HELPING YOU NAVIGATE

The Benefits Maze

Benefits 2017

WHAT'S INSIDE

Welcome to Your Benefits in 2017-2018 2
What is New for 2017-2018? 3
Who is Eligible for Coverage? 5
Who Needs to Enroll? 5
How Can I Enroll in Benefits? 6
What Do I Need to Enroll? 6
Qualified Life Event Information 7
Completing Your Mid-Year Status Change Event 7
Medical, Dental, and Vision Plan Rates 8
Spousal Surcharge 8
"Quit Now" Tobacco Cessation Incentive Program 9
Healthcare Incentive Program 9
Managing Your Health 10
Prescription Drug Coverage 11
Real Life Claim Examples 12
Flexible Spending Accounts 13
Group Voluntary Critical Illness 14
Group Voluntary Accident 14
Dental Coverage 15
Vision Coverage 15
Protecting Your Wealth 16
Short Term Disability 16
Long Term Disability 16
Optional Long Term Disability Enhancment 16
Basic Term Life Insurance Coverage for Employees 17
Optional Employee Term Life and AD&D Insurance 17
Optional Spouse and Child(ren) Term Life Insurance 18
Business Travel Accident Insurance 18
Paid Annual Leave (PAL) 19
Purchased PAL 19
Unpaid Leave of Absence 20
Growing Your Wealth 20
Other Programs 20
CIGNA Health and Wellness Discounts 21
Contact Information 21
COBRA Continuation of Coverage 22
Employee Rights and Responsibilities under FMLA 23
Your Rights Under USERRA 24

As part of our ongoing effort to communicate the importance and value of your Benefit Program, the Benefits Department has put together this comprehensive booklet to assist you through the benefit enrollment process for the 2017-2018 plan year.

WELCOME TO YOUR BENEFITS IN 2017-2018

We would like to take a moment to thank you for your work in making The Fresh Market a place where we can make *Everyday Eating Extraordinary*! While we all focus on serving our guests in our stores, we also want to take time out to help you understand your benefit choices for the upcoming plan year. We recognize the importance of providing employees with access to comprehensive health and wellness programs. While the cost of health care continues to rise, we are committed to providing competitive benefit plans that attract and retain the talented people that drive our success.

You'll be pleased to know that for 2017, we will continue to offer three Medical plans with Cigna along with an option for dental and vision plans, and that despite the headlines about the increasing cost of health coverage, the premium you pay for your health plan has seen only minor increases over last year. Additionally, as we look to provide improved benefit offerings, we have elected to partner with CVS Caremark as our pharmacy provider. CVS offers tools and resources that make accessing your prescription benefits easier and more convenient all across the U.S. either at your local CVS or by home delivery.

Aside from the choices you have concerning your health benefits, The Fresh Market also offers a variety of other benefits such as group life insurance, disability insurance, and voluntary benefits such as critical insurance and accident care. By contributing to a flexible spending account or a health savings account, you can save "pre-tax' dollars to help offset the cost of medical care and/or child care throughout the year.

While The Fresh Market is committed to provide you with more choices on how you spend your money for healthcare, you can do your part to help control costs by making good choices when it comes to your health - get your routine preventive care, complete your health assessment along with biometrics, eat right, exercise routinely, quit smoking, and use the tools and resources available. Additionally, if you complete the Wellness program, you will be eligible for incentives from the plan.

Enrollment in benefits deserves your careful consideration. Remember, the choices you make during annual enrollment will be in effect for the plan year from May 1, 2017 to April 30, 2018. You will only be able to make changes during the plan year in the event of an IRS qualified change in status event. There are many resources available to assist you in making your choices, including our call center and online tools. There are no right or wrong decisions, only what works best for you.

Thank you for all your hard work and dedication throughout the year.

Sincerely,

Scott Duggan
SVP, General Counsel and Human Resources

WHAT IS NEW FOR 2017-2018?

We are excited to announce our benefit programs for the 2017-2018 plan year.

1. **Annual Enrollment for the 2017-2018 Plan Year will be a passive enrollment. If you would like your benefits to remain the same, you do not have to do anything unless you were enrolled in the following plans, which require action every annual enrollment in order to be effective:**
   - Medical Flexible Spending Account (FSA)
   - Dependent Care Flexible Spending Account (FSA)
   - Health Savings Account (HSA)
   - Purchased Paid Annual Leave (PPAL)

   If you would like to make a change, please call the Benefit Service Center at 1-866-664-3150 or go online at www.electbenefits.com/thefreshmarket.

2. **The Fresh Market has selected CVS/Caremark to provide prescription benefits to you.** If you are enrolled in one of the TFM medical plans, you are automatically enrolled in the pharmacy benefits. This coverage is bundled with the medical plan and cannot be elected separately. Everyone enrolled in a TFM medical plan will receive a CVS/Caremark prescription card in the mail.

   When it's time to fill a prescription, you can choose from its more than 68,000 network pharmacies nationwide, including independent pharmacies and chain pharmacies. Find a participating pharmacy at www.caremark.com. The first time you go to the pharmacy or order your prescription mail order after May 1st, you will need to take your prescription card.

   Choose one of the following easy ways to start using the Maintenance Choice program:

   1. Bring your prescription to a CVS/pharmacy location.
   2. Fill out and send in a mail service order form.
   3. Visit www.caremark.com/mailservice.
   4. Call Customer Care at **844-582-8173.**

   It is recommended that you refill any prescriptions prior to the end of the 2016-2107 plan year. You will not be able to transfer prescriptions from Cigna Home Delivery or your local pharmacy to the new CVS/Caremark pharmacy provider.

3. **Cigna Telehealth Connection**
   TFM now subscribes to Cigna Telehealth Connection. With Cigna Telehealth Connection, employees can get the care they need – including most prescriptions – for a wide range of minor conditions. They can connect with a board-certified doctor when, where and how it works best for them – via video or phone – without having to leave home or work.

   Choose when: Day or night, weekdays, weekends, and holidays.
   Choose where: Home, work, or on the go.
   Choose how: Phone or video chat.
   Choose who: AmWell or MDLIVE doctors.

   AmWell and MDLIVE televisits can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. Costs are the same or less than a visit with a primary care provider. Giving employees an easy-to-use and cost effective alternative to care can help reduce costs and non-urgent ER visits.

   You can register for one or both services, so they're ready when and if you and eligible dependent need care. Register by visiting the websites or calling:

   - AmWell: www.AmWellforCigna.com or call 1-855-667-9722
   - MDLIVE: www.MDLIVEforCigna.com or call 1-888-726-3171

4. **Wellness Program**
   The Fresh Market has enhanced its Wellness Program with incentives for its employees. You must be enrolled in one of TFM medical plans and complete the following requirements:
   - complete your annual physical exam
   - complete health assessment at www.myCigna.com
   - submit validated biometric screening results
   - complete at least 3 coaching calls with a Cigna Health Coach

   To earn the incentives, you must complete the requirements between January 2017 and April 2018. Incentives will be awarded through gift cards from Cigna. See page 9 for additional information.

