The ingles ADVANTAGE™

BENEFITS PROGRAM

Planning Ahead for Benefits

2020

Welcome to the Ingles Markets Benefit Enrollment

Providing a benefits package to help protect the lifestyle and financial security of our associates is important to us. Ingles Markets encourages a proactive approach to wellness while keeping our benefit plans as affordable as possible.

We recognize that each associate's family situation and insurance needs are different. With this in mind, we are pleased to provide this comprehensive benefit package including employer paid, shared cost and voluntary supplemental benefits.

This benefit guide contains the information you need to enroll in the following Ingles Markets Benefits:

- **Medical and Prescription Drug**
- **Dental**
- **Vision**
- **Health Savings Account (HSA)**
- **Flexible Spending Accounts (FSA)**
- **Basic Life and Accidental Death & Dismemberment (AD&D) Insurance**
- **Disability Income Protection Benefits**
- **Other Voluntary Benefits**

Please review the enclosed information carefully. Ingles Markets, Inc. is committed to our associates who help make us a successful company. We appreciate their support in helping us to fulfill our mission while promoting a positive and productive work environment.

The ingles ADVANTAGE™

Ingles Markets, Inc.
2913 US Highway 70 West
Black Mountain, NC 28711
1-800-635-5066

This communication serves as a Summary of Material Modifications to the Ingles Markets Benefits program, effective January 1, 2020. In the event the content of this brochure or any oral representation made by any person regarding the plan conflict or are inconsistent with the provisions of the plan document or insurance contacts, the plan documents or insurance contracts will govern.

Nothing contained in the benefit plans described herein shall be held or construed to create a promise of employment or future benefits, or a binding contract between Ingles Markets and its associates or their dependents, for benefits or for any other purpose.

Ingles Markets reserves the right, in its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of the benefit plans described herein, including any health benefits that may be extended to retirees and their dependents. Further, Ingles Markets reserves the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the benefit plans described herein, and to decide all matters arising in connection with the operation or administration of such plans.

For more complete information regarding any of Ingles Markets benefit programs, please refer to the Summary Plan Descriptions.

Table of Contents

HOW TO ENROLL

Benefit Eligibility

You must be actively employed and have worked at least 90 days at Ingles Markets to be eligible for benefits. Part-time associates are eligible to purchase Limited Reimbursement Plans after 90 days, and Voluntary Benefits after 1 year of service and completion of 1,000 hours. Coverage may also be available to eligible family members.

Here are the family members who are eligible for coverage:

Family Member	Requirements for Coverage
Your Spouse	Must be your legal spouse for federal tax purposes **An important note about spouse coverage in the Ingles Markets Group Health Plan.** If your spouse is eligible to participate in a group health plan through their employer, they are not eligible for the Ingles Markets Medical Plan. This applies whether or not they choose to enroll in their employer's health plan.
Your Children, Including: • Biological, legally adopted, placed with you for adoption and step children	Children must be dependents for whom you have legal custody and: • Under age 26 or • A medically certified disabled child of any age

How to Complete Your Enrollment — New Hire

To enroll in your benefits, you can call the Ingles Markets Benefits Enrollment Center and speak with one of our trained benefit specialists no later than 90 days after your hire date. During the call, our benefit specialist will verify information for you and your dependents, confirm beneficiary information, discuss your benefit options as they relate to your personal situation and accept your benefit elections.

The Ingles Markets Benefits Enrollment Center will be open Monday through Friday 8 am to 6 pm EST at 1-866-840-9610

We urge you to contact the benefits enrollment center or enroll online immediately. You must complete all benefit enrollment within your first ninety (90) days of employment. Even though you are not required to enroll in any employer paid benefits, you are also eligible for voluntary supplemental benefits. The enrollment session takes about 20-25 minutes. We recommend you call or log on from home where you can have your enrollment materials in front of you.

Before you enroll, please read and review all benefit material provided and gather the following information:

- Social Security Numbers and dates of birth for all eligible family members you plan to enroll

Once You Have Enrolled

You will receive a confirmation statement in the mail within 7-10 business days, verifying your elections, dependents and beneficiaries. If you enrolled eligible family members, you must submit dependent verification information no later than your coverage effective dates such as birth certificates, marriage license or tax returns. Verification documents may be faxed to 704-815-2351. Include a phone number where you can be reached in case the documents are unreadable.

If You Need to Make Changes

Call the Benefits Enrollment Center within 3 business days from the date you receive your confirmation statement, if you need to make any changes. Please be sure to carefully review your confirmation statement. The benefit choices you make during your enrollment will remain in effect for the entire plan year unless you have a qualified life status change. See page 7 for more details.

BEST ONLINE EXPERIENCE EVER.

We made the experience simple and pain-free—and it only takes a few minutes. Here's how it works in 5 easy steps.

1. **Learn**
   Education makes complex ideas simple.
2. **Shop**
   Easily navigate available benefit products with a familiar online experience.
3. **Compare**
   Advanced decision support tools make finding the best coverage easier than ever.
4. **Select**
   Pick your plan in a matter of minutes.
5. **Enroll**
   Finalize your choice with confidence knowing you got the right coverage.

Online enrollment not your thing?
No worries. You can still call to enroll at 866.840.9610 any time during annual enrollment.

Beginning October 21, 2019 visit ingles.maestroedge.com and enroll with your Ingles Group Code: 755291.

Follow your enrollment guide for assistance.

maestro health™ | The ingles ADVANTAGE

Get in touch:
866.840.9610| inglesenrollment@maestrohealth.com

© Maestro Health 2018 m20034

How to Complete Your Enrollment — Current Associate

All associates are asked to review the Ingles Markets benefit options and make an election each year during the open enrollment period. Please review your options carefully when making decisions for the coming year. **Remember** — the choices you make now cannot be changed after the enrollment period closes until the next open enrollment, unless you have a qualified life status change. Your coverage effective date for open enrollment elections is January 1, 2020.

Open Enrollment for 2020 benefits is Monday October 21, 2019 — Tuesday November 12, 2019

To enroll in your benefits, you can call the Ingles Markets Benefits Enrollment Center and speak with one of our trained benefit specialists during the Open Enrollment period.
For life status change enrollments, see page 7.

The Ingles Markets Benefits Enrollment Center will be open Monday through Friday 8 am to 6 pm EST at 1-866-840-9610

In addition, you are able to enroll online. If you have an email address on file, you will receive an email with an invitation to enroll and create an account.

If you do not have an email address on file, go to https://ingles.maestroedge.com/.
You can create an account using the **group code 755291**.

Enrollment Deadlines

You have an opportunity to elect your benefit plans and voluntary coverages as a new hire and during the annual enrollment period, typically near the beginning of the plan year. Remember — you cannot make changes until next year's annual open enrollment period unless you experience a qualified life status change.

Participant Status	Enrollment Opportunity	Coverage Effective Date
New Hires	Must enroll within 90 days of your date of hire	First day following completion of the 90 day waiting period. Voluntary coverage provided through Allstate Benefits are effective as dictated by the carrier.
Current Associate	Annually during the enrollment period. This year from Monday, 10/21/2019 to Tuesday, 11/12/2019	January 1, 2020
Adding an Eligible Dependent, e.g. Spouse or Child	Prior to meeting eligibility requirements	First day of the pay period following eligibility.
Participants Who Experience a Qualified Life Status Change	Changes must be made within 30 days of life status change	Effective date may vary depending on life status change.
Termination of Employment	Continuation of medical coverage under the COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985).	You have 60 days after event to elect coverage continuation. Premiums are paid by you at 102% of plan cost for up to 18 months.

