax-free; funds used for non-qualified expenses are taxed at a 20% penalty in addition to standard income taxes.**
- Save money tax-deferred for retirement. Whatever money you don't use in your HSA rolls over from year to year. Any money left in your HSA when you turn age 65 is yours to use for any purpose. You will just pay normal income taxes on the money you withdraw for nonmedical expenses. Withdrawals for qualified medical expenses are NEVER taxed.

Save Even More with a Limited-Purpose FSA

Choose a Limited-Purchase Flexible Spending Account (LPFSA) along with your HSA and save even more. A Limited-Purpose FSA lets you set aside tax-free funds to pay for ONLY certain eligible dental and vision care expenses. With a Limited-Purpose FSA, general medical expenses **ARE NOT** eligible for reimbursement. See page 24 for more information on FSAs.

Note: This applies to both the HSA and Value Plan

How can I Fund an HSA?

Anyone can make contributions to your HSA—you (the account holder), a third party (such as a family member on behalf of the account holder) and/or an employer. However, the money in your HSA belongs to you no matter who contributes.

You can also open an account with a smaller amount, then conveniently make deposits anytime after your HSA is open through automatic payroll deductions.

Once you enroll in the HSA Plan, you will receive a kit in the mail explaining how to open your savings account.

If you do not open the account, you will not be able to receive your wellness dollars.

***Check your account often to see if you are going to go over the limit and adjust accordingly.*

2015 IRS HSA Limits

The Internal Revenue Service sets annual limits for Health Savings Account participants each year. The 2015 limits, including KeHE's contributions, are as follows:

Coverage Type	Annual Contrib. Limit	55 and Older Catch-Up Contrib.
Single	$3,350	$1,000
Family	$6,650	$1,000

Comparison of Consumer-Directed Health Plan Accounts & FSAs

Feature	Health Care Account (HCA)	Health Savings Account (HSA)	Flexible Spending Account (FSA)
Who is eligible?	All benefits-eligible employees enrolled in the HCA Plan	All benefits-eligible employees enrolled in the HSA or Value Plan	All benefits-eligible employees. Depending upon plan election, benefits-eligible employees may enroll in an FSA or a Limited-Purpose FSA
Who may contribute to the account?	Employer only*	Employee, employer or both; plus any third-party on behalf of employees	Funded by employee through payroll deductions
What are the contribution limits?	No federal limits; employers typically set limits equal to or less than the amount of the deductible of employees' health plan	$3,350 for individuals $6,650 for families	The limit for the 2015-2016 plan year is $2,550
What is the tax treatment of contributions?	Employer contributions are generally excluded from employee's gross income	Employee contributions are tax deductible; employer contributions are excluded from gross income and not subject to employment taxes**	Employees don't pay any federal, Social Security or state taxes on contributions
Can funds be carried over each year?	Yes***	Yes	$500 can be rolled over at the end of the 2015-2016 plan year
Are accounts portable?	No	Yes	No
Does interest accrue on funds in the account?	No	Yes, interest and investment income accrue tax-free**	No

* KeHE will add funds to accounts once certain wellness activities are completed.

** HSA contributions and earnings aren't subject to federal taxes or state taxes in most states.

*** If you change from HCA to HSA, any unused funds in your HCA are forfeited

For more information on FSA, please see page 24

Take Your Medicine with Prescription Drug Coverage

Prime Therapeutics is the preferred provider for our Blue Cross plans. They offer prescription drug coverage for a wide selection of drugs at retail pharmacies nationwide or by mail-order for drugs you take on an ongoing basis. PrimeMail is dedicated to providing convenience, savings and service including ordering refills by mail, phone or Internet.

Low Cost Maintenance Medications

Prime Therapeutics, Blue Cross Blue Shield's pharmacy partner, fills prescriptions for millions of members who take medications for arthritis, asthma, diabetes, high cholesterol, high blood pressure and other chronic conditions. With this mail-order program, you'll enjoy:

- **Convenient, consistent care**—Instead of monthly trips to the pharmacy, get medications shipped directly to your home.
- **Greater supplies, lower copays**—Receive a 90-day supply instead of a 30-day amount (with doctor's approval), and perhaps even pay less for the larger amount than for three smaller retail refills.
- **Fewer worries**—With medicine delivered to your home in greater supply, you're more likely to stay on track with your treatment plan.

Coverage	BCBS HCA		BCBS HSA		BCBS Value Plan	
	Full FSA Allowed		Limited FSA Allowed		Limited FSA Allowed	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Annual Deductible						
Individual	$1,000	$2,000	$1,600	$3,200	$2,000	$4,000
Family	$3,000	$6,000	$3,200	$6,400	$4,000	$8,000
Out-of-Pocket Maximum (includes deductible)						
Individual	$5,000	$6,000	$6,350	$7,200	$6,350	$12,000
Family	$12,700	$18,000	$12,700	$18,400	$12,700	$24,000
Physician's Office Visits (after deductible)						
Specialists	85%	65%	80%	60%	60%	50%
Surgery*	85%	65%	80%	60%	60%	50%
X-rays, lab work, etc.	85%	65%	80%	60%	60%	50%
Well-Child Care						
Office Visits	100%	65%	100%	60%	100%	50%
Immunizations	100%	65%	100%	60%	100%	50%
Adult Preventive Care						
Routine physicals	100%	65%	100%	60%	100%	50%
GYN exams	100%	65%	100%	60%	100%	50%
Prostate exams	100%	65%	100%	60%	100%	50%
Mammograms	100%	65%	100%	60%	100%	50%
Immunizations	100%	65%	100%	60%	100%	50%
Durable Medical Equipment						
Supplies	85% after ded.	65% after ded.	80% after ded.	60% after ded.	60% after ded.	50% after ded.
Hospital Care						
Preadmission testing, inpatient treatment, outpatient facility, physician services, and outpatient surgery	85% After ded.	65% After ded.	80% After ded.	60% After ded.	60% After ded.	50% After ded.
Emergency room services *Accidents and Illness*	85% after ded.	85% after ded.	80% after ded.	80% after ded.	60% after ded.	60% after ded.
Retail Prescription Drugs (34-day supply)***						
Generic	$10		15% after ded.		15% after ded.	
Formulary	$40		25% after ded. ($30 min./$75 max.)		25% after ded. ($30 min./$75 max.)	
Non-formulary	$60		50% after ded. ($100 min./$200 max.)		50% after ded. $100 min./$200 max.)	
Mail-Order Prescription Drugs (90-day supply)***						
Generic	$20		15% after ded.		15% after ded.	
Formulary	$80		25% after ded. ($60 min./$150 max.)		25% after ded. ($60 min./$150 max.)	
Non-formulary	$120		50% after ded. ($100 min./$200 max.)		50% after ded. ($100 min./$200 max.)	
Behavioral Health (after deductible)						
Inpatient	85%	65%	80%	60%	60%	50%
Outpatient	85%	65%	80%	60%	60%	50%
Physical, Speech and Occupational Therapies (after deductible)						
Office visits	85%	65%	80%	60%	60%	50%
Treatments	85%	65%	80%	60%	60%	50%

Note: Please consider a BDC+ provider for Knee and Hip Replacement, Spine Surgery, Cardiac Care, and Transplants (See page 15 for additional information)
Note: Under the HCA plan, copayments do apply to the out of pocket maximum.

Blue Distinction Centers® +

The Blue Distinction Centers recognition program was developed to identify hospitals with proven expertise in delivering specialty care. Recognition is based on the following criteria:

- Expertise of the medical team;
- How many times the hospital has performed the procedure; and,
- Hospital's track record for procedure results.
- Cost Efficiency, which means lower out of pocket costs

Blue Distinction Centers+ (plus) have a proven history of delivering better results — including fewer complications and readmissions — than hospitals without these recognitions. This program can help you and your doctor have an informed discussion about how to find the right hospital for your specialty care needs.