5. **Health Savings Account (HSA)**
   This is a High Deductible Health Plan with an individual deductible of $3,000. You must meet your deductible amount prior to the company contributing towards your health cost. Additionally, you may save money towards your health benefits by contributing to the HSA funding account with TFM matching your contributions up to $300 if employee only or up to $500 if coverage includes dependents. Unlike a medical FSA, there is no "use it or lose it" condition to the HSA. The funds in the HSA Plan continue to grow and are available when you and your family have a medical, dental or vision expense.

The Health Savings Account (HSA) Plan

The HSA Plan is a High Deductible medical plan that pairs a medical plan with a Health Savings Account (HSA). With the HSA Plan, you will be responsible for most expenses up to a certain dollar limit, known as the deductible. After you meet the deductible, you'll share expenses with The Fresh Market in the form of coinsurance. There is also an out-of-pocket maximum, which limits the total amount that you could be responsible for in a given year. If you reach the "in-network" out-of-pocket maximum, the plan picks up the cost of all covered services from that point forward for the rest of the year.

When you enroll in the HSA Plan, you will have a HSA opened for you to set aside dollars to use for medical, dental, and vision needs. You will choose the amount you wish to contribute to the HSA. The maximum annual limits are $3,400 for single and $6,750 greater than single. You may not contribute to an HSA and a medical flexible spending account (FSA) in the same year.

What is a HSA?
HSA stands for Health Savings Account and is separate from your health insurance and is used to fund the pre-tax savings account.

- A HSA is an individual bank account – you own and manage it
- Funds accumulate year-to-year – no "use it or lose it" provision
- HSAs are portable – you keep your account and 100% of the funds when you change jobs or retire
- Tax savings – contributions are pre-tax or tax deductible, earnings are non-taxable, and qualified distributions are tax-free

WHO IS ELIGIBLE FOR COVERAGE?

Full-time employees working 30 or more hours per week are eligible for full-time benefits on the first day of the pay period following 60 days of service. Employees may also enroll their spouse and their children, under the age of 26. Children include your biological children, adopted children, any stepchildren (living in your home), and those for whom you have legal guardianship.

WHO NEEDS TO ENROLL?

During Annual Enrollment:

Annual Enrollment for the 2017/2018 Plan Year will be a passive enrollment. If you would like your benefits to remain the same, you do not have to do anything unless you were enrolled in the following plans, which require action every annual enrollment in order to be effective:
- Medical Flexible Spending Account
- Dependent Care Flexible Spending Account
- Health Savings Account (HSA)
- Purchased Paid Annual Leave (PPAL)

If you do not enroll, the benefits you had for the 2016-2017 plan year will rollover to the 2017-2018 plan year. If you would like to make a change, please call the Benefit Service Center at 866-664-3150 or go online at www.electbenefits.com/thefreshmarket.

Annual Requirements:

1. Employees enrolled in a Medical Plan must complete the Non-Tobacco Affidavit on-line or by calling the call center. This must be completed during your initial enrollment in a Medical Plan and during every Annual Enrollment thereafter. If you fail to complete the Affidavit, standard medical rates apply.
2. All employees who have a spouse enrolled into a TFM medical plan must complete the Spousal Surcharge form online or by calling the call center. This must be completed during your initial enrollment of a spouse into a Medical Plan and during every Annual Enrollment thereafter. If you fail to complete the form, the Spousal Surcharge will apply.

Newly Eligible Employees:

You must enroll online at www.electbenefits.com/thefreshmarket or call Benefit Communications Inc. at 866-664-3150 for all benefit plans in which you want to be covered. **Newly eligible employees must enroll before their 60th day of employment.** Employees who change from part-time to full-time must enroll before their 60th day of full-time status. If you are enrolling a spouse or dependent child in coverage, you must also supply proof of your dependents (spouse and\or child(ren)) by your 60th day of employment or full-time status. If you fail to complete your enrollment process, you will only be enrolled in the company provided benefits.

Enroll in your benefits between Feb. 28 - March 15 for coverage in 2017/2018.

HOW CAN I ENROLL IN BENEFITS?

The Fresh Market partners with Benefit Communications, Inc. as our online vendor. You always have two ways to enroll, either online or by phone. To get started, use the enrollment option most convenient to you.

During Annual Enrollment

DO NOT WAIT UNTIL THE LAST DAY OF ANNUAL ENROLLMENT TO ENROLL. If you do and run into internet connection issues, or trouble accessing a customer service specialist, you will not be given additional time to enroll. If you are covering a dependent not currently covered, you will have to submit proof by the enrollment deadline.	
Enroll Online	www.electbenefits.com/thefreshmarket
Enroll by Phone: Available Monday - Friday, 8 a.m. - 5 p.m. CST	866-664-3150

Newly Eligible Employees

DO NOT WAIT UNTIL THE LAST DAY TO ENROLL. If you experience internet connection issues or have trouble accessing a benefits department representative, you will not be provided additional time to enroll. If you are covering anyone besides yourself, you must supply proof of your dependents by your 60th day (enrollment deadline) even if your 60th day is a weekend/holiday.	
Enroll Online @	wwww.electbenefits.com/thefreshmarket
Enroll by Phone - Available Monday - Friday, 8 a.m. - 5 p.m., CST	866-664-3150
TFM Benefits Department (Available 8 a.m. to 5 p.m. ET)	800-520-1550

WHAT DO I NEED TO ENROLL?

As you prepare to enroll through one of the options outlined, please make sure to have the following pieces of information.

1. Your Employee ID Number and birthdate to log into the website
2. Social Security Number for you and your eligible dependents
3. Dates of Birth for you and your eligible dependents
4. Proof of all dependents (spouse/children) you are adding to the plan for the first time. Examples of proof include marriage certificates for spouses and birth certificates for all children. Review our website for submission or additional information at www.electbenefits.com/thefreshmarket or by contacting the Benefits Department. All required documents (marriage certificates, birth certificates, and federal tax return) must be submitted by your enrollment deadline.
5. Dates of birth for your beneficiaries

QUALIFIED LIFE EVENT INFORMATION

You will be required to provide proof of both your dependent's eligibility and the life event's occurrence before your enrollment information will be sent to payroll and to your selected insurance carriers. Life Event Status changes will be effective as of the first day of the pay period following the Life Event. The status change may be retroactive and employees have up to 30 days to provide required proof. For birth of child or adoption, the coverage is effective as of their date of birth or placement for adoption. Due to Life Event Status change, some situations may require retroactive payment of premiums.

> **Important:** Any required documentation must be provided within 30 days of your life event. For example, if you get married on May 7, you have only until June 6 to make your enrollment change AND provide any supporting documentation. If you do not provide the supporting documentation within 30 days of your life event, your enrollment change will be cancelled and you will not be permitted to make any changes until the next Annual Enrollment.

All benefit changes must be consistent with the Life Event Status change, as defined by the IRS.

