One thing that makes Harris Teeter an incredible place to work is our extensive benefits package. As a Harris Teeter associate, you are eligible to enroll in one of the most comprehensive benefits programs in the grocery industry.

Our benefits program is designed to help you:

- Stay healthy and access the right Medical, Dental, and Vision care when you need it.
- Protect your income and provide for your family if you become disabled, have a critical illness or die.
- Handle day-to-day stresses, family concerns and legal or financial issues through confidential access to counselors and legal or financial professionals.

This Enrollment Guide highlights our many benefit programs and provides you with one easy-to-read resource for your benefit enrollment.

Your benefits include:

- Medical Coverage ....................... 6
  - CIGNA Prescription Drug Plan .......... 7
  - Wellness Benefits ....................... 12
  - How to Access Your Health Assessment . 18
- Dental Coverage ......................... 21
- Vision Coverage ........................ 23
- Flexible Spending Accounts .............. 24
- Short-Term Disability (STD) ............. 27
  - Supplemental Short-Term Disability ... 27
- Long-Term Disability (LTD) .............. 28
  - Supplemental Long-Term Disability ... 28
- Life Insurance .......................... 29
  - Basic Term Life .......................... 29
  - Supplemental Term Life .................. 30
  - Supplemental Dependent Term Life ..... 31
- Accidental Death & Dismemberment (AD&D) . 33
  - Supplemental AD&D Benefits .......... 34
- Commuter Benefit Program ............... 36
- Voluntary Benefits ....................... 37
  - Individual Life ........................ 37
  - Critical Illness ......................... 38
  - Accident Insurance ..................... 42
  - Hospital Indemnity ..................... 46
- Other Important Benefits ................ 49
  - WorkLife Solutions (EAP) ............... 49
  - Hugh G. Ashcraft Foundation .......... 50
- Important Notices ....................... 50

The information described in this Enrollment Guide is only intended to be an easy-to-understand summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD)/certifcate/Policy for a complete summary of your benefits. If the information on the enclosed pages conflicts in any way with the Summary Plan Description (SPD)/certifcate/Policy, the contract provisions of the appropriate policy or plan document (available with your employer) will prevail.

While Harris Teeter expects to continue your benefits program, it reserves the right to amend, change, modify or terminate the program at any time and for any reason. This Guide is not an offer or contract of continued employment with Harris Teeter Supermarkets, Inc., Harris Teeter, Inc. or any of its affiliates.
Benefits Enrollment

As a new hire, you have until your eligibility date to enroll for benefits. If you don’t enroll during your eligibility window, you will not be enrolled in most benefits until the next annual open enrollment period, unless you experience a qualifying life status change event which is described on page 3, under “Making Changes”.

Each year, during the Open Enrollment period, you will have the opportunity to enroll or make changes to your coverage and your covered dependents. The dates of the enrollment period will be announced prior to the start of Open Enrollment.

To enroll in benefits, go to www.myHTspace.com and set up your User ID and Password as instructed. On the home page, click on “Benefits Enrollment” then “Enroll in Benefits”. Additional information regarding your benefits, including the rates for your health care coverage can be found by clicking on “Benefits Enrollment” on the home page.
Benefit Basics

Understanding the basics such as eligibility, coverage levels, qualifying life status change events and the difference between before-tax and after-tax benefits should help you use your benefits to the fullest.

Who is Eligible?

You are eligible to participate if you are an active full-time associate who has completed 90 days of continuous full-time employment. As long as you enroll on or before your eligibility date, coverage will begin on your 91st day of full-time employment.

There may be separate eligibility requirements for the Voluntary Benefits plans.

When Does Coverage End?

Coverage in group benefit plans ends immediately on the earliest of the following:

- Date your employment ends,
- Date you are no longer a full-time associate, or the
- Date you cancel coverage as a result of a qualifying life status change event, or the
- Date you cancel coverage or fail to pay premiums on a timely basis while on leave of absence.

If you are no longer eligible for group benefits as a result of termination of employment or reduction in hours, you will be offered continuation of your healthcare coverage in compliance with COBRA, unless your termination of employment is due to gross misconduct.

Who Qualifies to Be a Dependent?

You are eligible to cover the following dependents for medical, dental and vision coverage:

- Your legal spouse. A legal spouse is an individual who is legally married to a Participant under the law of the state in which the Participant resides.
- Any child born to you, legally adopted by you, or legally placed with you for adoption who is:
  - Less than 26 years old without regard to such child’s status as a full-time student; status as a tax dependent of the Employee as defined under Code Section 152; residency; marital status; or disability status; or
  - 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child’s condition and dependence must be submitted to CIGNA HealthCare within 31 days after the date the child ceases to qualify above. During the next two years CIGNA HealthCare may, from time to time, require proof of the continuation of such condition and dependence. After that, CIGNA HealthCare may require proof no more than once a year.

Benefits for a Dependent child will continue until the last day before your Dependent’s birthday, in the year in which the limiting age is reached. No one may be considered as a Dependent of more than one Employee.
Notwithstanding the foregoing, the term Dependent shall not include any child of a covered Employee if such child is eligible for coverage under a group health plan (other than a group health plan sponsored by the employer of either parent) as an employee or a dependent.

The definition of a dependent for coverage under the life and accidental death and dismemberment plans::

- Your legal spouse. A legal spouse is an individual who is legally married to a Participant under the law of the state in which the Participant resides.
- Any child born to you, legally adopted by you, or legally placed with you for adoption who is:
  - Less than 19 years old without regard to such child’s status as a full-time student; status as a tax dependent of the Employee as defined under Code Section 152; residency; marital status; or disability status; or
  - Any stepchild of yours, foster child or child for which you are appointed legal guardian who is:
    - Less than 19 years old without regard to such child’s status as a full-time student; status as a tax dependent of the Employee as defined under Code Section 152; residency; marital status; or disability status; or

Benefits for a Dependent child will continue until the last day before your Dependent’s birthday, in the year in which the limiting age is reached.

No one may be considered as a Dependent of more than one Employee.

Auditing Dependent Status

The plan has the right to conduct periodic audits of dependent status. During an audit you will be required to provide proof of your dependent’s relationship.

Making Changes

The elections you make when you enroll remain in effect for the full plan year – January 1 through December 31. Each year during the annual open enrollment period, you will have the opportunity to change your elections to keep pace with you and your family’s changing needs. No changes are allowed to your elections during the plan year, unless you experience a “qualifying life status change event.” It is the associate’s responsibility to make sure that qualifying life status changes are made within 30 days of the qualifying life status change event. If a covered dependent ages out, no longer meets the definition of a covered dependent or dies and the associate does not drop the coverage within 30 days, then the covered dependent will no longer have coverage and the associate will continue to pay the same premium amount until the end of the plan year. Enrollment in Supplemental Disability coverage and Supplemental Term Life coverage is limited to your newly eligible period and/or each subsequent annual open enrollment period.

A qualifying life status change event includes:
- Marriage, divorce or legal separation
- Birth or placement for adoption of a child
- Death of a dependent
- Marriage of dependent
- Medicare entitlement
- Child dependent turns age 26 or becomes eligible for healthcare coverage from his or her employer
Termination or commencement of your dependent’s employment that affects benefits

Please note that the IRS requires that any change in your elections be consistent with your change in qualifying life status change event. You must make any changes to your benefit elections within 30 days of the qualifying life status change event. You may be asked to provide proof of eligibility, such as a marriage license or birth certificate to cover your dependents.

Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage and subsequently lose that coverage, you may be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependents experience a loss of eligibility for Medicaid or your State Children’s Health Insurance Program (SCHIP) coverage, you may be able to enroll for coverage provided you request enrollment within 60 days of the date you lose eligibility under one of these programs. If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee’s portion of the health insurance premium, you may enroll within 60 days of when eligibility is determined.

Paying for Coverage

Many of the benefit plans provided to you are paid for by Harris Teeter.

- Basic Life Insurance
- Dependent Life Insurance
- Basic Accidental Death & Dismemberment (AD&D)
- Short – Term Disability (STD) benefits
- Long – Term Disability (LTD) benefits
- Employee Assistance Program (EAP)
- Wellness Benefits

Harris Teeter also pays the majority of the cost for most of the other benefits provided to you. If you are an hourly associate, your deductions for coverage will be withheld on a weekly basis. If you are a salaried associate, your deductions will be withheld semi-monthly. For more information regarding your costs, click “Benefits Enrollment” at www.myHTspace.com, then click “Full Time Enrollment Information” and then “Rate Sheet.”
Before – and After – Tax Benefits
What’s the Difference?

Dollars spent on most of your benefits are tax-free and are not subject to social security tax, federal income, state or local taxes. This means the dollars you spend to help pay for benefits go directly to the cost of the benefits without being taxed, increasing your take-home pay.

In contrast, dollars spent on after-tax benefits are first subject to social security tax, federal income and any state or local income taxes that you pay.

**Before-tax benefits include:**
- Medical
- Dental
- Vision
- Flexible Spending Accounts
- Commuter Benefit Program

**After-Tax benefits include:**
- Supplemental Life Insurance
- Supplemental Short-Term Disability
- Supplemental Long-Term Disability
- Supplemental AD&D
- Aflac Hospital Indemnity
- UNUM Accident Insurance
- Aflac Critical Illness Insurance
- Boston Mutual Individual Life
When you or a covered family member need medical care, your benefits program provides valuable healthcare assistance. You have a choice of two medical options through CIGNA HealthCare:

**Open Access Plus Plan**

An Open Access Plus Plan offers you the cost savings of an HMO but the freedom to use any doctor you choose at any time. Each of the two Plan options offers comprehensive medical benefits for you and your family. The difference between the two options is the amount you pay in medical costs each year, as well as the percent you pay of covered services.

To see if your doctor is part of the national network, or to find a network physician, please contact CIGNA at 1-800-633-7232 or go online at [www.myHTspace.com](http://www.myHTspace.com) and click on the myCIGNA link.

**LIMITED OPEN ACCESS PLUS PLAN**

*NOTE: Options may be limited during subsequent Open Enrollment if certain requirements are not met.*

**Maintenance of Benefits (MOB)**

MOB limits the benefits payable to the total plan benefit CIGNA HealthCare would have paid as the primary carrier. CIGNA HealthCare pays the difference between its normal liability and the primary carrier's payment. CIGNA HealthCare will subtract the primary plan's payment from the normal liability. If the liability is less than the primary plan's payment, CIGNA HealthCare will pay nothing.

**Eligibility and Costs**

The Plan is available to all active, full-time associates after 90 days of continuous full-time employment.

You and Harris Teeter share the cost of coverage for you and your dependents. The amount you contribute depends on the option and coverage level you choose.

**Women’s Health and Cancer Rights Act**

Subject to the medical plans required deductible and co-insurance provisions, the medial plan covers mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edema). Call CIGNA at 1-800-633-7232 for additional information.
Spousal Surcharge

Medical plan cost may include a $100 per month surcharge for working spouses with access to medical coverage with no annual limit for essential benefits. If you are married and you elect to cover your spouse under the medical plan, please note how the spousal surcharge applies:

- If your spouse is not employed, or is employed but is not eligible for medical coverage by his/her employer with no annual limit for essential benefits, you can elect to cover your spouse and the $100 per month surcharge will not apply.

- If your spouse is employed and is offered medical insurance with no annual limit for essential benefits by his/her employer, but elects to stay on the Harris Teeter group medical plan, the $100 per month surcharge will apply.

- If your spouse is employed part-time and is offered medical insurance with no annual limit for essential benefits by his/her employer, you can elect to cover your spouse and the $100 per month surcharge will not apply.

- If during the year your spouse qualifies for or loses coverage under his or her own employer’s plan, you will need to notify the Benefits Department of his/her change in eligibility or coverage within 30 days. This change in eligibility or coverage will be considered a qualifying life status change event, which will allow you to make election changes to your medical coverage, without waiting for the next annual open enrollment period. The surcharge will be added or deleted, consistent with the change in your spouse’s eligibility for employer provided medical benefits with no annual limit for essential benefits, as indicated above.

CIGNA Prescription Drug Plan

When you enroll in the medical plan, you are automatically enrolled in the prescription drug plan. This plan is administered by CIGNA and all associates and covered dependents who enroll in the medical plan can expect to receive a CIGNA medical/prescription card mailed to their home.

What is a Prescription Drug List?

The prescription drug list-known as a “formulary” by medical professionals – is an extensive list of generic and brand-name prescriptions drugs. The majority of the prescriptions you get from your doctor will be for drugs that are already on the list. Your benefit plan covers the cost of the Prescription Drug List medications, less any applicable co-payments, coinsurance, and deductibles.

Using the Prescription Drug List

All physicians in the CIGNA network have a copy of the prescription drug list. When you need a prescription, ask your doctor to prescribe a drug that is on the CIGNA HealthCare Prescription Drug List.

Some medications do require prior authorization. This means that your doctor must obtain prior approval for you to receive coverage for that particular medication. In addition, quantity limits and/or age requirements may apply to coverage for a particular drug. Although you will be notified of these restrictions by your pharmacy, you or your doctor may obtain additional details about your medication by calling CIGNA at 1-800-633-7232.
If your doctor believes that for medical reasons you must have a specific drug and the drug is not on the prescription drug list or the drug requires prior authorization for coverage under the CIGNA pharmacy plan, he or she can request prior authorization for coverage from CIGNA HealthCare. If the medication is authorized for coverage, you will pay the applicable co-pay, coinsurance, and/or deductible for the covered prescription.

When you have a prescription filled at a participating pharmacy, the pharmacy’s computer system will indicate whether the medication is on the prescription drug list and/or requires prior authorization. Your pharmacist will call your physician to discuss medication alternatives when your drug is not on the prescription list and/or requires prior authorization. If you elect to bypass the required authorization process or you elect to purchase a drug which is not on the prescription drug list, you will be subject to higher costs.

**Generic Drugs Help You Keep Your Costs Down**

Under the prescription drug plan, generic drugs will be substituted for brand-name drugs whenever available.