What is Covered?

Knee and Hip Replacement, Spine Surgery, Cardiac Care, and Transplants are covered under the Blue Distinction Centers® recognition program

Note: You will receive the greatest benefit for these treatments when you use the BDC+ Network, NOT the BDC Network. Please reference the chart below for specific

Specialty Program	BDC+	In-Network	Out-of-Network
Knee and Hip Replacement	90%	70%	50%
Spine Surgery	90%	70%	50%
Cardiac Care	90%	70%	50%
Transplants	90%	70%	50%

Specialty Care When and Where you Need it Most

Blue Distinction Centers+ (plus) are available nationwide no matter where you work, live or travel — and finding one is easy.

To find a BDC+ near you, visit the Blue Cross and Blue Shield of Illinois (BCBSIL) Provider Finder® tool:

1. Go to bcbsil.com
2. Click on Find a Doctor
3. Select 'Search Now' under Find a Doctor or Hospital
4. Select State
5. Select Health Plan
6. Select Provider Type
7. Check 'Show only Blue Distinction Centers® / Blue Distinction Centers® +
8. Ensure that the provider is within Blue Distinction+. See the note below for more information.

NOTE: You MUST select Blue Distinction +, NOT Blue Distinction. This network has been validated for both quality and cost.

Virgin Pulse Wellness

JOIN

VIRGIN PULSE

EXPLORE

ENGAGE

TRACK

PROGRESS

EARN

REWARDS

KeHE has teamed up with Virgin Pulse to offer you a program that is designed to help you live better everyday:

- Activity Tracking
  - You'll receive a free MAX Activity Tracker to record your activity (and earn points!)
- Nutrition Tracking
  - Through Virgin Pulse's partnership with MyFitnessPal, you'll have a comprehensive view of your calories consumed vs. calories burned.
- Sleep Tracking
  - Track your sleep to establish good sleep habits and feel fresh every morning (and earn points!)
- Biometrics Tracking
  - Take your measurements at a Health Station and track your progress throughout the year (and earn points!)

Earn Wellness Rewards with Virgin Pulse

New To Virgin Pulse

Join.virginpulse.com/kehe

Similar to last year, you can access a highly interactive web portal with mobile capabilities that allow you to access and track your wellness activities from you mobile phone, tablet or PC. Virgin Pulse provides you with a wearable activity tracking device that will help you monitor your steps toward reaching your goal. Finally, you have the ability to invite your personal social network to participate in the program in order to support you in reaching your goals. We know that your family and friends are very important and having them participate in our program will help us all to meet our goals. In the upcoming plan year, we ask that you track activities that are advantageous to your health such as exercise, nutrition, and sleep. Additionally, we encourage biometric measurements and routine physical examinations.

Watch your mail for updates and additional information regarding exciting enhancements to this wellness program!

How it Works

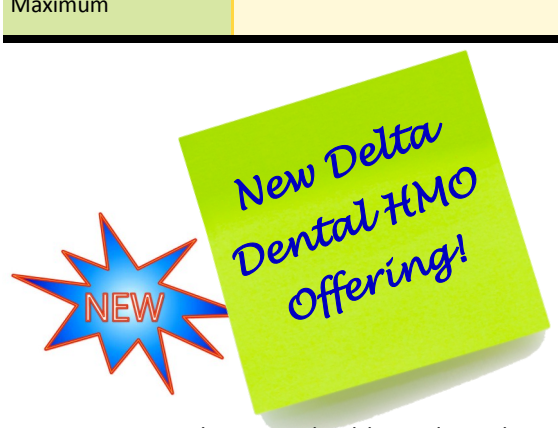
Getting more active, getting more sleep, eating nutritious food—healthy behaviors like these deliver noticeable benefits like reducing your risk of certain diseases, increasing your focus, and just making you feel great! The more healthy decisions you make, the more HealthMiles (points) you earn, the more rewards you get!

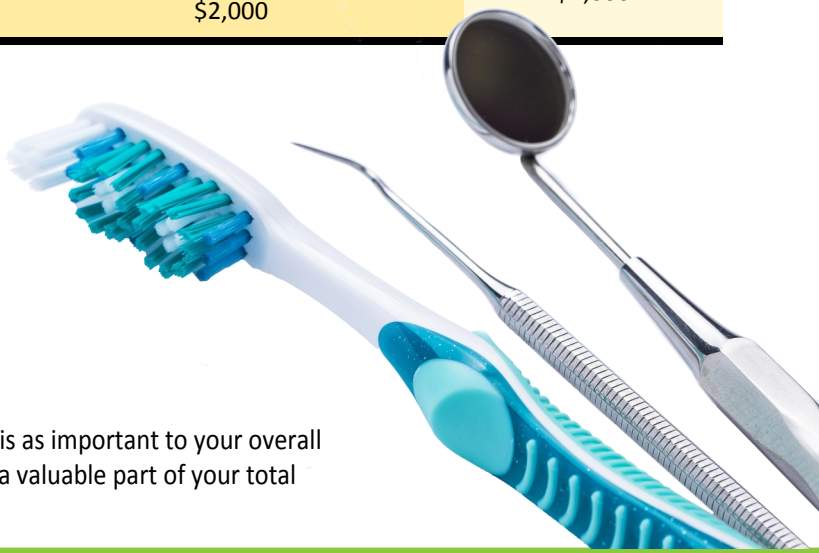
Dental Coverage

Your Dental Benefits

Keeping your teeth fit now may keep you from having major expenses later. KeHE is pleased to provide you with a choice of three dental care plans at an affordable price through Delta Dental. These plans will help pay for the cost of routine checkups—and just about any other type of dental work you might need: crowns, root canals and even orthodontia. Your three dental options are listed below.

Coverage	Delta Dental Preventive Plan			Delta Dental Comprehensive PPO Plan			Delta Dental HMO
	In-Network Plan Pays	*Premier Network Plan Pays*	*Out-of-Network Plan Pays*	*In-Network Plan Pays*	*Premier Network Plan Pays*	*Out-of-Network Plan Pays*	*HMO*
Annual Deductible							
Individual Family	$0 $0			$50 $150			$0
Preventative and Diagnostic Care							
Routine exams, cleanings, fluoride treatments, sealants, bitewing X-rays	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Basic Care							
Full-Mouth X-rays, extractions, fillings	Not covered	Not covered	Not covered	Covered at 100%	Covered at 80%	Covered at 80%	80%
Major Care							
Root canals, oral surgery, gum disease treatment, crowns, bridges, dentures	Not covered	Not covered	Not covered	Covered at 60%	Covered at 50%	Covered at 50%	50%
Plan Annual Maximum	$500			$1,500			Unlimited
Orthodontia Lifetime Maximum	Not covered			100% up to a lifetime maximum of $2,000			$2,000





Everyone deserves a healthy smile, and your dental health is as important to your overall health as it is to your smile. That's why Dental coverage is a valuable part of your total benefits package.

Vision Insurance

The health of your eyes is an indicator of your overall health. So, vision care should be one of your top health care priorities.

Save Even More with an FSA or Limited-Purpose FSA

Choose a Limited-Purpose Flexible Spending Account (LPFSA) along with your HSA and save even more. A Limited-Purpose FSA lets you set aside tax-free funds to pay for ONLY certain eligible dental and vision care expenses. With a Limited-Purpose FSA, general medical expenses **ARE NOT** eligible for reimbursement. See page 24 for more information about a FSA.