- **Marriage:** If you get married, within 30 days you will need to provide a copy of your state marriage certificate as proof of your marriage. If you are adding stepchildren, you will need to provide a copy of a birth certificate listing your spouse as the parent.
- **Divorce:** If you got divorced, within 30 days you will need to provide a copy of the divorce papers with the judge's signature.
- **Birth of Child:** If you or your spouse have a baby, within 30 days you will need to supply proof of birth from the hospital listing the child's name, date of birth, and the employee's name as a parent. Do not wait for the official birth certificate as you may not receive this within 30 days of the birth.
- **Adoption:** If you or your spouse have adopted a child or have had a child placed for adoption in your home, within 30 days you will need to supply a copy of your adoption paperwork.
- **Participant or Dependent Lost Coverage Elsewhere:** If you, your spouse, or an eligible dependent lost coverage, within 30 days you will need to supply proof of the loss of coverage, including names of those covered, which shows the coverage and date the coverage ended. If adding your spouse, you will need to provide a marriage certificate and if adding a dependent child you will need a birth certificate.
- **Participant or Dependent Gained Coverage Elsewhere:** If you, your spouse, or an eligible dependent gain coverage, within 30 days you will need to provide proof of enrollment in other coverage which shows who gained coverage, what coverage was gained, and the date the coverage began.
- **Change in Medicare/Medicaid Status:** If you have recently gained or lost Medicare or Medicaid eligibility, within 60 days you will need to provide proof of the gain or loss of Medicare or Medicaid that shows the effective date of the coverage or the date the coverage ended. If adding your spouse, you will need to provide a marriage certificate and if adding a dependent child you will need a birth certificate.

COMPLETING YOUR MID-YEAR QUALIFIED LIFE EVENT

To change your benefit coverage outside of Annual Enrollment, you must complete a Qualified Life Event Status change by calling Benefit Communications Inc. at 866-664-3150, press option 2 for Service Center. Qualified Life Event Status changes require proof of the event and verification of relationship for any dependents (spouse, children, stepchildren, and adopted children) that you are adding to the plans. All information must be submitted within the applicable time period (30 days for normal changes and 60 days for changes in Medicare/Medicaid status).

If you do not complete a Qualified Life Event Status change within the time permitted, you will not be able to add/remove a dependent or make any other changes until the next Annual Enrollment Period, with benefits coverage effective the following May 1. *If your dependent becomes ineligible and you fail to complete a Mid Year Status change, including submitting the required document(s) within 30 calendar days of the event, your payroll deduction will not change; however, the ineligible dependent will no longer be covered under the plan*. See Summary Plan Descriptions for eligible dependent definitions.

MEDICAL, DENTAL, AND VISION PLAN RATES

Employee Contribution Schedule (Bi-Weekly)

	TFM Copay Plan EE Contribution Schedule		TFM HRA Plus Plan EE Contribution Schedule		TFM HSA Plan EE Contribution Schedule		Dental	Vision
	Bi-Weekly						Bi-Weekly	
	Standard	Non-Tobacco	Standard	Non-Tobacco	Standard	Non-Tobacco	Standard	Standard
Employee	$121.00	$81.00	$97.00	$57.00	$78.00	$38.00	$9.00	$1.99
Employee + Spouse	$257.00	$217.00	$210.00	$170.00	$171.00	$131.00	$17.00	$3.98
Employee + Child(ren)	$205.00	$165.00	$167.00	$127.00	$136.00	$96.00	$14.00	$4.02
Family	$305.00	$265.00	$238.00	$198.00	$185.00	$145.00	$21.00	$6.41

Employee Contribution Schedule (Weekly)

	TFM Copay Plan EE Contribution Schedule		TFM HRA Plus Plan EE Contribution Schedule		TFM HSA Plan EE Contribution Schedule		Dental	Vision
	Weekly						Weekly	
	Standard	Non-Tobacco	Standard	Non-Tobacco	Standard	Non-Tobacco	Standard	Standard
Employee	$61.00	$41.00	$49.00	$29.00	$39.00	$19.00	$4.50	$0.99
Employee + Spouse	$129.00	$109.00	$105.00	$85.00	$86.00	$66.00	$8.50	$1.99
Employee + Child(ren)	$103.00	$83.00	$84.00	$64.00	$68.00	$48.00	$7.00	$2.01
Family	$153.00	$133.00	$119.00	$99.00	$93.00	$73.00	$10.50	$3.21

SPOUSAL SURCHARGE

Employees who choose to cover their spouse on The Fresh Market medical plan, where the spouse has coverage available through his/her employer but chooses not to enroll in that coverage, will be subject to an additional $10 per week/$20 bi-weekly surcharge on their contributions.

If your spouse is covered on another medical plan and loses eligibility for medical coverage through their employer, you have 30 calendar days to notify The Fresh Market of this change. Please contact the Benefits Department for information on making these changes.

“QUIT NOW” TOBACCO CESSATION INCENTIVE PROGRAM

The Fresh Market is committed to sponsoring programs that improve the quality of life for our employees and their families. One way to uphold this commitment is to promote health and well-being and provide wellness opportunities for The Fresh Market employees. We feel that it is our responsibility to promote a culture of health that will extend past your hours of employment and become part of your personal habits. In addition to improving health, The Fresh Market hopes to initiate change that will help to impact medical cost escalation that affects everyone.

One of the ways we can support healthier lifestyles for our employees is to promote and support tobacco-use cessation. Tobacco use includes the burning of, inhaling from, exhaling the smoke from, or the possession of a lighted cigar, cigarette, pipe or any other matter or substance which contains tobacco or any other matter that can be smoked, or the inhaling or exhaling of smoke or vapor from an electronic smoking device. In promotion of a healthier environment, The Fresh Market offers a non-tobacco user discount of $20 (weekly)/$40 (biweekly) to all employees who qualify. If you participate in Cigna’s tobacco cessation program or hit your one year anniversary of going tobacco free, contact the Benefits Department to see if you qualify for the non-tobacco premium discount. In addition, as always, those electing to attempt tobacco cessation with the help of over-the-counter medication can be reimbursed through their Flexible Spending Account (FSA) contributions or HSA, as appropriate.

Call Cigna (800-244-6224 or 800-CIGNA24) and speak to a Personal Health Team member to enroll in Quit Today. They have coaches who will help you handle cravings and withdrawal symptoms as well as point you to local resources.

HEALTHCARE INCENTIVE PROGRAM

Earn $$$ in Your Medical Plan Accounts with Healthy Activities

Get involved in healthy activities during the year! All medical plans let you earn dollars as a part of your medical plan by completing healthy activities. It can really pay off!