Qualifying Event Defined

You may make changes to your Medical, Dental, Vision, Disability, Life Insurance, and FSA elections during the year only if you experience a qualifying event. A qualifying event is defined by the IRS as one of the following:

- A change in legal marital status (marriage, divorce or legal separation)
- A change in the number of dependents (birth/adoption or placement of adoption of a child, dependent satisfies or ceases to satisfy eligibility requirements)
- A change in employment status (for you, your spouse or your dependent that affects healthcare coverage, e.g. if your spouse loses coverage elsewhere)
- A change in residence (for you, your spouse or your dependent), which results in a change in eligibility
- If an associate's hours of service are reduced so that the associate is expected to average less than 30 hours of service per week, the associate may prospectively revoke coverage, even if the reduction of hours does not render the associate ineligible for the group health plan
- An associate who seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplaces' annual open enrollment period, may be permitted to revoke an election under this Plan provided that the employee enrolls for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Changes to your benefit election must be consistent with your qualifying event, e.g. you are covered under your spouse's medical plan but your spouse loses coverage so you wish to enroll for coverage for you and your spouse and eligible dependents. Benefit election changes must be made within 30 days of the event. To make benefit election changes, complete and submit a change form within 30 days of the qualifying event. Once approved, effective date may vary depending on life status change. Any such changes will remain in effect for the remainder of the plan year.

Ingles Markets, Inc. Group Benefits Plans at a Glance

Benefits	Who Is Eligible	Who Pays
Medical Plans • Standard Plan • High Deductible Health Care Plan (HDHP)	Full-Time and eligible Part-Time associates who meet the hours criteria	Ingles Markets & You
Limited Reimbursement Plans • Plan Level 1 • Plan Level 2	Full-Time and Part-Time	You
Health Savings Account	Full-Time and eligible Part-Time: • If enrolled in HDHP • If not enrolled in Medicare • If not enrolled in any other HDHP coverage • If you cannot be claimed on a tax return as a dependent filed by someone other than a spouse	Ingles Markets & You
Flexible Spending Accounts • Health Care FSA • Dependent Care FSA	Full-Time and eligible Part-Time	You
Dental	Full-Time	Ingles Markets & You
Vision	Full-Time	You
Basic Term Life / AD&D Insurance	Full-Time	Ingles Markets
Short-Term Disability	Full-Time	You
	Full-Time Salaried Associates, Pharmacists and Department Managers	Ingles Markets
Employer Paid Long-Term Disability	Full-Time Salaried Associates, Pharmacists and Department Managers	Ingles Markets
Voluntary Benefits • Critical Illness • Universal Life • Accident (Part-Time Only) • Supplemental Term Life (Full-Time Only) • Supplemental Dependent Life • Supplemental Disability	Full-Time and Part-Time employed at least one year who meet eligibility requirements	You

HEALTHY CHOICES

Medical and Prescription Drug Plan

Ingles Markets offers four options for health coverage to associates. Election of the benefit is voluntary and the company pays the majority of the cost of coverage for associates choosing the Standard Plan or High Deductible Health Plan (HDHP). Associate contributions for the Standard Plan and the HDHP are made on a pre-tax basis unless otherwise stated. Once elected, changes to medical plan options cannot be made during the plan year 2020 unless you experience a qualifying event. Ingles Markets Group Health Plan coverage is provided through the Cigna network and is administered by Maestro Health. The charts on the following pages show the rates and a comparison of the plan options.

The Standard Plan and HDHP

- 100% Preventive Care Coverage. Annual physicals and associated covered testing cost you nothing out-of-pocket, when you use an in-network provider.
- Standard Plan Includes $50 Vision Benefit.
- HDHP Offers a Health Saving Account With Triple Tax Savings. Money from Ingles Markets and you goes in tax-free, can be invested and grow tax-free and, when used for qualified medical expenses, comes out tax-free. Balances can roll over from year to year.
- Provides In- and Out-of-Network Coverage. You and your family can receive coverage for both in-network and out-of-network care. To get quality care for the best value, always use a Cigna In-Network PPO provider*. Cigna providers can be found by visiting www.Cigna.com and choosing PPO, Choice Fund PPO or registering on www.myCigna.com.
- Join Healthy Track and Reduce Your Cost of Coverage. To promote healthy lifestyle choices, preventive health care and health maintenance, Ingles Markets has implemented a wellness program called Healthy Track for Standard Plan and High Deductible Health Plan (HDHP) participants. See page 13 for more details.

Refer to the Summary Plan Description (SPD) located in Human Resources or on the Ingles intranet for additional information and details on plan coverage provisions and expenses.

Save $$ on Premiums with the Healthy Track Program.

If you are a Standard Plan or HDHP participant and you enroll in the Healthy Track Program, you will get a significantly reduced weekly contribution for health care.

Here's How it Works

You qualify for this lower premium by submitting a clinical data sheet (CDS) to identify your health risks and meeting the program's criteria. Both you and your spouse may participate.

*As of the printing of this booklet, Cigna is still in negotiations with Mission Hospital for a new contract. Our intent is to join the Cigna network in North Carolina for the Plan Year beginning 1/1/20, provided they are first able to reach an agreement with Mission Hospital.

If Cigna is unable to reach an agreement with Mission Hospital, alternate plans will be announced. North Carolina associates will have access to a network that includes Mission Hospital as a preferred location.

Save Money at an Ingles Pharmacy

Your prescription drug card is designed to be used only at an Ingles Market Pharmacy unless there are none within a 10 mile radius. This is to support our own pharmacy business and reduce prescription costs. Cards will not work at our grocery competitors' pharmacies.

Health Plan Options for Full-Time Associates and Eligible Part-Time Associates

Plan Features	Standard Plan	High Deductible Health Plan (HDHP)
Plan Summary	Comprehensive plan with higher associate contributions but lower annual deductible and out-of-pocket costs. Copays, including prescription copays, count towards the Annual Out-of-Pocket Maximum.	Comprehensive plan with lower associate contributions but higher annual deductibles, Out-of-Pocket maximums and co-insurance percentage. Full family deductible must be met prior to plan paying benefits. Eligible for Health Savings Account. Copays, including Rx copays, count towards the Annual Out-of-Pocket Maximum. These copays are limited to preventive prescriptions only.
Annual Deductible (All benefits are subject to annual deductible unless otherwise stated)	$800 Per Person In-Network $1,600 Per Person Out-of Network	In-Network $2,000 Single/$4,000 Family Out-of-Network $4,000 Single/$8,000 Family
Annual Out-of-Pocket Maximum (includes deductible)	In-Network $7,350 Single/$14,700 Family Out-of-Network $15,000 Single/Unlimited Family	In-Network $6,650 Single/$13,300 Family Out-of-Network $13,300 Single/$26,600 Family
Calendar Year Maximum Benefit	Unlimited	Unlimited
Covered Services	**Plan Pays**	**Plan Pays**
Preventive Care (Includes periodic health exam, well child care office visit, immunizations, routine lab and x-rays, routine prostate test, routine pap test, routine mammograms, etc.)	$100% of eligible expenses In-Network 60% after deductible Out-of-Network	100% of eligible expenses In-Network 50% after deductible up to a $250 annual maximum benefit Out-of-Network
Primary Care Office Visits (Office charge only, labs and x-rays are not included with copay)	100% after $25 copay In-Network 60% after deductible Out-of-Network	70% after deductible In-Network 50% after deductible Out-of-Network
Specialist Office Visits	80% after deductible In-Network 60% after deductible Out-of-Network	70% after deductible In-Network 50% after deductible Out-of-Network
Chiropractic Services	50% after deductible	50% after deductible
Outpatient Surgery (Includes surgery facility, diagnostic laboratory, x-rays and physician services)	80% after deductible In-Network 60% after deductible Out-of-Network	70% after deductible In-Network 50% after deductible Out-of-Network
Inpatient Hospital Services (Includes room/board, physician, diagnostic laboratory, x-rays, and inpatient surgery)	80% after deductible In-Network 60% after deductible Out-of-Network	70% after deductible In-Network 50% after deductible Out-of-Network
Hospital Emergency Services (Emergency room plus a $200 penalty charge for non-emergency use)	80% after deductible In-Network, Non-emergency penalty applies 80% after deductible Out-of-Network, limited to usual, customary and reasonable fees Non-emergency penalty applies	70% after deductible In-Network, Non-emergency penalty applies 70% after deductible Out-of-Network, limited to usual, customary and reasonable fees Non-emergency penalty applies

This medical plan summary is a partial description of the Plan and does not detail all benefits, limitations and exclusions.
For a detailed summary of plan features, contact the Human Resources Department for a Summary Plan Description.