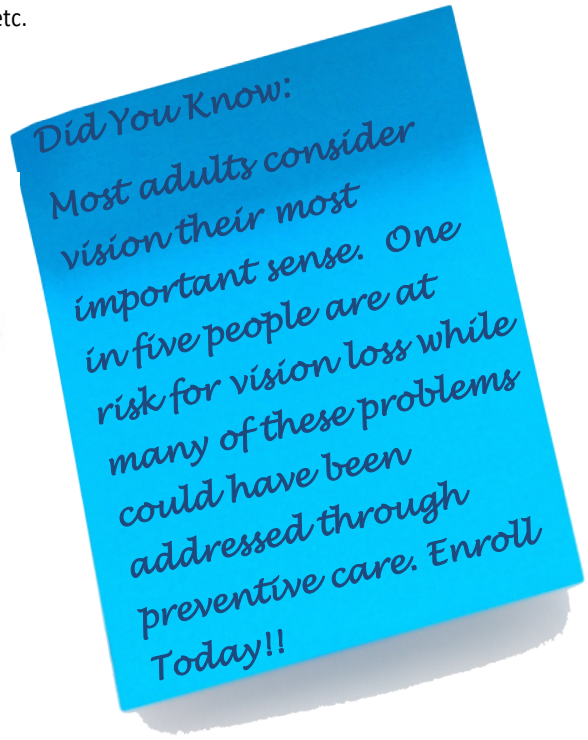
See Clearly With Vision Coverage

The advantages of Vision Insurance are clear. Your EyeMed Vision Plan (EyeMed) covers periodic eye exams, eyeglasses and contact lenses for you and your eligible dependents.

Do You Need Vision Insurance?

There are several factors to consider when deciding whether you need Vision Insurance:

- Do you expect to need new eyeglasses or contacts in the next year?
- What is your total cost for care with the EyeMed coverage (consider your coverage cost and your share of the cost for services)?
- Would you use network providers for greater savings?
- Which would work best for you—Vision Insurance or paying expenses through the Health Care FSA, or a combination of both?
- The BCBS health plans include one vision examination per year. The BCBS health plans do not include lenses, frames, etc.



Importance of Eye Exams

Annual eye exams not only help correct vision problems, but comprehensive exams can also reveal the warning signs of more serious undiagnosed problems, such as high blood pressure, heart disease and diabetes. No matter what your age, yearly eye exams are important to your productivity and health and should be an important part of your benefit election.

Visit **portal.eyemedvisioncare.com** for plan information and where to find a provider near you.

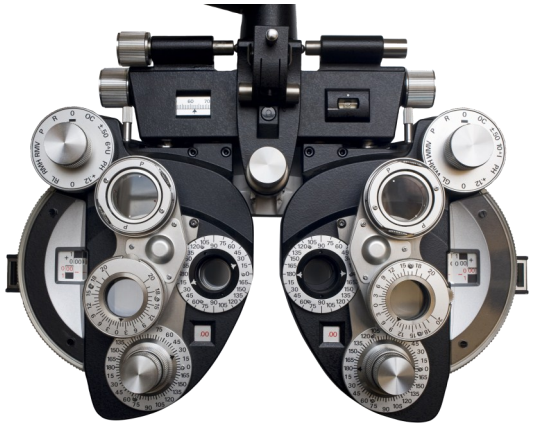
Vision Insurance

Your Vision Benefits

Coverage	EyeMed	
	In-Network *You Pay*	*Out-of-Network* *Reimbursement Up To*
Eye Exam (every 12 months)		
With dilation (as necessary)	$10 copay	Up to $35
Frame (every 24 months)		
Any available frame at provider location	$0; $130 allowance; 20% off balance over $130	Up to $45
Prescription Lenses (every 12 months)		
Single vision	$20	Up to $25
Bifocal	$20	Up to $40
Trifocal	$20	Up to $55
Lenticular	$20	Up to $55
Contact Lens Exam (every 12 months)		
Standard contact lens fit and follow-up	Up to $55	N/A
Premium contact lens fit and follow-up	Receive 10% off retail	N/A
Contact Lens Materials		
Conventional	$0 copay; $130 allowance; 15% off balance over $130	Up to $105
Disposables	$0 copay; $130 allowance	Up to $105
Medically necessary	$0 copay; Paid in Full	Up to $200
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Benefit	Members also receive a 40% discount off complete pair of prescription eyeglasses ; 20% off Non-Prescription sunglasses; 20% off re-maining balance beyond plan coverage	N/A

Take a Closer Look at Vision Care

With EyeMed, you can save on vision-related products and services throughout the year. You'll also have broad access to providers.



Added Peace of Mind

While no one likes to think about it, planning for your family's financial security in the event of your death, sickness or serious injury is one of the greatest gifts you can give your loved ones.

Life/AD&D Protects Your Family

KeHE provides Basic Life and Accidental Death and Dismemberment (AD&D) Insurance through Cigna — at no cost to you. If you want added protection for you and your family, you can also purchase Supplemental Life Insurance. Here's a quick overview of the Life/AD&D coverages available to you.

Who Pays?	Coverage
KeHE pays* the cost for:	*Basic employee Life Insurance* 1.5 times your annual compensation rounded to the next higher $1,000 subject to a maximum of $1 million
	*Basic employee AD&D*** 1.5 times your annual compensation rounded to the next higher $1,000 subject to a maximum of $1 million
You pay the cost for:	*Voluntary Employee Term Life and AD&D Insurance** 1 to 5 times your annual compensation up to a maximum of $1 million rounded to the next higher $1,000. EOI required if amount is over 3 times your annual compensation or $500,000.
	Voluntary Spousal Term Life and AD&D Insurance In units of $5,000, not to exceed $50,000 (cannot exceed 50% of employee's Voluntary Life benefit); Spouses can be covered only up to age 70
	Voluntary Child Term Life and AD&D Insurance An amount elected in units of $5,000, maximum $10,000 benefit

* Federal tax law requires KeHE to report the cost of company-paid Life Insurance in excess of $50,000 as imputed income.

** AD&D benefits are paid in addition to any Life Insurance if you die in an accident or become seriously injured or physically disabled.

+ You may have to complete an Evidence of Insurability (EOI) medical questionnaire to determine whether you or your spouse are insurable for Supplemental Life Insurance amounts. If required, one will be provided to you.

Name Your Beneficiaries

It's important to remember to name a beneficiary for both the Basic and Supplemental Life Insurance you choose for yourself. If you don't, your benefit will be paid according to insurance company guidelines. You're automatically listed as the beneficiary for any dependent Life Insurance you may select.

Dependent Life Insurance through Cigna

Dependent Life Insurance is designed to help you and your family handle unexpected expenses caused by the death of a spouse or child. For your spouse or child to be eligible for Dependent Life Insurance coverage, you must be covered under the Employee Supplemental Life plan. Dependent Life Insurance for a spouse is available in increments of $5,000, up to a maximum of $50,000 (not to exceed 100% of employee's salary) and cannot exceed 50% of your Employee Supplemental Life Insurance amount. If you select coverage after your initial election period, you will be required to provide Evidence of Insurability for your spouse. Spouses are covered only up to age 70. Dependent children are covered up to age 19. Full-time students or disabled dependents may be covered up to age 26.

AD&D Insurance through Cigna

Should you lose your life, sight, hearing, speech or use of your limb(s) in an accident, AD&D provides additional benefits to help keep your family financially secure. Available for all employees and their dependents, AD&D benefits are a percentage of your coverage amount — from 25% to 100% - depending on the type of loss, as shown below.

