“Thank you”

to all of the great Circle K employees across the country who provide outstanding customer experiences every day.
Your 2017 Benefits Programs

Dear Circle K Employee:

Nothing is more important than your health and your financial security. That’s why Circle K is committed to providing you with benefit programs that help you:

- **Be healthy**—with medical, prescription drug, dental and vision coverage; and
- **Have a secure financial future**—with life, accident and disability insurance, as well as 401(k) and Employee Stock Purchase Plans.

This Enrollment Guide provides an overview of the plans available to you for the 2017 plan year. Take the time to read this material and share it with the members of your family.

If you need additional information on your benefit offerings, at the end of each section you’ll see phone numbers and websites where you can contact our various benefit partners directly with any questions. You can also find information about your benefits on the Circle K Intranet Site.

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**YOUR “TO DO” LIST**

- **READ** this *Guide* to learn about your benefits options,
- **REVIEW** your other enrollment materials,
- **CHOOSE** your benefits for 2017, and
- **ENROLL** online.
- **REVIEW** and update your beneficiary designations.

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Thanks for being part of the Circle K team! If you have any questions or need additional information about our benefit programs, just contact us—we’re here to help so you can **Take it Easy!**

Thank You!

*Your Circle K Benefits Team*

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This guide describes the benefit plans and policies to eligible employees of Circle K. The details of these plans and policies are contained in the official plan and policy documents, including some insurance contracts. This guide is meant to cover the major points of each plan or policy. It does not contain all of the details that are included in your Summary Plan Descriptions as described by the Employees Retirement Income Security Act.

If there is ever a question about one of these plans and policies, or if there is a conflict between the information in this guide and the formal language of the plan or policy documents, the formal wording in the plan or policy documents will govern.

Please note that the benefits described in this guide may be changed at any time and do not represent a contractual obligation on the part of Circle K.
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Your Benefits at a Glance

Circle K offers you a variety of benefit programs. Some benefits are provided automatically by the company at no cost to you, while others are voluntary coverages. You pay the cost for any voluntary coverages you elect through employee premium deductions.

<table>
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<tr>
<th>Health Care Insurance</th>
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<th>Savings and Investment Options</th>
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</tr>
</thead>
<tbody>
<tr>
<td>• Medical</td>
<td>• Company Paid Term Life</td>
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<td>• 401(k) Plan</td>
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<td>• Dental</td>
<td>• Company Paid Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</td>
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<td>• Employee Stock Purchase Plan</td>
<td>• Health Savings Account</td>
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</tr>
<tr>
<td>• Vision</td>
<td>• Voluntary Employee Term Life Insurance</td>
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<td>• Voluntary Child Term Life Insurance</td>
<td>• Voluntary Child Term Life Insurance</td>
</tr>
<tr>
<td>• Critical Illness</td>
<td>• Voluntary Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</td>
<td>• Voluntary Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</td>
<td>• Critical Illness Insurance</td>
<td>• Voluntary Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</td>
<td>• Voluntary Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</td>
</tr>
</tbody>
</table>

Important Changes for 2017

Each year, Circle K carefully reviews the benefit package offered to our employees. Changes are made annually to provide a comprehensive and competitive benefit program.

**HIGHLIGHTS FOR 2017 INCLUDE:**

- **401(k) Plan:** Our plan now allows *after-tax Roth contributions*. Certain IRS rules apply to the use of the Roth 401(k), so make sure you understand them completely before choosing this option. You can find more information on Roth 401(k) in IRS Publication 4530 ([http://www.irs.gov/pub/irs-pdf/p4530.pdf](http://www.irs.gov/pub/irs-pdf/p4530.pdf)).
- **Sonic Boom Wellness:** A fun, energizing wellness program that promotes healthy behaviors and lifestyle. See page 43 of this guide for more information.
- **PayFlex:** New Flexible Spending Accounts and COBRA administrator.
Enrolling in 2017 Benefits

HOW TO ENROLL
Start your enrollment process by reviewing this Enrollment Guide and the information on the HR Benefits page on the Circle K Intranet site or by viewing the guide at the enrollment site. To log in to the enrollment site, go to https://my-act.circlek.com and enter your User ID and Password.

<table>
<thead>
<tr>
<th>What is my User Name and Password?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a Circle K email address</td>
</tr>
</tbody>
</table>
| If you DO NOT have a Circle K email address | • If you're an employee of Circle K, log in using your Epik/Train Tracks user id and password
• If you're an employee of Circle K Midwest/Great Lakes/Heartland, log in with your User ID (your Employee ID Number) and Password. If this is your first log in, your default password is:
  - The first three letters of your last name in upper case,
  - The last four digits of your Social Security number, and
  - The last two digits of your birth year. |

NEED HELP LOGGING IN?
If you have a problem logging in or need your password reset, please contact:
• Circle K – Contact your Payroll Representative at 1-888-477-6583
• Circle K Midwest/Great Lakes/Heartland IT Help Desk at 1-877-324-7968, option 4

Once you’re logged into the system:
• Go to Main Menu > Self Service > Benefits > Benefits Enrollment and click the Select Open Event button.
• Select the Edit button next to the plan(s) you want to enroll in or make changes to.
• Update or add dependent(s).
• Review/confirm your benefit elections and print a copy of your elections page for your records.