Brand-name drugs are protected by a patent and manufactured by a specific company. Generic drugs are manufactured according to the same chemical formula of the brand-name drugs whose patents have expired. The U.S. Food and Drug Administration requires that generic drugs have the same active chemical composition, have the same potency and be offered in the same form as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs. If you have your prescription filled with a brand-name drug when a generic equivalent is available, your cost may be higher.

**Step Therapy**

Often, there are several medication choices available to treat a given medical condition. Although the safety and clinical effectiveness of these choices can be equivalent, the cost can vary widely.

Some medications used for treatment of medical conditions such as high blood pressure and high cholesterol will be included in CIGNA’s Step Therapy Program. The Step Therapy program will require members to try a “first step” medication for the condition, generally a generic, before stepping to a higher cost medication, if medically necessary. If the generic drug is deemed to be not effective, members will be prescribed a “second step” medication – typically a Preferred Brand on the Preferred Drug List. Use on “third step” medications, typically Non-Preferred Brands on the Preferred Drug List will be limited to cases in which a “first step” and a “second step” medication are not effective.

During this process, you and your doctor will receive additional information from CIGNA about the step therapy program.

**Acute Medication**

Acute medications are medications that are to be used for a short period of time. This can include medications that are given to you as a starter dose. Go to a participating retail pharmacy and present your ID Card.*

**Maintenance Medication**

Maintenance medication, also referred to as long-term medications, are required to be filled at a Harris Teeter Pharmacy or through Cigna Home Delivery Pharmacy. Maintenance medications include medication for high blood pressure, asthma, diabetes, and birth control. You will be allowed two fills before you are required to use Harris Teeter Pharmacy or Cigna Home Delivery Pharmacy. At that time, if you choose not use Harris Teeter Pharmacy or Cigna Home Delivery Pharmacy, the plan will not cover the cost of your medication. Prescriptions for specialty medications are not required to be filled at Harris Teeter or through Cigna Home Delivery. For a full list of Maintenance Medications visit www.myhtspace.com.

**HT Network**

If you elect the Open Access Plan and live within a five (5) mile radius of a Harris Teeter Pharmacy or work at a Harris Teeter store with a pharmacy, you will be placed into the Harris Teeter Network Plan. You will pay a higher co-payment when you purchase prescriptions for you and your covered dependents at another approved network pharmacy such as CVS, Walgreens or Rite Aid.

*Other grocery retailers including but not limited to Kroger, Bi-Lo, Safeway as well as Wal-Mart, Kmart, Sam’s Club, BJ’s, Costco and Target are not considered participating pharmacies.
Medical Rates

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Weekly Premium</th>
<th>Semi-Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Only</td>
<td>$66.62</td>
<td>$144.33</td>
</tr>
<tr>
<td>Associate Only with Wellness Discount</td>
<td>$36.42</td>
<td>$78.92</td>
</tr>
<tr>
<td>Associate &amp; Spouse</td>
<td>$160.96</td>
<td>$348.74</td>
</tr>
<tr>
<td>Associate &amp; Spouse with Single Wellness Discount</td>
<td>$130.77</td>
<td>$283.33</td>
</tr>
<tr>
<td>Associate &amp; Spouse with Multiple Wellness Discount</td>
<td>$100.58</td>
<td>$217.91</td>
</tr>
<tr>
<td>Associate &amp; Children</td>
<td>$109.98</td>
<td>$238.28</td>
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<tr>
<td>Associate &amp; Children with Wellness Discount</td>
<td>$79.78</td>
<td>$172.87</td>
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<tr>
<td>Associate &amp; Family</td>
<td>$193.90</td>
<td>$420.11</td>
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<tr>
<td>Associate &amp; Family with Single Wellness Discount</td>
<td>$163.70</td>
<td>$354.69</td>
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<tr>
<td>Associate &amp; Family with Multiple Wellness Discount</td>
<td>$133.51</td>
<td>$289.28</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Weekly Premium</th>
<th>Semi-Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Only</td>
<td>$43.24</td>
<td>$93.68</td>
</tr>
<tr>
<td>Associate Only with Wellness Discount</td>
<td>$18.12</td>
<td>$39.26</td>
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<tr>
<td>Associate &amp; Spouse</td>
<td>$97.84</td>
<td>$211.99</td>
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<tr>
<td>Associate &amp; Spouse with Single Wellness Discount</td>
<td>$72.73</td>
<td>$157.58</td>
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<tr>
<td>Associate &amp; Spouse with Multiple Wellness Discount</td>
<td>$47.61</td>
<td>$103.16</td>
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<tr>
<td>Associate &amp; Children</td>
<td>$63.57</td>
<td>$137.73</td>
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<tr>
<td>Associate &amp; Children with Wellness Discount</td>
<td>$38.45</td>
<td>$83.32</td>
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<td>Associate &amp; Family</td>
<td>$118.51</td>
<td>$256.77</td>
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<tr>
<td>Associate &amp; Family with Single Wellness Discount</td>
<td>$93.39</td>
<td>$202.36</td>
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<tr>
<td>Associate &amp; Family with Multiple Wellness Discount</td>
<td>$68.28</td>
<td>$147.94</td>
</tr>
</tbody>
</table>

During Open Enrollment you and your spouse, if covered, will need to complete the confidential online Health Risk Assessment. You and your spouse will be able to take the assessment between October 16, 2013 and December 31, 2013. If you do not complete the Health Risk Assessment, you will pay an additional $75 per month for medical coverage beginning January 1, 2014. If your spouse is enrolled in the plan, he or she must also complete the assessment by December 31, 2013 or you will pay an additional $75 per month for your enrolled spouse. Newly eligible employees have 60 days from your coverage start date to complete the Health Risk Assessment.

A spousal surcharge of $23.07 (weekly) and $50.00 (semi-monthly) will be also applied per pay period if your spouse works full time for another employer besides Harris Teeter and has access to medical coverage with no annual limit for essential benefits with his/her employer. If your spouse's access to coverage changes throughout the plan year, please contact the Benefits department at 704-844-4748 (HR4U). The spousal surcharge will be adjusted accordingly.

Dental Rates

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Basic Dental Plan</th>
<th>Deluxe Dental Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Only</td>
<td>$1.78</td>
<td>$3.85</td>
</tr>
<tr>
<td>Associate &amp; Spouse</td>
<td>$3.57</td>
<td>$7.73</td>
</tr>
<tr>
<td>Associate &amp; Children</td>
<td>$4.37</td>
<td>$9.46</td>
</tr>
<tr>
<td>Associate &amp; Family</td>
<td>$6.16</td>
<td>$13.34</td>
</tr>
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</table>

Vision Rates

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Weekly Premium</th>
<th>Semi-Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Only</td>
<td>$2.08</td>
<td>$4.51</td>
</tr>
<tr>
<td>Associate &amp; Spouse</td>
<td>$3.54</td>
<td>$7.68</td>
</tr>
<tr>
<td>Associate &amp; Children</td>
<td>$3.61</td>
<td>$7.82</td>
</tr>
<tr>
<td>Associate &amp; Family</td>
<td>$5.82</td>
<td>$12.62</td>
</tr>
</tbody>
</table>
## Open Access Plus Plan

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td>$600 Individual</td>
<td>$1,800 Individual</td>
</tr>
<tr>
<td></td>
<td>$1,800 Family</td>
<td>$5,400 Family</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum (Excluding Deductible)</strong></td>
<td>Based on Salary Range Individual $2,250 (up to $25,000) $4,000 ($25,000 to $50,000) $5,750 ($50,000 and over)</td>
<td>Based on Salary Range Individual $6,750 (up to $25,000) $13,500 ($25,000 to $50,000) $17,250 ($50,000 and over)</td>
</tr>
<tr>
<td></td>
<td>Family $1,800 Individual</td>
<td>$5,400 Family</td>
</tr>
<tr>
<td></td>
<td>$5,400 Family</td>
<td>$16,800 Family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Plan pays 80% of eligible charges; you pay 20% after deductible</td>
<td>Plan pays 50% of eligible charges; you pay 50% after deductible</td>
</tr>
<tr>
<td><strong>Annual Maximum per Member</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Physician Office Visits</strong></td>
<td>$25 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Specialist Office Visits (adult/child)</strong></td>
<td>$45 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Preventative Care (Annual Physical, Well Women Exam, Mammogram, Colonoscopy)</strong></td>
<td>No charge (age requirements may apply)</td>
<td>Covered in-network only</td>
</tr>
<tr>
<td><strong>MD Live</strong></td>
<td>$10 copay</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Care (pre-certification required)</strong></td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Ambulance (emergency only)</strong></td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$200 copay (waived if admitted)</td>
<td>$200 copay (waived if admitted)</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>$50 copay (waived if admitted)</td>
<td>$50 copay (waived if admitted)</td>
</tr>
<tr>
<td><strong>Outpatient X-rays &amp; Lab Tests</strong></td>
<td>No charge ($100 copay for MRIs, CAT scans, PET scans, etc.)</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td>$20 or $40 copay for initial office visit; subsequent visits and delivery fees are 20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Facility Services</strong></td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Mental Health &amp; Substance Abuse</strong></td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><em>Inpatient</em></td>
<td>20% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><em>Outpatient</em></td>
<td>$20 copay per session or office visit</td>
<td>50% after deductible</td>
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<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em><em>Retail</em> (up to 30 days)</em>*</td>
<td>$7 Generic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$30 Brand Name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50 Brand Non-Formulary</td>
<td>No coverage</td>
</tr>
<tr>
<td><strong>Mail Order (up to 90 days)</strong></td>
<td>$21 Generic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$90 Brand Name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$150 Brand Non-Formulary</td>
<td>No coverage</td>
</tr>
<tr>
<td><strong>Non-Sedating Antihistamines (NSAs)</strong></td>
<td>NSAs with generic or over the counter equivalents require a 50% coinsurance.</td>
<td></td>
</tr>
</tbody>
</table>

*NOTE: Associates who live within 5 miles of a Harris Teeter Pharmacy or who work at a Harris Teeter with a pharmacy pay an additional $5 per 30-day prescription (up to 30 days) when filled at a non-Harris Teeter approved network pharmacy.*
## Limited Open Access Plus Plan

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td>$1,200 Individual</td>
<td>$3,600 Individual</td>
</tr>
<tr>
<td></td>
<td>$3,600 Family</td>
<td>$10,800 Family</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum (Excluding Deductible)</strong></td>
<td>$20,000 Individual</td>
<td>$40,000 Individual</td>
</tr>
<tr>
<td></td>
<td>$40,000 Family</td>
<td>$80,000 Family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Plan pays 75% of eligible charges; you pay 25% after deductible</td>
<td>Plan pays 50% of eligible charges; you pay 50% after deductible</td>
</tr>
<tr>
<td><strong>Annual Maximum per Member</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Physician Office Visits</strong></td>
<td>$45 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Specialist Office Visits (adult/child)</strong></td>
<td>$90 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Preventative Care</strong></td>
<td>No charge (age requirements may apply)</td>
<td>Covered in-network only</td>
</tr>
<tr>
<td><em>Annual Physical, Well Women Exam, Mammogram, Colonoscopy</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MD Live</strong></td>
<td>$10 copay</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Care</strong></td>
<td>25% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><em>pre-certification required</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>25% after deductible</td>
<td>25% after deductible</td>
</tr>
<tr>
<td><em>emergency only</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$200 copay (waived if admitted)</td>
<td>$200 copay (waived if admitted)</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>$100 copay (waived if admitted)</td>
<td>$100 copay (waived if admitted)</td>
</tr>
<tr>
<td><strong>Outpatient X-rays &amp; Lab Tests</strong></td>
<td>No charge</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>($200 copay for MRIs, CAT scans, PET scans, etc.)</td>
<td></td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td>$45 or $90 copay for initial office visit; subsequent visits and delivery fees are 25% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Facility Services</strong></td>
<td>25% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Mental Health &amp; Substance Abuse</strong></td>
<td>25% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>$45 copay per session or office visit</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>($100 deductible — for retail prescriptions only — per family per plan year)</td>
<td></td>
</tr>
<tr>
<td><strong>Retail</strong></td>
<td>25% Generic</td>
<td>No coverage</td>
</tr>
<tr>
<td><em>(up to 30 days)</em></td>
<td>25% Brand Name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25% Brand Non-Formulary</td>
<td></td>
</tr>
<tr>
<td><strong>Mail Order</strong></td>
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<td></td>
</tr>
</tbody>
</table>
Medical Plan Exclusions

These are examples of the exclusions in your plan. The complete list of exclusions is provided in your Summary Plan Description.

- Any service or supply not described as covered in the Covered Expenses section of the plan.
- Any medical service or device that is not medically necessary.
- Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
- Any services and supplies for, or in connection with, experimental, investigational or unproven services.
- Treatment of TMJ disorder.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, however, charges made for services or supplies provided for, or in connection with, an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of the accident.
- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
- Court ordered treatment or hospitalizations.
- Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Any services, supplies, medications or drugs for the treatment of male and female sexual dysfunction.
- Medical and hospital care and cost for the child of a dependent, unless this infant child is otherwise eligible under the plan.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
- Consumable medical supplies other than ostomy supplies and urinary catheters.
- Private hospital rooms and/or private duty nursing unless determined to be medically necessary by the medical doctor.
- Artificial aids, including but not limited to hearing aids for adults, semi-implantable hearing devices, audient bone conductors, bone anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in the plan.
- Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
- Genetic screening or pre-implantation genetic screening.
- Fees associated with the collection or donation of blood or blood products.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Expenses incurred for medical treatment by a person age 65 or older, who is covered under the plan as a retiree, or his dependents, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan.
- Expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from a participating provider of the primary plan.
- The following services are excluded from coverage regardless of clinical indications: massage therapy; cosmetic surgery and therapies; macromastia or gynecomastia surgeries; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; orthognathic surgeries; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; transsexual surgery; non-medical counseling or ancillary services; assistance in the activities of daily living; cosmetics; personal or comfort items; dietary supplements; health and beauty aids; aids or devices that assist with non-verbal communications; treatment by acupuncture; dental implants for any condition; telephone consultations; email and internet consultations; telemedicine; health club membership fees; weight loss program fees; smoking cessation program fees; reversal of male and female voluntary sterilization procedures; and extracorporeal shock wave lithotripsy for musculoskeletal and orthopedic conditions; surgical treatment of varicose veins unless medically necessary.
- Custodial services not intended primarily to treat a specific injury or sickness, or any education or training.
- Charges in excess of reasonable and customary.
- Speech therapy which is not restorative in nature.
Wellness Benefits

Harris Teeter is committed to providing its group medical plan members with incentives for living a healthy lifestyle as well as providing resources and tools to those members looking to improve their health and well-being.

