

HY-VEE

ELECTIVE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

(Effective August 1, 2004)

INTRODUCTION

Effective August 1, 2004, Hy-Vee, Inc. (“Hy-Vee” or “Employer”) has established for certain eligible employees an employee welfare benefit plan entitled “Hy-Vee Elective Benefits Plan” (“Plan”). The Plan provides eligible full-time, regular and part-time employees and their eligible dependents various “Benefits Programs” depending upon their employment status. All of the Benefits Programs are available on an after-tax basis and some of the Benefits Programs are available on a pre-tax basis. The “Benefits Programs” currently available are as follows:

Full-Time/Regular Employees

- vision;
- group life insurance;
- group long-term disability insurance;
- legal insurance;
- cancer insurance; and
- premium payment program.

Part-Time Employees

- cancer insurance;
- group life insurance
- group medical insurance; and
- premium payment program.

Any eligible part-time employee who elects group medical insurance automatically receives \$5,000 of life insurance without any additional payment. Also, part-time employees who elect medical insurance can, at their option, pay for vision, dental, and/or short-term disability coverage under the same policy issued by Pan-American Life Insurance Company. **Note that this is different vision insurance coverage than is available to full-time and regular employees.** See the Benefit Description issued by Pan-American Life Insurance Company for additional information about these benefits.

Hy-Vee is the Plan Sponsor and Plan Administrator of the Plan. All of the benefits available under the Plan are fully insured. The insurer for each Benefits Program is listed in the Claims Administration Section of this booklet.

This booklet has been designed to provide important information to eligible employees who have elected coverage under one or more of the available Benefits Programs. You will also receive separate materials directly from the insurer for each benefit you elect. These materials are often referred to as Certificates of Insurance or Coverage. For purposes of this booklet, these materials will be referred to as “Benefit Descriptions.”

This booklet provides an explanation of the general eligibility and enrollment rules under the Plan as well as details regarding important rights you have as a participant in the Plan. The Benefit Description for each Benefits Program you elected coverage in explains in detail the benefits provided under the Benefits Program and any requirements or limitations imposed by the insurer on receiving benefits under the Benefits Program. Each Benefit Description may include specific rules for that particular Benefits Program that may be different from the other

Benefits Programs offered under the Plan, such as, the procedures for submitting claims for benefits and the requirements for dependent eligibility.

It is important for you read this booklet and the materials you receive from each insurer fully and carefully. You should keep these materials available for future reference.

This booklet, when read in conjunction with the Benefit Descriptions provided by each insurer, is intended to be the Summary Plan Description for purposes of ERISA. The Plan's official terms are in the document entitled "Hy-Vee Elective Benefits Plan" including the insurance policies insuring the various Benefits Programs. The Plan Administrator and the insurers use the Plan's official documents to administer the Plan and resolve any disputes. If there is a discrepancy between this booklet and the plan documents, the plan documents will control.

If you have questions about your benefits or the Plan generally or regarding this Summary Plan Description, you may contact:

L&K Insurance
Ten Ten Court Ave.
P. O. Box 737
Chariton, IA 50049
1-800-622-0057

You may request an additional copy of this Summary Plan Description by sending a written request to the above address. You will be charged a reasonable fee for any additional copies provided.

If you wish to obtain a copy of the official plan document, you need to send a written request to the address below. You will be charged a reasonable fee for any additional copies provided.

Hy-Vee, Inc.
5820 Westwon Parkway
West Des Moines, IA 50266
1-515-267-2800

Important Notes

Hy-Vee reserves the right to amend, modify or terminate the Plan or replace or add benefits provided under the Plan at any time and for any reason, in whole or in part, at its sole discretion. Nothing in this Summary Plan Description shall conflict with Hy-Vee's right to terminate an employee for any reason at the will of Hy-Vee.

Each insurer has the sole authority, discretion and responsibility to interpret and construe the terms of the Benefits Program it insures, determine all factual and legal questions under such Benefits Program, including but not limited to eligibility for benefits, the entitlement of benefits and the amounts of benefits to be paid, and determine all questions arising in the administration of such benefit option. The insurer for each Benefits Program is listed in the Claims Administration section of this booklet.

ELIGIBILITY

Note that specific Benefits Programs may have additional eligibility requirements. Not every eligible employee under the criteria below is eligible for every Benefits Program offered under the Plan. That is why it is important for you to refer to the applicable Benefit Description to determine the eligibility rules that apply to each Benefits Program.

Full-Time/Regular Employees

If you are classified by Hy-Vee or a Participating Employer on both payroll and personnel records as a full-time or regular employee working at least 30 hours per week and you satisfy all the eligibility requirements of the particular Benefits Program, you will be eligible to participate in the following Benefits Programs after satisfying the waiting period:

- vision;
- group life insurance;
- group long-term disability insurance;
- legal insurance;
- cancer insurance; and
- premium payment program.

Part-Time Employees

If you are 19 years of age or over and classified by Hy-Vee or a Participating Employer on both payroll and personnel records as a part-time employee and you satisfy all the eligibility requirements of the particular Benefits Program, you will be eligible to participate in the following Benefits Programs after satisfying the waiting period:

- cancer insurance;
- group life insurance;
- group medical insurance; and
- premium payment program.

Any eligible part-time employee who elects group medical insurance automatically receives \$5,000 of life insurance without any additional payment. Also, part-time employees who elect medical insurance can, at their option, pay for vision, dental, and/or short-term disability coverage under the same policy issued by Pan-American Life Insurance Company. **Note that this is different vision insurance coverage than is available to full-time and regular employees.** See the Benefit Description issued by Pan-American Life Insurance Company for additional information about these benefits.