If bodily injuries result in:	Then, Cigna will pay this percentage of your benefit amount:
Loss of any combination of two: hands, feet or eyesight	100% of the principal amount paid
Paraplegia (total paralysis of both lower limbs)	75% of the principal amount paid
Hemiplegia (total paralysis of upper and lower limbs on one side of the body) **loss of one hand, foot, sight in one eye, hearing in both ears**	50% of the principal amount paid
Loss of thumb and index finger of the same hand	25% of the principal amount paid

Age Reduction Amounts

It's important to know that your Basic and Supplemental Life Insurance coverage amounts are reduced by 35% at age 65, 55% at age 70, 70% at 75 and 80% at 80 because of insurance company guidelines. The reduction takes affect on May 1 following your birthday. Spouses are covered only up to age 70.

How Much Insurance Is Right For You?

Not sure how much Voluntary Life Insurance to purchase for your family?

Consider the following factors:

- Who is the primary income provider for your family?
- Do you have any other sources of income?
- What major expenses, such as a mortgage or college education, do you have or expect to have?
- How much money would your family need to maintain their standard of living without your paycheck? Without your spouse's paycheck?

Added Peace of Mind

It's hard to imagine yourself disabled, especially when you're active and healthy. But a surprising number of people do find themselves hurt or sick and unable to work—even if only for a short time.

Disability insurance protects your ability to earn an income. Consider the buy-up options for greater income protection.

Disability Safeguards Your Finances through Cigna

KeHE helps you plan against the unexpected by paying the full cost of two Disability plans. These plans work together to replace a portion of your income while you're unable to work:

- Short-Term Disability (STD)
- Long-Term Disability (LTD)

You also have a Buy-up Option to purchase additional Short-Term or Long-Term Disability Insurance coverage.

Enhanced Benefit

LTD Buy-up Option: 60% to a maximum of $12,000.

What is Considered a Disability?

A disability is caused by a sickness or injury (other than a work-related disability). Your doctor will determine how long you should be out based on your condition. KeHE and the insurance company are also involved in approving any claims . Your doctor will be required to submit a claim form and

Coverage	Benefit	
	Short-Term Disability	*Long-Term Disability*
Core benefit you receive	60% of weekly* covered earnings	50% of monthly covered earnings
Core Maximum benefit payable	None	Up to $7,500 per month
Voluntary Buy-up benefits you can elect	75%	60%
Voluntary Buy-up Maximum benefit payable	None	Up to $12,000 per month
Waiting period	7 days	180 days
Maximum benefit period	26 weeks	To age 65

**Based on a 7 day work week.*

Universal Life Insurance

Even if you already have a Basic Life Insurance policy, it's important to ask yourself whether it provides the protection you need to cover all of your financial responsibilities in the event of your passing.

Universal Life Insurance through Allstate

KeHE provides all employees with a basic term life benefit equal to 1.5 times their annual salary. For some people, this is enough coverage to provide for final arrangements and other financial obligations. However, we also recognize that your life insurance needs can change according to your age and stage of life. That's why we are giving you the chance to buy coverage in the form of Universal Life Insurance.

With Universal Life, you own the policy, so you can keep the coverage if you leave your job or retire. Universal Life Insurance can gain cash value over time with variable interest rates, and the premiums are funded through payroll deductions. In addition to its cash value (which can be used for children's educations, to supplement retirement income and for incidental expenses), Universal Life Insurance is flexible enough to change as your needs change. You can purchase Universal Life policies to cover yourself, you spouse, and your children or grandchildren.

This benefit is only offered at Open Enrollment or during the new hire eligibility period.

Universal Life Insurance Advantages

- Portability—You own the policy.
- Cash Value—Policy can gain value over time with variable interest rates.
- Convenience—Pay the premiums through payroll deductions.
- Flexibility—Cover yourself, your spouse, your children and grandchildren.

Universal Life Benefit Amounts

Employee:

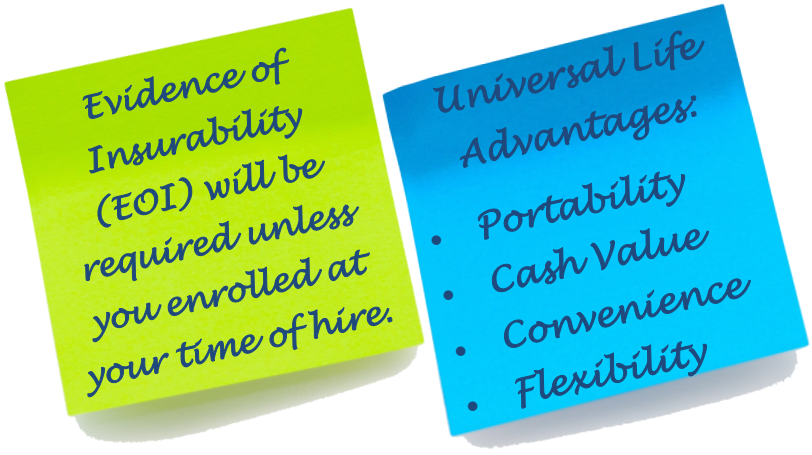
- $20 per week, up to $150,000 for employees ages 18-65
- Evidence of Insurability (EOI) will be required unless you are a new hire.

Spouse:

- $8 per week, up to $100,000 for working spouses to age 65
- $5 per week, up to $100,000 for non-working spouses to age 65
- Evidence of Insurability (EOI) required for spouses.

Child/Grandchild:

- $3 per week, up to $50,000 for children from birth to age 18
- Evidence of Insurability (EOI) required for children ages 19-26.



Critical Illness and Accident Insurance

What is EOI?

Evidence of Insurability (EOI), also known as the proof of good health, Is the documentation of the good health condition of the beneficiary. It can also be required for spouse coverage.

The average financial burden associated with a critical illness is $30,000—most of which is linked to lost income. On average, households spend $4,976 on out-of-pocket medical expenses not covered by group health insurance.

Critical Illness Insurance through Allstate

Critical Illness Insurance can help fill a financial gap if you or an enrolled dependent experience a life-threatening illness. Upon diagnosis of a covered illness, a lump-sum benefit is immediately paid after a claim has been filed with the carrier. This will help cover out-of-pocket medical expenses or costs associated with adjusting to life following a covered critical illness. You may choose coverage amounts of either $15,000 or $30,000. The chart below illustrates some more common covered conditions and their payable lifetime amount.

Critical illness lump sum payments can be used for medical fees, household/ childcare costs, travel/lodging expenses and more.

Note: The Critical Illness policy also includes a Wellness Benefits. See your Summary Plan Description to learn more.

Covered conditions	Amount payable per lifetime	Covered conditions	Amount payable per lifetime
Cancer	100%	Blindness	100%
Benign brain tumor	100%	Major organ failure	100%
Carcinoma in situ	25%	Complete hearing loss	100%
Heart attack	100%	Permanent paralysis	100%
Stroke	100%	Coma	100%
Coronary artery bypass surgery	25%	End-stage renal (kidney) failure	100%

Accident Insurance through Allstate

Would your finances be able to survive an accidental injury? An accident can wreak havoc on your savings if you're not prepared for it. That's why we've added Accident Insurance to your benefit lineup. It gives you a cushion to help cover medical expenses and living costs when you get hurt unexpectedly.

Allstate's Accident Insurance can pay lump-sum benefits based on the off-the-job injury you receive and the treatment you need, including emergency room care and related surgery. The benefit can help offset the out-of-pocket expenses that medical insurance doesn't pay, including deductibles and copayments. Because Accident Insurance is a supplemental plan, it works in addition to other insurance you may have. You can use the policy on its own or to fill a gap left by other coverage. For a list of covered injuries, visit **www.allstateatwork.com/mybenefits**.