1 Healthy Incentive Program

Our Healthy Incentive Program rewards those members, through lower premiums, who:

- Have a body mass index below 30 and
- Do not use tobacco and
- Do not have the potential to develop a serious medical condition as determined by CIGNA

Associates and covered spouses who:

- Use tobacco 90 days prior to their enrollment for medical coverage or
- Have a BMI greater than or equal to 30 or
- Who are considered as having the potential to develop a serious medical condition by CIGNA based on Health Assessment results or medical and pharmacy claim data

will pay the full premium for their coverage. However, if you and/or your covered spouse fall into one of these categories you have the opportunity to lower your cost of coverage by contacting CIGNA and working with a Personal Health Coach.

BMI and Tobacco Use Validation

In order to protect the integrity of the Healthy Incentive Program and make sure that all associates can have confidence in it, we may randomly perform Tobacco and BMI validation. Both BMI measurement and nicotine testing will is now a part of the current random drug testing procedure. In addition to the drug screening, associates who are randomly selected we may have their height and weight measured (for BMI calculation) and a urine test to detect the presence of nicotine.

Personal Health Coach Program

At Harris Teeter, we believe that better health makes a difference for each of us personally— and a healthier workforce makes all of us more successful together. Harris Teeter wants to provide the tools and resources to our associates and family members to help us all live healthier lifestyles. That’s why we offer the Personal Health Coach Program and the premium reduction for participating in it.

The Personal Health Coach Program provides easy access to one team of health professionals – including individuals trained as nurses, coaches, dieticians, clinicians, counselors, and more. This team provides comprehensive care coordination and will listen to understand a person’s needs, and help find solutions.
Individuals can partner with a Personal Health Coach one-on-one to:

- understand health assessment results
- achieve better work/life balance
- find local counselors, doctors, or other health professionals
- get support for mental health, substance abuse, and personal crises
- know what to expect if time in the hospital is required
- get unbiased advice on options in order to make an informed decision with your health professional
- understand the importance of preventive screenings and annual exams
- identify stress triggers and how to cope
- quit tobacco
- improve eating and exercise habits in order to manage or lose weight
- better manage chronic health conditions like high blood pressure, high cholesterol, diabetes, coronary artery disease, asthma, osteoarthritis, depression or anxiety, and more.

You can reach a CIGNA Personal Health Coach by calling 1-800-633-7232. Through the coaching program, you will also have access to a number of programs to support the total health needs of you and your family.

**Steps to Engaging With a Personal Health Coach**

To receive the discounted premium you will need to:

1. Contact the Personal Health Coach Program within 60 days from your effective date of medical coverage if your BMI is \( \geq 30 \) or you are a tobacco user. The earlier you call, the sooner you will receive the discounted premium.

   In the event you are identified as having the potential to develop a serious medical condition as a result of information you provided on your Health Assessment or your claims data, CIGNA will notify you of your “at risk” status.

2. Establish, along with your Personal Health Coach, goals that you would like to work on throughout the plan year.

3. Make progress towards the goals you set throughout the remainder of the plan year.

NOTE: Incentives are adjusted each calendar quarter based on member participation as of February 28, May 31, August 31 and November 30.

The following illustration should help you understand how CIGNA will determine whether or not a member is progressing towards his or her goals and therefore eligible for the Healthy Incentive.
<table>
<thead>
<tr>
<th>BMI</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI 31.5 - weight 232 and height 6ft</td>
<td>BMI 36 - weight 245 and height 5'9&quot;</td>
<td></td>
</tr>
</tbody>
</table>

### Goals Set
- Decrease portion sizes of food at each meal
- Walk 3 times a week around local track
- Reduce intake of unhealthy snacks (chips, candy) and substitute with fruit
- Decrease weight to 222 over next 2 months

### Progress Toward Goals
- **Member reports he went on a business trip and got off track on his goals and lost his motivation.** Member weight remains unchanged. Only walking once a week if he is able. Continues to keep the unhealthy snacks in the house instead of substituting fruit.
- **Member lost 7lbs in the last month.** On track with 45 minutes/4 days a week on elliptical machine and also even walking outside twice a week during lunch for 15 minutes. Has completely eliminated potato chips and colas and is drinking only water and crystal light drinks. Feeling that his pants are looser in the waist and very motivated.

### Incentive Status
- **Member does not qualify for incentive - pays full premium**
- **Member does qualify for incentive - pays lower premium**

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### Healthy Incentive/Personal Health Coach Programs

#### Frequently Asked Questions and Answers

1. **What does it mean to be considered as having the potential for a serious medical condition?**
   
   As seen above, there are a lot of reasons for connecting with a Personal Health Coach. But one of the most important reasons is that you may not be aware that you are considered to have the potential for a serious medical condition. A person might be identified through the health assessment, medical and/or pharmacy claims data, or by the information you provide to the coach on a call. “The identifications can be made based on a variety of medical conditions or lifestyles that could put you at risk for a more serious long-term condition or a sudden illness or event. Here are examples:

- Asthma
- Diabetes
- Congestive Heart Failure
- Coronary Artery Disease (heart attack, angina, blocked arteries)
- Chronic Obstructive Pulmonary Disease (chronic bronchitis, emphysema)
- Depression (anxiety, bipolar)
- Low Back Pain
- Osteoarthritis (ex. May have had hip or knee replacement)
- Peripheral Artery Disease
- Overweight/Obesity (elevated BMI)
- High Stress
What if I receive an outreach and I am not sure why? What if I don’t think I have the potential for a serious medical condition?

It is always best to call and speak to a Health Coach so they can review your file and determine why you triggered for outreach. You may benefit from learning about all of the services and resources that are available to you through the Personal Health Coach program and may decide to participate in the program.

What personal medical information can the health coach see? Why do they ask me what medications I am taking if they can view it?

- The health coach can view medical claims information, pharmacy history/listing of medications filled, behavioral claims, records for inpatient admissions or outpatient procedures, Health Assessment results and engagement in any of the programs.
- The health coach will ask you to confirm your medications to assure that the records CIGNA has are accurate and that you are remaining compliant with your treatment regimen as prescribed.
- Talking to a health coach about your medications also gives you an opportunity to ask questions about the medication that you might not have asked your doctor or can generate questions that you should be asking your doctor.

What happens on the first call with a coach and how long will it take? How long will all future coaching calls take?

- The first call or initial assessment is usually scheduled for 45 – 60 minutes. The initial call is typically longer than other calls as it takes time to gather all the necessary information from you, prepare you for future calls and set your short and long term goals.
- Follow up calls are usually scheduled for 30 – 45 minutes but this may vary depending on the focus of the coaching. Typically the coach will see how you have progressed since the last call, check on goals and if progressing since the last coaching call, discuss barriers or challenges that possibly kept you from meeting or progressing toward goals and/or discuss what successes you may have experienced that made reaching goals easier.
- Each call ends with setting and discussing goals to follow up on and setting up the next coaching appointment.

What days and hours are the health coaches available?

- Monday through Friday 9am – 9pm in all time zones and Saturday 8am – 4:30pm central time.
- Once you are engaged with a health coach you will work one on one with them and they will set up appointments based on what will work best for your schedule.

Why do I have to talk to a Health Coach if I see my doctor regularly, have an annual physical and age appropriate screenings and take my medication as prescribed?

- Your Health Coach is an additional resource available to you that can offer specific and ongoing support to help you reach or maintain the health goals you set with your physician. The coach is aware of all the services and resources that are available to you that your doctor may not know about.

  For example, you may have high blood pressure and while you are managing your condition by taking your medications and seeing your doctor, you also want to lose a few pounds and eat better. Through the Personal Health Coach program you have a great opportunity to work on those additional goals with 1:1 support!

- Your health coach will take into consideration everything you are already doing to manage your condition and may determine that you don’t need to be contacted as frequently. Your coach can set up periodic check-ins just to make sure you are on track with your condition and treatment regimen.

What happens when I do call in and want to engage?

- When you first call in, you will speak to one of the Health Coach Advocates, whose role is to review your
• If you agree to coaching, they will identify the appropriate resource on the team and set up an appointment that will work best for you. When it is time for your appointment the health coach will call you on the phone number that you provided and you will begin your coaching with the initial assessment and goal setting. You will talk about what areas you are ready to focus on and receive the appropriate guidance.

What if my personality does not fit well with my assigned health coach’s personality? Can I switch?

Call back into the Personal Health Coach Program and talk with one of the health coach advocates to explain the situation. They can work on assigning you to another coach and setting up a new appointment.

What if my doctor says my medical condition prevents me from being able to achieve a health goal to get the incentive?

If it is unreasonably difficult due to a medical condition for you to achieve the goals in order to receive the premium reduction, contact the Benefits Department and ask for the Healthy Incentive Program Exception Request Form. You can also find this form on www.myHTspace.com.

If I decide to participate in the program during the year, am I still eligible for the healthy incentive?

Yes, CIGNA will determine which members are progressing towards their goals three times per year - February 28, May 31, August 30 and November 30. Associates should expect to see changes to their premiums based on their status the first paycheck of the first month of the quarter following these dates: April, July and October.

Health Assessment

The CIGNA Health Assessment is an on-line tool to provide you with information on how healthy you are, what your health risks are, and what steps you can take to improve your health and reduce your risks for many preventable conditions.

We believe that it’s important for all associates covered by a Harris Teeter medical plan to complete a Health Assessment – so important, in fact, that we make it a requirement for every adult enrolled in medical coverage. You have 60 days from your medical coverage effective date to complete the confidential on-line Health Assessment at www.mycigna.com. If you do not complete the Health Assessment, you will pay an additional $75 per month for medical coverage. If your spouse is enrolled in the plan, he or she must also complete the Health Assessment or you will pay an additional $75 per month for your spouse.

CIGNA Healthy Rewards

CIGNA members also are eligible for the Healthy Rewards discount program that offers a number of discounts on wellness services, including Weight Watchers, chiropractic care, acupuncture, massage therapy, fitness club memberships, magazine discounts, eye exams and laser vision correction and much more!

Simply go to www.CIGNA.com for a range of other wellness opportunities!

Lifestyle Management Program

We all know the importance of maintaining a healthy lifestyle. And many of us try to do so, but have difficulty staying on track all of the time. Changing poor habits and maintaining good habits is easier when you have the
information, tools, and support that you need. CIGNA’s programs, designed by health professionals, can help you reach your health goals — and stick with them for life. Personal health coaching is the key to making these programs successful. Members work one-on-one with a highly trained personal health coach who will support them throughout their program enrollment. This program offers the ability to participate in any of the following programs:

- **Quit Today** — a personalized program to help them with your tobacco cessation efforts, including over-the-counter nicotine replacement therapy (NRT) at no charge, one time per year.

- **Strength & Resilience Stress Management Program** — a stress management program for a more balanced life, individually designed to help them understand the sources of the stress in their life, learn coping techniques and manage the stress both on and off the job.

- **Healthy Steps to Weight Loss** — a sensible approach to weight loss and healthy living, which includes assistance in building members’ confidence, becoming more active, eating healthier, and changing some of their habits.

Each program provides an assessment to evaluate your health, lifestyles, preferences and goals. After completing the assessment, your personal health coach will design a plan that fits your specific needs. You will also have access to interactive tools online to chart your progress as you move closer to accomplishing your goal.

You and your eligible dependents can participate in one, two, or all three of the programs at no additional cost. To obtain more information on the CIGNA Lifestyle Management program, contact your the Personal Health Coach Program at 1-800-633-7232.

**GlobalFit®**

Through **GlobalFit®**, you and your family have access to enhanced membership benefits at area health clubs, at substantially discounted rates. The following is a list of some of the enhanced benefits you will receive:

- **Access to thousands of fitness centers**, from respected national chains to small independent facilities, all with the lowest rates (up to 60% off).

- **Month-to-month membership** — no long term contract

- **Free Guest Passes** to try out a club

- **A special low price on NutriSystem®,** the convenient weight-loss program with delicious, pre-packaged meals and individualized phone/email counseling

- **Healthy Changes**, customized, one-on-one programs to help you quit smoking, lose weight, reduce stress, or reach any healthy living goal

- **Exclusive discounts on at-home fitness equipment** from Smooth Fitness™ and videos from Beachbody®

It's so easy! You can become a member by calling **GlobalFit®** at 1-800-294-1500 or by registering on-line at www.globalfit.com/harristeeter.
Health Risk Assessment (HRA) Instructions

FOR THOSE WHO HAVE ACTIVE COVERAGE WITH CIGNA

Harris Teeter Associates

Click on the www.mycigna.com Direct Link from the www.myhtspace.com homepage

- If you have previously registered with myCIGNA.com, you will be automatically logged in – Select the Take My Health Assessment link (red apple promo) on the homepage. On the next page, select the link to take your health assessment.

- If you have not previously registered with myCIGNA.com, you will be prompted with a link to register for the website. After registration – Select the Take My Health Assessment link (red apple promo) on the homepage. On the next page, select the link to take your health assessment.

Harris Teeter Spouses

Use this website address to take the health assessment on myCigna.com: https://my.cigna.com/myhealth/Web/Pages/Home.aspx

- If you have previously registered with myCIGNA.com, enter your ID and Password – On the my health & wellness center page, select the link to take the health assessment.