The table below shows the types of activities that can earn your dollars. **You must complete your Physical and Health Assessment first before you can earn $$$ for other healthy activities.**

Requirement	Activity	Incentives
Get a physical	Did you know annual physicals are free when going to an in network doctor? Additionally, employees may be eligible to receive additional incentive from voluntary benefits. The physical and health assessment must be completed first before you can earn your Wellness incentives.	Employees will receive $50 for getting a physical
Provide biometric data to Cigna	Ask your doctor to complete and certify your biometric data. Know your numbers to help you improve or maintain your health (blood pressure, cholesterol, and weight).	Employees will receive $20 for providing your biometric data to Cigna (get the required form at www.mycigna.com)
Complete a health assessment online	The health assessment is an easy online questionnaire about your health and well-being.	Employees will receive $15 for completing the health assessment (get the required form at www.mycigna.com)
Complete 3 coaching calls with personal health team	Contact the personal health team to help you make simple changes to improve your health.	Employees will receive $15 for completing coaching calls

For more details, visit myCigna.com. Click on “Manage My Health” then “Incentive Awards Program.”

TFM offers three medical plan options: Copay Plan, HRA Plus Plan, and HSA Plan; when you enroll in one of these medical plans, prescription drug coverage is included as a part of the plan.

Medical Plan Summary:
TFM partners with Cigna to obtain access to Cigna's Open Access Plus Provider Networks. The grid below outlines the important features of our three plan offerings for both "In" and "Out" of Network coverage. The Summary of Benefits and Coverages can be found online at www.electbenefits.com/thefreshmarket and www.myCigna.com.

Benefit Details	TFM Copay Plan		TFM HRA Plus Plan		TFM HSA Plan	
Plan Benefit	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Annual Deductible Individual	$1,000	$2,500	$2,000	$12,000	$3,000	$12,000
Family*	$2,000	$5,000	$4,000	$24,000	$6,000	$24,000
For Family Deductibles only*	After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.		All eligible family members contribute towards the family plan deductible. Once the family deductible has been met, the plan will pay each eligible family member's covered expenses based on the coinsurance level specified by the plan.		All eligible family members contribute towards the family plan deductible. Once the family deductible has been met, the plan will pay each eligible family member's covered expenses based on the coinsurance level specified by the plan.	
Annual Out of Pocket Maximum Individual	$4,000	$10,000	$6,000	$12,000	$6,000	$12,000
Family*	$8,000	$20,000	$12,000	$24,000	$12,000	$24,000
For Family Out of Pocket Maximums Only*	After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.		After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.		After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.	
HRA / HSA Contribution from TFM	NA		Individual - $300 Family - $500		Individual - up to $300 Family - up to $500	
Coinsurance	75% (After Deductible)	50% (After Deductible)	60% (After Deductible)	50% (After Deductible)	60% (After Deductible)	50% (After Deductible)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out of Pocket Maximums include all Copays, Deductibles, and Coinsurance payments.						
Office Visits						
Child Preventive Care (Up to Age 19)	Covered 100% (Deductible Waived)	Not Covered	Covered 100% (Deductible Waived)	Not Covered	Covered 100% (Deductible Waived)	Not Covered
Adult Routine Annual Physical	Covered 100% (Deductible Waived)	Not Covered	Covered 100% (Deductible Waived)	Not Covered	Covered 100% (Deductible Waived)	Not Covered
Physicians Office Visit	$25 Copay	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)
Specialist Office Visit	$45 Copay	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)
In/Out Patient Hospital Care						
Emergency Room Visit	$250 Copay (waived if admitted)	$250 Copay (waived if admitted)	Covered 60% (After Deductible)	Covered 60% (After Deductible)	Covered 60% (After Deductible)	Covered 60% (After Deductible)
Hospital Inpatient	Covered 75% (After Deductible)	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)
Hospital Inpatient Maternity Care	Covered 75% (After Deductible)	$250 copay (waived if admitted)	Covered 60% (After Deductible)	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)
Outpatient Care	Covered 75% (After Deductible)	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)
X-Ray and Laboratory Services						
X-Ray & Lab Tests	Covered 75% (After Deductible) If your provider's office conducts its own X-rays/ Lab test (and is not contracted out) these services are included in your office visit copay. Check myCigna.com for details.	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)

Benefit Details	TFM Copay Plan		TFM HRA Plus Plan		TFM HSA PLAN	
Plan Benefit	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Therapy Services						
Physical, Occupational, Chiropractic Therapy and Speech Therapy (Limit 60 Visits Per Year)	Covered 75% (After Deductible)	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)
Mental Health & Substance Abuse Services						
Office Visits	$45 Copay	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)	Covered 60% (After Deductible)	Covered 50% (After Deductible)
Inpatient & Outpatient	Covered 75% (After Deductible)					

PRESCRIPTION DRUG COVERAGE

Welcome to your new prescription benefit plan. Starting May 1, 2017, we will be working with CVS/Caremark to administer the prescription benefit portion of your health plan. You and your enrolled dependents automatically receive prescription drug benefits when you select a medical plan option. This coverage is bundled with the medical plan and cannot be elected separately. The coverage is as follows:

	TFM Copay Plan	TFM HRA Plus Plan	TFM HSA PLAN
	Retail Dispensed	Retail Dispensed	Retail Dispensed
Generic	$7 Copay	$7 Copay	60% after deductible
Preferred Brand	$40 Copay	$40 Copay	60% after deductible
Non-Preferred Brand	$60 Copay	$60 Copay	60% after deductible
	Mail Order Dispensed	Mail Order Dispensed	Mail Order Dispensed
Generic	$14 Copay	$14 Copay	60% after deductible
Preferred Brand	$80 Copay	$80 Copay	60% after deductible
Non-Preferred Brand	$120 Copay	$120 Copay	60% after deductible

Important Information For Mail Service Pharmacy Users
CVS/caremark is your new mail service prescription provider. Starting 5/1/17, CVS/Caremark will become your new provider instead of CIGNA. Feel free to register at www.caremark.com or call Customer Care toll-free at 844-582-8173 for more information after 4/1/17.

Existing refills with CIGNA
CVS/caremark will not have access to your mail service refill information until 5/1/17. To avoid any delay in processing during this transition, we recommend you choose one of the following:

1. Ask your doctor or other prescriber to write a new prescription for up to a 90-day supply, plus refills when appropriate. Bring your prescription to a CVS pharmacy location or send your prescription to CVS/Caremark. Call Customer Care toll-free at 844-582-8173 for more information after 4/1/17.
2. Send your refill request after 4/1/17.

Choose one of the following easy ways to start using the Maintenance Choice program:

1. Bring your prescription to a CVS pharmacy location.
2. Fill out and send in a mail service order form.Mail order forms may be obtained at www.caremark.com.
3. Visit www.caremark.com/mailservice.
4. Call Customer Care at 844-582-8173.

Medications that cannot be transferred
Controlled substances and compound medications cannot be transferred to CVS/Caremark Mail Service Pharmacy. If you have existing refills for these types of medications, ask your doctor or other prescriber for a new prescription and mail it to CVS/Caremark.

Other questions about your CVS/Caremark prescription benefits?
Visit www.caremark.com to learn more about mail service, order refills, check drug cost and coverage, print a claim form and more.

REAL LIFE CLAIM EXAMPLES

The goal behind TFM's medical plans is to offer our employees a choice in selecting the health care plan that best fits your individual and family needs. To help you better understand how these plans may work for you when using the plan, we have provided two common claim scenarios along with the illustration of your expected costs.