Health Plan Options for Full-Time Associates and Eligible Part-Time Associates (continued)

Plan Features	Standard Plan	High Deductible Health Plan (HDHP)
Covered Services	**Plan Pays**	**Plan Pays**
Prescription Drugs Standard Plan only: 30 day supply, max of $300 per Rx except for specialty drugs which have a $500 max Rx copays represent the member responsibility	Generic: The greater of $20 or 20%	Generic: 70% after deductible, some drugs at copay of the greater of $20 or 20%
	Preferred Brand: The greater of $40 or 40%	Preferred Brand: 70% after deductible; some drugs at copay of greater of $40 or 40%
	Non-Preferred: The greater of $60 or 50%	Non-Preferred: 70% after deductible, some drugs at copay of greater of $60 or 50%
	Specialty: Copay of 50% with $500 maximum per 30 day supply	Specialty: 70% after deductible
Vision Care Benefit (Includes eye exam, lenses and frames)	100% of eligible expenses, up to $50 per member per year	No coverage
Inpatient Mental Health and Substance Abuse Care	80% after deductible In-Network 60% after deductible Out-of-Network	70% after deductible In-Network 50% after deductible Out-of-Network
Outpatient Mental Health and Substance Abuse Care	100% after $25 copay In-Network 60% after deductible Out-of-Network	70% after deductible In-Network 50% after deductible Out-of-Network

This medical plan summary is a partial description of the Plan and does not detail all benefits, limitations and exclusions.
For a detailed summary of plan features, contact the Human Resources Department for a Summary Plan Description.

Limited Reimbursement Plan Options for Full-Time and Part-Time Associates

The Limited Reimbursement Plans (LRP) provide a basic level of coverage for a very low weekly contribution. Review the medical plan summaries carefully before making a decision to ensure that your and your family's needs are met. These plans are pay-upfront reimbursement plans only and are not classified as major medical. These plans are not eligible for the Healthy Track incentives. You do not need to complete a Clinical Data Sheet (CDS), or a Nicotine Attestation Form if you choose one of the Limited Reimbursement Plans.

Limited Reimbursement Plan Level 1	Claim Type	Plan Reimbursement to You
Illness	**Physician Office Visits** (Includes primary care, specialty care, or urgent care)	**$50 per day** (Up to 5 days per person per year)
	Outpatient Diagnostic, X-Ray and Lab	**$50 per day** (Up to 3 x-ray/labs per person per year)
	Outpatient Hospital/Hospital Emergency Room Medical Expense Benefit	**$100 per day** (Up to 5 outpatient days per person per year)
	Inpatient Hospital (Includes hospital facility fees and any ancillary or related provider fees)	**$200 per day** (Maximum of 60 days per calendar year)
Injury	**Accidental Medical Benefit**	**Covered as any other illness based upon the schedule above**
Prescriptions	**Prescription Discount**	**Discounts on brand name and generic drugs**
	Prescription Benefit	**Not applicable — discount card only**

Limited Reimbursement Plan Level 2	Claim Type	Plan Reimbursement to You
Illness	**Physician Office Visits** (Includes primary care, specialty care, or urgent care)	**$75 per day** (Up to 5 days per person per year)
	Outpatient Diagnostic, X-Ray and Lab	**$75 per day** (Up to 3 x-ray/labs per person per year)
	Outpatient Hospital/Hospital Emergency Room Medical Expense Benefit	**$250 per day** (Up to 5 outpatient days per person per year)
	Inpatient Hospital (Includes hospital facility fees and any ancillary or related provider fees)	**$500 per day** (Maximum of 60 days per calendar year)
Injury	**Accidental Medical Benefit**	**Covered as any other illness based upon the schedule above**
Prescriptions	**Prescription Discount**	**Discounts on brand name and generic drugs**
	Prescription Benefit	**Not applicable — discount card only**

This medical plan summary is a partial description of the Plan and does not detail all benefits, limitations and exclusions. For a detailed summary of plan features, contact the Human Resources Department for a Summary Plan Description.

Take the Healthy Track — Reduce Your Premiums

One of the most effective ways to control health care costs and promote healthy living is through prevention and wellness. All associates who enroll in the Standard or HDHP Plan and their enrolled spouses have the opportunity to take advantage of a free, confidential Health Coaching service from Maestro Health. Participation in the program and corresponding improvements in your health could net you hundreds in savings on your Health Plan premiums each year. **Here is how it works:**

The Healthy Track Program

If you wish to sign up for the Healthy Track programs, complete the steps in the box below. Maestro Health Coaches will work with you to create a plan to improve your health with a primary focus on the following conditions, which impact your overall health:

- High Cholesterol
- Pre-Pregnancy Program
- Hypertension (High Blood Pressure)
- Nicotine Cessation
- Weight Management Program
- Diabetes
- Asthma
- Healthy Babies Program
- Fitness Program
- Stay Healthy Program

How to Enroll and Save Money with Healthy Track

To enroll in the program and start earning your way to savings take the following steps:

1. Call Maestro Health at 1-800-817-2259.
2. Have your doctor complete a Clinical Data Sheet and submit it to Maestro Health and Wellness. Forms can be faxed to 1-704-321-3162 or emailed to healthytrack@maestrohealth.com.
3. It will take 3-4 weeks to receive your results letter in the mail. When you receive it, follow your Coach's instructions to enroll in Healthy Track.
4. Your Coach will help you determine the best Healthy Track program(s) to improve your targeted condition(s). When you meet certain criteria, you will earn a medical premium discount.

Healthy Track is only available if you have signed up for the Standard or High Deductible Health Plans.

Special Note to Associates Ready to Quit Nicotine

There is an added incentive to those who enroll in the Healthy Track Nicotine Cessation program. In addition to the free Coach and premium incentives, you will receive 100% reimbursement for over-the-counter nicotine cessation products and prescription cessation drugs.

Your Cost for Health Coverage

Associate contributions for coverage under the Standard Plan and the HDHP will be deducted from your paycheck on a pre-tax basis.

Associate Weekly Standard Plan and HDHP Contributions (Effective 1/1/2020)

Coverage Level	Standard Plan				High Deductible Health Plan (HDHP)			
	Healthy Track		Regular		Healthy Track		Regular	
	Non-Nicotine	Nicotine	Non-Nicotine	Nicotine	Non-Nicotine	Nicotine	Non-Nicotine	Nicotine
Associate Only	$38.75	$58.75	$58.75	$78.75	$25.55	$45.55	$45.55	$65.55
Associate + Child(ren)	$88.84	$108.84	$108.84	$128.84	$61.16	$81.16	$81.16	$101.16
Associate + Spouse	$103.44	$123.44 / $143.44**	$143.44 / $163.44**	$163.44 / $183.44**	$70.33	$90.33 / $110.33**	$110.33 / $130.33**	$130.33 / $150.33**
Associate + Family	$123.86	$143.86 / $163.86**	$163.86 / $183.86**	$183.86 / $203.86**	$82.15	$102.15 / $122.15**	$122.15 / $142.15**	$142.15 / $162.15**

**Discount for Healthy Track is $20 employee and spouse. Surcharge for nicotine use is $20 per employee and spouse. If you do not meet the requirements for Healthy Track or use nicotine products, contact 800-817-2259 to learn more about the Alternative Minimum Standards program.