- If you have not previously registered with myCIGNA.com, select the “Register Now” button and complete the registration process. After registration – Select the Take My Health Assessment link (red apple promo) on the homepage. On the next page, select the link to take your health assessment.
Health Risk Assessment (HRA) Instructions

FOR THOSE WHO DO NOT HAVE ACTIVE COVERAGE WITH CIGNA

Harris Teeter Associates and Spouses

Use this pre-enrollment link to access and take the health assessment: https://myhealth.cigna.com/myhealth/Web/Registration/ConfirmUserDetails.aspx?

- You will need to follow the steps to complete registration and take the health assessment, which includes creating a new ID and Password.

**Note:** This is the same ID and Password that you will use to access myCigna.com, when you have active coverage with Cigna.
Dental Coverage

A clean, happy smile requires regular dental care and check-ups. Harris Teeter knows that dental care is an important part of your overall health. That’s why the Company provides two dental options — so you can determine the level of protection that you need for you and your family at the cost that is right for you.

Your Dental options are:

**Basic Dental Plan**

- Annual Deductible: $50 Individual, $100 Family
- Annual Maximum: $500
- Preventive & Diagnostic (Class I)
  - Exams (twice/year)
  - Routine cleanings (twice/year)
  - Full mouth X-rays (once/three years)
  - Bitewing X-rays (twice/year)
  - Fluoride Applications (once/year for persons under age 19)
  - Emergency Care to relieve pain
- Basic Restorative Care (Class II)
  - Fillings
  - Periodontal Scaling & Root Planing
  - Gingivoplasty (per quadrant)
  - Osseous surgery
  - Root Canal Therapy
  - Oral Surgery
    - Routine extractions per tooth
    - Surgical removal per tooth
    - Alveolectomy (per quadrant)
    - Anesthetics
- Major Restorative Care (Class III)
  - Crowns
  - Dentures
  - Bridges
- Orthodontia (Class IV)
  - Not covered
- Oral Surgery (Class VII)
  - Surgical removal of impacted wisdom teeth
  - Soft tissue impaction per tooth
  - Partially bony impaction per tooth
  - Completely bony impaction per tooth

**Deluxe Dental Plan**

- Annual Deductible: Not Applicable
- Annual Maximum: $1,000
- Preventive & Diagnostic (Class I)
  - No charge
- Basic Restorative Care (Class II)
  - 50% after deductible
  - 20%, no deductible
- Major Restorative Care (Class III)
  - 50%, no deductible
- Orthodontia (Class IV)
  - Not covered
  - 50%, no deductible
  - $2,000 lifetime maximum
- Oral Surgery (Class VII)
  - Not covered
  - 20%, no deductible, $2,000 plan year maximum

Both options are administered by CIGNA HealthCare. Although you have the freedom to see any dentist, visiting a dentist within the CIGNA dental PPO network for either plan can provide additional out-of-pocket savings. To find a provider in the Dental PPO Plan, contact CIGNA at 1-800-633-7232 or go online at www.mycigna.com.
Pre-Treatment Review

Pre-Treatment review is suggested when dental work in excess of $200 is proposed.

CIGNA Dental Exclusions and Limitations

Coverage will not include, and no payment will be made for, expenses incurred for:

- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Any replacement of a bridge, crown or denture which is or can be made usable according to common dental standards;
- Replacement of a bridge or denture within five years following the date of its original installation;
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally-involved teeth, or restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second or third molars;
- Bite registrations; precision or semi-precision attachments; or splinting;
- A surgical implant of any type including any prosthetic device attached to it;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Charges made by a hospital which performs services for the U.S. government if the charges are directly related to a condition connected to a military service;
- Experimental or investigational procedures and treatments;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
- For charges for unnecessary care, treatment or surgery;
- Any injury resulting from, or in the course of, any employment for wage or profit;
- Any sickness covered under any worker's compensation or similar law;
- Charges in excess of the reasonable and customary allowances.
Vision Coverage

There’s no underestimating how important sight is. That’s why Harris Teeter offers vision coverage through Vision Service Plan (VSP). Your out-of-pocket costs generally are less if you use a VSP provider.

Vision Service Plan (VSP)

<table>
<thead>
<tr>
<th>VSP Benefits</th>
<th>What’s Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Lenses</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Frames</td>
<td>Once every 24 months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Services</th>
<th>Member Provider Benefit</th>
<th>Non-Member Provider Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>100% after $5 copay</td>
<td>Up to $45</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>100% after $10 copay</td>
<td>Up to $46</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>100% after $10 copay</td>
<td>Up to $65</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>100% after $10 copay</td>
<td>Up to $85</td>
</tr>
<tr>
<td>Lens options</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blended Lenses</td>
<td>100% after $10 copay</td>
<td>Up to $65</td>
</tr>
<tr>
<td>Progressive Lenses</td>
<td>100% after $10 copay</td>
<td>Up to $85</td>
</tr>
<tr>
<td>Frames</td>
<td>Up to $130 after a $10 copay, plus 20% off any out-of-pocket costs</td>
<td>Up to $47</td>
</tr>
</tbody>
</table>

Contact Lenses *(in lieu of glasses)*

<table>
<thead>
<tr>
<th>Elective</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Up to $140</td>
</tr>
</tbody>
</table>

Extra Discounts and Savings

- Laser Vision Correction Discount
- Prescription Glasses
  - Polycarbonate lenses for dependent children covered in full.
  - Up to 40% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives.
  - 30% off additional prescription glasses and sunglasses (available from the same VSP network doctor who provided your eye exam within the last 12 months).
- Contacts
  - 15% discount off the cost of contact lens exam (fitting and evaluation).

Vision Plan ID Cards

Participants in the Vision Plan are able to create an ID card by visiting [www.vsp.com](http://www.vsp.com). You will need to register to access your card. *Here are the steps:*

- Click “Members” on the landing page
- Log in (if you are registering for the first time, use the last 4 digits of your SSN)
- Under the “My Benefits” tab at the top left side, go to “Benefit Resources” and click on “Member Vision Card”
- Confirm your state of residence and you will be able to print the card
- If you have any questions you can call VSP at 800-877-7195.
Harris Teeter offers you the opportunity to participate in the HealthCare Flexible Spending Account and/or the Dependent Day Care Flexible Spending Account. With these Flexible Spending Accounts, you can set aside money each calendar year to pay for non-reimbursable expenses on a pre-tax basis — before the money in your paycheck is taxed. All eligible family members are covered under this Plan as long as they are claimed on your federal tax return.

When you have an eligible expense, simply use your Healthcare Account debit card or submit a claim form and receipt, and you’ll be reimbursed with tax-free dollars from your account. It’s the easiest way to reduce your taxes. When you pay fewer taxes, you have more money in your pocket to save or spend. It’s easy and so flexible … that flexibility is part of the name!

### How Much Can You Contribute?

<table>
<thead>
<tr>
<th></th>
<th>HealthCare Account Annual Limit</th>
<th>Dependent Day Care Account Annual Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Minimum</strong></td>
<td>$5 per pay period</td>
<td>$5 per pay period</td>
</tr>
<tr>
<td><strong>Annual Maximum</strong></td>
<td>$2,500</td>
<td>$5,000 (or $2,500 if you are married and file separately)</td>
</tr>
</tbody>
</table>

**HealthCare Spending Account**

You can use your HealthCare Spending Account to pay for expenses not covered by your medical plan, such as deductibles, copays, coinsurance, non-covered vision and hearing expenses, prosthetics and durable medical equipment, non-covered prescription medications and over-the-counter (OTC) medications and drugs prescribed by a doctor.

Healthcare Flexible Spending Account participants will enjoy the convenience of the Health Care Account Debit Card. The Card is a convenient and easy-to-use tool that allows you immediate access to your FSA funds. You may use the card to purchase the same eligible items and services listed above with the exception of OTC prescribed medications and drugs. You will automatically receive a Card in the mail following your enrollment in the Health Care Flexible Spending Account.

Examples of expenses not eligible for your HealthCare Spending Account include meals and lodging while away from home for medical treatments, health club membership fees, insurance premiums, and cosmetic surgery.
Dependent Day Care Spending Account

Through the Dependent Care Account, you can use pre-tax dollars to pay for the cost of day care for your children (under age 13) or other eligible dependents, such as an elderly parent or disabled spouse.

Expenses that qualify for reimbursement include:

- Care provided in your home, as long as you do not claim the caregiver as a dependent on your federal income tax return.
- Services provided outside your home for a dependent that regularly spends at least eight hours a day in your home.
- Both parents (if married) must work outside the home in order to be eligible to participate in the Dependent Care Spending Account.

Dependent Day Care Tax Facts

Depending on your personal tax situation, it may be more beneficial for you to use the Dependent Day Care Account or the dependent care tax credit on your federal income tax form. It’s always a good idea to check with the IRS to see which program is best for you.

For more information on the Flexible Spending Accounts (FSAs), contact the ADP Solutions Center at 1-800-654-6695 or go online at www.flexdirect.adp.com.

Example: Increase Your Take-Home Pay

Through your Spending Accounts, you can actually increase your take-home pay by paying for your medical, dental, and vision benefits on a pre-tax basis. The following charts illustrate examples of possible savings.

Example: Let’s assume you earn $30,000 a year and have $2,500 in qualified out-of-pocket healthcare and/or dependent care expenses. How much would you save in taxes during the year if you contributed to a Flexible Spending Account?

In this case, you would actually increase your take-home pay by $716 a year!

<table>
<thead>
<tr>
<th></th>
<th>Without FSA</th>
<th>With FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Income</td>
<td>$30,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Flexible Spending Account Contribution</td>
<td>0</td>
<td>$2,500</td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$30,000</td>
<td>$27,500</td>
</tr>
<tr>
<td>Federal Income Tax (estimate: 15%)</td>
<td>$4,500</td>
<td>$4,125</td>
</tr>
<tr>
<td>State Income Tax (estimate: 6%)</td>
<td>$1,800</td>
<td>$1,650</td>
</tr>
<tr>
<td>FICA-Social Security Tax (6.2%)</td>
<td>$1,860</td>
<td>$1,705</td>
</tr>
<tr>
<td>FICA-Medicare Tax (1.45%)</td>
<td>$435</td>
<td>$399</td>
</tr>
<tr>
<td>After-Tax Contribution for Out-of-Pocket Expenses</td>
<td>$2,500</td>
<td>0</td>
</tr>
<tr>
<td>Associate Take-Home Pay</td>
<td>$18,905</td>
<td>$19,621</td>
</tr>
<tr>
<td>Savings With FSA Contributions</td>
<td></td>
<td>$716 a year!</td>
</tr>
</tbody>
</table>

Note: Actual savings will vary based on deductions. Any reduction in taxable income may also lead to a reduction in Social Security benefits.
How Your Money is Reimbursed

For the Health Care FSA, the Debit Card will automatically debit your FSA account for eligible expenses. The Card is accepted at medical and dental offices, hospitals, clinics and pharmacies, including Harris Teeter pharmacies. Because your Health Care Flexible Spending is funded with pre-tax dollars, the IRS regulations require that you retain all the itemized receipts for purchases made with the Card. It may be necessary for you to submit a receipt to prove the eligibility of a purchase you have already made. ADP, the FSA administrator will notify you if a receipt is needed for a particular purchase.

If you do not use the Card, you are required to file a claim for eligible expenses during the plan year. You are reimbursed from the claims administrator by a check mailed to your home or direct deposit.

The Dependent Day Care Flexible Spending Account allows no-wait reimbursement by direct deposit to the account of your choice for incurred expenses, not to exceed the balance in your account.

Keep These Important Rules in Mind

The government imposes certain restrictions on Flexible Spending Accounts to give you the following pre-tax advantages.

- For the HealthCare and Dependent Day Care Flexible Spending Accounts, you lose any unused portion of your account balance remaining at the end of the year. Because of this “use it or lose it” rule, it is important for you to carefully estimate the money you set aside. There is, however, a two month “run-out period” after the end of the year to submit all expenses incurred during the preceding year.

- Contributions are held in separate Spending Accounts, and balances cannot be moved back and forth between accounts.

- You can increase, decrease, suspend or enroll mid-year only if you have a qualifying life status change event.

- If you terminate employment during the plan year, you will have 60 days from your date of termination to submit eligible claims. Only claims incurred while you were an active participant in the plan will be considered reimbursable.

- If your year-to-date contributions to the HealthCare Flexible Spending Account exceed your year-to-date reimbursement, you will be offered continuation coverage through COBRA.
Disability

It’s always a good idea to plan for life’s unforeseen occurrences. Short-Term and Long-Term Disability benefits provide you with valuable income protection when you are seriously ill or injured.

As an hourly associate, Harris Teeter provides you with STD and LTD coverage equal to 40% of your weekly pay. This coverage is provided to you as a free benefit, and you are covered automatically; no enrollment is necessary. If you want to increase your coverage, you have two options:

- **Short-Term Disability:** You may increase your Short-Term Disability from 40% to 60% of your weekly pay.
- **Short- and Long-Term Disability:** You may increase your Short-Term Disability from 40% to 60% of weekly pay and increase your Long-Term Disability benefit from 40% to 60% of weekly pay. You cannot increase your LTD benefit only.

Harris Teeter’s Disability Plan is administered by CIGNA. For more information, call 1-800-633-7232.

**Short-Term Disability (STD)**

As an hourly associate, Short-Term Disability benefits begin on the 8th day of an off-the-job illness or injury. The Plan pays 40% of your weekly gross pay for up to 26 weeks from the date of disability. After 26 weeks of disability, benefits are provided through our Long-Term Disability Plan.

**Example:** Let’s assume you earn $10/hour and work 40 hours a week.

Here’s how you calculate your Short-Term Disability benefit:

<table>
<thead>
<tr>
<th>Core STD Benefit</th>
<th>$10.00 Hourly rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiply your hourly rate ($10) x hours worked (40 hours) x 40%</td>
<td>x 40 Hours worked per week</td>
</tr>
<tr>
<td>x 40%</td>
<td>= $160.00 Core STD Benefit (weekly)</td>
</tr>
</tbody>
</table>

Your core STD is paid entirely by Harris Teeter; no enrollment is necessary. Since this benefit is provided at no cost to you, it will be taxed when you receive the benefit.