All of the examples assume that in network providers were used.

Claim Example #1- Brand Name Prescription, Employee Only Coverage

In this example the brand name prescription costs $245 at the pharmacy, no FSA was elected, and HRA and HSA have sufficient funds. Here's how each plan would pay:

	TFM Copay Plan	TFM HRA Plus Plan	TFM HSA Plan
Stated Cost of Prescription	$245	$245	$245
Allowed Amount by Plan	$196	$196	$196
Member Cost at Pharmacy	$40	$40	$196
HRA / HSA Pays	N/A	$40	$196
Deductible Remaining	$1,000	$1,960	$2,804

Allowed amount shown above is hypothetical and does not represent a guaranteed discount.

TFM Copay Plan - At the time of service, no FSA is available. Copays are not processed against the deductible under the Copay Plan. You will pay $40 and have a remaining deductible of $1,000.

TFM HRA Plus Plan - At the time of service, you will present your FSA/HRA debit card for payment. The claim will be processed against your deductible and $40 will be paid from your HRA account.

TFM HSA Plan - At the time of service, you will present your HSA debit card for payment. The claim will be processed against your deductible and $196 will be paid from your HSA account.

Claim Example #2 - Specialist Office Visit with FSA, Employee Only Coverage

The cost of the office visit is $300, FSA, HRA and HSA have sufficient funds. Here's how each plan would pay:

	TFM Copay Plan	TFM HRA Plus Plan	TFM HSA Plan
Provider's Stated Cost of Office Visit	$300	$300	$300
Allowed Amount by Plan	$220	$220	$220
Member Owes Doctor's Office	$45	$220	$220
FSA Pays	$45	$220	N/A
HRA / HSA Pays	N/A	N/A	$220
Deductible Remaining	$1,000	$1,780	$2,780

Allowed amount shown above is hypothetical and does not represent a guaranteed discount.

TFM Copay Plan - At the time of service, you will present your FSA/HRA debit card for payment. The claim will be processed and $45 will be paid from your FSA account. Copays are not processed against the deductible under the Copay Plan. You will have a remaining deductible of $1,000.

TFM HRA Plus Plan - At the time of service, you will present your FSA/HRA debit card for payment. The claim will be processed on your FSA card in the amount of $220. You will have $1,780 remaining for your deductible. The $220 will be applied to your out of pocket maximum.

HSA - At the time of service, you will present your HSA debit card for payment. The $220 will be applied to your deductible and out of packet maximum.

FLEXIBLE SPENDING ACCOUNTS: FOR 2017/2018 PLAN YEAR

The Company offers employees the opportunity to take advantage of Flexible Spending Accounts (FSAs) that allow you to pay for eligible health care and dependent day care expenses with pre-tax dollars. Cigna provides you with the FSA/HRA debit card for easy use. You are eligible to enroll in the following options:

Health Care Flexible Spending Account	Dependent Care Flexible Spending Account
Annual Contribution Maximum: $2,600	Annual Contribution Maximum: $5,000 ($2,500 if married and filing separate tax returns)
Eligible Expenses (for you & your eligible dependents) • Co-payments, deductibles and coinsurance • Medical, dental, vision, hearing and prescription drug expenses not covered by your plan(s) • Special services and equipment for the disabled See IRS Publication 502 for a complete list or visit www.myCigna.com	Eligible Expenses • Qualified dependent day care facilities for children or adults (must be a dependent for tax purposes) • Dependent care provided inside your home or in another private home • Adult day care • Pre-school tuition • Day camp programs See IRS Publication 503 for a complete list or visit www.myCigna.com

Please Note: If you enroll in the HSA Plan, you may not contribute to the healthcare flexible spending account.

To Get Started:

- Visit www.electbenefits.com/thefreshmarket to estimate your FSA contribution needs and potential tax savings
- Select your Contribution Amount during your applicable enrollment period
- Deductions for these plans are taken on a Pre-Tax Basis and out of each of your paychecks during the plan year

Filing A Paper Claim

- For Eligible Health Care Costs - You will have the option of enrolling in the Healthcare Flexible Spending Account and obtaining a FSA/HRA Debit card to utilize for your healthcare cost. The FSA/HRA debit card will be used for services you receive at the point of service. Your Healthcare Flexible Spending Account dollars will be available to you as of May 1, per the goal amount you choose for the year. If you had a FSA/HRA debit card from the 2016/2017 plan year, you will use this card to utilize for the 2017/2018 plan year. If enrolled in the HRA Plus Plan, your Health Care FSA will be deducted first, followed by any remaining HRA dollars. By using Cigna's in-network doctors, dentists, and other providers, you will be able to avoid multiple requests for receipts as you have experienced in the past. You will be able to view and manage your balances on www.mycigna.com.
- For Eligible Dependent Care Costs - You must submit your reimbursement claim directly to Cigna by mail, fax, or online.
- Cigna cuts reimbursement checks on a daily basis, but you can also set up direct deposit for your reimbursement at myCigna.com.

Important Dates to Remember

- For Dependent Care expenses, you have a total of 12 months to incur claims. This means you have through April 30, 2018 to incur claims.
- For Health Care expenses, you have a total of 12 months to incur claims, with the exception of up to $500. If you have $500 or less in your account at the end of the plan year you can roll this into the next plan year.
- You must enroll in Health Care FSA the following year to be able to utilize the rollover amount available from the prior year.

Important Tax Information

The IRS has established certain guidelines regarding your participation in Flexible Spending Accounts. It's important for you to be aware of these rules.

- Changes to your contribution rates are not allowed during the year. Once you determine your contribution amount for the year, you may not increase, decrease, or discontinue your contributions unless you experience a Qualified Live Event. (See the Qualified Life Event section on page 7 for more information.)
- These accounts are separate. You may not use money in one account to pay for expenses in the other.
- Unused Health Care funds above $500 and all unused Dependent Care funds are forfeited.
- Claims must be incurred during the Plan Year and submitted by the 90th day following the Plan Year.

CRITICAL ILLNESS INSURANCE

With the rising cost of healthcare, getting seriously ill could have a big impact on your life as well as your finances. Group Voluntary Critical Illness Insurance can help give you the power of taking control of your health when faced with a critical illness. This insurance coverage pays you lump-sum cash benefits to help pay for treatment or bills and a wellness benefit to help cover the cost of health screening tests. Some covered illnesses include:

- Heart Attack
- Coronary Artery
- Stoke
- Bypass Surgery
- Major Organ Transplant
- Cancer

Group Voluntary Critical Illness offers three level options, $10,000, $15,000 or $20,000. Spouse and child(ren) are eligible for coverage. Premiums do not increase with age. No reduction in coverage amounts at older ages. If you terminate employment with The Fresh Market, you will be able to continue the coverage through Allstate.

ACCIDENT INSURANCE

Even when you live well, accidents happen. No one plans to have an accident. But it can happen at any moment throughout the day, whether at home, traveling or at play. Most major medical insurance plans only pay a portion of the bills. Accident Care coverage can help pick up where other insurance leaves off and provide cash to help cover the expenses. This coverage pays you cash benefits that correspond with hospital confinement. The cash benefits can be used to help pay for deductibles, treatment, house payments, and more.