Long Term Care Insurance through LifeSecure

Benefit Bank: You choose an amount between $75,000 and $1,000,000.
Your Benefit Bank represents the lifetime dollar benefit amount available to you. Your Benefit Bank balance is reduced by any benefits paid to you or on your behalf.

Monthly Benefit Access Limit: You choose 1%, 2%, or 3%* of your Benefit Bank

Your Monthly Benefit Access Limit represents the dollar benefit amount available on a monthly basis for your long term care needs. The original dollar amount is calculated as a percentage of your Benefit Bank. The Monthly Benefit dollar amount cannot be less than $1,800.

*3% Monthly Benefit Access Limit not available for Benefit Bank amounts over $500,000.

Benefit Bank		Access Limit		Monthly Benefit
$300,000	X	1%	=	$3,000

Benefit Payout Structure: When you become eligible for benefits, LifeSecure will reimburse you for covered long term care expenses up to your full Monthly Benefit each calendar month. These covered expenses include care at home through a home care agency or independent provider, or in an assisted living facility, adult day care center or in a nursing home. Hospice care is also covered.

LifeSecure®
Live well. Worry less.

Important Note

Our **BudgetPointPricing** tool can help you choose a plan! By entering your age and your own target premium, you can quickly and easily find the right plan that fits your personal budget.

Try it at www.YourLifeSecure.com under "Quote Calculator".

For more information, contact LifeSecure at 1.866.582.7701, or visit **www.YourLifeSecure.com.**

Flexible Spending Accounts

Even the most comprehensive benefits program doesn't cover every expense. Flexible Spending Accounts (FSAs) are a tax-effective way to pay for certain expenses not covered by other benefits.

Flexible Spending Accounts

KeHE offers both a medical and dependent care Flexible Spending Account (FSA) that lets you set aside pretax dollars out of your paycheck to pay for certain expenses such as copayments, medical equipment and day care costs. With an FSA, you get to keep more money and pay less in taxes. Each year during Open Enrollment, you can elect to contribute up to:

- $2,550 per year in a Health Care FSA or Limited-Purpose FSA
- $5,000 per year (or $2,500 if married filing separate tax returns) in a Dependent Care FSA
- You can roll over $500 in a medical FSA at the end of the 2015/2016 plan year.

Important Note

You will be required to re-enroll in the FSA during open enrollment. Your election will not carry over year-over-year.

How an FSA Works

- **You must re-enroll in any FSA each year during the annual Open Enrollment period.**
- Your contributions will be deducted from your paychecks in equal amounts during the plan year.
- As you pay for eligible expense out of your own pocket, you are reimbursed from your account(s).
- Money can't be transferred between the Health Care and Dependent Car accounts; each are separate accounts.
- You can't stop or change your FSA contributions during the plan year unless you have a qualified status change.

Important Note

If you are covering ONLY YOURSELF for medical and/or dental coverage, you can still use your medical FSA to pay for a dependents' out-of-pocket medical expenses, even if the dependent IS NOT covered under your plan.

Limited –Purpose FSA

Those enrolled in a Health Savings Accounts (HSA) plan are not eligible to choose a standard Flexible Spending Account, too. HSA participants can, however, enroll in a Limited-Purpose FSA (LPFSA) that provides reimbursement for eligible dental, vision and hearing expenses such as contacts, prescription eyeglasses, vision correction surgery, dental fillings, roots canals, orthodontia, hearing aids, etc.

Flexible Spending Accounts

Keep in mind, an LPFSA is only available to you if you're enrolled in the BCBS HSA Plan or the Value Plan. Just like with the standard FSA, when you chose an LPFSA you can reduce your taxable income by using tax-free LPFSA dollars for dental, vision, while preserving your HSA funds for other medical expenses.

An FSA is strictly governed by IRS regulations. For more details and a list of eligible expenses, you can refer to IRS Publications 502 and 503 available at **ww.irs.gov** or call 1-**800-TAX-FORM**.

*Important Notice

Over-the-Counter Medication Reimbursement

Due to health care reform, effective January 1, 2011, you may no longer receive tax-free reimbursements for over-the-counter medications from your Health Care Flexible Spending Account. This means that tax-free reimbursements are available only for medications or drugs purchased with a physician's prescription. The one exception is insulin, which does not require a physician's prescription.

Per the IRS, all FSA claims must be substantiated with PayFlex.

Watch Your Tax Savings Grow

Let's see how your Health Care FSA may save you money. The average U.S. family of four can expect to pay close to $1,600 on expenses such as office visits, prescription copays, dental work and new glasses—or an unexpected hospital stay.

Out-of-Pocket Expenses	U.S. Yearly Averages
Doctor Visits and Hospital Copays	$1,008
Prescription Drug Copays	$168
Dental	$374
Vision	$50
TOTAL	$1,600

If that $1,600 were put into a Health Care FSA, the family could have saved more than $400* because of lowered taxable income.

* Sample savings are provided for illustrative purposed only. Actual savings may vary depending on individual circumstances, including FICA and state taxes. Consult your tax advisor before making any financial decisions.

Is an FSA for me? How much?

Before participating in an FSA, ask yourself several questions:

- How much were my out-of-pocket health care and dependent care expenses last year?
- Do I expect to pay for some health care costs that are not totally covered by my benefits?
- Do I pay someone to care for my dependents while I work?
- Am I eligible for a tax credit for any health care or dependent care-related expenses? If so, will the tax credit or FSA participation be better for me?
- Does my spouse have FSAs available through an employer? If so, how do we want to coordinate our accounts?

Flexible Spending Accounts

Use these worksheets to calculate what health care and dependent care contributions work best for you and your family.

Health Care

How much do you spend out-of-pocket for:	Amount spent during an average year on:
Routine doctor visits?*	$0
Hospital services?*	
Hearing exams/aids?*	
X-rays, lab exams, tests?*	
Eye doctor visits?	
Glasses/contacts and cleaning supplies?	
Prescriptions?*	
Dental expenses?	
Total: regular expenses (max. yearly contribution = $2,550)	
/Number of paychecks you receive each year	/
= Amount to deposit into your Health Care FSA each pay period	=

Dependent Care

How much do you spend out-of-pocket for:	Amount spent during an average year on:
Last year's tax-credit-eligible day care expenses?	
Day care/ preschool programs?	
After-school programs?	
Adult day care or elder care?	
+Any fee increases?	
Total: regular expenses (max. yearly contribution = $5,000)	
/ Number of paychecks you receive each year	/
= Amount to deposit into your Dependent Care FSA each pay period	=

Please Note: The FSA is only available to employees enrolled in the HCA Plan. Employees enrolled in the HSA or Value Plan can only enroll in a Limited-Purpose FSA, which only covers dental and vision expense.

*Not applicable if enrolled in the Limited FSA

Retirement Savings

Your goal is simple: Maximize your savings so you can retire comfortably. But with people living longer today and enjoying more time as retirees, reaching this goal may seem overwhelming. Fortunately, your benefit programs provide you with valuable savings and investment options to help build the nest egg you'll need.

401(k) Retirement Savings Plan

There are many excellent reasons to start contributing to the KeHE Distributors 401(k) Retirement Savings Plan:

- **Tax-deferred contributions**—Generally, you don't have to pay income tax on the part of your salary that you contribute to your plan until you take a withdrawal. Earnings from plan contributions are also tax-deferred until distributed.
- **Vesting**—You are always 100% "vested" in any salary reduction contributions and rollover contributions you make to your 401(k) Plan. This means you own the money (contributions and earnings) in your account.
- **You decide where to invest your money**—You have a variety of professionally managed investment options to choose from—and you can change your investment mix as your needs change.
- **Automatic payroll deductions**—If you don't touch it, you can't spend it.