When you are absent from work for seven consecutive days, call CIGNA at 1-800-633-7232 to start your Short-Term Disability claim process. The claim center will obtain all the necessary information and forward it to your claim manager who will contact you to complete the processing of your claim.

**Supplemental Short-Term Disability**

During the annual open enrollment period, you have the opportunity to increase your Short-Term Disability coverage from 40% to 60% of your weekly pay. If you don’t enroll when first eligible, evidence of insurability will be required.
Example: Let’s assume you earn $10/hour and work 40 hours a week and want to purchase Supplemental coverage, increasing your STD benefit to 60% of your weekly pay.

To calculate your Supplemental STD benefit:

<table>
<thead>
<tr>
<th>Supplemental STD Benefit</th>
<th>$ 10.00 Hourly rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiply your hourly rate ($10) x hours worked (40 hours) x 20%</td>
<td>x 40 Hours worked per week</td>
</tr>
<tr>
<td>x 20%</td>
<td>Supplemental STD Benefit (weekly)</td>
</tr>
<tr>
<td>= $ 80.00</td>
<td></td>
</tr>
</tbody>
</table>

New Total Disability Benefit
Add your Core STD Benefit ($160/week) to your Supplemental STD Benefit ($80/week).

<table>
<thead>
<tr>
<th>New Total Disability Benefit</th>
<th>$160.00 Core STD Benefit (weekly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ $ 80.00 Supplemental STD Benefit (weekly)</td>
<td>= $240.00 New Total Disability Benefit</td>
</tr>
</tbody>
</table>

As you can see, the Supplemental coverage can significantly increase your Short-Term Disability benefit.

You have the option of purchasing the Supplemental STD only. Or, for maximum income security, you can purchase Supplemental coverage for Short-Term and Long-Term Disability.

Long-Term Disability (LTD)

After 26 weeks, the Long-Term Disability benefit for hourly associates pays 40% of your weekly gross pay, up to a monthly maximum of $3,500. The following chart shows your maximum benefit duration.

<table>
<thead>
<tr>
<th>Your Age When Disability Benefits Begin</th>
<th>Your Maximum Benefit Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to age 61</td>
<td>60 months</td>
</tr>
<tr>
<td>Age 61</td>
<td>54 months</td>
</tr>
<tr>
<td>Age 62</td>
<td>48 months</td>
</tr>
<tr>
<td>Age 63</td>
<td>42 months</td>
</tr>
<tr>
<td>Age 64</td>
<td>36 months</td>
</tr>
<tr>
<td>Age 65</td>
<td>30 months</td>
</tr>
<tr>
<td>Age 66</td>
<td>27 months</td>
</tr>
<tr>
<td>Age 67</td>
<td>24 months</td>
</tr>
<tr>
<td>Age 68</td>
<td>21 months</td>
</tr>
<tr>
<td>Age 69 and older</td>
<td>18 months</td>
</tr>
</tbody>
</table>

Your core LTD benefit is paid entirely by Harris Teeter; no enrollment is necessary. Since this benefit is provided at no cost to you, it will be taxed when you receive the benefit.

Supplemental Long-Term Disability

During the annual open enrollment period, you have the opportunity to increase your Long-Term (along with your Short-Term) Disability coverage from 40% to 60% of your weekly pay. If you don’t enroll when first eligible, evidence of insurability will be required to enroll during a subsequent annual enrollment period.
Deferred Effective Date

STD and LTD:

If an Associate is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to any occupation for the Employer on a Full-time basis.

An Associate is in Active Service on a day which is one of the Employer’s scheduled work days if either of the following conditions are met.

1. The Associate is performing his or her regular occupation for the Employer on a full-time basis. He or she must be working on one of the Employer’s usual places of business or at some location to which the employer’s business requires an Associate to travel.

2. The day is a scheduled holiday or vacation day and the Associate was performing his or her regular occupation on the preceding scheduled work day.

An Associate is in Active Service on a day which is not one of the Employer’s scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Life Insurance

Basic Term Life

Harris Teeter provides you with Basic Group Life Insurance at no cost to you!

If you should die, your beneficiary receives your Basic Group Life benefit amount.

The guidelines for the basic Group Life benefit are:

<table>
<thead>
<tr>
<th>Position</th>
<th>Basic Group Life Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 Hour Full-Time Associate*</td>
<td>$5,000</td>
</tr>
<tr>
<td>44 Hour Full-Time Associate*</td>
<td>$10,000</td>
</tr>
<tr>
<td>Salaried Associate</td>
<td>1.5 x annual base earnings</td>
</tr>
</tbody>
</table>

* Upon reaching age 25 and two years of service, your Basic Group Life amount automatically increases to 1.5 x annual base earnings.

When you reach age 65 and older, your Basic Group Life benefit amount is reduced by:

- 35% at age 65
- 55% at age 70
- 70% at age 75

If an eligible dependent should die, you will receive a $1,500 dependent life benefit amount.
Imputed Income

Federal regulations require you to pay imputed income taxes on the value of your total Basic Life Insurance in excess of $50,000. This means that the value of your life insurance coverage in excess of $50,000 will be included as taxable income on your W-2 form, based on the IRS tax table.

Supplemental Term Life

If you need more life insurance than your Basic Life amount, you may purchase Supplemental Life Insurance on an after-tax basis. You may purchase an additional 1, 2, or 3 times your basic annual base earnings, rounded up to the next higher $1,000. The cost is based on your age. The maximum benefit is $600,000 (less the amount of your Basic Life Insurance).

If you purchase Supplemental Life when you are first eligible, no proof of good health is required. However, if you waive coverage and then wish to enroll at a future annual open enrollment period, proof of insurability is required by the insurance carrier.

**Example:** Let’s assume you are age 30 and earning $30,000 a year. You elect two times your annual base earnings ($60,000).

Multiply your cost per $1,000 of coverage based on your age ($0.086) by 60 (for $60,000) to determine your monthly cost.

\[
\begin{align*}
\text{Cost per$1,000 of coverage} & = 0.086 \\
\times 60 & = 5.16 \\
\text{Two times your annual earnings} & = 5.16 \\
\text{Monthly Cost} & = 5.16
\end{align*}
\]

As you can see, your monthly cost for Supplemental Term Life coverage would be $5.16.

**Monthly Rate**

<table>
<thead>
<tr>
<th>Age</th>
<th>Per $1,000 of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 24</td>
<td>$0.057</td>
</tr>
<tr>
<td>25 – 29</td>
<td>$0.076</td>
</tr>
<tr>
<td>30 – 39</td>
<td>$0.086</td>
</tr>
<tr>
<td>40 – 44</td>
<td>$0.114</td>
</tr>
<tr>
<td>45 – 49</td>
<td>$0.162</td>
</tr>
<tr>
<td>50 – 54</td>
<td>$0.266</td>
</tr>
<tr>
<td>55 – 59</td>
<td>$0.467</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$0.789</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$1.378</td>
</tr>
<tr>
<td>70 &amp; up</td>
<td>$2.223</td>
</tr>
</tbody>
</table>
Life Reduction Rate Table

When you reach age 65 and older, your Supplemental Term Life benefit is reduced by:

- 35% at age 65
- 55% at age 70
- 70% at age 75

Your cost for Supplemental Life is adjusted to reflect the reduction in coverage amount.

Supplemental Dependent Term Life

If you elect supplemental coverage on yourself, you may elect supplemental term life coverage for your spouse and/or eligible dependents.

Spousal Coverage

You may elect supplemental spousal coverage in the amount of $10,000 or $20,000.

Note: Associates cannot elect spousal coverage if their spouse is also an active and eligible Harris Teeter associate.

Child(ren) Coverage

You may elect supplemental term life coverage for your dependent child(ren) in the amount of $5,000 or $10,000 on children less than 19 years of age.

<table>
<thead>
<tr>
<th>Supplemental Life Cost for Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Amount</td>
</tr>
<tr>
<td>$10,000</td>
</tr>
<tr>
<td>$20,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supplemental Life Cost for Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Amount</td>
</tr>
<tr>
<td>$5,000</td>
</tr>
<tr>
<td>$10,000</td>
</tr>
</tbody>
</table>
In this example, your monthly cost for Dependent Coverage would be $5.46.

Example: Let’s assume you elect $20,000 coverage for your spouse and $10,000 coverage for each child.

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 4.04</td>
<td>Spouse coverage</td>
</tr>
<tr>
<td>+ $ 1.14</td>
<td>Child coverage</td>
</tr>
<tr>
<td>= $ 5.18</td>
<td>Monthly Cost</td>
</tr>
</tbody>
</table>

Other Important Features

- **Living Benefits Option:** If you are diagnosed as terminally ill with a 12-month life expectancy, you may request up to a maximum of 80% of your coverage, not to exceed $500,000.

- **Waiver of Premium for Supplemental Life Insurance:** If you become totally disabled before age 60 and your disability lasts at least nine months, your coverage will continue without premiums up to your Normal Retirement Age.

- **Portability:** If you leave Harris Teeter and want to continue your coverage, you must apply and pay the premium within 31 days of your termination (Supplemental Life only).

Deferred Effective Date

**Basic and Supplemental Life**

What is the Active Service provision for Associates?

An Associate will be considered in Active Service with the Employer on a day which is one of the Employer’s scheduled work days if either of the following conditions are met.

1. He or she is actively at work. This means the Associate is performing his or her regular occupation for the Employer on a Full-time basis, either at one of the usual places of business or at some location to which the Employer’s business requires the Associate to travel.

2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

An Associate is considered in Active Service on a day which is not one of the Employer’s scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

If an eligible Associate is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service.

If an eligible Spouse or Dependent Child is an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or confined to his or her home under the care of a Physician on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage.
Accidental Death & Dismemberment (AD&D)

This benefit helps protect you against losses due to a covered accident. Coverage is paid for by Harris Teeter. You receive at no cost, accident insurance equal to one times your eligible earnings, up to a maximum of $1 million.

“Covered Accident”: A sudden unforeseeable event that results in injury or death and that occurs while coverage is in force.

Basic AD&D Coverage

The Plan pays for the full benefit amount in the event of an accidental loss of life occurring within 365 days of a covered accident. In addition, to help survivors of severe accidents adjust to new living circumstances, the Plan pays benefits for paralysis, dismemberment, loss of eyesight, speech or hearing.

<table>
<thead>
<tr>
<th>If, within 365 days of a covered accident, bodily injuries result in:</th>
<th>This percent of the benefit amount will be paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of life, or total paralysis of upper and lower limbs, or loss of two hands or feet or eyesight in both eyes or loss of speech and hearing in both ears</td>
<td>100%</td>
</tr>
<tr>
<td>Total paralysis of both lower limbs, or total paralysis of upper and lower limbs on one side of the body, or loss of one hand, foot or sight in one eye, or loss of speech, or loss of hearing in both ears</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of thumb and index finger of the same hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

Travel Assistance

As part of your group Basic AD&D benefit, you automatically receive this FREE benefit.

When you’re traveling, emergencies can occur. Help is only a phone call away. Toll-free emergency assistance is available to you and your covered dependents 24/7 when traveling 100 miles or more from home on business or vacation domestically or internationally. The benefit is provided automatically, at no cost to you.

Cigna’s Secure Travel Program provides three kinds of services — pre-trip information, emergency medical assistance, and emergency personal services. Call 1-888-226-4667 from the U.S. or Canada. All other locations, call 202-331-7635. Provide your employer’s name, a phone number where you can be reached, nature of the problem and this Travel Assistance I.D. Policy Number: OK 812635 and Group Number: 57.

If you have a serious medical emergency, obtain emergency medical services first, and then contact CIGNA for additional assistance.
Supplemental AD&D Coverage

Associate Coverage
If you want additional coverage, you may purchase from $10,000 to $500,000 (in multiples of $10,000).

Family Coverage

**Spouse:** Your spouse is eligible for coverage until he/she reaches age 70. Your spouse’s benefit will be 40% of your benefit amount (or 50% if you have no dependent children).

**Dependent Child(ren):** Your unmarried child(ren) from the moment of birth until 19 years of age. This includes stepchildren who reside with the associate, children for whom the associate is legal guardian, legally adopted children, and children of adopting parents pending adoption procedures. Each of your eligible dependent’s benefit will be 10% of your benefit amount (if your spouse is also covered) or 20% of your benefit amount (if your spouse is not covered).

### Supplemental Accident Coverage (per $1,000 of Coverage)

<table>
<thead>
<tr>
<th></th>
<th>Associate Coverage</th>
<th>Family Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$.02/month</td>
<td>$.035/month</td>
</tr>
</tbody>
</table>

### Examples: Let’s assume you are married with two children and you elect $50,000 in Supplemental Accident coverage.

<table>
<thead>
<tr>
<th></th>
<th>Associate Coverage</th>
<th>Family Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spouse</strong></td>
<td>Multiply your chosen coverage amount 50 (for $50,000) by the cost per month per $1,000 of coverage ($0.02).</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>$50 x $0.02</td>
<td>= $1.00</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td>Multiply your chosen coverage amount 50 ($20,000 for spouse and $5,000 for each child) by the cost per month per $1,000 of coverage ($0.035).</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>$25 x $0.035</td>
<td>= $1.75</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Cost</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$1.00</td>
<td>$1.75</td>
</tr>
</tbody>
</table>


Additional Supplemental AD&D Benefits

- **College Education and Spouse Training (Supplemental AD&D only)**
  - **Children:** If you die in a covered accident, the Plan will pay an extra benefit for each insured child who enrolls in a school of higher learning before he or she is age 23. To help pay school expenses, the Plan will pay the benefit amount of 2% or $5,000, whichever is less, for each qualifying child. This benefit is payable each year for four consecutive years as long as your child continues in school.
  