Voluntary Accident insurance can help you take care of out-of-pocket expenses and medical costs beyond what your health insurance plan covers like:

- Hospital stays
- Ambulance bills
- Emergency Room
- Physical therapy
- Other medical expenses related to an accident

This coverage is guaranteed issue coverage, meaning you are not required to answer medical questions. You can cover your spouse and child(ren). Group accident insurance even provides you with greater cash options because you get to determine how you want to use the cash. The cash can be used to assist you with living expenses, mortgage or a trip. If you terminate employment with The Fresh Market, you will be able to continue the coverage through Allstate.

The Fresh Market's Accident Plan has been enhanced to include:

- Basic Accident Benefits
- Benefit Enhancement Rider
- Additional Benefits include: Dislocation/Fracture Rider; Accident Treatment & Urgent Care Rider; Emergency Room Services Rider; Outpatient Physician's Benefit Rider; Accidental Death, Dismemberment and Functional Loss Rider

Access Your Benefits and Claim Filings

Accessing your benefit information using MyBenefits has never been easier.

MyBenefits is an easy-to-use website that offers you 24/7 access to important information about your benefits. Plus, you can submit and check your claims (including claim history), request your cash benefit to be direct deposited, make changes to personal information, and more.

www.allstatebenefits.com/mybenefits

DENTAL COVERAGE

In order to have coverage you must enroll in this plan separately from the Medical Plan. A summary of this coverage is below:

	In Network	Out of Network*
Type A – Preventive (Oral Exams, Cleaning and X-Ray's every 6 Months)	100% (No Deductible Applies)	100% with Maximum Reimbursable Charge (MRC)
Type B – Basic (Simple extractions, endodontics, routine fillings, space maintainers, etc.)	80% (After Deductible)	80% of MRC Fee**
Type C – Major (Covered after 12 months on the Plan) (Full or partial dentures, bridges, crowns, periodontics, etc.)	50% (After Deductible)	50% of MRC Fee** (After Deductible)
Type D – Child Orthodontia	50% (After Deductible) $1,000 Lifetime Maximum per Child	50% of MRC Fee** (After Deductible)
Annual Deductible	$50 Per Participant	$50 Per Participant
Annual Maximum	$1,750 Per Participant	$1,750 Per Participant

* Out of Network Utilization: Cigna will reimburse you for using an Out of Network provider. However, Cigna providers will typically charge lower fees and file your claims directly.

**Out of Network Costs: Using an Out of Network provider may result in higher out of pocket costs for you and your dependents. Our plan will reimburse you the maximum reimbursable charge schedule. See your Summary of Benefits at myCigna.com (or at www.electbenefits.com/thefreshmarket) for more details.

Know Before You Go
For charges expected to exceed $200 or more, you can request a benefit estimate by filing a claim in advance of the services.

VISION COVERAGE

Employees and their eligible dependents are eligible for this separate Vision plan. In order to have coverage, you must enroll in this plan separately from the Medical Plan. A summary of this coverage is below:

	In Network	Out of Network	Frequency
Exam Copay	$10	N/A	12 months
Exam Allowance (once per frequency period)*	Covered 100% after Copay	Up to $45	12 months
Eyeglass Lense Copay	$25	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period) - Single Vision - Bifocal - Trifocal - Lenticular	 Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	 Up to $32 Up to $55 Up to $65 Up to $80	 12 months 12 months 12 months 12 months
Contact Lenses Allowances: (no Copay, one pair or single purchase per frequency period) - Elective - Therapeutic	 Up to $100 Covered 100%	 Up to $87 Up to $210	 12 months 12 months
Frame Retail Allowance (one per frequency period)	Up to $100	Up to $55	24 months

*Your Frequency Period begins on May 1st

- To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.
- If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses. Claim forms are available at myCigna.com.

PROTECTING YOUR WEALTH

Our Company understands the importance of helping employees build and protect their wealth and assets against life's unforeseen events. For that reason, **we provide all full time employees with Basic Life Insurance and Long Term Disability coverage at no cost**.

SHORT TERM DISABILITY

This coverage helps provide a weekly source of income if you are unable to work due to a medical condition that continues for more than a week. This is a stand-alone benefit, and you do not have to be enrolled in any other benefit in order to enroll in Short Term Disability.*NJ & NY Employees – These states have mandated disability laws. NJ/NY employees must file through Liberty Mutual and will be paid the greater of the TFM plan or the state mandated disability benefit. All claims must be submitted to Liberty Mutual. Eligible benefits are paid directly from Liberty Mutual. A description of the benefit is outlined in the grid below:

	Hourly Employees	Salaried Employees
Benefit Payable	$250 per week tax free for up to 12 weeks	Less than 3 Years of Service as of May 1 - 60% of your Base Pay (include cost of living where applicable) 3 or more Years of Service as of May 1 - 75% of your Base Pay (include cost of living where applicable)
Waiting Period	Following seven (7) consecutive calendar days due to illness or disability (includes cost of living where applicable)	
Evidence of Insurability (EOI) Requirement	If you do not enroll during your initial enrollment, you must submit EOI, and be approved before deductions and benefits begin	

LONG TERM DISABILITY

The Company provides all full-time employees with a Long Term Disability benefit at no cost. This coverage helps provide a monthly source of income if you are unable to work due to a disability or extended illness that continues beyond 90 days.

Benefit Payable	60% of your pay coordinated with other benefits like Social Security
Waiting Period	Your benefit period will commence following 90 days of consecutive illness or disability
Evidence of Insurability (EOI) Requirement	Benefits will continue until your Social Security Normal Retirement Age (SSNRA) or until you are no longer disabled

OPTIONAL LONG TERM DISABILITY ENHANCEMENT

In addition to the Long Term Disability coverage provided at no cost, you may also apply for an additional 15% of your Total Pay through a deeply discounted, non-cancellable and guaranteed renewable individual policy.

Who is eligible to apply: Salaried employees who earn $100,000 or more.

To apply for this coverage, you can call HFCB at 1-800-258-8429. Your coverage will become effective on the 1st day of the month after it is approved.

BASIC TERM LIFE INSURANCE COVERAGE FOR EMPLOYEES

The Company provides full-time employees with Basic Life insurance:

- 1.5 times your Annual Base Pay (rounded to the next higher $1,000) up to $500,000 at no cost to you.