Your Cost for Health Coverage (continued)

Associate Weekly Limited Reimbursement Plan Contributions (Effective 1/1/2020)
Please note: Healthy Track requirements and rate reductions do not apply to these plans.

Coverage Level	Limited Reimbursement Plan Level 1	Limited Reimbursement Plan Level 2
Associate Only	$10.93	$20.08
Associate + Child(ren)	$25.64	$47.09
Associate + Spouse	$26.88	$49.57
Associate + Family	$40.63	$75.14

HEALTH SAVINGS ACCOUNT

ONLY participants who choose the High Deductible Health Plan (HDHP) will be eligible for the Health Savings Account (HSA).

What is a Health Savings Account (HSA)?

A health savings account can only be used with a High Deductible Health Care Plan. Money saved in this account can be used to pay for qualified medical, dental and vision expenses not typically covered by the plan, like deductibles, copays, coinsurance and more. HSAs have triple tax protection. The money goes into the account tax free. It can be invested and grow tax free. And, when you use it for your health care expenses, it comes out tax free. There is no use-it-or-lose it provision on this account. Money in the account can be rolled over from year to year if it is not used. You also have access to the funds at any time, even if you leave Ingles Markets or retire as long as it is for qualified health care expenses. Future use of the account even applies to health care premiums such as Medicare or long-term care insurance. The account is totally portable.

Contributions

In 2020, you can contribute pre-tax up to $3,550 for single enrollments and $7,100 for family plans. If you are older than age 55, you may also invest an additional $1,000 as a catch-up contribution. Ingles will match your account contribution $1 for $1 up to $250 each year. The annual limit includes both your contribution and the Ingles Markets matching contributions. Your contributions may be made through payroll deduction, or you can also contribute a lump sum tax-deductible deposit on your own. The amount you contribute can change throughout the year so you are allowed to increase or decrease that amount.

Ingles Markets makes a $1 for $1 match on payroll contributions to your health savings account up to $250 each year.

Rules about HSAs

To be eligible for the HSA, the following criteria must be met:

- Enrollees must be enrolled in the High Deductible Health Plan (HDHP)
- Enrollees must not be enrolled in Medicare
- Enrollees must not be enrolled in any other health coverage that's not a High Deductible Health Plan (HDHP)
- Enrollees and spouses must not be enrolled in a Flexible Spending Account (FSA) for health expenses. You may still have a dependent care flexible spending account and contribute to an HSA however.
- Enrollees cannot be claimed as a dependent on someone else's tax return, other than as a spouse.

FLEXIBLE SPENDING ACCOUNTS

Ingles Markets provides you the opportunity to budget your out-of-pocket health and dependent care expenses through pre-tax saving in a flexible spending account (FSA). Pre-tax contributions to the account can save you from 20-40% in payroll taxes. This account is administered by Maestro Health.

Know the Rules

Your FSA can only be elected if you are a new hire or during the benefit open enrollment period unless you experience a qualified life status change. Any money saved in the accounts must be claimed by the reimbursement deadlines or it will be forfeited.

You may elect a Dependent Care FSA regardless of your medical coverage.

Claims Deadlines

Claims must be incurred between January 1, 2020 and December 31, 2020. You may file claims at any time during the year however, you have only until March 31, 2021 to make a claim. The Carryover provision allows up to $500 of unused FSA funds to roll over and be used during the following plan year; as long as you sign up for the FSA Plan the following year.

Using an FSA Debit Card

Once enrolled, you will receive a debit card, which may be used to make purchases at qualified retailers for qualified expenses. Even if you use the debit card to make purchases you may still need to submit the receipts through the claims process. Keep in mind however, you may not use your debit card to be reimbursed for prescribed over-the-counter medications and products. For over-the-counter items, you must submit claims for health care reimbursement manually by submitting a paper form to Maestro Health. Forms MUST be submitted with your health provider's prescription and cash register receipts.

Access Your Flexible Spending Accounts from Anywhere with mSAVE

Online

Go to: **msave.maestrohealth.com**
Registration ID: Select **"Card Number"** and enter the 16 digit number on your Maestro Health Debit Card

mSAVE Mobile App

Search **"Maestro Health mSAVE"** in the Apple or Android App stores

Using Your Accounts is Easier than Ever Before

- Submit claims and track reimbursements
- Attach receipts and documents to your transactions
- Check your balance

FLEXIBLE SPENDING ACCOUNT

The chart below provides examples of eligible expenses for the flexible spending account plans and is not comprehensive.

Plan Features	Health Care Flexible Spending Account	Dependent Care Flexible Spending Account
Contribution Limit	**$2,700**	**$5,000**
Eligible Expenses	Health-related expenses, products and services such as: • Deductibles, coinsurance and copays • Contact lenses and eyeglasses • Dental services and braces • Hearing aids • Over-the-counter drugs and supplies such as allergy medications, asthma medications, pain relievers, bandages and first-aid kits when accompanied by a doctor's order	Dependent care related expenses as follows: • Licensed nursery programs and daycare centers for children • Licensed day care centers for disabled dependents • Costs for family and adult day care facilities • Dependent care provided by other individuals outside or inside your home (excluding your tax dependents and your children younger than age 19)
Claims Deadlines and Guidelines (unclaimed funds will be forfeited)	Qualifying health-related expenses must be: • **Incurred between January 1, 2020 and December 31, 2020** • Incurred by you or by anyone you claim as a dependent on your tax return • Medically necessary • Not reimbursable under any other plan • Tax deductible under IRS rules • Not related to cosmetic procedures	Qualifying dependent care expenses must be: • **Incurred between January 1, 2020 and December 31, 2020** • Incurred by you • Necessary so you can work • If you are married — necessary so your spouse can work or attend school full-time or necessary to care for your mentally or physically disabled spouse
When Funds Can Be Used	You do not need to have the money already "saved" in your account to be reimbursed but you may not use more than your contribution limit for the year. Balances up to $500 may be rolled over to the next year, as long as you sign up for the flex plan the following year. Any additional funds will be forfeited.	Money must be already "saved" in your account before you can be reimbursed for dependent care expenses. Any unused funds will be forfeited.

DENTAL BENEFITS

Since proper dental care improves overall health, Ingles Markets provides you with dental care coverage through Maestro Health. This coverage provides two free cleanings per year and a percentage benefit for basic and major services with a $25 deductible amount.

Examples of basic services covered at 80% include extractions and fillings. Examples of major services covered at 50% include crowns, bridgework and dentures. Orthodontia services are covered at 50% up to $1,000 lifetime maximum for dependent children up to age 19 only. Maximum calendar year benefit for dental services is $1,000 per covered person.

Your Cost for Dental Coverage

Level of Coverage	Weekly (Effective 1/1/2020)
Associate Only	**$2.50**
Associate + Child(ren)	**$4.65**
Associate + Spouse	**$4.95**
Associate + Family	**$7.45**

IMPORTANT NOTE:
Please note, there are benefit limitations for late enrollees. A Late Enrollee is anyone who did not enroll in the Dental Plan when it was first available to them and/or through special enrollment. During the first 12 months of coverage, benefits for Late Enrollees will be limited. Class III Major Repair and Restorative Services will not be covered and Class IV Orthodontia Services will not be covered in those first 12 months of coverage.

VISION BENEFITS

Get access to the best in eye care and eye wear with Ingles Markets and VSP. This is a voluntary benefit with a choice of two affordable plans, so you may choose the right plan for your needs. If you choose to elect Vision coverage, you will have a small contribution enabling you access to great doctors (both in- and out-of-network) and quality eyewear at an affordable cost.