  - **Spouse:** If, within one year of your death in a covered accident, your spouse enrolls in an accredited school to gain skills needed for employment, the Plan will pay the actual cost of this education for not more than one year, up to a maximum of $3,000.

  If, at the time of accident, Family Plan coverage is in force but there is no dependent who is or could become eligible for “special education” benefits, the plan will pay an additional benefit of $1,000 to the Insured's designated beneficiary.

- **Seatbelt Benefit (Basic & Supplemental AD&D)**

  This benefit is payable if an insured person dies as a result of injuries sustained in a covered accident while driving or riding in a private passenger car equipped with seat belts. If that person was wearing a properly fastened seat belt, the death benefit will be increased by 10%, but not less than $1,000 or more than $10,000.

Deferred Effective Date

The effective date of insurance will be deferred for any Employee or eligible Spouse or Dependent Child who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date he returns to Active Service and the date coverage would otherwise have become effective.

An Associate is in Active Service on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. The Associate is performing his or her regular occupation for the Employer on a full-time basis. He or she must be working on one of the Employer’s usual places of business or at some location to which the employer's business requires an Associate to travel

2. The day is a scheduled holiday or vacation day and the Associate was performing his or her regular occupation on the preceding scheduled work day.

An Associate is in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

A person other than an Employee is considered in Active Service if he/she is none of the following:

1. An inpatient in a hospital or receiving outpatient care for chemotherapy or radiation therapy;

2. Totally disabled
Commuter Benefit Program

A Commuter Benefit Account, administered through ADP, allows you to deposit a portion of your income, tax-free, into an account that is then used to purchase transit passes for any transit authority in your area. By using pre-tax dollars, you can save an average of 25% to 40% on your commuting expenses. For 2014, the pre-tax maximum monthly contribution is $245 for parking expenses and $125 for commuting/mass transit expenses. These limits are subject to IRS regulations and may change each year.

You determine how much you want to contribute into your Commuter Benefit Account each month for the transit method of your choice. This amount will be automatically deducted from your paycheck and deposited into your account on a monthly basis. Each month, ADP sends your transit pass to your home address or payment for parking expenses to the management company of your parking lot.

Unlike most benefit programs that provide pre-tax savings, you can enroll, make changes to, or cancel your commuter benefit election throughout the year, without experiencing a qualifying life status change event. Any unused balance from one month will roll over to the following month.

Qualifying Expenses

- **Parking**: Expenses to park your car near your workplace, or expenses to park your car where you can commute to work.
- **Transit Passes**: Expenses for any pass, token, voucher or similar item entitling you to use mass transit facilities, or transportation in a vehicle with a seating capacity of at least six adults (excluding the driver)
- **Van Pool**: Expenses for travel between your home and workplace in a vehicle that has a seating capacity of at least six adults and at least 80% of the vehicle’s mileage is for transporting associates to and from work.

For more information on the Commuter Benefit Program, call the Harris Teeter Benefits Department at 1-704-844-4748 (HR4U) or 1-700-844-4748 (HR4U) if calling from outside of a Charlotte area Harris Teeter location.

How Your Money is Reimbursed

With the Commuter Benefits Program, you can elect a transit and/or parking expense account. When electing the transit account, the transit pass of your choice is purchased each month online. Your transit pass is shipped to your home address for use on the 1st day of the month, for which you elected the pass. The value of your monthly election can be added to your current transit pass for added convenience. You can make recurring monthly elections if your transit expenses and method of transit remain the same throughout the year.

When electing a parking expense account, ADP can send payment directly to your parking lot management company or you can pay for your parking expenses out-of-pocket and be reimbursed by submitting a claim to ADP.
Voluntary Benefits

To complement your group benefit options, Harris Teeter also offers four additional benefits to help meet the needs of you and your family. These important benefits include:

- Individual Life
- Critical Illness
- Accident Plan
- Hospital Indemnity

Boston Mutual Individual Life

Many families wonder if they have enough life insurance coverage ... or the right kind. That is why Harris Teeter is providing you the opportunity to purchase a life insurance policy that provides long-term financial protection for you and your entire family. The policy builds cash value.

With payroll deductions starting at $2 a week, you can purchase coverage without the worry of premium notices in your mailbox, checks to write or postage to pay.

Unlike group insurance, you personally own the Individual Life policy.

Coverage Amount

Associate

Coverage is available from $2 to $15 per week.

If you enroll for even a small amount now, you are guaranteed that during a later annual open enrollment period, you can increase your coverage up to a maximum of $15 a week with no health questions! However, if you decline now and want to enroll at a later date, evidence of insurability will be required.

Family

- Spousal coverage is available for $2 per week.
- Coverage for children is from $1 to $2 per week.

The maximum coverage per individual policy is $126,000.
Eligibility

You are eligible if you are a full-time associate between the ages of 18 and 69. The following dependents are also eligible:

- Your legal spouse between the ages of 18 and 69.
- Your unmarried dependent children include natural or adopted children, stepchildren who depend on you for support, from 15-days-old until age 21 (or age 23 if a full-time student).

Advantages of Individual Life

Some of the advantages of this Whole Life Insurance plan are:

- No health questions asked. As a full-time active associate, you can apply for up to $12 in coverage with no health questions asked.
- Portable benefits. Even if you retire or leave Harris Teeter, you can continue the coverage. You simply make direct payments to the insurer.
- The policy builds cash value. Each year after your policy anniversary, you will receive a statement to keep you informed of all your policy values.
- Loan Value. After premiums have been paid for two-three years and a value is established, you may borrow against the policy loan value for emergency cash, education, retirement income or any other purpose. (Interest will be charged on the loan at 8% and the loan will reduce your death benefits.)
- Accelerated Death Benefit. This feature pays an advance on your Whole Life Insurance benefit if a physician certifies you as having a life expectancy of 12 months or less. The original diagnosis must occur after your coverage begins. The maximum payout is $50,000. Your coverage face amount will be reduced by any paid advance and the remainder, if any, will be paid to your beneficiary following your death.
- Coverage for Spouse and Children. Even if you don’t enroll, you can cover your spouse and children (where permitted by state law).
- Payor Waiver of Premium (Optional): If you become totally disabled before age 60 and your disability lasts at least six months, your coverage will continue without premium payments for as long as you are disabled.

The Individual Life Insurance Plan is offered through Boston Mutual Insurance Company. If you have questions regarding the Whole Life policies, please call 1-800-669-2668 ext. 222 or visit online at www.bostonmutual.com.

Aflac Critical Illness Insurance

Cancer, heart attack, stroke, and other critical illnesses are life-changing events. Medical coverage will help pay a large portion of your medical expenses, but what about the out-of-pocket medical expenses? Health insurance is not generally designed to cover many of the sizable expenses which frequently accompany a critical illness — costs due to lost wages, experimental treatment, in-home care. These expenses place an increased burden on patients and families. The Critical Illness Plan, offered through Aflac can complement your medical coverage with a lump-sum cash benefit payment.

With Aflac’s Critical Illness Plan, you select the amount of the benefit — from $5,000 to $50,000 (in multiples of $5,000). There are no deductibles and you’ll receive your cash benefit regardless of any medical plan you have (unless otherwise assigned). You decide how the money should be spent.
At the time you enroll, a few health questions will be asked if you apply for a benefit amount over the guaranteed-issue amount. You’ll be notified if you have been approved for coverage and how much coverage will be issued.

Eligibility

You are eligible if you are a full-time associate, age 18 to 69, or a part-time associate, age 18 to 69, and work a minimum of 16 hours per week.

The following dependents are also eligible:

- Your legal spouse, age 18 to 69.
- Your dependent children are eligible if they are natural children, step-children, foster children, legally adopted children or placed for adoption, who are under age 26.

Important Plan Features

- **Lump-sum benefits** — from $5,000 to $50,000 — paid directly to you following the diagnosis of each covered critical illness (unless otherwise assigned).
- **Dependent Coverage** — Spouse coverage available for up to $25,000. Each dependent child is covered at 25 percent of the associate’s amount at no additional charge.
- **Annual health screening benefits included.**
- **Rates cannot be increased** due to your age, health or because of any claims.

How the Plan Works

First Occurrence Benefit

After the Waiting Period, you may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness. At age 70, benefits are reduced by 50%.

<table>
<thead>
<tr>
<th>Covered Critical Illnesses</th>
<th>Percentage of Face Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack</td>
<td>100%</td>
</tr>
<tr>
<td>Stroke</td>
<td>100%</td>
</tr>
<tr>
<td>Major Organ Transplant</td>
<td>100%</td>
</tr>
<tr>
<td>Renal Failure (End Stage)</td>
<td>100%</td>
</tr>
<tr>
<td>Internal Cancer</td>
<td>100%</td>
</tr>
<tr>
<td>Carcinoma in situ**</td>
<td>25%</td>
</tr>
<tr>
<td>Coronary Artery Bypass Surgery**</td>
<td>25%</td>
</tr>
</tbody>
</table>

** A partial benefit (25%) is payable for carcinoma in situ and coronary artery bypass surgery. Payment of the partial benefit for carcinoma in situ will reduce the benefit for internal cancer by 25%. Payment of the partial benefit for coronary artery bypass surgery will reduce the benefit for a heart attack by 25%.
**Additional Occurrence Benefit**

We will pay benefits for each different Critical Illness in the order the events occur. We will pay benefits for any one Critical Illness once every six months. Therefore, no benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated by at least 12 months (Cancer benefits must be medically unrelated to any cancer for which benefits have already been paid).

**Re-occurrence Benefit**

We will pay benefits for the reoccurrence of any Critical Illness once every twelve months. Therefore, once benefits have been paid for Critical Illness, no additional benefits are payable for that same Critical Illness unless the dates of diagnosis are separated by at least 12 months (Cancer benefits must be medically unrelated to any cancer for which benefits have already been paid).

**Health Screening Benefits**

After the waiting period, you and your spouse are eligible to each receive up to $50 for any one covered screening test per calendar year. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years you can receive the health screening benefit. A few of the covered health screening tests include:

- Stress test on a bicycle or treadmill
- Mammogram
- Pap Smear
- PSA (blood test for prostate cancer)
- Chest X-ray
- Colonoscopy
- Flexible Sigmoidoscopy

*Note:* This benefit does not apply to dependent children. Please see your certificate for a complete list of covered tests.

**Limitations and Exclusions**

This plan contains a 30-day Waiting Period. This means no benefit is payable for any Insured Person who has been diagnosed with a Specified Critical Illness before their coverage has been in force 30 days from the Effective Date shown in the Certificate Schedule. If an insured is first diagnosed during the Waiting Period, benefits for treatment of that Critical Illness will apply only to loss commencing after 12 months from their Effective Date or at the Employee’s option, they may elect to void the Certificate from the beginning and receive a full refund of premium.

Benefits will not be paid for a loss due to:

1. Intentionally self-inflicted injury or action;
2. Suicide or attempted suicide while sane or insane;
3. Illegal activities or participation in an illegal occupation;
4. War declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
5. Substance abuse;
6. Pre-existing conditions.
7. No benefits will be paid for diagnosis made or Treatment received outside the United States.
Pre-Existing Conditions Limitation

“Pre-existing Condition” means a sickness or physical condition which, within the 12-month period prior to the effective date of the certificate, resulted in a covered person’s receiving medical advice or treatment.

We will not pay benefits for any sickness or physical condition starting within 12-months of an Insured’s Effective Date which is caused by or resulting from a Preexisting Condition.

A claim for benefits for loss starting after 12 months from the effective date of the certificate will not be reduced or denied on the grounds that it is caused by a pre-existing condition.

A condition will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date of the certificate.

“Treatment” means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

TERMS YOU NEED TO KNOW

The Effective Date of your insurance will be the date shown in your Certificate Schedule.

Employee means the insured as shown in the Certificate Schedule.

Spouse means an Employee’s legal wife or husband.

Dependent Children means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26.

Your natural Children born after the Effective Date of the Rider will be covered from the moment of live birth. No notice or additional premium is required.

Coverage on Dependent Children will terminate on the child’s 26th birthday. However, if any child is incapable of self-sustaining employment due to mental or physical handicap and is dependent on his parent(s) for support, the above age 26 shall not apply. Proof of such incapacity and dependency must be furnished to the Company within 31 days following such 26th birthday.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or injury involving the cardiovascular system. Cardiac arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include all of the following criteria: 1. New and serial electrocardiographic (EKG) findings consistent with Myocardial Infarction; 2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal [in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used]; and 3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echo cardiograms.

Stroke means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident which begins on or after your Effective Date.

Stroke does not include transient ischemic attacks and attacks of vertebrosacral ischemia. We will pay a benefit for Stroke that produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from computed axial tomography (CAT scan) or magnetic resonance imaging (MRI). Stroke does not mean head injury, transient ischemic attack, or chronic cerebrovascular insufficiency.

Cancer (Internal or Invasive) means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes leukemia. Excluded are Cancers that are noninvasive, such as (1) Premalignant tumors or polyps; (2) Carcinoma in Situ; (3) Any skin cancers except melanomas; (4) Basal cell carcinoma and squamous cell carcinoma of the skin; and (5) Melanoma that is diagnosed as Clark’s Level I or II or Breslow thickness less than .77 mm.
Cancer is also defined as a disease which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.

Carcinoma in Situ means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Renal Failure (Kidney Failure) means the end-stage renal failure presenting as chronic, irreversible failure of both of your kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemodialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

Coronary Artery Bypass Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as but not limited to balloon angioplasty, laser relief, stents or other nonsurgical procedures.

Treatment means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

A doctor, physician, or pathologist does not include an insured or a family member.

**Portable Coverage**

When coverage would otherwise terminate because the Employee end employment with the employer, coverage may be continued. The employee will continue the coverage that is in force on the date employment ends, including dependent coverage then in effect.

The employee will be allowed to continue the coverage until the earlier of the date the employee fails to pay the required premium or the date the group master policy is terminated. Coverage may not be continued if the employee fails to pay any required premium or the group master policy terminates.