If you have questions or need assistance, Circle K employees should contact the Benefits Department by calling the Tempe Employee Service Center at 1-888-HR-SOLVE (1-888-477-6583), or Circle K Midwest/Great Lakes/Heartland employees should contact the Columbus Employee Service Center at 1-877-324-7968, option 7.
Enrolling in 2017 Benefits continued...

WHAT HAPPENS IF YOU DON’T ENROLL?

For the coverage options that best fit your wants and needs, be sure to go online and make your elections before the deadline! **If you do not enroll online for 2017:**

- Your participation in a 2016 FSA will end on December 31, 2016. You must actively enroll in a 2017 FSA plan if you wish to participate for 2017. Your 2016 FSA enrollment will NOT carryover.

- You must make a new pledge to continue payroll deductions for your 2017 Health Spending Account. (Requires enrollment in the Anthem HSA Medical Plan).

- With the exception of the Flexible Spending Accounts and Health Savings Accounts, if you continue to meet the eligibility requirements, your 2016 coverage will roll over.

- If you are a new benefits eligible employee, you must enroll in order to have coverage in 2017.

**BE SURE TO NAME YOUR BENEFICIARIES!**

It’s important that you name a beneficiary for your company-paid Life and AD&D Insurance coverage, as well as for any Voluntary Life, Accident or AD&D insurance you elect. If you don’t, benefits will be paid according to insurance company guidelines.

You’re automatically listed as the beneficiary for any Voluntary Life insurance you elect for your dependents.
Eligibility

FOR YOU
In general, you’re eligible for Circle K’s benefit plans if you are:

• A full-time Store Manager, Manager in Training, QSR Supervisor or a Non-Store Employee working at least 30 hours a week, and

• You have completed 45 days of service.

• The 401(k) Plan and Employee Stock Purchase Plan have different eligibility requirements. See these sections of this Enrollment Guide for details.

FOR YOUR DEPENDENTS
You can also cover eligible dependents under certain Circle K benefit plans. Your eligible dependents include:

• Your legally married spouse.

• Your registered domestic partner.

• Your children younger than 26 regardless of financial dependency, residency, student status, marital status or the eligibility for other health insurance coverage.

• Your disabled children of any age who depend on you for full financial support.

For the purposes of dependent eligibility, your children include biological children, adopted children, step-children, children of a qualified domestic partner or as determined by a court order.

IF YOU COVER A DOMESTIC PARTNER
Domestic partners (DPs) are eligible for Medical, Dental, Vision and Voluntary Life Insurance coverages only. To enroll your DP and/or child(ren) of your domestic partner, you must have an Affidavit of Domestic Partnership on file with Human Resources.

For details contact the Tempe Employee Service Center at 1-888-477-6583 (Circle K) or the Columbus Employee Service Center at 1-877-324-7968, option 7 (Circle K Midwest/Great Lakes/Heartland).
VERIFYING DEPENDENT ELIGIBILITY

It’s important that you carefully review the eligibility rules for our benefit plans. You are responsible for ensuring that each person you enroll meets the eligibility criteria. Likewise, you are responsible for immediately removing dependents when they no longer meet the eligibility requirements.

Circle K incurs significant costs to provide benefits to employees and their dependents. To ensure that only those who are truly eligible for coverage are enrolled, Circle K requires acceptable supporting documentation for all newly-eligible dependents. This information includes, but is not limited to, marriage certificates, birth certificates, tax returns, court orders and/or adoption papers, among others. In addition, you’ll need to provide a valid Social Security Number for each dependent you enroll.

*If you fail to submit the required documentation, your dependent will not be covered.*

Disciplinary action, up to and including termination, may result from knowingly enrolling an ineligible dependent or for failing to notify the Benefits Department that your dependent no longer meets the eligibility requirements. If this occurs, you’ll be responsible for any claims and penalties resulting from those claims.

DEPENDENT SOCIAL SECURITY NUMBERS

Circle K is required to collect Social Security numbers for all members enrolled in the plans offered by the company. This includes your covered spouse/domestic partner and dependent children. This change is due to recent legislation and reporting requirements that all insurance companies are required to follow.