Using Your VSP Benefits is Easy

Get started by creating an account at vsp.com. Choose a provider — in-network, through a participating retail chain or out-of-network. At your first appointment, tell them you have VSP. No ID card is needed, but if you would like one as a reference, it can be printed at vsp.com.

Your Weekly Cost for Vision Coverage

Level of Coverage — VSP Choice Provider Network	Base Plan	Buy Up Plan
Associate Only	**$1.07**	**$1.90**
Associate + Child(ren)	**$2.28**	**$4.08**
Associate + Spouse	**$2.13**	**$3.80**
Associate + Family	**$3.64**	**$6.50**

Your VSP Vision Benefits Summary

Base Plan — **VSP Provider Network: VSP Choice**

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every plan year	$10
Prescription Glasses		$20
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • Every other plan year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every plan year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20–25% on other lens enhancements • Every plan year	$55 $95–$105 $150–$175
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every plan year	Up to $60
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$20

Buy Up Plan

VSP Provider Network: VSP Choice

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every plan year	$10
Prescription Glasses		$20
Frame	• $180 allowance for a wide selection of frames • $200 allowance for featured frame brands • 20% savings on the amount over your allowance • Every other plan year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for adults and children • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Anti-reflective lenses • Average savings of 20–25% on other lens enhancements • Every plan year	$0 $0 $0 $0
Contacts (instead of glasses)	• $160 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every plan year	Up to $60
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$20

Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

Your Coverage with Out-of-Network Providers	Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit vsp.com for plan details.		
	Exam: Up to $45 Frame: Up to $70 Single vision lenses: Up to $30	Lined bifocal lenses: Up to $50 Lined trifocal lenses: Up to $65	Progressive lenses: Up to $50 Contacts: Up to $105

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

©2018 Vision Service Plan. All rights reserved. VSP, VSP Vision care for life, eyeconic.com and WellVision Exam are registered trademarks, and "Life is better in focus." is a trademark of Vision Service Plan. Flexon is a registered trademark of Marchon Eyewear, Inc. All other company names and brands are trademarks or registered trademarks of their respective owners.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

As an important part of your personal financial planning, Ingles Markets provides all full-time associates with Basic Life and Accidental Death and Dismemberment (AD&D) Insurance through The Hartford to protect your family in the event of your death or if you experience a catastrophic injury. In addition to the basic company-paid coverage, if eligible, you may elect to participate in the Voluntary Term and Voluntary Universal Life for yourself, your spouse and your children. Participation in the additional coverage is voluntary, and may be subject to evidence of insurability. Associates pay 100% of the premium for Voluntary Term and Universal Life coverage.

Company-Paid Basic Term Life and AD&D Insurance

Coverage Amount Paid to Your Beneficiary	**1 x your annual earnings up to a maximum of $150,000**

Voluntary Term Life Insurance (Full-Time Associates Only)

You have the opportunity to purchase additional life insurance coverage for yourself, your spouse* and your children. Consider costs such as funeral expenses, legal expenses, and general living expenses for your surviving family members when determining an appropriate amount of additional coverage.

If you do not purchase supplemental life insurance when first eligible or request an amount exceeding the guaranteed issue limits, you will be required to complete an Evidence of Insurability form.

***Please Note** — Ingles full-time associates cannot elect supplemental term life insurance coverage for spouse, if their spouse is also an Ingles full-time associate.

Amounts Available

Associate
1, 2, or 3x annual earnings up to $300,000

Spouse
$10,000 or $25,000

Children
$2,000 or $5,000

Voluntary Life Benefits

Plan	Associate	Spouse	Dependent Child
Voluntary Term Life	1, 2, or 3x annual earnings up to $300,000	$10,000 or $25,000	$2,000 or $5,000

Voluntary Universal Life Insurance

Allstate Benefits coverage provides a lump-sum cash benefit upon death. You have the freedom to choose the amount of coverage you need. The benefit is portable, meaning if you leave Ingles Markets, you can continue the coverage by paying the monthly cost directly to Allstate Benefits. Universal life coverage helps offer peace of mind during life's changing events and can also help provide financial security as you age and your needs change.

DISABILITY INCOME PROTECTION BENEFIT

Ingles Markets provides you with the option to purchase Short-Term and Long-Term Disability benefits to provide you and your family with financial protection in the event of an illness or injury. See below for the cost of coverage (if any), the coverage provider and when you may enroll.

Protect Your Paycheck When You Can't Work

This benefit provides for continuance of your income should you be unable to work due to an illness or personal injury causing a disability. The voluntary STD Plan covers absences related to:

- Illnesses that last several weeks
- Recovery after surgery or accidents outside the workplace
- Pregnancy

Short-Term Disability (STD)

Short-Term Disability benefits pay the amount you choose, not to exceed 60% of your average weekly compensation. Average Weekly Compensation is determined by dividing your total wages over the thirteen week period immediately prior to your illness or injury by thirteen. Eligibility for each plan varies based on when you enroll. Costs also vary based on the option you choose.

Ingles Markets Short-Term Disability Plan Coverage Options and Weekly Contributions

Enrollment in the Ingles Markets Short-Term Disability Plan may only be completed when you first become eligible for the plan. Some employee groups are eligible for company-paid coverage. Please see the chart below for additional information.

	STD Benefit Begins	Coverage Duration	Benefit Amount	Weekly Cost
Option 1	On the 15th continuous day of disability	Up to 24 weeks	60% of Average Weekly Compensation	$0.88 per $100 of payroll*
Option 2	On the 31st continuous day of disability	Up to 22 weeks	60% of Average Weekly Compensation	$0.55 per $100 of payroll

*Ingles Markets pays the full cost of the STD premium for regular full-time salaried associates, eligible hourly managers and full-time pharmacists.

Allstate Benefits Voluntary Short-Term Disability Plan Benefits Coverage Options and Weekly Contributions

You are eligible to enroll in the Allstate Benefits Voluntary Short-Term Disability plan only if you are not currently enrolled in the Ingles Short-term Disability plan. Enrollment in this plan may take place only during the enrollment period if you have not previously enrolled in the Ingles Markets Short-Term Disability Plan.

	STD Benefit Begins	Coverage Duration	Benefit Amount
Option 1	On the 15th continuous day of disability	Up to 24 months	60% of monthly earnings, up to $4,500 per month
Option 2	On the 31st continuous day of disability	Up to 24 months	60% of monthly earnings, up to $4,500 per month

Long-Term Disability (LTD)

The following full-time associate classes are eligible for company-paid LTD coverage:

- Regular full-time salaried associates, eligible hourly managers, and full-time pharmacists

Voluntary Long-Term Disability Benefits

Long-Term Disability provides for continuance of a portion of your income should your Short-Term Disability extend beyond the allotted period and you are still unable to work. You are eligible to enroll in the Allstate Benefits Long-Term Disability Plan if you are currently enrolled in the Ingles Markets Short-Term Disability Plan. Long-Term Disability benefits, if approved, typically begin once your Short-Term Disability benefits are exhausted and extend up to 2 years if you cannot perform the material duties of your occupation because of that illness, injury or disabling pregnancy-related condition. The benefit will be equal to the lesser of 60% of your pre-disability wages up to a maximum benefit of $6,000 per month. You may purchase the coverage in $100 increments, with a minimum benefit of $400.

CRITICAL ILLNESS COVERAGE

Ingles Markets provides all full-time associates and eligible part-time associates with the opportunity to purchase Critical Illness coverage that can protect your assets and assist with a variety of expenses in the event of a heart attack, cancer and other serious diagnosis. The Critical Illness coverage is provided through Allstate Benefits. Lump-sum benefits are paid directly to you, allowing you to cover daily out-of-pocket expenses such as your mortgage, doctor visits and prescriptions. The cost of coverages is paid 100% by you at a significantly discounted group rate. As part of the Critical Illness coverage, you may receive an annual wellness benefit of $50 when you have a preventive health screening performed. You must be 18 years or older and actively working to enroll in this benefit.