Waiting Period

You are not eligible to participate in any of the Benefit Programs until you have satisfied a 60-day waiting period, during which you must be continuously employed by Hy-Vee or a Participating Employer. An absence from work due to an approved leave of absence or for a health reason, as determined by Hy-Vee or a Participating Employer, will count towards the 60-day waiting period. If you are reclassified from a full-time or regular employee to a part-time employee or visa versa, your prior service with Hy-Vee or a Participating Employer will count towards satisfying the 60-day waiting period.

Excluded Individuals

Employees who are classified as follows are **not** eligible to participate in the Plan:

- temporary employees;
- employees subject to a collective bargaining agreement that does not provide for participation in this Plan;
- United States citizens performing services outside of the United States, unless approved by Hy-Vee;
- employees employed in a division or facility of Hy-Vee which was acquired, established, founded or produced by the liquidation of a separate subsidiary on or after August 1, 2004, unless approved by Hy-Vee; or
- non-resident aliens who are not receiving earned income from Hy-Vee from sources within the United States, unless approved by Hy-Vee.

Persons who are not classified by Hy-Vee or a Participating Employer as employees (such as leased employees, temporary workers, independent contractors, and other persons who are not classified as common law employees) are not eligible to participate in the Plan.

Hy-Vee's or a Participating Employer's classification of an individual is conclusive and binding for purposes of determining benefit eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency or otherwise, without regard to whether or not Hy-Vee agrees to such reclassification, shall make the person retroactively or prospectively eligible for benefits. However, Hy-Vee, in its sole discretion, may reclassify a person as benefits eligible on a prospective basis. Any uncertainty regarding an individual's classification will be resolved by excluding the person from eligibility.

Dependent Eligibility

Coverage under certain Benefits Programs, such as medical, vision and group life insurance, is also available for your eligible dependents. Generally, your eligible dependents will include:

- Your spouse; and
- Unmarried dependent children, subject to various age and student status limitations.

However, the dependent eligibility provisions of each Benefits Program will determine whether a dependent is, in fact, eligible for benefits under the applicable Benefits Program. The dependent eligibility rules for each Benefits Program may differ. You should refer to the applicable Benefit Description to determine the dependent eligibility rules that apply to each Benefits Program.

Enrolling ineligible dependents is a violation of company policy and will be treated accordingly. If Hy-Vee determines that an ineligible dependent has been enrolled, coverage will be canceled retroactively. Hy-Vee reserves the right to recover any and all benefit payments made for services received by ineligible dependents and to take disciplinary action up to and including termination of employment.

ENROLLMENT

Initial Enrollment

When you first become eligible to participate, you will have an opportunity to elect coverage under the following Benefits Programs:

Full-Time/Regular Employees

- vision;
- group life insurance;
- group long-term disability insurance;
- legal insurance;
- cancer insurance; and
- premium payment program.

Part-Time Employees

- cancer insurance;
- group life insurance;
- group medical insurance; and
- premium payment program.

Any eligible part-time employee who elects group medical insurance automatically receives \$5,000 of life insurance without any additional payment. Also, part-time employees who elect medical insurance can, at their option, pay for vision, dental, and/or short-term disability coverage under the same policy issued by Pan-American Life Insurance Company. **Note that this is different vision insurance coverage than is available to full-time and regular employees.** See the Benefit Description issued by Pan-American Life Insurance Company for additional information about these benefits.

How To Enroll

To enroll for coverage under one or more of the Benefit Programs, you must complete and submit the required enrollment forms to the L&K Insurance office (or a representative of L&K Insurance) prior to the end of the 60 day waiting period. If you want coverage for your eligible dependents, you must enroll them at the same time as you enroll yourself.

Generally, your election will be for the remainder of the year, except for vision insurance. If you elect to participate in the vision insurance Benefit Program, your election is for two full premium years and you will not be permitted to change your election until the second annual enrollment after your enrollment, unless you experience a Change in Status Event (described below). Except for cancer insurance coverage, if you do not enroll during initial enrollment, you must wait until the next annual enrollment. You may enroll for cancer insurance after the initial enrollment period, but must pay for your coverage on an after tax-basis.

Paying for Coverage: Pre-Tax or After-Tax

During initial enrollment, you can elect to pay for medical, vision, group long-term disability and cancer insurance coverage on a pre-tax or after-tax basis. You can elect to pay for group life and

legal insurance coverage only on an after-tax basis. If you are a part-time employee who elects vision, dental and/or short-term disability coverage in addition to medical, your decision whether to pay for medical coverage pre-tax or after tax will determine whether the additional benefits (vision, dental and/or short-term disability coverage) are pre-tax or after tax. In other words, all part-time benefits you elect will be paid for entirely pre-tax or after tax, and your decision about how to pay for the medical benefit will determine how any other elected benefits are treated.

For vision benefits under the Vision Service Plan for full-time and regular employees, your pre-tax or after-tax election is for two full premium years.

IMPORTANT NOTE

If you pay for your short-term or long-term disability coverage on a pre-tax basis, the benefits you receive as a result of a disability **will be taxable income, and reported to you on your Form W-2 and may, in some circumstances, be subject to Social Security tax.** If you pay for your short-term long-term disability coverage on an after-tax basis, any benefits you receive as a result of a disability will be non-taxable.

Enrolling for Coverage on a Pre-Tax Basis

To receive coverage under the medical, vision, group long-term disability or cancer insurance Benefits Program on a pre-tax basis, you must complete and submit the required enrollment forms to the L&K Insurance office (or a representative of L&K Insurance) prior to the end of the 60 day waiting period.

In addition, if you want to pay for medical, vision, group long-term disability or cancer insurance benefits on a pre-tax basis, you must affirmatively enroll in the Premium Payment Program by completing and returning the required pre-tax election form to the L&K Insurance office (or a representative of L&K Insurance) prior to the end of the 60 day waiting period. If you fail to complete and timely submit the form, you will pay for your medical, vision, group long-term disability or cancer insurance benefits on an after-tax basis.