An employee or dependent cannot be added to any of the benefit plans without a valid Social Security number being provided at the time of enrollment. You have a 30-day grace period (from date of birth) to provide a valid Social Security number for newborns. Please have these numbers available when you are ready to make your elections.
Making Changes to Your Benefits

Your benefit elections remain in effect for the plan year, which runs from January 1 to December 31, 2017. Generally, you can only change those elections during the Annual Benefits Enrollment Period. However, you can change certain Circle K benefits during the year if you have a Qualified Change in Family Status.

A Qualified Change in Family Status includes:

- A birth, adoption or placement for adoption of an eligible child.
- Your marriage, divorce or legal separation.
- The death of your spouse or covered child.
- A change in your child's eligibility for benefits.
- You become eligible for Medicare or Medicaid.
- A change in your or your spouse's work status that affects benefits eligibility (for example, starting a new job or leaving a job).
- A change in your residence or work site that affects your eligibility for coverage (for example, moving out of a medical plan's network area).
- A significant change in your or your spouse's health coverage attributable to your spouse's employment.
- Your spouse or child moves to the United States.
- You receive a Qualified Medical Child Support Order (QMCSO).
- Loss of coverage through Medicaid or CHIP because you are no longer eligible or become eligible for a state's premium assistance program under Medicaid or CHIP.

You have 31 days following the date of your status change to change your benefits. Any changes you make must be directly related to your status change. For example, following a birth or adoption you'll be allowed to add your child to your medical plan, but you will not be allowed to change medical plans or enroll in Voluntary Long-Term Disability coverage.

If you lose Medicaid or CHIP coverage because you are no longer eligible or if you become eligible for a state’s premium assistance program under Medicaid or CHIP, you will have 60 days (instead of 31 days) from the date of the Medicaid/CHIP eligibility change to request enrollment in the Circle K medical plans. NOTE: This 60 day extension does not apply to enrollment opportunities other than due to Medicaid/CHIP eligibility changes.

If you have a Qualified Change in Family Status, contact the Tempe Employee Service Center at 1-888-477-6583 (Circle K) or the Columbus Employee Service Center at 1-877-324-7968, option 7 (Circle K Midwest/Great Lakes/Heartland) for assistance. You must submit the required documentation of the event to the HR Department and complete your enrollment process no later than 31 days from the event.
Eligibility continued...

WHEN YOUR BENEFITS END

Your benefits will end on the earlier of the following dates:

- Your employment with Circle K ends.
- The group insurance contract is terminated.
- You fail to pay, when due, any contributions required for coverage.
- You retire.
- You are on a personal leave of absence longer than 30 days.
- You are on a military leave of absence.
- You are on any other type of leave longer than 6 months (exhausting of active benefits).
Medical Plans

Circle K offers several medical plan options. The options available to you depend on where you live:

- Anthem Blue Cross Blue Shield (BCBS) HSA Medical Plan
- Anthem Blue Cross Blue Shield (BCBS) Preferred Provider Organization (PPO Plus Plan)
- Kaiser Permanente Health Maintenance Organization (HMO Plan), available if you live in California.
- Anthem Blue Cross Blue Shield (BCBS) Out-of-Area Plan, if you live in an area that doesn’t offer the HSA, PPO Plus or HMO Plans.

Anthem’s HSA and PPO Plans use the national Bluecard® PPO network, while Anthem’s Out-of-Area Plan uses the traditional network. The HMO Plan uses the Kaiser network.

**HOW THE PLANS WORK**

For care under each of the medical plans:

<table>
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<th>Under the HSA, PPO Plus and Out-of-Area Plans</th>
<th>Under the HMO Plan</th>
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<tr>
<td>Providers</td>
<td>You can visit any provider, but you will pay less out of pocket for care received from in-network providers who charge pre-negotiated rates.</td>
<td>You are required to choose a Primary Care Physician to coordinate your care. In addition, the plan does not cover out-of-network care.</td>
</tr>
<tr>
<td>Out-of-Pocket Costs</td>
<td>You must meet an annual deductible before the plan begins sharing in the cost of benefits. Once you meet the annual deductible, you pay coinsurance for services, up to your out-of-pocket maximum. Once you reach your annual out-of-pocket maximum, the plans pay 100% of all remaining medical costs for that plan year. If you’re enrolled in the HSA Medical Plan, the Health Savings Account (HSA) feature can help you offset some of your out-of-pocket costs—see page 19 for details. If you are enrolled in the PPO Plus Plan, you can also offset your costs by participating in the Flexible Spending Accounts, as described on page 31.</td>
<td>There is no annual deductible or coinsurance. Instead, you’ll pay a series of copays each time you receive medical care, up to the annual out-of-pocket maximum. You can offset some of your out-of-pocket costs by participating in the Flexible Spending Accounts, as described on page 31.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>The amounts you pay out of pocket for prescription drugs count toward meeting your annual deductible and annual out-of-pocket maximum. The HSA plan includes a Preventative RX Plus Program with preventative drugs covered for $0 coinsurance. This plan includes medications to treat Asthma, Blood Clots, Diabetes, Heart Health &amp; High Blood Pressure, High Cholesterol and stroke.</td>
<td>The amounts you pay out of pocket for prescription drugs count toward meeting your annual out-of-pocket maximum.</td>
</tr>
</tbody>
</table>
| Levels of Coverage        | • Employee Only  
• Employee + Spouse  
• Employee + Child(ren)  
• Employee + Family | • Employee Only  
• Employee + Spouse  
• Employee + Child(ren)  
• Employee + Family |