OFF-THE-JOB ACCIDENT COVERAGE
(For Part-Time Associates Not Enrolled in Ingles Medical Coverage)

Group voluntary accident coverage from Allstate Benefits pays cash benefits for expenses associated with off-the-job injuries. Accident coverage helps offer peace of mind when an accidental injury occurs, and can help pick up where any other insurance leaves off and provide cash to help cover expenses. This coverage also includes an Outpatient Physician's Benefit, which will pay you $25 up to twice a year for any physician's visit, whether accident related or not.

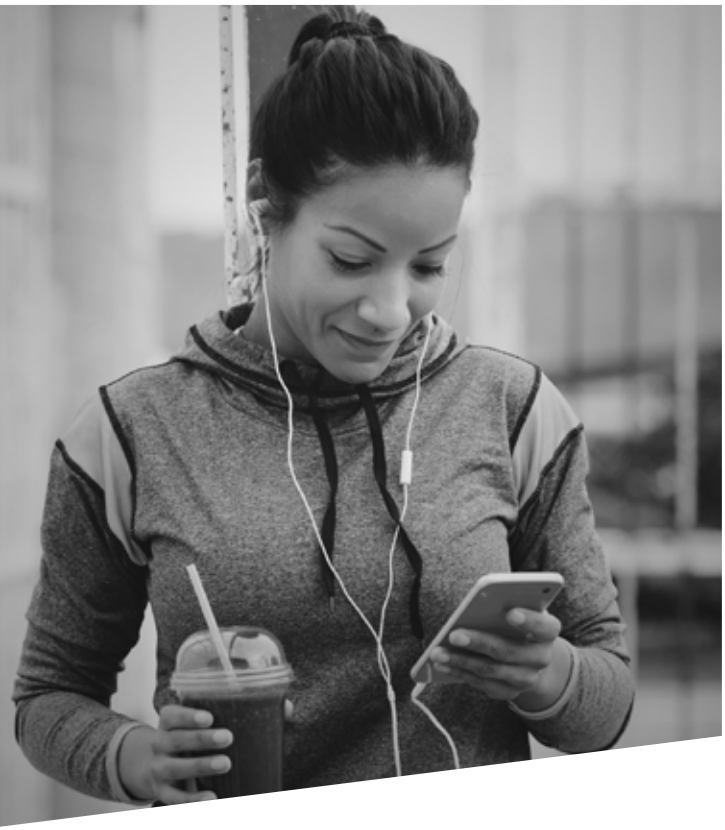
HOW TO GET HELP WITH YOUR BENEFITS

Contacts

For help with your benefits, please call the Ingles Markets Benefits Enrollment Center at 1-866-840-9610 between 8am and 6pm EST Monday through Friday. Call the vendor directly for help with an issue or claim.
Please refer to the chart below:

Benefit/Carrier	Telephone	Internet/Email/Fax
Medical Plan Claims Questions Maestro Health	1-800-821-4398	http://mybenefits.maestrohealth.com/ email: info@maestrohealth.com
Medical Plan PPO Network Cigna	1-800-821-4398	www.cigna.com
Prescription Drugs Southern Scripts	1-833-439-9616	www.southernscripts.net
Dental Maestro Health	1-800-821-4398	http://mybenefits.maestrohealth.com/ email: info@maestrohealth.com
Vision VSP Choice Network	1-800-877-7195	www.vsp.com
Flexible Spending Accounts Maestro Health	1-888-488-5054	https://msave.maestrohealth.com/ email: questions@maestrohealth.com
Health Savings Account HSA Bank	1-800-357-6246	www.hsabank.com
Life & AD&D Insurance The Hartford	1-888-563-1124 or 1-888-755-1503	https://abilityadvantage.thehartford.com/
Ingles Markets STD Maestro Health	1-800-821-4398	http://mybenefits.maestrohealth.com/
Ingles Markets LTD The Hartford	1-888-301-5615	https://abilityadvantage.thehartford.com/
Hartford Evidence of Insurability (EOI) Status The Hartford	1-800-331-7234	https://abilityadvantage.thehartford.com/
Voluntary Short and Long-term Disability Benefits Allstate Benefits	1-866-202-2779	www.allstatebenefits.com/mybenefits
Critical Illness Coverage Allstate Benefits	1-866-202-2779	www.allstatebenefits.com/mybenefits
Group Accident Coverage Allstate Benefits	1-866-202-2779	www.allstatebenefits.com/mybenefits
Universal Life Insurance Coverage Allstate Benefits	1-866-202-2779	www.allstatebenefits.com/mybenefits

BENEFITS. ANYTIME. ANYWHERE.



Access all your benefits information anytime, anywhere with your new online benefits portal—available via desktop or mobile app.

Your online benefits portal offers you flexibility and easy access to everything you need:

- **An interactive dashboard** — Your benefits at-a-glance
- **Medical expenses summary** — Your plan discount, payments, responsibilities and more
- **Total out-of-pocket expenses summary** — Progress towards your in-and out-of-network deductibles
- **Eligibility** — The plans you're enrolled in are highlighted
- **Claims summary** — Details of your five most recent claims
- **Claims History** — Your past submitted claims
- **HIPAA-Compliant Messaging** — Easy and fast way to contact us

Download our mobile app.
Visit the Apple App Store or Google Play Store to download **mBENEFITS (Maestro Health).**

Visit our web portal.
Visit **mybenefits.maestrohealth.com** to access your benefits online.

maestro health™ | The ingles ADVANTAGE™

© Maestro Health 2018 p50703.1

IMPORTANT INFORMATION ABOUT YOUR HEALTH CARE RIGHTS

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, 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, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't 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, contact the Department of Labor at www.askebsa.dol.gov or call 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, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: www.myalhipp.com/

Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: http://myakhipp.com/

Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/

Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/

Health First Colorado Member Contact Center: 1-800-221-3943, State Relay 711

CHP+ Customer Service: 1-800-359-1991, State Relay 711

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/hipp/

Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

Healthy Indiana Plan for Low-income Adults 19–64

Website: http://www.in.gov/fssa/hip/

Phone: 1-877-438-4479

- All other Medicaid

Website: http://www.indianamedicaid.com

Phone: 1-800-403-0864

IOWA – Medicaid

Website: http://dhs.iowa.gov/Hawki

Phone: 1-800-257-8563

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/

Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website:
http://chfs.ky.gov

Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website:
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331

Phone: 1-888-695-2447

MAINE – Medicaid

Website:
http://www.maine.gov/dhhs/ofi/public-assistance/index.html

Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/

Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Telephone: 1-800-694-3084

NEBRASKA – Medicaid

Website:
http://www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website:
http://www.dhhs.nh.gov/oii/hipp.htm

Phone: 603-271-5218

Toll free number for the HIPP Program:1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

Medicaid Phone:1-609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website:
http://www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON – Medicaid

Website:
http://healthcare.oregon.gov/Pages/index.aspx

http://www.oregonhealthcare.gov/index-es.html

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/

Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov

Phone: 1-888-828-0059

TEXAS – Medicaid

Website:
https://www.gethipptexas.com/

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website:
http://medicaid.utah.gov/

CHIP Website:
http://health.utah.gov/chip

Phone: 1-877-543-7669

VERMONT– Medicaid

Website:
http://www.greenmountaincare.org
Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: http://www.hca.wa.gov/
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/
Phone: 1-855-MyWVHIPP
(1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid

Website:
https://wyequalitycare.acs-inc.com/
Telephone: 1-307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the plan, provided that you request enrollment within 30 days after your other coverage ends (COBRA or state continuation coverage ends, divorce, legal separation, death, termination of employment or reduction in hours worked; or because the employer contributions cease).