If you elect to participate in the medical, group long-term disability or cancer insurance Benefits Programs on a pre-tax basis under the Premium Payment Program, your elections are irrevocable for the year. This means you will not be permitted to change your elections until the next annual enrollment, unless you experience a Change in Status Event or a Special Enrollment Event. If you elect to participate in the vision insurance Benefits Program on a pre-tax basis under the premium payment program, your election is irrevocable for two full premium years. This means you will not be permitted to change your election until the second annual enrollment after your enrollment, unless you experience a Change in Status Event.

Enrolling for Coverage on an After-Tax Basis

You may elect to pay for coverage under any of the Benefits Programs on an after-tax basis.

To receive coverage under any Benefits Program on an after-tax basis, you must complete and submit the required enrollment forms to the L&K Insurance office (or a representative of L&K Insurance) prior to the end of the 60 day waiting period. If you timely enroll for coverage under a Benefit Program but do not enroll in the Premium Payment Program, your benefits automatically will be paid with after-tax dollars.

Unlike a pre-tax election, if you elect to pay for your benefits on an after-tax basis, you may change them during the year. However, except for cancer insurance, if you do not enroll during initial enrollment, you must wait until the next annual enrollment. You may enroll for cancer insurance at any time during the year on an after-tax basis. Once you elect to pay for benefits on an after-tax basis, you cannot elect to pay for them on pre-tax basis during the year. You must wait to the next annual enrollment to change from after-tax to pre-tax.

When Coverage Begins

If you enroll for coverage, when your coverage begins will depend on the type of Benefit Program. Except as noted below, coverage for most Benefit Programs begins on the first payroll period following the date your election is approved. For cancer insurance and long term disability insurance, coverage is effective the date your election is approved. For the vision Benefit Program, coverage is effective the first of the month following the month in which a premium is deducted to pay for coverage.

Annual Enrollment

You will have the opportunity to reconsider your benefit elections each year during annual enrollment (except for vision benefits, which, once you have elected coverage, cannot be changed for two years). During annual enrollment, you may elect to participate on an after-tax basis (for all benefits) or on a pre-tax basis (for medical, vision, group long-term disability and cancer insurance benefits), change your prior elections or cancel coverage altogether (subject to the special rule for vision). If you are eligible for coverage, you will receive annual enrollment materials. Your annual enrollment elections will be effective on the following August 1 (or if later, the date your coverage is approved by the applicable insurer).

If you do not submit the enrollment election materials, your benefits will remain the same. This means that if you elected to pay for your benefits on a pre-tax basis, you will continue to do so.

Changing Your Enrollment Elections During the Year – Pre-Tax Election

If you pay for medical, vision, group long-term disability or cancer insurance benefits on a pre-tax basis, once your benefit elections become effective, you may not change them, unless you experience a Change in Status Event or, for medical benefits only, you experience a Special Enrollment Event.

This section lists the Change in Status Events and the consistency requirements that must be met in order to make a change and provides details on which events result in automatic changes and which events permit you to request a change.

Special Enrollment only applies to the medical Benefits Program. As a result, the rules for Special Enrollment are not contained in this booklet, but may be found in the Benefit Descriptions applicable to the medical Benefits Program.

If you have questions about changing your benefit elections during the year, please contact the L&K Insurance office.

Please note that mid-year changes will only be permitted to the extent the terms of the insurance policy governing the benefit in question, as interpreted by the insurance company, permit the desired change.

Change in Status Events

If you are enrolled in medical, vision, group long-term disability or cancer insurance coverage on a pre-tax basis and you experience a Change in Status Event during a plan year, you may be able to change some or all of your pre-tax benefits elections during the year subject to any applicable requirements or limitations in a Benefits Program for a change in coverage. Your right to elect a change depends on the Change in Status Event that you experience, the benefit you want to change, and whether the change you want to elect is consistent with and on account of the Change in Status Event (the “Consistency Rule”). The Change in Status Events are described in the following chart, followed by an explanation of the Consistency Rule.

<u>Benefits Affected</u>	<u>List of Change in Status Events</u>
<ul style="list-style-type: none"> ■ Medical ■ Vision ■ Group Long-Term Disability ■ Cancer 	<ul style="list-style-type: none"> ◆ Marital Status Change. Your legal marital status changes because of marriage, divorce, legal separation, annulment, or death of your spouse. ◆ Change in Number of Dependents. Your number of eligible dependents changes because of birth or adoption of a child, the placement of a child with you for adoption, or death of your dependent. ◆ Change in Dependent Eligibility. Your dependent satisfies or ceases to satisfy the eligibility requirements for coverage. ◆ Employment Status Change. You, your spouse or your dependent experience a change in employment status due to one of the following events: <ul style="list-style-type: none"> ○ Termination or commencement of employment; ○ Commencement of or return from an unpaid leave of absence; ○ Change from part-time to full-time or vice-versa; ○ Any other change in employment status that affects benefits eligibility. ◆ Residence Change. You, your spouse or your dependent change residence. ◆ Change under Another Employer Plan. You may make a prospective change to your elections if it is on account of and corresponds with a change made under another employer plan due to a permitted change event or during the annual enrollment period of the other employer plan, if different from Hy-Vee’s annual enrollment period.