This coverage reduces to 65% of your benefit amount at age 65 and to 50% at age 70. Optional Spouse Life coverage will also decrease based on the employee age. **You must designate a beneficiary for this benefit.**

OPTIONAL EMPLOYEE TERM LIFE AND AD&D INSURANCE FOR EMPLOYEES

In addition to the coverage provided to you at no cost, you have the option of purchasing additional Life Insurance coverage or coverage against accidental death and dismemberment (AD&D). If you would like to purchase additional coverage, you may do so according to the following guidelines:

Term Life Insurance	
Available Coverage Amounts:	$10,000 to $200,000 in increments of $10,000
Coverage Limitations:	Guaranteed Issue Limit - $200,000 if selected within your initial eligibility period Evidence of Insurability (EOI) – Will be required if you select an amount exceeding your current election by more than $10,000 and/or you enroll in coverage outside your initial eligibility period.
Rates:	Rates are available online, by calling the Benefits Department or BCI our online vendor. Remember rates may increase when reaching ages in the multiples of 5 (25, 30, 35, 40,...,70).
AD&D Insurance	
Available Coverage Amounts:	$150,000 for you, $75,000 for your spouse, ($15,000 if you are covering a spouse and dependent child(ren)) and $15,000 per child
Coverage Features:	Full benefits are paid in the event of accidental death and reduced benefits for dismemberment. You may purchase coverage for yourself only, or for you plus your family.
Rates:	Employee only rates - biweekly $1.11/weekly $0.55, family rates - biweekly $1.66/weekly $0.83

OPTIONAL SPOUSE AND CHILD(REN) TERM LIFE INSURANCE

The Company provides employees the opportunity to obtain Optional Life Insurance coverage for their Spouse and eligible Dependent Child(ren). **You must be enrolled in Optional Employee Life** in order to enroll your dependents in either of these plans. The coverage options of these benefits include:

For Spouse	
Available Coverage Amounts:	$5,000 to $100,000 in increments of $5,000, and not exceeding half of the Optional Life for the employee coverage amount. EOI approval is needed for all amounts above $50,000.
Annual Enrollment Increase Option:	At Annual Enrollment each year, you may increase your spouse coverage by $5,000 without EOI up to a maximum of $100,000 or half of your coverage.
Rates:	Rates are available online by calling the Benefits Department or BCI, our online vendor. Remember rates are based on the date of birth of the employee.
For Child(ren)	
Available Coverage Amounts:	$10,000 per child, all eligible children can be covered under one policy
Definition of Child	If you elect an Optional Life Child policy, only those child(ren) meeting the definition below will be provided coverage: a) Your unmarried child(ren), including adopted child(ren) upon finalization of adoption proceedings who are not self-supporting and are under 26 years of age; and b) Child(ren), under age 26 and you support; and c) Your child(ren) beyond the limiting age who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who is chiefly dependent on you for support and maintenance.
Rates:	Biweekly $.83/weekly $.42

BUSINESS TRAVEL ACCIDENT INSURANCE

TFM provides Business Travel Accident Insurance to employees while on travel. Coverage is 3 times your base pay up to $500,000 for full-time employees. Part-time employees with at least one year of service are covered for 3 times base pay up to $250,000.

PAID ANNUAL LEAVE (PAL)

PAL is paid time off that may be used for any reason, such as vacation, personal illness, illness of a family member, or other reasons. PAL accrues each pay period on the following schedule, based on an employee's number of years of service with the Company prior to the preceding January 1. A year of service equals one full year and ends on the anniversary of the employee's date of hire.

Years of Service Completed Prior to January 1	Eligible PAL – Annual Basis	PAL Accrual per Week
Hired in current calendar year	prorated based on 40 hours per year	0.7693 hours per week
Hired in previous calendar year	40 hours	0.7693 hours per week
1 - 4 years of service	80 hours	1.5385 hours per week
5 - 9 years of service	120 hours	2.3077 hours per week
10 - 14 years of service	160 hours	3.0770 hours per week
15 - 19 years of service	200 hours	3.8462 hours per week
20+ years of service	240 hours	4.6154 hours per week

- PAL may be used on or after your 61st day of employment
- Up to 80 hours of PAL may be carried over from year to year
- Unused PAL days are not paid if you are terminated for cause or fail to work a full two-week notice
- See the complete Paid Annual Leave policy for full information or contact Payroll at 336-272-1338 x1519 or HR Services at 866-817-1968

If you work in a state or locality with a paid sick leave law, you will receive the greater of the amount of PAL shown above or the amount to which you are entitled under applicable law.

PURCHASED PAL

Employees may buy additional PAL time to be **used between May 1 and the following March 31**. Purchased PAL days may be used at any time during the Plan Year provided that you have used all available company-provided PAL. Unused purchased PAL days will be reimbursed to you at the end of the Plan Year, or, if earlier, upon your termination of employment.

You are eligible to enroll in Purchased PAL during Annual Enrollment. Full-time new hires are eligible to enroll in Purchased PAL during their New Hire event, as are employees that go from part-time to full-time.

- You may purchase, 8, 16, 24, 32, or 40 hours of PAL.
- To determine your cost, take your hourly rate (found on your paystub) and multiply it by the numbers of hours you wish to purchase. For example, $12/hour X 40 hours = $480. Now take that $480 and divide it by 24 paychecks (50 if you are paid weekly) and you get $20, which is your per paycheck deduction for your election. There is a calculator in the enrollment event online that does all the math for you.
- Your Purchased PAL rate is locked in for the year during Annual Enrollment. If you receive a raise during the year, this will not change your Purchased PAL benefit. This means when you use Purchased PAL days you are paid at the rate in which you elected the benefit.
- All standard PAL notification requests and approval processes apply.

If you have questions, please contact the Benefits Department at 800-520-1550.

UNPAID LEAVE OF ABSENCE

The Company allows employees to apply for unpaid leave. Eligibility for this benefit is subject to approval by FMLASource, the Benefits Department, or Human Resources depending on the type of leave taken. Unpaid leave may be taken for the following events:

- Personal Medical Leave of up to 6 weeks for employees who have worked for 60 days or more
- Family and Medical Leave of up to 12 weeks for employees who have worked for 1 year and have worked at least 1,250 hours in the last 12 months
- Military Leave provided to the extent required by law
- Personal Leave of up to 30 days (minimum of 7) is available to employees with at least 60 days of service
- Please see The Fresh Market Leave of Absence Policy, included in the enrollment packet for details.

GROWING YOUR WEALTH

The Fresh Market, Inc. Employees' Savings and Profit Sharing Plan (401K Plan)
It's never too early to start thinking and planning for your retirement. Although some of your retirement income will come from Social Security, the Company helps you supplement that amount with the Fresh Market 401(K) Plan.

How Can I Enroll or Make a Change?	Log on to: www.bbt.com/plantrac Call Toll Free: 800-228-8076 (Monday - Friday, 8 a.m. to 8 p.m., EST)	
When am I Eligible to Enroll?	You are eligible to enroll on the 1st day of the month following 60 days of service	
What is the Annual Contribution Limit?	In 2017, you may contribute up to $18,000 of your Pre-Tax Gross Earnings	
"Catch Up" Contribution (Employees 50 yrs and older)	For employees who are 50 years and older, the plan allows you to make an additional annual contribution of $6,000	
Company Match	50% of employee contribution up to 6% of salary paid per pay period	
Vesting Schedule	Employees hired 01/01/2014 and after are subject to a 4-year vesting schedule on any employee matching contributions	• 1 year of service = 25% vested • 2 years of service= 50% vested • 3 years of service= 75% vested • 4+ years of service= 100% vested

OTHER PROGRAMS

Discounts for Employees
Employees* are eligible for a discount on most purchases you make at The Fresh Market. As your years of service increase, so does your discount!