401(k) Plan Highlights:

- Automatic payroll deductions make savings effortless.
- You may contribute up to $18,000 in calendar year 2015: between 0 and 75% of your annual pay before taxes and 0 to 10% of your annual pay after taxes.
- You may contribute up to an additional $6,000 if you are 50 or older.
- You may change your contribution amount anytime by contacting Prudential.
- A wide array of investment options enables you to develop a strategy that best suits your needs.
- Your contribution amount will be automatically bumped up 1% each July until you are at a maximum of 10%—unless you opt out of this feature.

Retirement Savings

Timing is Everything

The sooner you start saving for retirement, the faster your account will grow. Conversely, the longer you wait to get started, the harder it will be to catch up.

Here's the hypothetical example: Let's say you contributed $5,000 a year to a 401(k) for 10 years—assume that your investment earned 8% a year and all investment earnings were reinvested in your account. Depending on how old you were when you made those contributions, you would see wildly different amounts at age 65 when you retire.

- If you started saving at 25, stopping at 35, when you retire at 65 your account would be worth about $787,000.
- If you started saving at 35, stopping at 45, it would be worth about $364,000.
- If you started at 45 and stopped at 55, its value would be only about $170,000.
- And, if you waited to start saving until you reach 55 and contributed until 65, you'd only amass about $78,000.

These examples assume that you only invest $5,000 a year for 10 years and then stop. If you were to contribute that amount consistently from ages 25 to 65, you would amass more than $1.35 million during those 40 years.

How to Enroll

Eligible employees may begin participating on their 31st day of employment. You are automatically enrolled into the 401(k) plan at 3% unless you decline participation by contacting prudential at **prudential.com/online/retirement** or 877-778-2100 within 30 days prior to your eligible plan entry date. Automatic enrollment is a process by which you are enrolled in your retirement plan without taking any action. You can change the amount of your contributions, rollover funds from your previous employer, stop them altogether or redirect your investment options.

Employee Stock Ownership Plan (ESOP)

In addition to the 401(k) Retirement Savings Plan, KeHE also provides you with the opportunity to share in the company's financial success through an Employee Stock Ownership Plan. KeHE will make contributions on your behalf to the ESOP. You do not contribute any of your own money.

KeHe contributes to your ESOP Account

ESOP Highlights

- The plan provides eligible employees an opportunity to share in the profitability and growth of KeHE and to earn additional income for retirement.
- The plan provides a stake in the company's success.
- The ESOP is not directly affected by the ups and downs of the stock market. What we do each day and how the company performs directly impacts the ESOP.
- For more information refer to your ESOP plan description

When KeHe does well your ESOP can grow

To view your statement when it becomes available or to change your beneficiary, go to **www.croweesopadvantage.com**

Live a Balanced Life

KeHE cares about its employees. We offer many tools such as the EAP, Health Advocate and Care Partners to assist employees with personal issues.

Employee Assistance Program (EAP)

As you go through life, you may be faced with health, personal, family or work-related challenges. Problems arising from illnesses, day care issues, loss of a loved one, relationship conflicts or financial difficulties can affect your life at home and at work.

Now there is a resource that can help you sort things out—the Employee Assistance Program. KeHE has contracted with Bensinger, DuPont & Associates (BDA) for these services. Through the EAP, you and your family can receive counseling and referrals at no cost to you. Any help you receive is completely confidential and not shared with KeHE.

When to Use the EAP

When you call your EAP anytime, 24 hours every day, there's always someone available who will:

- Ask about your situation
- Help you clarify the problem
- Offer guidance and support
- Connect you with experts who can help with work-life issues
- Refer you to a local EAP counselor for 3 face-to-face sessions

Simply call the EAP's toll-free number **1-800-272-2727** and choose to speak with a trained professional about everything from marriage and family concerns to legal and financial issues or even child and elder care referrals.

How to Uses the EAP

If you want or need additional counseling, you can schedule an appointment with an EAP counselor. The EAP can also provide referrals to other providers or community resources if you need additional assistance.

If you're referred to a provider outside the EAP, the cost of that treatment isn't covered by the EAP. However, the treatment may be covered by your health insurance. For more information about mental health benefits covered by your health insurance, please see your KeHE medical coverage materials. You can also view additional resources at BDA's website. Go to **www.bdaeap.com** and enter the password "kehe."

Care Partners

Care Partners offers onsite or remote support 24/7 to confidentially discuss difficult issues such as marriage concerns, parenting issues, care of aging parents, health, death and other personal issues. Support is also available via phone at 800-757-7657.

Health Advocate

Company employees and dependents enrolled in a company medical plan have access to a complementary benefit concierge service called Health Advocate. The service model is focused on providing continuity of support during the course of an entire consultation or transaction by providing you with a single case manager.

HealthAdvocate™

Your Lifeline for Healthcare Help

24/7 Support

866.695.8622

HealthAdvocate.com/members

Important Note

Please note that due to privacy laws, Health Advocate will need you to complete an initial form in order to provide resources and claim assistance on your behalf.

Employee Contributions for 2015 – 2016

The information shown here illustrates the premiums for each benefit plan. Please review each option carefully and choose the coverage that fits your (and your family's) budget and lifestyle. The rates shown are effective May 1, 2015 to April 30, 2016.

Medical Options

BCBS HCA Plan *(Health Care Account)*	Weekly Rates	Biweekly Rates
Employee	$31.54	$63.08
Employee + Spouse	$78.85	$157.70
Employee + Child(ren)	$68.10	$136.19
Family	$121.86	$243.72

BCBS HSA Plan *(Health Care Account)*	Weekly Rates	Biweekly Rates
Employee	$14.50	$29.00
Employee + Spouse	$36.25	$72.49
Employee + Child(ren)	$31.30	$62.61
Family	$56.01	$112.03

BCBS Value Plan	Weekly Rates	Biweekly Rates
Employee	$7.09	$14.18
Employee + Spouse	$15.60	$31.19
Employee + Child(ren)	$13.47	$26.94
Family	$24.10	$48.21

Employee* & Spouse** Supplemental Life

Employee Age	Monthly Cost per $1,000
<20	$0.054
20 - 24	$0.054
25 - 29	$0.065
30 - 34	$0.086
35 - 39	$0.097
40 - 44	$0.107
45 - 49	$0.161
50 - 54	$0.269
55 - 59	$0.495
60 - 64	$0.753
65 - 69	$1.440
70+	$2.214

Dental Options

Delta Dental PPO	Weekly Rates	Biweekly Rates
Employee	$1.78	$3.56
Employee + Spouse	$4.76	$9.52
Employee + Child(ren)	$4.07	$8.13
Family	$6.83	$13.66

Delta Dental Preventative	Weekly Rates	Biweekly Rates
Employee	$0.55	$1.09
Employee + Spouse	$1.09	$2.19
Employee + Child(ren)	$1.45	$2.90
Family	$2.39	$4.78

Dental HMO	Weekly Rates	Biweekly Rates
Employee	$1.02	$2.03
Employee + Spouse	$2.03	$4.06
Employee + Child(ren)	$1.85	$3.69
Family	$2.86	$5.72

Vision Coverage

EyeMed	Weekly Rates	Biweekly Rates
Employee	$1.19	$2.38
Employee + Spouse	$2.26	$4.53
Employee + Child(ren)	$2.38	$4.76
Family	$3.50	$7.00

Calculate Your Cost!

Use the worksheet on the following page to calculate the estimated cost of your benefits based on the election you make during Open Enrollment.