**Deferred Effective Date**

To be eligible for new or increased coverage, you must be actively at work on the application (enrollment) date and the effective date of the new or increased plan. If you are on a leave of absence during your enrollment period, you are eligible to apply for coverage within 30 days following your return to work. If you are actively at work on the application (enrollment) date, but not on the scheduled effective date of the new or increased plan, your coverage will become effective on the 1st day of the month following your return to work.

**Note:** If this coverage will replace any existing individual policy please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. Continental American Insurance Company • 2801 Devine Street • Columbia, South Carolina 29205 • 1-800-433-3036 toll-free • 1-866-849-2970 fax • www.aflacgroupinsurance.com
Unum Accident Insurance

Every 10 minutes, over 700 Americans suffer an injury severe enough to seek medical help.* Are you prepared for the extra expenses that result from a sudden accident?

Unum’s Accident Insurance provides supplemental coverage that can pay benefits directly to you for covered injuries caused by a covered accident. These benefits can help your family cover the out-of-pocket expenses that may remain after payment is made by your health insurance.

The Plan covers a wide range of on- and off-the-job injuries and accident-related expenses such as hospitalization, physical therapy, hospital intensive care, transportation and lodging, plus coverage for accidental death and catastrophic accidents that involve the loss of use of sight, hearing, speech, arms or legs.

Premiums are conveniently paid through payroll deduction.

Family Coverage

The Accident Insurance Plan is available for you, as well as your eligible covered family members.

Eligibility

- Full-Time associates, ages 17 – 80, who have satisfied the 90-day waiting period and who are actively at work on the date of application.

- Part-time associates, ages 17 – 80 who have satisfied the 90-day waiting period, are actively at work on the date of application and who work a minimum of 16 hours per week.

Definition of being “actively at work:” On the day you apply for coverage, you are working at one of the Company’s business locations, or you are working at a location where you are required to represent Harris Teeter. If you are applying for coverage on a day that is not one of your scheduled workdays, then you will be considered actively at work if you meet this definition as of your last scheduled workday. You are not considered actively at work if your normal duties are limited or altered due to your health, or if you are on a leave of absence.

- Spouses age 17 to 80 are eligible to apply, if they are not disabled.

- Dependent children of the employee who are from 14 days to 26 years old are eligible, if they are not disabled.

Coverage is Guaranteed Renewable

Your coverage is guaranteed renewable for life as long as premiums are paid on time. This means the policy provisions cannot be changed.

You Own the Policy

Coverage is individually owned, which means you own your policy and can take it with you if you leave your company for any reason. Should you leave and decide to keep your policy, Unum will bill you directly at home at the same premium rate on a monthly, quarterly or semi-annual basis.

Benefits Overview

The Accident Insurance Plan offers you and your family the following benefits:

<table>
<thead>
<tr>
<th>Accident/Injury</th>
<th>Benefit Amount</th>
<th>Accident/Injury</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental death</td>
<td>Fractures</td>
<td>Employee</td>
<td>$25,000</td>
</tr>
<tr>
<td>Spouse</td>
<td>$10,000</td>
<td>Child</td>
<td>$5,000</td>
</tr>
<tr>
<td>Child</td>
<td>$5,000</td>
<td>Fractures</td>
<td>Up to $5,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spouse</td>
<td>$20,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

The accidental death benefit doubles if you are injured as a fare-paying passenger on a common carrier (i.e., commercial airlines, trains, buses, subways, boats, etc. that operate on a regular schedule). Employee — $50,000; Spouse — $20,000; Child — $10,000

<table>
<thead>
<tr>
<th>Accident/Injury</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>$100</td>
</tr>
<tr>
<td>Air ambulance</td>
<td>$500</td>
</tr>
<tr>
<td>Appliance</td>
<td>$100</td>
</tr>
<tr>
<td>Blood, plasma and platelets</td>
<td>$300</td>
</tr>
<tr>
<td>Burns</td>
<td>Laceration</td>
</tr>
<tr>
<td></td>
<td>Second degree for 36% or more of body surface</td>
</tr>
<tr>
<td></td>
<td>$750</td>
</tr>
<tr>
<td></td>
<td>Third degree for 9 – 34 square inches of body surface</td>
</tr>
<tr>
<td></td>
<td>$1,500</td>
</tr>
<tr>
<td></td>
<td>Third degree for 35 or more square inches of body surface</td>
</tr>
<tr>
<td></td>
<td>$10,000</td>
</tr>
<tr>
<td></td>
<td>Skin grafts</td>
</tr>
<tr>
<td></td>
<td>Lodging</td>
</tr>
<tr>
<td></td>
<td>$100</td>
</tr>
<tr>
<td></td>
<td>Loss of finger, toe, hand, foot or sight of an eye</td>
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<tr>
<td></td>
<td>Loss of both hands, feet, sight of both eyes, or any combination of two or more losses</td>
</tr>
<tr>
<td></td>
<td>$15,000</td>
</tr>
<tr>
<td></td>
<td>Loss of one hand, foot, sight in one eye</td>
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<tr>
<td></td>
<td>$7,500</td>
</tr>
<tr>
<td>Accident/Injury</td>
<td>Benefit Amount</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Catastrophic accident (loss of use of sight, hearing, speech, arms or legs)**</td>
<td>Employee &lt;65 years $100,000</td>
</tr>
<tr>
<td></td>
<td>Spouse or child &lt;65 years $50,000</td>
</tr>
<tr>
<td></td>
<td>Age 65 – 69 Amount reduced 50%</td>
</tr>
<tr>
<td></td>
<td>Age 70+ Amount reduced 75%</td>
</tr>
<tr>
<td></td>
<td>Concussion $100</td>
</tr>
<tr>
<td></td>
<td>Dental work, emergency</td>
</tr>
<tr>
<td></td>
<td>Extraction $50</td>
</tr>
<tr>
<td></td>
<td>Crown $150</td>
</tr>
<tr>
<td></td>
<td>Dislocations</td>
</tr>
<tr>
<td></td>
<td>Open Up to $4,000</td>
</tr>
<tr>
<td></td>
<td>Closed Up to $2,000</td>
</tr>
<tr>
<td></td>
<td>Without anesthesia Reduced 25%</td>
</tr>
<tr>
<td></td>
<td>Doctor's office initial visit $50</td>
</tr>
<tr>
<td></td>
<td>Emergency room treatment (includes x-rays) $150</td>
</tr>
<tr>
<td></td>
<td>Eye injury</td>
</tr>
<tr>
<td></td>
<td>Requires surgery or removal of foreign body $200</td>
</tr>
<tr>
<td></td>
<td>Follow-up treatment for accident</td>
</tr>
<tr>
<td></td>
<td>Initial follow-up visit $50</td>
</tr>
</tbody>
</table>

**Catastrophic accident benefits are payable after fulfilling a 365-day elimination period. See policy for details.

Benefits may vary in FL, NC, and WA.
Exclusions

Unum will not pay benefits for losses that are caused by or occur as the result of the insured’s:

- Involvement in war or act of war, whether it is declared or undeclared;
- Riding in or driving any motor vehicle in a race, stunt show or speed test;
- Operating, learning to operate, serving as a crew member of or jumping, parachuting or falling from any aircraft or hot-air balloon, including those which are not motor-driven. This does not include flying as a fare-paying passenger;
- Engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, para-kiting or any similar activities;
- Participating or attempting to participate in an illegal activity; and/or being incarcerated in a penal institution;
- Committing or trying to commit suicide or injuring him/herself intentionally, whether he/she is sane or not;
- Having any sickness or declining process caused by a sickness, including physical or mental infirmity. Unum will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by an injury;
- Practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received; or

Terminations

The policy will terminate on the earliest of the following:

- Written request by the insured to terminate the policy;
- Failure to pay the premiums for the policy, subject to the grace period allowed; or
- Death of the insured.

The base plan is an accident-only policy. Benefit amounts may vary by state.

This information is not intended to be a complete description of the insurance coverage available and some coverage options may not be available in all states. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form: L-21762 and contact your Unum representative.

Underwritten by Provident Life and Accident Insurance Company, Chattanooga, Tennessee

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CU-3191 (9-12)
Most hospital stays are unexpected and may leave you unprepared financially to handle the expenses associated with a hospitalization. The supplemental hospital indemnity insurance helps provide financial support and enhances the coverage currently available to you under the core medical benefit plan.

The Supplemental Hospital Insurance Plan provides you and your family with additional benefits should you or a covered family member be hospitalized due to a covered accident or sickness. The plan pays $200 per day for a hospital confinement up to 180 days and $300 per hospital admission. The benefit is paid directly to you, not the hospital or doctor. The payment is made to you regardless of the amount CIGNA paid towards the hospital stay.

### Plan Benefits

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Confinement (up to 180 days per confinement)</td>
<td>$200 per day</td>
</tr>
<tr>
<td>Hospital Admission</td>
<td>$300 per admission</td>
</tr>
<tr>
<td>Hospital Intensive Care (30 day maximum for any one period of confinement)</td>
<td>$200 per day</td>
</tr>
<tr>
<td>Surgical and Anesthesia Benefit</td>
<td>Surgery - $2000</td>
</tr>
<tr>
<td></td>
<td>Anesthesia - $500</td>
</tr>
<tr>
<td>Hospital Emergency Room/Physician Benefit (Medical Fees)</td>
<td>Physician - $50 per visit</td>
</tr>
<tr>
<td></td>
<td>Laboratory Fees - $25 per visit</td>
</tr>
<tr>
<td></td>
<td>X-ray - $50 per visit</td>
</tr>
<tr>
<td></td>
<td>Injections/medications - $25 per visit</td>
</tr>
<tr>
<td></td>
<td>Family Calendar Year Maximum - $1,000</td>
</tr>
<tr>
<td></td>
<td>Insured Calendar Year Maximum - $250</td>
</tr>
<tr>
<td>Well Baby Care</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Out of Pocket Hospital Prescription Drug Benefit</td>
<td>$10 with a 5 prescription maximum per year</td>
</tr>
</tbody>
</table>

### Eligibility

**Spouse and Dependent Children Coverage Available**

The employee may purchase Group Supplemental Hospital Indemnity coverage for their spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate.

**Eligible participants include:**

1. Full time employee, who has satisfied the 90-day waiting period and whose actively at work on the date of the application
2. For employee and spouse, ages 18 to 64
3. Dependent children of the employee

   Dependent Children means your natural children, step-children, foster children, legally adopted
children or children placed for adoption, who are under age 26.

a. Coverage on Dependent Children will terminate on the child’s 26th birthday. However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, the above age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday, and not more frequently than annually from then forward.

b. Newborn Children of an Employee and/or his/her insured spouse and newborn Adopted Children shall automatically be covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.

c. Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in the Employee’s home, under the same terms and conditions that apply to the natural, dependent children of covered persons.

d. If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:
   i. Must allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
   ii. Must enroll the child under family coverage upon application of the child’s other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.
   iii. May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.
   iv. Will not impose pre-ex limitations or waiting periods.

e. If Dependent Children are covered under the plan, Dependent Children born or placed in the Employee’s home after the Effective Date of this Rider will also be covered from the moment of birth. No notice or additional premium is required and the enrollment period will be waived. The company will not impose pre-ex limitations or waiting periods for newborn children, foster and adopted children if they are enrolled upon placement or children covered by the court or administrative order.

Exclusions
We will not pay benefits for loss caused by pre-existing conditions.

We will not pay benefits for loss contributed to, caused by, or resulting from:

- War—participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
- Suicide—committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries—injuring or attempting to injure yourself intentionally.
• Intoxication—being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.

• Illegal Acts—participating or attempting to participate in an illegal activity, or working at an illegal job.

• Sports—participating in any organized sport: professional or semiprofessional.

• Custodial Care. This is care meant simply to help people who cannot take care of themselves.

• Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.

• Services performed by a relative.

• Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.

• A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.

• Elective abortion.

• Treatment, services, or supplies received outside the United States and its possessions or Canada.

• Dental services or treatment.

• Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.

• Mental or emotional disorders without demonstrable organic disease.

• Alcoholism, drug addiction, or chemical dependency.

• Injury or Sickness for which benefits are paid or payable by Worker's Compensation

• Traveling - traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.

• Racing - Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.

• Aviation - operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.

• Routine physical exams and rest cures.

Pre-Existing Condition Limitation

Pre-Existing Condition means within the 12-month period prior to the Effective Date of the certificate those conditions for which medical advice or treatment was received or recommended.

We will not pay benefits for any loss or injury which is caused by, contributed to by, or resulting from a pre-existing condition for 12 months after the Effective Date of the certificate, or for 12 months from the date medical care, treatment, or supplies were received for the pre-existing condition, whichever is less.

A claim for benefits for loss starting after 12 months from the Effective Date of a certificate, as applicable, will not be reduced or denied on the grounds that it is caused by a pre-existing condition. Pregnancy is a “pre-existing condition” if conception was before the effective date of a certificate.

If a certificate is issued as a replacement for a certificate previously issued under this Plan, then the pre-existing condition limitation provision of the new certificate applies only to any increase in benefits over the prior certificate. Any remaining period of pre-existing condition limitation of the prior certificate would continue.

Terms You Need To Know

• Covered Person - If the certificate is issued as: Individual coverage, the Covered Person means you; Employee/Spouse coverage, Covered Person means you and your legal spouse; Single Parent Family coverage, Covered Person means you and your covered dependent children as defined in the applicable rider, that have been accepted for coverage; Family coverage, Covered Person means you and your
spouse and covered dependent children, as defined in the applicable rider, that have been accepted for coverage.

- **Injury or Injuries** - An accidental bodily injury or injuries caused solely by or as the result of a Covered Accident.

- **Covered Accident** - An accident, which occurs on or after a Covered Person’s Effective Date, while the certificate is in force, and which is not specifically excluded.

- **Sickness** - An illness, infection, disease or any other abnormal condition, which is not caused solely by or the result of an Injury.