- 20% discount for employees with less than 5 years of service
- 25% discount for employees with at least 5 but less than 10 years of service
- 30% discount for employees with 10+ years of service

*Full-time and Part-time employees spouses and domestic partners are also eligible. Under IRS law, discounts used by domestic partners are considered taxable income to the employee.

Retiree Discount

- Employees that leave the company in good standing and meet the age and service criteria are eligible to receive a 20% discount for the rest of their life. To receive the lifetime retiree discount, an employee must obtain 70 points between age and years of service. Spouses may utilize the lifetime discount also. **Example**: Age 50 with 20 years of service or age 55 with 15 years of service.

Employee Assistance Plan (EAP) for You and Your Family

- Call 877-695-2789 anytime, 24 hours per day and 7 days a week, to get counseling over the phone or to schedule sessions with a counselor to get help for the following kinds of issues:
  - Marital/family/personal problems such as stress, anger, depression, death/dying/divorce/separation
  - Legal needs such as landlord problems, document preparation, etc.
  - Financial issues like credit, taxes, etc.
  - Alcohol or drug abuse
  - Online will preparation

Bright Horizons Care Advantage
Bright Horizons provides The Fresh Market employees with back-up child care and adult/elder care for up to 7 days per year at a copay of $10/child/day or $15/family/day for center based child care or $4/hour for in-home care. You have access to in-home care and center based care in the Bright Horizons network of quality child care centers. Care is available 24/7 to cover your work schedule and changes.

Bright Horizons Care Advantage also offers the most comprehensive online care database with proprietary matching technology for evening, weekend, and pet care.

Register online at: www.careadvantage.com/TheFreshMarket
Username: Fresh Password: Market or call: 877-242-2737.

CIGNA HEALTH AND WELLNESS DISCOUNTS

Save money when you purchase health and wellness services through the Cigna Healthy Rewards program including:

- Fitness, mind, and body programs
- Vision and hearing care services
- Vitamins, health, and wellness products
- Alternative medicine services
- Healthy lifestyle products

Cigna Telehealth Connection
Now Cigna provides access to two telehealth services as part of your medicalplan – **AmWell** and **MDLIVE**.

Cigna Telehealth Connection lets you get the care you need – including most prescriptions – for a wide range of minor conditions. Now you can connect with a board-certified doctor via secure video chat or phone, without leaving your home or office. When, where, and how it works best for you!

Choose when: Day or night, weekdays, weekends, and holidays.
Choose where: Home, work, or on the go.
Choose how: Phone or video chat.
Choose who: AmWell or MDLIVE doctors.

Say it's the middle of the night and your child is sick. Or you're at work and not feeling well. If you pre-register on both AmWell and MDLIVE, you can speak with a doctor for help with:

- sore throat
- stomach ache
- cold and flu
- headache
- fever
- allergies
- rash
- acne
- UTIs & more

The cost savings are clear
Televisits with AmWell and MDLIVE cost less than going to a convenience or urgent care clinic, and significantly less than going to the emergency room. And the cost of a phone or online visit is the same or less than with your primary care provider. Remember, you should only use telehealth services for non-life threatening conditions.

Choose with confidence
AmWell and MDLIVE are both quality national telehealth providers, so you can choose your care confidently. When you can't get to your doctor, Cigna Telehealth Connection is here for you.

Signing up is easy!

- Set up and create an account with one or both AmWell and MDLIVE
- Complete a medical history using their "virtual clipboard"
- Download vendor apps to your smartphone/mobile device

Register for one or both today so you'll be ready to use a telehealth service when and where you need it.

www.AmWellforCigna.com or call 855-667-9722
www.MDLIVEforCigna.com or call 888-726-3171

CONTACT INFORMATION

Benefits Enrollment and website		
Benefit Communications Inc. (BCI)	866-664-3150 fax: 615-750-8653	www.electbenefits.com/thefreshmarket
Medical, Dental, Vision, FSA, and Cobra Benefits		
Cigna	800-244-6224	www.myCigna.com
Short and Long Term Disability		
Liberty Mutual	800-713-7384	www.Mylibertyconnection.com
401(k) Retirement Savings Plan		
BB&T – 401(k) Retirement Savings Plan	800-228-8076	www.bbt.com/plantrac
Employee Assistance Program		
Employee Assistance Program	877-695-2789	www.bensingerdupont.com/MLA Password: MLASSIST
Voluntary Benefits		
Allstate	800-521-3535	allstatebenefits.com/mybenefits
Benefit Questions		
TFM Benefits Department	800-520-1550	benefits@thefreshmarket.net
TFM Payroll	336-272-1338 x1519	PayrollDepartment@thefreshmarket.net
HR Service Center	866-817-1968	HR_ServiceCenter@thefreshmarket.net

COBRA CONTINUATION OF COVERAGE

The right to COBRA continuation coverage was created by a 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. COBRA continuation allows you to continue your current medical, dental, vision, and FSA benefits.

An Employee would be eligible to continue coverage through COBRA if you lose eligibility for group coverage under the Plan due to any of the following events:

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

The covered spouse of an employee would be eligible to continue coverage through COBRA if the spouse loses eligibility for group coverage under the Plan due to any of the following events:

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

A covered dependent child would be eligible to continue coverage through COBRA if the child loses eligibility for group coverage under the Plan due to any of the following events:

- 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 (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."

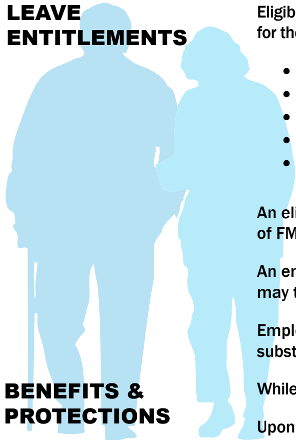
COBRA Monthly Rates

Coverage Level	TFM Copay Plan	TFM HRA Plus Plan	TFM HSA Plan	Dental Plan	Vision Plan
Single	$557.27	$509.43	$468.48	$28.91	$4.40
Employee + Spouse	$1,142.42	$1,044.31	$960.40	$56.26	$8.79
Employee + Child(ren)	$902.79	$825.26	$758.96	$66.87	$8.88
Family	$1,549.23	$1,416.19	$1,302.40	$94.24	$14.17

If you experience a divorce, or a child loses eligibility please contact the Benefits Department at 800-520-1550. The Fresh Market will then notify Allegiance who will send COBRA enrollment information to the address we have on file. For additional information please see the Summary Plan Description.

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

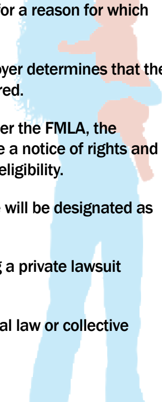
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.

- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date—October 2008