*Employee-only rate

** Spouses not covered over the age of 70.

2015 - 2016 Biweekly Contribution Worksheet

Benefit Type	Cost Calculation Method	Apply Formula	Biweekly Cost
Core Benefits			
Medical Dental Vision	See previous page for rates	N/A	$ $ $
Short –Term Disability			
Basic Coverage (60% weekly salary)	$0 - paid for by KeHE	N/A	$0.00
Buy-Up Coverage (Additional 15% weekly salary)	Monthly Cost = $0.37 per $10 of covered benefit	($_____ / 52 x .15) / 10 x .37 x 12 / 26 annual salary	$
Long-Term Disability			
Basic Coverage (50% monthly salary)	$0 - paid for by KeHE	N/A	$0.00
Buy-Up Coverage (Additional 10% monthly salary)	Monthly Cost = $0.14 per $100 of covered benefit	($_____ / 12) / 100 x .14 x 12 / 26 annual salary	$
Flexible Spending Accounts (FSAs)			
Health Care FSA or Limited –Purpose FSA	Annual election ($2,550 max.) divided by 26 pay periods per year	$_____ / 26 annual election amount	$
Dependent Care FSA	Annual election ($5,000 max.) divided by 26 pay periods per year	$_____ / 26 annual election amount	$
Life and AD&D Insurance			
Company-provided Basic Life	$0 - paid for by KeHE	N/A	$0.00
Company –provided Basic AD&D	$0 - paid for by KeHE	N/A	$0.00
Employee Supplemental Life (1x, 2x, 3x, 4x or 5x salary)	See previous page for rates by employee age	($_____ / 1,000) x _____ x 12 / 26 chosen benefit amount EE age rate	$
Employee Voluntary AD&D (1x, 2x, 3x, 4x, or 5x salary)	Monthly cost = $0.02 per $1,000 of covered benefit	($_____ / 1,000) x .02 x 12 / 26 chosen benefit amount	$
Dependent Supplemental Life (Up to $50,000 in $5,000 increments)	Spouse rate based on spouse age EE age rate - see previous page for rates	($_____ / 1,000) x _____ x 12 / 26 chosen benefit amount EE age rate	$
Dependent Voluntary AD&D (Up to $50,000 in $5,000 increments)	Monthly cost = $0.02 per $1,000 of covered benefit	($_____ / 1,000) x .02 x 12 / 26 chosen benefit amount	$
Child Supplemental Life	$5,000: $0.625 per month $10,000: $1.25 per month	($_____ x 12) / 26 monthly rate (from left)	$
Child Voluntary AD&D	$5,000: $0.10 per month $10,000: $0.20 per month	($_____ x 12) / 26 monthly rate (from left)	$
Accident Insurance Critical Illness Insurance Universal Life Insurance	Cost Varies by individual	Call Allstate directly to receive pricing 1-800-521-3535	$ $

(Divide this amount by 2 if you are paid weekly) $_____

Important Notices

For more information about the following notices, please contact your local Human Resources representative.

Health Insurance Portability and Accountability Act of 1996 - Privacy

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) requires health plans to maintain the privacy of your health information and to provide you with a notice of the plan's legal duties and privacy practices with respect to your health information. The notice describes how the plan may use or disclose your health information, under what circumstances it may share your health information without your authorization (generally to carry out treatment, payment, or health care operations), and your rights with respect to your health information.

As required by HIPAA, KeHe maintains the confidentiality of your health information and has policies and procedures in place to help protect it from improper use and disclosure.

Don't Forget!

If you experience a Qualified Life Event (QLE) as a result of marriage, birth or adoption, you must request enrollment within 31 days of the event and must submit proper documentation.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his/her employment. If you notify KeHe within 31 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 31 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

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

Offer Free Or Low-Cost Health Coverage To Children And Families

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 dependent are already enrolled in Medicaid or CHIP, 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-KIDSNOW** (1-877-543-7669) or **www.insuredkidsnow.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, 2014. Contact your State for more information on eligibility –

Medicaid and the Children's Health Insurance Program (CHIP) Continued

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
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	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	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	**MONTANA** – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

Medicaid and the Children's Health Insurance Program (CHIP) Continued

LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
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	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414

Medicaid and the Children's Health Insurance Program (CHIP) Continued

OREGON – Medicaid	VERMONT– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid	**WASHINGTON – Medicaid**
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

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

US 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 10/31/2016)

Genetic Information Non-Discrimination Act of 2008 (GINA)

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family members of the individual, except as specifically allowed by this law. To comply with this law, KeHe will generally never require a benefits participant to provide any genetic information when responding to any request for medical information in connection with enrollment in any KeHe benefits plan or accessing any of your KeHe plan benefits. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic test, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

For more information about GINA, visit **www.dol.gov/ebsa/faqs/faq-GINA.html**

Uniformed Services Employment & Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) was enacted in 1994 following U.S. military action in the Persian Gulf. USERRA prohibits discrimination against individuals on the basis of membership in the uniformed services with regard to any aspect of employment. Since its enactment, USERRA has been modified and expanded by additional federal laws, such as the Veterans Benefits Improvement Act of 2008 (2008 Act).

MAINTENANCE OF BENEFITS DURING LEAVE

A person who is reemployed upon returning from completion of uniformed service is entitled to the rights and benefits that he or she would have attained if he or she had remained continuously employed.

Health Benefits

An employer must allow individuals absent due to uniformed services to elect to continue health insurance coverage for themselves and their dependents. Health insurance coverage must be continued until the earlier of:

- 24 months beginning on the date when the absence began; or
- The day after the date the employee fails to apply for return to work following completion of their service.

Individuals who are absent from work for less than 31 days may not be required to pay more for coverage than the employee share charged to employees that are actively at work. Employers may charge all other individuals no more than 102 percent of the full premium under the plan.

If benefits are cancelled because the employee did not elect to continue coverage or failed to pay premiums, the employer must restore to the employee benefits equivalent to those the employee would have had if leave had not been taken, including family or dependent coverage. The employee cannot be required to serve a new pre-existing condition waiting period, wait for open enrollment or pass a medical examination to obtain reinstatement of coverage.

The Mental Health Parity and Addiction Equity Act of 2008

The *Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) requires group health plans to apply the same treatment limits on mental health or substance-related disorder benefits as they do for medical and surgical benefits. The MHPAEA also extends this parity requirement to inpatient and outpatient services, whether in-network or out-of-network, and to emergency care services and prescription drugs.

MHPAEA revised the definition of "mental health benefits" to include substance use disorder benefits. The MHPAEA also requires group health plans to apply the same beneficiary financial requirements to mental health or substance use disorder benefits as they apply for medical and surgical benefits, including limits on deductibles, co-payments and out-of-pocket expenses. Plan administrators are also required to make the criteria for "medical necessity" determinations with respect to mental health and substance use disorder benefits available to plan participants, beneficiaries or providers upon request.

Medicare Part D Notice of Creditable Coverage

Important Notice from KeHe About Your Prescription Drug Coverage and Medicare

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

Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

For more information about Medicare prescription drug coverage, visit www.medicare.gov.

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

Medicare Part D Notice of Creditable Coverage

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

Enrollees of the KeHe Medical plans are automatically enrolled in prescription drug coverage. It is not possible to enroll in KeHe's Medical coverage and decline or waive the prescription drug component of the coverage. If you decide to join a Medicare drug plan, you are not required to drop your current KeHe Medical plan coverage. If you elect Medicare Part D coverage in addition to your KeHe Medical coverage, the pharmacy benefits you are eligible for under your KeHe Medical plan will coordinate with your Part D coverage.

If you do decide to join a Medicare drug plan and drop your current KeHe Medical plan coverage, be aware that you and your dependents will be able to get this coverage back during Annual Open Enrollment or following a qualified special enrollment event.

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

You should also know that if you drop or lose your current coverage with KeHe's Medical plan and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage contact Human Resources for additional information.

NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if coverage through KeHe's Medical plan changes. You may also request a copy of this notice at any time from the Human Resources Department.

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

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

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

For more information about Medicare prescription drug coverage, visit www.medicare.gov.

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

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under this Act. 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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Newborns' and Mothers' Health Protection Act of 1996

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery. 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 the length of stay not in excess of 48 hours or 96 hours, as the case may be.

Important Terms

There are several terms associated with benefit programs and insurance used in this guide. Learn the basics below.

Beneficiary—The person you designate to receive your benefits in the event of your death.

Blue Distinction Centers (BDC)—Blue Distinction Centers® recognition program was developed to identify hospitals with proven expertise in delivering specialty care. See page 13 for additional information.

COBRA—A federal law that allows workers and dependents who lose their medical, dental, vision or Health Care FSA coverage to continue any group coverage for a specific length of time.

Coinsurance—The percentage of medical costs you have to pay after meeting the deductible amount that is attached to your plan.

Copayment—A specified dollar amount to be paid to your provider (doctor/facility) on each visit.

Deductible—The amount you must pay in medical expenses before your insurance company will begin to cover your medical bills.

Dependent—A dependent includes your legally married spouse as defined under federal law and/or dependent child(ren) under the age of 26 as defined by the plan.

Evidence of Insurability (EOI)—A questionnaire that insurance companies use to ask about the health of a participant. Depending on the responses, this may lead to the requirement of a physical exam. These forms are often used if you apply for an amount above the Guaranteed Issue amount.

Explanation of Benefits (EOB)—A notice sent to the covered person after a claim for payment has been processed by the insurance company. The form explains the action taken on the claim. This explanation usually indicates the amount paid, the benefits available, the reasons for denying payment or the claims appeal process.

Formulary—A list of preferred medications identified by the medical carrier. These medications are generally brand-name drugs. Brand-name drugs that are not on the formulary list usually require a higher copay.

Mail Order—A benefit that allows you to order certain maintenance medications at a reduced cost. You receive multiple months' worth of medication by mail.

Network Providers—A group of health care professionals who provide care at a predetermined lower rate. Staying in the network to receive care is an effective way for you to control your health insurance costs.

Out-of-Pocket Maximum (OOP)—Generally, the maximum amount of money a member will have to pay each year. The out-of-pocket maximum most often applies to coinsurance. An individual who meets the out-of-pocket maximum may still be responsible for copayments.

Precertification (Preauthorization) - Before surgery or hospitalization, the insurance company must be contacted to get approval for a medical service to take place. Failure to do so typically means the insurance company will not pay for the service or may pay reduced benefits for services provided without preauthorization. This does not apply in an emergency situation, although the insurance company should be contacted as soon as possible.

Premium—The per pay period cost of benefits.

Reasonable & Customary (R&C) Charge—The usual amount charged by most doctors for a particular service. The R&C charge may be different in two different geographic area or if the service was provided under different circumstances (for example, in an emergency versus a nonemergency). R&C charges may apply only if you use out-of-network providers. You're responsible for paying any amount that exceeds the R&C limit.

Frequently Asked Questions

Here are some of the most common questions employees have about their benefits.

Q: What happens if I miss the deadline to enroll in KeHE's benefit programs?

A: If you don't make your benefit elections within 31 days after your eligibility date, you won't be able to enroll until the next Open Enrollment period unless you experience a Qualified Life Event.

Q: Can I see any licensed doctor or dentist I want?

A: Yes. Our plans have both in-network and out-of-network benefits. However, network doctors have agreed to a discount of their fees. So, you may pay lower out-of-pocket expenses when you use an in-network provider.

Q: What if I get married, divorced or have a new child in my family during the plan year?

A: You must notify Human Resources within 31 days of any Qualifying Life Event. Otherwise, you will have to wait until the next enrollment period to change your benefit options or coverage levels. You may also be required to show official documentation as proof of the change such as a marriage license, birth certificate or court papers.

Q: How do I know if my provider is in the network?

A: Check the plan sponsor's website or call your provider directly.

Q: Why do I pay for some benefits with pretax money?

A: Paying for certain optional benefits with pretax money lowers the amount of your pay that is taxable; therefore, you pay less in taxes. IRS code specifies that the value of any Life Insurance coverage provided to employees that exceeds $50,000 must be considered as taxable income.

Q: Are prescription drugs included in the Medical plans?

A: Yes, through a retail pharmacy and mail-order prescriptions.

Q: How can I receive additional or replacement ID cards?

A: Call the benefit providers directly or go online to the provider's website list on page 3 of this guide.

Frequently Asked Questions

Q: Does Accidental Death and Dismemberment Insurance (AD&D) pay on top of any Life Insurance benefits I may receive?

A: Yes. Accidental Death and Dismemberment (AD&D) is similar to regular life insurance. If you die in an accident, your beneficiary will receive the amount of your AD&D coverage in addition to your Life Insurance benefits. AD&D also pays a benefit if you're seriously injured in an accident, such as losing a limb or eyesight, or if you become physically disabled.

Q: What is the difference between the Allstate Universal Life Insurance and the Cigna Life Insurance?

A: Both life insurance offerings provide portable insurance for your entire family at affordable rates with cash benefits upon death. Premiums are deducted from your payroll check. The Allstate Life Insurance has fund-value accumulation and allows for loans and withdrawals when needed. Allstate Insurance rates are also fixed at the rate upon purchase whereas the Cigna rates are age banded and will change.

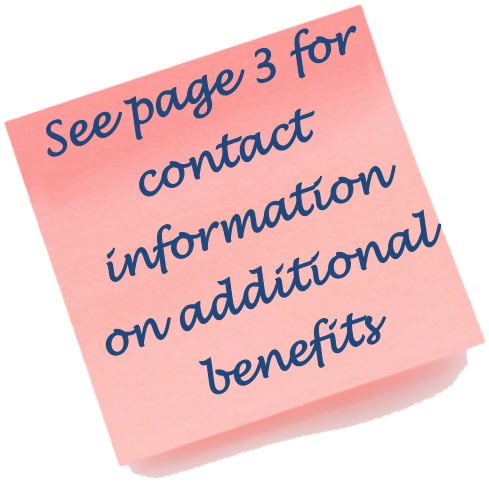
Q: If I leave the company, when will my benefits end?

A: All coverage ends the last day of the pay period in which you worked. However, you may elect COBRA to extend your medical, dental, vision and Health Care FSA benefits. After your termination, you will be sent COBRA information. You have 60 days to make the election.

Q: When can I continue coverage under COBRA?

A: You and/or your dependents are eligible to continue group health care under COBRA if coverage is lost because:

- *You leave KeHE for any reason other than "gross misconduct"*
- *Your work hours are reduced below the benefits-eligibility requirement*
- *You die*
- *You become entitled to and enroll in Medicare prior to electing COBRA*
- *You divorce*
- *Your dependent loses dependent status*



Notes

Notes

Notes

Recession of Coverage

KeHe reserves the right to terminate the health coverage of you/and your dependent prospectively without notice for cause (as determined by KeHe), or if you and/or your dependents are otherwise determined to be ineligible for coverage under the plan. In addition, if you or your dependents commits fraud or intentional misrepresentation in an application for health coverage under the plan, in connection with a benefit claim or appeal, or in response to any request for information by **KeHe** or its delegates (including **the plan administrator or a claims administrator**), **KeHe** may terminate your coverage retroactively upon 30 days of notice. Failure to inform **KeHe** that you or your dependent is covered under another group health plan or knowingly providing false information in order to obtain coverage for an ineligible dependent are examples of actions that constitute fraud under the plan.