<u>Benefits Affected</u>	<u>List of Change in Status Events</u>
<ul style="list-style-type: none"> ■ Medical 	<ul style="list-style-type: none"> ◆ Special Enrollment Event. You, your spouse or dependent experience a Special Enrollment Event as defined in the applicable Benefit Description.
<ul style="list-style-type: none"> ■ Medical ■ Vision ■ Cancer <p>(collectively referred to as “health coverage”)</p>	<ul style="list-style-type: none"> ◆ Significant Change in Cost of Coverage. The cost of your elected health coverage significantly increases or decreases on a plan-wide level. ◆ Medicare or Medicaid Eligibility Change. You, your spouse or dependent enroll in or lose eligibility for Medicare or Medicaid. ◆ Loss of Eligibility for Governmental or Education Plan. You, your spouse or eligible dependent lose coverage under a group health plan sponsored by a governmental or educational institution. ◆ New or Improved Benefit Option. You become eligible for a new or improved health benefit option. ◆ Qualified Medical Child Support Order. You, your spouse, former spouse, or another individual is required by a Qualified Medical Child Support Order to provide health coverage for a child. ◆ Employer Imposed Overall Coverage Change. An overall reduction occurs in your elected coverage that generally applies to all participants, but does not result in a loss of coverage, as determined in the sole discretion of Hy-Vee. ◆ Reduction of Individual Coverage. Your elected coverage is significantly reduced or limited causing you to lose coverage, as determined in the sole discretion of Hy-Vee.

Consistency Rules

In most circumstances, you can **only** change your pre-tax benefits elections if the change you request satisfies the **Consistency Rules**. The Consistency Rules differ for different types of benefit elections. In addition, the Consistency Rules have some special applications to certain types of Change in Status Events. Thus, because of the Consistency Rules, you may experience a Change in Status Event that does not allow you to change your benefit elections. The following list explains in more detail the various Consistency Rules, however, under some circumstances, there may be additional limitations imposed on your ability to make changes. If you have specific questions regarding a change you wish to make to your benefits elections, contact the L&K Insurance office.

- ◆ **Consistency Rule for Medical, Vision or Cancer Coverage.** To change your medical, vision or cancer coverage, the Change in Status Event you experience generally must affect your or your family member’s eligibility for coverage for that benefit. This

Consistency Rule has some special applications when you experience certain Change in Status Events as demonstrated by the following explanations and examples.

- **Loss of Dependent Eligibility.** If the Change in Status Event you experience is divorce, annulment, death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements and you are enrolled in medical, vision or cancer coverage, you may only cancel the coverage or decrease contributions for that spouse or dependent. Coverage may not be cancelled for you or any other covered family member, unless some other Change in Status Event applies.
- **Gaining Eligibility under another Employer Plan.** If, due to a change in marital status or employment status, you, your spouse or dependent become eligible for coverage under a plan sponsored by your spouse's or dependent's employer, you may decrease or cancel coverage for yourself, your spouse or dependent as long as a corresponding election to add or increase coverage is made under the other employer's plan.
- **Tag Along Rule.** If, due to a permitted election change event, you elect to increase coverage under the medical, vision or cancer plan, at that time you may enroll your spouse or dependents who were not previously covered (regardless of whether they experienced the event).

Deadline for Making a Change

Change in Status Events. For all other Change in Status Events, you must actively elect to change your benefits **within 31 days** of the date the Change in Status Event occurred by contacting the L&K Insurance office. If you do not do so within the **31-day deadline**, you will not be permitted to make a change to your benefit elections.

Special Enrollment Events. Special Enrollment Events only allow you to increase your medical coverage elections. To change your medical coverage as a result of a Special Enrollment Event, you must request a change **within 31 days** of the Special Enrollment Event by contacting the L&K Insurance office. If you do not do so **within the 31-day** deadline, you will not be permitted to enroll or otherwise change your medical coverage.

Please note:

You may need to provide proof of the Special Enrollment or Change in Status Event and the date the event occurred. Failure to do so may result in denial of your change request.

Changing Your Enrollment Elections During the Year – After-Tax Election

Your after-tax elections can be changed during the year, but you cannot change an after-tax election during the year to a pre-tax election even if you experience a Change in Status Event or Special Enrollment Event. (Remember that you can change after-tax elections to pre-tax elections at annual enrollment.)

Leaves of Absence

The special rules that apply when you go on an approved leave of absence are:

- **Military Leaves.** If you leave employment with Hy-Vee to serve in the military and are rehired within certain time limits, the Uniformed Services Employment and Reemployment Rights Act (“USERRA”) provides you certain rights under the Plan. For additional information regarding your rights under USERRA, you should contact the L&K Insurance office.
- **Paid Leave.** While you are on a paid leave of absence, your benefit elections will remain in effect and your contributions will continue to be deducted from your pay as long as the underlying insurance policies so provide.
- **Unpaid Leave.** See the Benefit Descriptions for information on availability of coverage during an unpaid leave of absence. If coverage can continue during the unpaid leave, regardless of whether you revoke or continue coverage, you will have the same right as any other participant to change your benefit elections consistent with the Change in Status or Special Enrollment provisions described in this booklet. If you begin an unpaid FMLA leave of absence, your vision coverage will continue during your unpaid leave.
 - **Continuation of Coverage.** If coverage is available during an unpaid leave under the Benefits Description, you may continue your participation by making payment with after-tax dollars during your leave of absence.
 - *If you do not return to employment after an unpaid leave, Hy-Vee reserves the right to recover the cost of the coverage provided during the leave period.*

COST OF COVERAGE

The benefits provided under the Elective Benefits Plan are exclusively employee paid. This means you pay the full cost of the benefits you elect. You may elect to pay for any benefits provided under the Elective Benefits Plan on an after-tax basis. You may elect to pay the cost of the following benefits on a pre-tax basis under the Premium Payment Program:

- medical;
- vision;
- group long-term disability insurance*; and
- cancer insurance.

In addition, a part-time employee who elects vision, dental, and/or short-term disability coverage under the policy issued by Pan-American Life Insurance Company will pay for those benefits on a pre-tax basis if the employee elects to pay for medical insurance coverage on a pre-tax basis. If the part-time employee elects to pay for medical insurance on an after-tax basis, then vision, dental, and/or short-term disability benefits will be paid on an after-tax basis.