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 dependent lose coverage under a Medicaid Plan or Children's Health Insurance Program (CHIP), or become eligible for group health plan premium assistance under a Medicaid Plan or under the CHIP, you may request enrollment within 60 days after coverage under the Medicaid or CHIP ends or within 60 days after you or your dependent is determined to be eligible for state premium assistance under CHIP.

Women's Health & Cancer Rights Act

On October 21, 1998 Congress passed a bill called the Women's Health and Cancer Rights Act. The new law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Physical complications during all stages of mastectomy, including lymph edemas

In addition, the plan may not:

- interfere with a woman's rights under the plan to avoid these requirements, or
- offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and copays consistent with other coverage provided by the plan.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans offering group health coverage generally may not:

- Restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.
- Set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
- Require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain pre-certification for any days of confinement that exceeds 48 hours (or 96 hours). For information on pre-certification, please refer to the Benefit Summaries.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) privacy rules require that health plans distribute a notice to participants of their privacy rights. This notice was provided to you upon enrollment in the plan. You may also request a hard copy of the notice by contacting the Human Resources Department at 800-635-5066.

Notice of Participant Election in the Section 125 Plan

In order to minimize the impact of your insurance deduction from your paycheck, the deduction for your medical coverage, dental coverage, vision coverage, Flexible Spending Account (FSA) and Health Savings Account (HSA) will be made on a pre-tax basis. This means that your insurance will be taken out of your check before taxes are figured. The result will be less taken out of your pay. Your income as reported on your year-end W-2 Form will be reduced by the amount of your insurance contribution. You will pay less tax. This feature in our program is permitted under Section 125 of the Internal Revenue Code and is better known as a "Cafeteria Plan." Any short term disability, dependent life insurance or any other voluntary benefit premium will be deducted on a post tax basis from your paycheck. This deduction will reduce your salary by an amount equal to your share of the cost of the insurance and this money will automatically be deducted from your payroll check. After electing coverage, your salary reduction cannot be changed until the Annual Open Enrollment period, UNLESS YOU HAVE A CHANGE IN YOUR FAMILY STATUS (which includes marriage or divorce, birth or adoption of a child, death of a spouse, death of a child, or a change of your spouse's employment status.) Beginning January 1, 2020, our Plan Year begins January 1st and ends December 31st.

Ingles Markets, Inc. Employee Benefits Plan — Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the privacy practices of the Ingles Markets, Incorporated Employee Benefits Plan, referred to in this Notice as the "Health Plan," as well as the privacy practices of all employees, staff, and personnel of the Health Plan.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of payment for services you receive that are paid from the Health Plan. We need this record to provide payment and to comply with certain legal requirements. This notice applies to all of the records generated by the Health Plan. This Notice explains the ways in which we may use and disclose medical information about you. The Notice also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

Federal law requires us to:

- ensure that medical information that identifies you is kept private;
- give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the Notice that are currently in effect.

How We May Use and Disclose Your Medical Information

Health-Related Benefits and Services. The Health Plan may use your medical information to tell you about other health-related benefits or services.

For Payment. We may use and disclose medical information to determine payment for your care, to coordinate coverage with other payors, and to determine the adjudication of claims appeals.

For Health Care Operations. We may use and disclose medical information about you for Health Plan operations. These uses and disclosures are necessary to operate the Health Plan and make sure that you receive quality service. For example, we may use your medical information for quality assessment, fraud auditing, business management, underwriting, and administrative activities.

A. With Your Authorization

We may use or disclose your medical information for purposes other than treatment, payment, or health care operations only if: 1) you sign an Authorization form, or 2) there are special circumstances as described below in section B. You may revoke your written Authorization at any time, except to the extent that the Health Plan has already relied on the Authorization. If you decide to revoke your written Authorization, you should complete an Authorization Revocation Form and submit it to the Health Plan. Your revocation will become effective upon its receipt by us.

B. Special Circumstances — Without Your Authorization

There are special circumstances when we are permitted to use or disclose your medical information without your Authorization. The following explains what these special circumstances are.

Individuals Involved in Your Care or Payment for Care. We may release medical information about you to a friend or family member who is involved in your medical care. If you are present or coherent, we can disclose your medical information to family and friends when you agree or do not object or we can reasonably infer that you agree. If you are not present or you are incapacitated, we can disclose certain medical information to family and friends when we determine that the disclosure would be in your best interests.

Threat to Health or Safety. We may use or disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Public Health Activities. We may disclose medical information about you for public health activities to federal and state authorities. These activities generally include the following:

- Disclosures to public health authorities to prevent or control disease, injury, or disability;
- Disclosures to report reactions to medications or problems with products to the U.S. Food and Drug Administration
- Disclosures to notify individuals of recalls of products they may be using;
- Disclosures to individuals who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- Disclosures as permitted under law if we reasonably believe that you are a victim of abuse, neglect, or domestic violence.

Health Oversight Activities. We may disclose your medical information to a government agency as required by law for activities such as audits, investigations, inspections, and licensure.

Lawsuits. If you are involved in a lawsuit or dispute, we may disclose your medical information in response to a court or administrative order. We may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release your medical information if asked to do so by a law enforcement official.

Coroners, Medical Examiners, and Funeral Directors. We may release your medical information to a coroner, medical examiner, or funeral director. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Specialized Government Functions. We may release your medical information to authorized units of the government with special functions, such as the U.S. military, the U.S. Department of State, or the U.S. Secret Service.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

As Required By Law. We will disclose medical information about you when required to do so by applicable federal, state, or local law.

Your Rights Regarding Your Medical Information

You have the following rights regarding your medical information that we maintain:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you should request a Participant Request to Access Protected Health Information (a "Request for Access"), complete the request and submit it to the Health Plan. Specific requirements for access to your medical information are described in the Request for Access.

Right to Amend. If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend your medical information. If you want to amend your information, you must obtain a Participant Request to Amend Protected Health Information (an "Amendment Form"), complete the form, and submit it to the Health Plan. Specific requirements for amending your medical information are described in the Amendment Form.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your medical information. To request this accounting of disclosures, you should request a Participant request for Accounting of Disclosures (an "Accounting Form"), complete the form, and submit it to the Health Plan. Specific requirements for an accounting of disclosures are described in the Accounting Form.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. To request restrictions, you should request a Participant Request for Restrictions on Uses and Disclosure of PHI (a "Restrictions Form"), complete the form, and submit it to the Health Plan. Specific information about the right to request restrictions is included in the Restrictions Form.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Health Plan on a Participant Request for Confidential Communications ("Confidential Communications"). Specific information about the right to request restrictions is included in the Confidential Communications Form. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the Health Plan.

Changes to This Notice

We reserve the right to change this Notice, and to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future, as of the effective date of the revised Notice. We will post a copy of the current Notice on our Internet site.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Health Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with us, submit your complaint in writing to:

Ingles Markets, Incorporated
Attn: Health Plan, Privacy Officer
2913 US Highway 70 West
Black Mountain, NC 28711
Telephone: 1-800-635-5066
Fax: 1-828-669-3531

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses Of Medical Information
Other uses and disclosures of medical information not covered by this Notice will be made only with your written authorization.