- **Covered Sickness** - An illness, infection, disease or any other abnormal physical condition which is not caused solely by or the result of any Injury which occurs while the certificate is in force; and was not treated or for which a Covered Person did not receive advice within 12 months before the Effective Date of his/her coverage; and is not excluded by name or specific description in the certificate.

- **Doctor or Physician** - A person, other than yourself, or a member of your immediate family, who is licensed by the state to practice a healing art; performs services which are allowed by his or her license; and performs services for which benefits are provided by the certificate.

- **A hospital is not** a nursing home; an extended care facility; a convalescent home; a rest home or a home for the aged; a place for alcoholics or drug addicts; or a mental institution.

- **A hospital intensive care unit is not** any of the following step down units: a progressive care unit; a sub-acute intensive care unit; an intermediate care unit; a private monitored room; a surgical recovery room; an observation unit; or any facility not meeting the definition of a hospital intensive care unit as defined in the certificate.

- **Effective Date** - The date as shown in the Certificate Schedule if you are on that date actively at work for the policyholder. If not, the certificate will become effective on the next date you are actively at work as an eligible employee. The certificate will remain in effect for the period for which the premium has been paid. The certificate may be continued for further periods as stated in the plan. The certificate is issued in consideration of the payment in advance of the required premium and of your statements and representations in the application. A copy of your application will be attached and made a part of the certificate. The certificate, on its Effective Date, automatically replaces any certificate or certificates previously issued to you under the plan.

- **Individual Termination** - Your insurance will terminate on the earliest of the date the plan is terminated; on the 31st day after the premium due date if the required premium has not been paid; on the date you cease to meet the definition of an employee as defined in the plan; on the premium due date which falls on or first follows your 70th birthday; or on the date you are no longer a member of an eligible class.

Termination of any Covered Person’s insurance under the certificate shall be without prejudice to his or her rights as regarding any claim arising prior thereto.

Note: If this coverage will replace any existing individual policy please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

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Other Important Benefits

WorkLife Solutions (EAP)

WorkLife Solutions is designed to help associates and their families address problems that can compromise personal satisfaction and sometimes, job performance. This program also provides referral services for child care, elder care, legal and/or financial assistance.

Harris Teeter has contracted with CIGNA Health to provide each of your eligible household members with access to confidential, professional counseling.

From time-to-time, everyone encounters problems and conflicts which can feel overwhelming. For example, you may experience:

- Difficult periods in your relationships with others,
- Stress arising from marital difficulties, separation or divorce,
- Pressures associated with work,
- A need for information about financial or legal resources in your community,
- Family turmoil associated with a troubled child,
- Illness or death of someone close, or
- The use of alcohol or drugs.

CIGNA network counselors are fully-licensed professionals who have the clinical training and expertise to help you and your family.

It's confidential. As provided by law, CIGNA's services are confidential. Treatment information will not be shared with anyone without your written consent.

It's convenient. CIGNA's network professionals are located near your home and work.

It's provided at no cost to you. You and each family member are eligible for 6 free counseling sessions.

It's easy to use. Simply call CIGNA — 1-800-633-7232 — for emergencies, crisis intervention, and to request an initial appointment. The hotline is available 24 hours a day, seven days a week.

In addition to your spouse and children being covered, even your parents and your spouse’s parents are eligible to use this free advocacy program.
Hugh G. Ashcraft Foundation

The Hugh G. Ashcraft Foundation is associates helping associates. The Foundation provides financial assistance for associates facing sudden and unforeseen personal tragedies caused by circumstances beyond their control.

By contributing to the Foundation, you’re helping your fellow associates get through life’s catastrophes. Grants and loans are available to help after six months of employment.

Qualifying events include:

- Uninsured death of an immediate family member;
- Extreme financial hardship resulting from death, divorce/separation, or loss of spouse’s employment;
- Damage from tornadoes, floods and other acts of nature;
- Fire to primary residence;
- Extensive non-covered medical expenses which seriously affect an associate’s quality of life or leave an associate unable to pay for life-sustaining necessities such as utilities, medication or mortgage;
- Other extreme financial hardships resulting from sudden and unforeseen circumstances.

To apply, contact a member of management or your Associate Relations Specialist for more information on accessing or contributing to the Foundation.

Important Notices

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 Harris Teeter Supermarkets, Inc. (“HTSI”) and Subsidiaries Groups Medical Insurance Plan 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 could compare your 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. HTSI has determined that the prescription drug coverage offered by the (“HTSI”) is, 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 November 15th through December 31st.

However, if you lost 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.

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

If you do decide to join a Medicare drug plan and drop your current Ruddick coverage, be aware that you and your dependents will not be able to get this coverage back.

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility –
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW (5436) 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 employer health plan premiums. The following list of States is current as of July 31, 2012.

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

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

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

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

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

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

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

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

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

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

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

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

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

### IDAHO – Medicaid
Website: http://www.accesstohealthinsurance.idaho.gov  
Medicaid Phone: 1-800-926-2588  
CHIP Website: www.medicaid.idaho.gov  
CHIP Phone: 1-800-926-2588

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

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

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

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

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

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

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

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

### NEW HAMPSHIRE – Medicaid
Website: http://www.ohioldhhs.org/medicaid/client/index.html  
Phone: 603-271-5218

### NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/  
Medicaid Phone: 1-800-356-1561  
CHIP Website: http://www.njfamilycare.org/index.html  
CHIP Phone: 1-800-701-0710
<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid/CHIP Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IDAHO</strong> – Medicaid</td>
<td>Medicaid Website: <a href="http://www.accesstohealthinsurance.idaho.gov">www.accesstohealthinsurance.idaho.gov</a>&lt;br&gt;CHIP Website: <a href="http://www.medicaid.idaho.gov">www.medicaid.idaho.gov</a>&lt;br&gt;Phone: 1-800-926-2588</td>
</tr>
<tr>
<td><strong>MONTANA</strong> – Medicaid</td>
<td>Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a>&lt;br&gt;Phone: 1-800-694-3084</td>
</tr>
<tr>
<td><strong>INDIANA</strong> – Medicaid</td>
<td>Website: <a href="http://www.in.gov/fssa">http://www.in.gov/fssa</a>&lt;br&gt;Phone: 1-800-889-9949</td>
</tr>
<tr>
<td><strong>NEBRASKA</strong> – Medicaid</td>
<td>Website: <a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a>&lt;br&gt;Phone: 1-800-383-4278</td>
</tr>
<tr>
<td><strong>IOWA</strong> – Medicaid</td>
<td>Website: <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a>&lt;br&gt;Phone: 1-888-346-9562</td>
</tr>
<tr>
<td><strong>NEVADA</strong> – Medicaid</td>
<td>Medicaid Website:  <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a>&lt;br&gt;Medicaid Phone: 1-800-992-0900</td>
</tr>
<tr>
<td><strong>KANSAS</strong> – Medicaid</td>
<td>Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a>&lt;br&gt;Phone: 1-800-792-4884</td>
</tr>
<tr>
<td><strong>KENTUCKY</strong> – Medicaid</td>
<td>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a>&lt;br&gt;Phone: 1-800-635-2570</td>
</tr>
<tr>
<td><strong>NEW HAMPSHIRE</strong> – Medicaid</td>
<td>Website: <a href="http://www.dhhs.nh.gov/oii/documents/hippapp.pdf">http://www.dhhs.nh.gov/oii/documents/hippapp.pdf</a>&lt;br&gt;Phone: 603-271-5218</td>
</tr>
<tr>
<td><strong>LOUISIANA</strong> – Medicaid</td>
<td>Website: <a href="http://www.lahipp.dhh.louisiana.gov">http://www.lahipp.dhh.louisiana.gov</a>&lt;br&gt;Phone: 1-888-695-2447</td>
</tr>
<tr>
<td><strong>NEW JERSEY</strong> – Medicaid</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>&lt;br&gt;Medicaid Phone: 1-800-356-1561&lt;br&gt;CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>&lt;br&gt;CHIP Phone: 1-800-701-0710</td>
</tr>
<tr>
<td><strong>MAINE</strong> – Medicaid</td>
<td>Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a>&lt;br&gt;Phone: 1-800-977-6740&lt;br&gt;TTY 1-800-977-6741</td>
</tr>
<tr>
<td><strong>MASSACHUSETTS</strong> – Medicaid and CHIP</td>
<td>Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a>&lt;br&gt;Phone: 1-800-462-1120</td>
</tr>
<tr>
<td><strong>NEW YORK</strong> – Medicaid</td>
<td>Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a>&lt;br&gt;Phone: 1-800-541-2831</td>
</tr>
<tr>
<td><strong>MINNESOTA</strong> – Medicaid</td>
<td>Website: <a href="http://www.dhs.state.mn.us/Click">http://www.dhs.state.mn.us/Click</a> on Health Care, then Medical Assistance&lt;br&gt;Phone: 1-800-657-3629</td>
</tr>
<tr>
<td><strong>NORTH CAROLINA</strong> – Medicaid</td>
<td>Website: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a>&lt;br&gt;Phone: 919-855-4100</td>
</tr>
<tr>
<td><strong>OKLAHOMA</strong> – Medicaid and CHIP</td>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>&lt;br&gt;Phone: 1-888-365-3742</td>
</tr>
<tr>
<td><strong>UTAH</strong> – Medicaid and CHIP</td>
<td>Website: <a href="http://health.utah.gov/upp">http://health.utah.gov/upp</a>&lt;br&gt;Phone: 1-866-435-7414</td>
</tr>
<tr>
<td><strong>OREGON</strong> – Medicaid and CHIP</td>
<td>Website: <a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a>&lt;br&gt;Phone: 1-888-314-5678</td>
</tr>
<tr>
<td><strong>VERMONT</strong> – Medicaid</td>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a>&lt;br&gt;Phone: 1-800-250-8427</td>
</tr>
<tr>
<td><strong>PENNSYLVANIA</strong> – Medicaid</td>
<td>Website: <a href="http://www.dpw.state.pa.us/hipp">http://www.dpw.state.pa.us/hipp</a>&lt;br&gt;Phone: 1-800-692-7462</td>
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<td><strong>VIRGINIA</strong> – Medicaid and CHIP</td>
<td>Medicaid Website:  <a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a>&lt;br&gt;Medicaid Phone: 1-800-432-5924&lt;br&gt;CHIP Website: <a href="http://www.famis.org/">http://www.famis.org/</a>&lt;br&gt;CHIP Phone: 1-866-873-2647</td>
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<td><strong>RHODE ISLAND</strong> – Medicaid</td>
<td>Website: <a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a>&lt;br&gt;Phone: 401-462-5300</td>
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<td><strong>WASHINGTON</strong> – Medicaid</td>
<td>Website: <a href="http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm">http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</a>&lt;br&gt;Phone: 1-800-562-3022 ext. 15473</td>
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<td><strong>SOUTH CAROLINA</strong> – Medicaid</td>
<td>Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a>&lt;br&gt;Phone: 1-888-549-0820</td>
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<td><strong>SOUTH DAKOTA</strong> – Medicaid</td>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>&lt;br&gt;Phone: 1-888-828-0059</td>
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<td><strong>TEXAS</strong> – Medicaid</td>
<td>Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a>&lt;br&gt;Phone: 1-800-440-0493</td>
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<td><strong>WYOMING</strong> – Medicaid</td>
<td>Website: <a href="http://health.wyo.gov/healthcarefin/equalitycare">http://health.wyo.gov/healthcarefin/equalitycare</a>&lt;br&gt;Phone: 307-777-7531</td>
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<tr>
<td><strong>SOUTH DAKOTA</strong> – Medicaid</td>
<td>Website: <a href="http://www.dss.mt.gov/medical-assistance/medicaid">http://www.dss.mt.gov/medical-assistance/medicaid</a> Services&lt;br&gt;Phone: 1-800-977-6740&lt;br&gt;TTY 1-800-977-6741</td>
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<td><strong>WEST VIRGINIA</strong> – Medicaid</td>
<td>Website: <a href="http://www.dhhr.wv.gov/bms/">www.dhhr.wv.gov/bms/</a>&lt;br&gt;Phone: 1-877-598-5820, HMS Third Party Liability</td>
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<td><strong>WISCONSIN</strong> – Medicaid</td>
<td>Website: <a href="http://www.badgercareplus.org/pubs/p-10095.htm">http://www.badgercareplus.org/pubs/p-10095.htm</a>&lt;br&gt;Phone: 1-800-362-3002</td>
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<td><strong>TEXAS</strong> – Medicaid</td>
<td>Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a>&lt;br&gt;Phone: 1-800-440-0493</td>
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<tr>
<td><strong>WYOMING</strong> – Medicaid</td>
<td>Website: <a href="http://health.wyo.gov/healthcarefin/equalitycare">http://health.wyo.gov/healthcarefin/equalitycare</a>&lt;br&gt;Phone: 307-777-7531</td>
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</tbody>
</table>

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

- U.S. Department of Labor<br>  Employee Benefits Security Administration<br>  www.dol.gov/ebsa<br>  1-866-444-EBSA (3272)<br>  Ext. 61565

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

OMB Control Number 1210-0137 (expires 09/30/2013)
To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

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Employee Benefits Security Administration
www.dol.gov/ebsa
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U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

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

**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 Harris Teeter Supermarkets, Inc. and don’t 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 November to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage …**

Contact the Benefits Department at 1-704-844-4748, or 1-700-844-4748 if you are calling outside of the Charlotte area from a Harris Teeter work location.

Note: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Harris Teeter Supermarkets, Inc. changes. You also may request a copy.

**For More Information About Your Options Under Medicare Prescription Drug Coverage**

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- 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).

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).

Date: 06/15/2008
Name of Entity/Sender: Harris Teeter Supermarkets, Inc. and Subsidiaries Group Medical Insurance Plan
Contact — Position/Office: Vice President, Benefits and Administration
Address: 701 Crestdale Road, Matthews, NC 28105
Phone Number: 1-704-844-3100
Grandfathered Plan Status Notice

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Harris Teeter Benefits department at 704-844-4748, option #4.