Pre-tax contributions are deducted from your earnings before federal income taxes (and, in most cases, state and local taxes) are deducted. Any deductions from your pay will generally be taken from each paycheck over the course of the year. You do not pay Social Security taxes on pre-tax contributions for pre-tax welfare benefits. As a result, your future Social Security benefits may be reduced slightly. The current tax savings generally outweighs the possible future impact on your Social Security benefits, but if you have any questions about this you should consult your tax or financial planner.

After-tax benefits are also deducted from your earnings but they are deducted after federal and state income taxes are deducted.

* If you elect to pay for your short-term or long-term disability coverage on a pre-tax basis, the benefits you receive as a result of a disability **will be taxable income, and reported to you on your Form W-2 and may, in some circumstances, be subject to Social Security tax.** If you pay for your short-term or long-term disability coverage on an after-tax basis, any benefits you receive as a result of a disability will be non-taxable.

WHEN COVERAGE BEGINS

When your coverage begins, including changes you make to your benefits, differs for each Benefits Program and may, in some cases, be dependent upon the approval of the insurer for the Benefits Program. As a result, you should refer to the applicable Benefit Description to determine when your coverage or coverage change for that particular benefit begins.

WHEN COVERAGE ENDS

When your coverage ends also may differ depending on the Benefits Program. As a result, you should refer to the applicable Benefit Description to determine when your coverage for that particular benefit ends.

However, notwithstanding the provisions of any Benefits Program to the contrary, your coverage under the Plan will end as of the date the first of the following events occurs*:

- You are no longer classified by Hy-Vee as an eligible employee;
- Your employment with Hy-Vee terminates;
- The Plan or any Benefits Program is amended such that you or your dependents are no longer eligible for coverage;
- You fail to pay the required premium; or
- The Plan or all the Benefits Program you participate in are terminated.

Additionally, coverage for your enrolled dependents under a particular Benefits Program will end on the date the dependent is no longer eligible for coverage under the terms of such Benefits Program. For example, coverage for your spouse will end on the date of your divorce or legal separation.

*In some instances, coverage may not end under a particular Benefits Program until the end of the month in which one of the above events occurs or coverage may be portable. You should refer to the applicable Benefit Description for additional information.

COBRA CONTINUATION COVERAGE

This section contains detailed information about your right to COBRA continuation coverage, which is a temporary extension of coverage for the group medical insurance benefits in the Plan after you or your eligible dependents lose coverage in certain circumstances.

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, your spouse and to your dependents who are covered under the health benefits in the Plan when you, your spouse or your dependents would otherwise lose health coverage under the Plan. This section generally explains COBRA continuation coverage, when it may become available to you, your spouse and your dependents, and what you need to do to protect the right to receive it.

COBRA Eligibility

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event, 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 a 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 coverage under the Plan because either one of the following qualifying events occur:

- (a) Your hours of employment are reduced.
- (b) 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 coverage under the Plan because any of the following qualifying events occur:

- (a) Your spouse dies.
- (b) Your spouse’s hours of employment are reduced.
- (c) Your spouse’s employment ends for any reason other than his or her gross misconduct.
- (d) You become divorced or legally separated from your spouse. (Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

Your dependent children (including children participating under a Qualified Medical Child Support Order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occur:

- (a) Parent-employee dies.
- (b) Parent-employee's hours of employment are reduced.
- (c) Parent-employee's employment ends for any reason other than his or her gross misconduct.
- (d) Parents become divorced or legally separated.
- (e) Child stops being eligible for coverage under the plan.

Notification of COBRA Continuation Coverage Election

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the employer must notify the COBRA 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), you, your spouse or your dependent must notify the COBRA Administrator at the address listed at the end of this COBRA section. Verbal notice, including notice by telephone, is not sufficient. You may deliver your written notice by mail, facsimile, or by hand.

You must submit written notice that states the type of qualifying event permitting you to elect COBRA continuation coverage. You do not need to complete a specific form, but you do need to provide certain information. Your written notice must include (i) the name of this plan, (ii) the type of qualifying event (*e.g.*, divorce), (iii) the date of the event, (iv) your name and the names of the other qualified beneficiaries, and (v) any supporting documentation (such as a copy of your divorce decree) required by the insurer.

You must provide notice in a timely manner. If mailed, your notice must be post-marked no later than the last day of the 60-day election period described above. Otherwise it must be received no later than that day. If you or your dependent fails to provide notice to the Plan Administrator during this 60-day notice period, any spouse and/or dependent child who loses coverage will not be offered the option to elect continuation coverage.

How is COBRA Coverage Provided?

Once the COBRA 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. For each qualified beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage will begin the

first of the month following the qualifying event. If you or your spouse and dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child losing eligibility, 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, COBRA continuation coverage generally lasts for up to 18 months.

There are three 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 who is a qualified beneficiary 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 qualified beneficiaries 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 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. The Plan Administrator must be notified in writing of the Social Security Administration's determination within 60 days of the date of the latest of (i) the determination, (ii) the qualifying event, or (iii) loss of coverage, and before the end of the 18 month period of COBRA continuation coverage.

If no notice is given within the required period, then there will be no disability extension of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your qualified beneficiaries experience another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children who are qualified beneficiaries can receive up to 18 additional months of COBRA continuation coverage, up to a maximum of 36 months (including the initial 18-month period), if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children who are qualified beneficiaries if the employee or former employee dies, gets divorced or legally separated, or if a dependent child who is a qualified beneficiary stops being eligible under the Plan as a dependent child. In all of these cases, the extension is available only if the event would have caused your spouse or dependent child to lose coverage under the terms of the Plan had the first qualifying event not occurred. In all of these cases, the Plan Administrator must be notified in writing of the second qualifying event within 60 days of the second qualifying event. If no notice is given within the required 60-day period, your spouse and dependent children will not receive the extension of COBRA continuation coverage.