Further Information
For further information or to obtain any of the forms described above, you may contact:

Ingles Markets, Incorporated
Attn: Health Plan, Privacy Officer
2913 US Highway 70 West
Black Mountain, NC 28711
Telephone: 1-800-635-5066
Fax: 1-828-669-3531

General Notice of COBRA Continuation Coverage Rights

Introduction
You are receiving this notice because you have recently become covered under a group health plan (Ingles Markets, Inc.). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may be eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because of any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."
- Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Ingles Markets, Inc. and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the COBRA Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You must provide this notice to the Human Resources Department. Any notice you provide must be in writing and state the name of the Plan, the name and address of the employee covered under the Plan, and the name(s) and address (es) of the qualified beneficiary (ies). Your notice must also name the qualifying event and the date that it happened. If these procedures are not followed or if notice is not provided in writing to the Plan Administrator during the 60-day notice period, then any spouse or dependent child who loses coverage will not be offered the option to elect continuation of coverage.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

How is COBRA Continuation Coverage Provided? (cont'd)

COBRA continuation coverage is temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified in writing of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Your notice of disability must also include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the Social Security Administration made its determination. Your notice of disability must include a copy of the Social Security Administration's determination. This notice should be sent to: Maestro Health. If these procedures are not followed or if the notice is not provided in writing then there will be no disability extension of COBRA coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, up to a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

This extension due to a second qualifying event is available only if you notify Maestro Health in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan). Your notice of a second qualifying event also must name the event and the date it happened. If the event is a divorce, your notice must also include a copy of the divorce decree.

Health FSA Component

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by reimbursable claims submitted up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA

coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact Maestro Health for more information.

More Information About Individuals Who May Be Qualified Beneficiaries

Children Born to or Placed for Adoption with the Covered Employee During COBRA Coverage Period

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is a qualified beneficiary if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Ingles Markets, Inc. during the covered employee's period of employment with Ingles Markets, Inc. is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Plan Administrator:

Ingles Markets, Inc.
Attn: Benefits Department
2913 US Highway 70 West
Black Mountain, NC. 28711
1-800-635-5066

COBRA Administrator:

Maestro Health
Attention: COBRA Department
P.O. Box 1240
Matthews, NC 28106
1-800-228-1803

Important Notice from Ingles Markets, Inc. About Your Prescription Drug Coverage under the Standard Plan 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 Ingles, Markets, Incorporated and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare 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. Ingles Markets, Incorporated has determined that the prescription drug coverage offered by the Ingles Markets, Incorporated Employee Benefits Plan — Standard Plan 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 October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current Ingles Markets, Incorporated coverage will not be affected. Under the Ingles Markets, Incorporated Employee Benefits Plan — Standard Plan, your prescription benefits are as follows:

Prescription Drug Program Pharmacy Purchase	
Drug Classification	**Copayment Requirement**
Generic Drugs	Greater of a $20 copayment or 20% of the cost of the drug to a maximum of $300 per 30-day supply
Formulary Brand Name Drugs	Greater of a $40 copayment or 40% of the cost of the drug to a maximum of $300 per 30-day supply
Non-Formulary Brand Name Drugs	Greater of a $60 copayment or 50% of the cost of the drug to a maximum of $300 per 30-day supply
Lifestyle Drugs (with prior authorization) • COX II Inhibitors • Antihistamines/Allergy Drugs	Greater of a $60 copayment or 50% of the cost of the drug to a maximum of $300 per 30-day supply
Specialty Drugs	50% of the cost of the drug to a maximum of $500 per 30-day supply

The prescription drug card is designed to be used at an Ingles Pharmacy. The prescription drug card will not work at any non-Ingles pharmacy that is within 10 miles of an Ingles pharmacy. The prescription drug card will also not work at other grocers or retail pharmacies.

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

When Will You Pay a Higher Premium (Late Enrollment Penalty) To Join a Medicare Drug Plan?

If you drop or lose your current coverage with Ingles Markets, Incorporated 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 October to join.

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

Contact Ingles Markets, Incorporated for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Ingles Markets, Incorporated changes. You also may request a copy of this notice at any time.

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:	August 28, 2019
Name of Entity Sender:	Ingles Markets, Incorporated
Contact-Position/Office:	Human Resources Department
Address:	2913 US Highway 70 West, Black Mountain, NC 28711
Phone Number:	1-828-669-2941

Important Notice from Ingles Markets, Inc. About Your Prescription Drug Coverage under the HDHP Plan 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 Ingles Markets, Incorporated 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Ingles Markets, Incorporated has determined that the prescription drug coverage offered by the Ingles Markets, Incorporated Employee Benefits Plan High Deductible Health Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Ingles Markets, Incorporated Employee Benefits Plan High Deductible Health Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Ingles Markets, Incorporated Employee Benefits Plan High Deductible Health Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully — it explains your options.

When Can You Join A Medicare Drug Plan?

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

However, if you decide to drop your current coverage with Ingles Markets, Incorporated, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Ingles Markets, Incorporated Employee Benefits Plan High Deductible Health Plan.

When Will You Pay a Higher Premium (Late Enrollment Penalty) To Join a Medicare Drug Plan?

Since the coverage under the Ingles Markets, Incorporated Employee Benefits Plan High Deductible Health Plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, your current Ingles Markets, Incorporated coverage will not be affected. Under the Ingles Markets, Incorporated Employee Benefits Plan High Deductible Health Plan your prescription benefits are as follows:

Prescription Drug Program Pharmacy Purchase	
Drug Classification	**Payment Level**
Generic Drugs	Reimbursed at 70% of the usual, customary and reasonable cost, after discount, per 30-day supply subject to the deductibles and out-of-pocket expense limits specified in the Schedule of Medical Benefits
Preventive Generic Drugs	100% after copayment (the greater of $20 or 20% of the cost of the drug) to a maximum of $100 per 30-day supply
Formulary Brand Name Drugs	Reimbursed at 70% of the usual, customary and reasonable cost, after discount, per 30-day supply, subject to the deductibles and out-of-pocket expense limits specified in the Schedule of Medical Benefits
Preventive Formulary Brand Name Drugs	Greater of a $40 copayment or 40% of the cost of the drug to a maximum of $100 per 30-day supply
Non-Formulary Brand Name Drugs	Reimbursed at 70% of the usual, customary and reasonable cost, after discount, per 30-day supply, subject to the deductibles and out-of-pocket expense limits specified in the Schedule of Medical Benefits
Preventive Non-Formulary Brand Name Drugs	Greater of a $60 copayment or 50% of the cost of the drug to a maximum of $100 per 30-day supply

The prescription drug card is designed to be used at an Ingles Pharmacy. The prescription drug card will not work at any non-Ingles pharmacy that is within 10 miles of an Ingles pharmacy. The prescription drug card will also not work at other grocers or retail pharmacies.

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

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

Contact Ingles Markets, Incorporated for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Ingles Markets, Incorporated changes. You also may request a copy of this notice at any time.

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).

Date:	August 28, 2019
Name of Entity Sender:	Ingles Markets, Inc.
Contact-Position/Office:	Human Resources
Address:	2913 US Highway 70 West, Black Mountain, NC 28711
Phone Number:	1-828-669-2941

Notice Regarding Wellness Program

Maestro Health and Ingles Markets Healthy Track is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. You will be asked to complete a biometric screening, which will include a blood test for total cholesterol, HDL cholesterol, LDL cholestertol, non-LDL, triglycerides, and blood sugar (glucose). You are not required to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of twenty (20) dollars each week for met wellness goals including body mass index (BMI) or waist circumference, fasting blood sugar, blood pressure, total cholesterol or LDL cholesterol, and Healthy Track participation. Although you are not required to participate in the biometric screening, only employees who do so will receive the incentive.

An additional surcharge of up to twenty (20) dollars each week may be applied for employees that use nicotine products. An additional twenty (20) dollars each week may be applied for spouses that use nicotine products. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive and/or avoid a surcharge, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Maestro Health at 800.817.2259.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as Healthy Track Program Enrollment. You also are encouraged to share your results or concerns with your own healthcare provider.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Ingles Markets, Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, Maestro Health Healthy Track will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the Maestro Health Team in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Melanie Johnson at 828-669-2941 x647 or mjohnson@ingles-markets.com.

The ingles ADVANTAGE™