Medicare extension for spouse and dependent children

If a covered employee (i) experiences a qualifying event that is either termination of employment or a reduction of hours, and (ii) that qualifying event occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children who are qualified beneficiaries receiving COBRA continuation coverage will end 36 months from the date the employee became entitled to Medicare. 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 date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Note that the covered employee's coverage period is not extended by Medicare entitlement; rather the employee's maximum COBRA continuation coverage will be the 18-month period (unless extended under the disability extension described above).

Election of COBRA Continuation Coverage

To elect COBRA continuation coverage, you must complete an election form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect COBRA continuation coverage. For example, the employee's spouse may elect COBRA continuation coverage even if the employee does not. COBRA continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA continuation coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA continuation coverage on behalf of all the qualified beneficiaries.

If you experience a qualifying event, in considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not elect and remain covered under COBRA continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of COBRA continuation coverage if you remain covered under COBRA continuation coverage for the maximum time available to you.

Procedures to Elect or Extend COBRA Continuation Coverage

The following are the Plan's procedures to elect or extend COBRA continuation coverage. To elect or extend COBRA continuation coverage, you must provide written notice to the COBRA Administrator. Verbal notice, including notice by telephone, is not sufficient. You may deliver your written notice by mail, facsimile, or by hand.

As part of the notice, you must submit the following information:

- (a) **To elect COBRA continuation coverage election** – You must submit a completed election form. If you do not have a copy of the election form, you may obtain it by calling the COBRA Administrator.
- (b) **To extend COBRA continuation coverage** – You must submit written notice that states the type of event permitting the extension. You do not need to complete a specific form, but you do need to provide certain information. Your written notice must include (i) the name of this plan, (ii) the type of event (*e.g.*, a disability determination), (iii) the date of the event, (iv) your name and the names of the other qualified beneficiaries, (v) information on your disability determination, second qualifying event, or entitlement to Medicare, and (vi) supporting documentation (such as a copy of the Social Security Administration’s determination of disability or a copy of your divorce decree) if required by the insurer.

You must provide notice in a timely manner. You must submit your notice by the following deadlines:

- (a) **To elect COBRA continuation coverage election** – If mailed, your election form must be post-marked no later than the last day of the 60-day election period described above. Otherwise it must be received no later than that day.
- (b) **To extend COBRA continuation coverage** – For an extension based on a second qualifying event, your notice must be post-marked no later than the last day of the 60-day election following the qualifying event. For an extension based on disability or entitlement to Medicare, your notice must be received within the period described above.

Cost of COBRA Continuation Coverage

Generally, each qualified beneficiary will be required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary will be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

If you are eligible for an 11-month extension of continuation coverage due to disability, you will be required to pay 150 percent of the otherwise applicable cost during such 11-month extension period.

Payment for COBRA Continuation Coverage

First payment for COBRA continuation coverage

If you elect COBRA continuation coverage, you do not have to send any payment with the COBRA Continuation Coverage Election Form. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your

election. (This is the date the election form is post-marked, if mailed.) If you do not make your first payment for COBRA continuation coverage in full not later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

Your first payment for COBRA continuation coverage should be sent to the COBRA Administrator.

Periodic payments for COBRA continuation coverage

After you make your first payment for COBRA continuation coverage, you will be required to make payments for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA continuation coverage are due on the first of each month. If you make a periodic payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that month without any break. The Plan will not send periodic notices of payments due each month. Periodic payments for COBRA continuation coverage should be sent to the same address as the first payment.

Grace periods for periodic payments

Although periodic payments are due on the first of each month, you will be given a grace period of 30 days after the first day of the month to make each periodic payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that month, you will lose all rights to COBRA continuation coverage under the Plan. If COBRA continuation coverage is cancelled for nonpayment, coverage will not be reinstated and you will have no further rights to COBRA continuation coverage.

Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period

COBRA continuation coverage will be terminated before the end of the maximum period if (i) any required premium is not paid on time, (ii) after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, (iii) after electing COBRA continuation coverage, a qualified beneficiary becomes entitled to Medicare, or (iv) the employer ceases to provide any group health plan for its employees. COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud). COBRA continuation coverage may also be terminated if you recover from a disability that extended your COBRA continuation coverage. If you become covered under another group health plan, you or a qualified beneficiary enrolls in Medicare, or you recover from disability, you must immediately provide verbal or written notice of this event to The COBRA Administrator (at the telephone number or address listed in the Additional Information section)

and provide The COBRA Administrator (i) the name of this plan, (ii) the type of the event, and (iii) the date of the event.

Special “Trade Act” Rules Concerning Tax Credit for COBRA Continuation Coverage

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (“eligible individuals”). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is available at www.doleta.gov/tradeact/2002act_index.asp.

Keep Your Plan Informed of Address Changes

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

Contact Information for COBRA Administrator

The COBRA Administrator for the group medical insurance benefits is the Fringe Benefit Group, whose contact information is:

Fringe Benefit Group
11910 Volente Road
Austin, TX 78776

Telephone: 1-800-656-4577

BENEFITS PROGRAMS

The benefits provided under each Benefits Program, including any limitations or requirements, are described in separate materials. Therefore, in addition to this booklet you will also receive separate Benefit Descriptions for each Benefits Program in which you enroll. The Benefit Descriptions applicable to each Benefits Program, as well as any other documentation that governs the terms of the Plan, are specified in the following chart.

Benefits Program	Identification of Benefit Description and Other Incorporated Documents
Medical	<p><i>Benefit Description</i></p> <ul style="list-style-type: none"> • Certificate of Coverage for Insurance Policy Number 91007 issued by Pan-American Life Insurance Company to Hy-Vee, Inc. (“Monthly Indemnity Plan”), as the same may be amended from time to time.
Vision	<p><i>Benefit Description</i></p> <ul style="list-style-type: none"> • Certificate of Coverage for Group Vision Care Policy Number 12173507 provided by Vision Service Plan, as the same may be amended from time to time .
Cancer Insurance	<p><i>Benefit Description</i></p> <ul style="list-style-type: none"> • Each individual Cancer and Specified Disease Policy of insurance issued by EMC National Life Company to individual Participants and their dependents, from time to time and as amended from time to time. <p><i>Other Incorporated Documentation</i></p> <ul style="list-style-type: none"> • The specimen Cancer and Specified Disease Policy of insurance Policy Number CX1234567 issued in the name of John Doe and provided by EMC National Life Company — Dated November 14, 2003.

Benefits Program	Identification of Benefit Description and Other Incorporated Documents
Group Long-Term Disability Insurance	<p><i>Benefit Description</i></p> <ul style="list-style-type: none"> • Certificate of Coverage for Policy Number 113681 001 provided to Participants by Unum Life Insurance Company of America, as amended from time to time. <p><i>Other Incorporated Documentation</i></p> <ul style="list-style-type: none"> • Group Master Policy Number 113681 001 issued to Hy-Vee by Unum Life Insurance Company of America — Effective February 1, 2004, as amended from time to time. <p>Any portable personal long-term disability policy of insurance or any other individual policy of disability insurance issued to you, whether or not sold by any insurance agent or broker who also assists in the administration of this Long-Term Disability Program, is not covered under the terms of this Plan or Benefits Program. The purchase of such policies is entirely voluntary. Such policies are not endorsed or sponsored by Hy-Vee and are not intended to be subject to the provisions of ERISA. The interpretation of any such policy shall be consistent with this provision.</p>
Group Life Insurance	<p><i>Benefit Description</i></p> <ul style="list-style-type: none"> • Transamerica Assurance Company Master Policy and Certificate (Policy No. TL0459), as the same may be amended from time to time. <p>Any individual life insurance policy issued to you, whether or not sold by any insurance agent or broker who also assists in the administration of this Life Insurance Benefits Program, is not covered under the terms of this Plan or Benefits Program. The purchase of such policies is entirely voluntary. Such policies are not endorsed or sponsored by Hy-Vee and are not intended to be subject to the provisions of ERISA. The interpretation of any such policy shall be consistent with this provision.</p>
Legal Insurance	<p><i>Benefit Description</i></p> <ul style="list-style-type: none"> • Certificate on Insurance for Legal Expense Insurance Plan, as the same may be amended from time to time. <p><i>Other Incorporated Documentation</i></p> <ul style="list-style-type: none"> • Group Legal Expense Insurance Policy, Number 10345, issued to Hy-Vee by ARAG Insurance Company, as the same may be amended from time to time.
Premium Payment Program	<p><i>Benefit Description</i></p> <ul style="list-style-type: none"> • None

If you have questions regarding whether an expense is a covered benefit or other more general coverage questions, please contact the applicable insurer for the Benefits Program as identified in the Claims Administration section of this booklet.

ADMINISTRATIVE INFORMATION

Plan Administrator

Hy-Vee, Inc. is the Plan Administrator and Sponsor and will make determinations that may be required from time to time in the administration of the Plan. The Plan Administrator will have the sole authority, discretion and responsibility to interpret and apply the terms of the Plan and to determine all factual and legal questions under the Plan, including entitlement to benefits and resolution of claims and appeals related to benefits, unless authority to make such determinations is delegated by the Plan Administrator to another person or third party. Benefits under this Plan will be paid only if the Plan Administrator or the person or entity to whom it has delegated authority decides in its discretion that the participant is entitled to them.

Hy-Vee may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the Plan Administrator shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan.

Hy-Vee has reserved the right to delegate or redelegate and allocate or reallocate to one or more entities or persons or to a committee of persons jointly or severally such functions assigned to or assumed by Hy-Vee in its role as Plan Administrator and Plan Sponsor as it deems advisable or desirable.

CLAIMS ADMINISTRATION

The benefits provided under the Plan are fully insured. As a result, the Plan Administrator has delegated to each applicable insurance company the sole authority, discretion and responsibility to interpret and apply the terms of the Benefits Programs insured by the company and to determine all factual and legal questions under the Benefits Programs insured by the company, including final determinations as to entitlement to benefits and the amount of benefits to be paid under the insurance contract, if any. Except for the Medical Program, claims for benefits should be sent to the insurance company. For the Medical Program, claims for benefits should be sent to the Claims Administrator. The insurance company, and not Hy-Vee, is responsible for paying claims.

In any legal action brought after the administrative remedies have been exhausted, all determinations made by the Plan Administrator, applicable insurer, or other fiduciary, shall be afforded the maximum deference permitted by law.

The following chart identifies the contact information for the insurers for each Benefits Program:

Benefits Program Name	Claims Administrator/Insurer
Medical Program	Pan-American Life Insurance Company (Insurer) 601 Poydras St. New Orleans, LA 70130 Telephone: 1-877-939-4558 Fringe Benefit Group (Claims Administrator) 11910 Volente Road Austin, TX 78726 Telephone: 1-800-656-4577
Vision Program	Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 95670 Telephone: 1-916-851-5000 / 1-800-877-7195
Group Life Insurance Program	Transamerica Life Companies Administrative Office 1020 West Fourth Street Little Rock, AR 72203 Telephone: 1-800-400-3042
Group Long-Term Disability Insurance Program	Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122 Telephone: 1-800-622-0057

Benefits Program Name	Claims Administrator/Insurer
Cancer Insurance	EMC National Life Company 4095 N.W. Urbandale Drive Urbandale, IA 50322 Telephone: 1-515-645-4000
Legal Insurance	ARAG Insurance Company 400 Locust Street, Suite 480 Des Moines, IA 50309 Telephone: 1-800-247-4184 Web: www.araggroup.com

General Claims Procedure Provisions

If you believe you are entitled to benefits or disagree with a decision regarding your benefits, you must follow the appropriate claims procedure contained in the applicable Benefit Description. No inquiry or question shall be deemed to be a claim or request for a benefit unless made in accordance with the applicable claims procedure. You may, at your own expense, have an attorney or representative act on your behalf, but you may be required to provide a written authorization for a person to act on your behalf.

Exhaustion of Administrative Remedies

The exhaustion of the claim and review procedure is mandatory for resolving every claim and dispute arising under this Plan or a Benefits Program.

Time Limitations for Commencing a Claim

You must follow the claim and review procedure contained in the applicable Benefit Description carefully and completely and you must file your claim before any applicable deadlines. If you do not do so, you may give up important legal rights.

Unless a Benefit Description contains a shorter deadline, in which case the shorter deadline shall apply, you must submit your claim for benefits to the applicable Insurer within 12 months after the earlier of the date on which: (1) you were denied benefits; (2) you received benefits at a different level than you believed the Benefits Program provides; or (3) you knew or reasonably should have known of the principal facts on which your claim is based. After you file your claim, you must complete the entire claim and review process before you can sue over your claim, unless otherwise permitted by law. It is important that you include all the facts and arguments that you want considered during the claims and review process.

Time Limitations for Commencing a Lawsuit

Unless a Benefit Description contains a shorter deadline, in which case the shorter deadline shall apply, you must commence any lawsuit within 2 years after you knew or reasonably should have known of the facts behind your claim or, if earlier, within 6 months after the claims procedure is completed.

FUNDING

The benefits provided under this Plan are fully insured and are paid exclusively by employee contributions. Each insurance company is responsible for the payment of all benefits offered under the Benefits Program that it insures. The liability of Hy-Vee is limited to forwarding premiums collected from employees through payroll deduction to the applicable insurance company. No covered employee, dependent or other person shall have any claim or cause of action against Hy-Vee as to the payment of benefits under any insurance policy or contract. Each covered person or other claimant entitled to the payment of benefits under an insured Benefits Program shall look solely to the applicable insurance policy or contract, and not to Hy-Vee for payment of such insured benefits.

GENERAL PROVISIONS

Amendment and Termination

Hy-Vee has reserved the right to amend or terminate the Plan or any of the Benefits Programs described in this booklet at any time, for any reason and in any respect at its sole discretion. Hy-Vee's right to amend or terminate the Plan or Benefits Programs includes, but is not limited to, changes in the eligibility requirements, premiums or other employee payments charged, benefits provided and termination of all or a portion of the coverages provided under the Plan. If the Plan or any Benefits Program is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination and your rights will be reduced, terminated, altered or increased accordingly, as of the effective date of the amendment or termination. You do not have ongoing rights to any Plan or Benefits Program, other than payment of any covered expenses you incurred or benefits to which you become otherwise entitled prior to the plan amendment or termination.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order ("QMCSO") is any judgment, decree or order (including approval of a settlement agreement) for one parent to provide a child or children with health coverage and which meets the requirements under federal law for a QMCSO. If Hy-Vee receives a QMCSO for your child or children, it will contact you concerning the procedures for such an order. You may also request a copy of the procedures from the L&K Insurance office at any time and without charge.

PLAN INFORMATION

Plan Name

The Plan name is the “HY-VEE ELECTIVE BENEFITS PLAN.”

Plan Number

The Plan and all of its component Benefits Programs are identified by the following numbers:

Plan Number: 502
Employer Identification Number (“EIN”): 42-0325638

Plan Sponsor and Administrator

Hy-Vee is the Plan Sponsor and Plan Administrator and a named fiduciary of the Plan and its address is:

Hy-Vee, Inc.
5820 Westown Parkway
West Des Moines, IA 50266
Telephone 1-515-267-2800

Type of Plan

The Plan is an employee welfare benefit plan.

Any individual life insurance policy, portable personal long-term disability policy of insurance or any other individual policy of disability insurance issued to an eligible employee, whether or not sold by any insurance agent or broker who also assists the Principal Sponsor with the administration of any Benefits Program offered under this Plan, is not covered under the terms of this Plan. The purchase of such policies is entirely voluntary on the part of the eligible employee. Such policies are not endorsed or sponsored by Hy-Vee and are not intended to be subject to the provisions of ERISA. The interpretation of any such policy shall be consistent with this provision.

Service of Legal Process

The agent for service of legal process for this Plan is:

General Counsel
Hy-Vee, Inc.
5820 Westown Parkway
West Des Moines, IA 50266
Telephone 1-515-267-2800

Plan Year

The Plan Year is the 12 consecutive month period beginning each August 1st and ending on July 31st.

Participating Employers

- Hy-Vee, Inc.
- Perishable Distributors of Iowa, LTD
- Lomar Distributing, Inc.
- Florist Distributing, Inc.
- The Meyocks Group
- Midwest Heritage Bank, FSB
- D&D Foods, Inc.
- Any entity that adopts the Plan with the consent of the Principal Sponsor and any successor thereof that adopts the Plan will be considered participating employers in the future.

Employee Retirement Income Security Act (ERISA) Statement of Rights

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Creditable Coverage

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. After you exhaust the Plan’s claims procedures, if your appeal is denied, in whole or in part, you may file suit in a Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.