* If your spouse is employed and has access to health care insurance through his or her employer, but declines that coverage and instead enrolls in a Circle K medical plan, you will be subject to a spousal surcharge. This surcharge is $100 per month, paid on an after-tax basis, and is in addition to your required premium contributions.
**QUICK FACTS**

**Step Therapy:** Step therapy is the practice of using certain drugs first when treating some conditions. These drugs are proven to work well for most people. Plus, members have the lowest out-of-pocket costs for these drugs. In rare cases when these drugs don’t work well for a member, the doctor can contact Anthem about approving coverage for a different drug. Trying drugs in this step-by-step way is called step therapy. You can find a list of these drugs online at [http://file.anthem.com/45234ANMENABS.pdf](http://file.anthem.com/45234ANMENABS.pdf).

**Prior Authorization:** Most prescriptions are filled right away when you take them to the pharmacy. But some drugs need to be reviewed by your health plan before they’re covered. This process is called prior authorization. Prior authorization focuses on drugs that may have a risk of side effects, a risk of harmful effects when taken with other drugs, potential for incorrect use or abuse, better options that may cost you less and work better, and rules for use with certain health conditions. The drugs listed at [http://file.anthem.com/45233anmenabs.pdf](http://file.anthem.com/45233anmenabs.pdf) need to be reviewed and approved by your health plan before they’re covered.
Medical Plans continued...

**ANTHEM 24/7 NURSELINE**

If you’re enrolled in the HSA, PPO Plus or Out-of-Area Plans, the 24/7 NurseLine takes the guesswork out of your health problems. When you call, you get instant access to registered nurses who can help you deal with a variety of medical issues.

To get your non-emergency medical questions answered, just call the 24/7 NurseLine at 1-800-700-9184—help is available 24 hours a day, seven days a week. You can also access Anthem’s Audio Health Library, where you can choose from over 300 prerecorded health topics. Visit [http://materials.anthem.com/47918MUMENABS.pdf](http://materials.anthem.com/47918MUMENABS.pdf) for a list of prerecorded topics and topic codes.

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**QUICK FACTS**

**Need quick care?** Consider a walk-in doctor’s office, retail or urgent care clinic for simple care issues. You can even search [anthem.com](http://anthem.com) or use the Anthem app to find a facility near you. In an emergency, however, always call 911 or go to the nearest ER for treatment.

*For common health concerns, a doctor is just a click away with LiveHealth Online!*

**What is LiveHealth Online?**

With LiveHealth Online, you have a doctor by your side 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. No appointments, no driving and no waiting at an urgent care center. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more! It's faster, easier and more convenient than a visit to an urgent care center.

**How does LiveHealth Online work?**

When you need to see a doctor, simply go to [livehealthonline.com](http://livehealthonline.com) or access the LiveHealth Online mobile app. Select the state you are located in and answer a few questions. Establishing an account allows you to securely store your personal and health information. Plus, you can easily connect with doctors in the future, share your health history and schedule online visits at times that fit your schedule. Once connected, you can talk and interact with the doctor as if you were in a private exam room.
**MEDICAL PLANS CHART**

The following comparison charts show what each plan offers.  
*Note: The percentages reflect what you must pay.*

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Anthem BCBS HSA Medical Plan</th>
<th>Anthem/BCBS PPO Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>Person / Family</td>
<td>$1,500 / $3,000</td>
<td>$3,000 / $6,000</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket</strong></td>
<td>$3,000 / $6,000</td>
<td>$6,000 / $12,000</td>
</tr>
<tr>
<td>Maximum (includes deductible, coinurance and copays) Person / Family</td>
<td>$850 / $1,700</td>
<td>$1,700 / $3,400</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Physician Office Visit</strong></td>
<td>• Deductible and $10 copay</td>
<td>• Deductible and 40%</td>
</tr>
<tr>
<td>• Convenience Care Clinic</td>
<td>• Deductible and 20%</td>
<td>• Deductible and 40%</td>
</tr>
<tr>
<td>• Primary Care</td>
<td>• $10 Copay</td>
<td>• $25 Copay</td>
</tr>
<tr>
<td><strong>Specialist Office Visit</strong></td>
<td>Deductible and 20%</td>
<td>Deductible and 40%</td>
</tr>
<tr>
<td>(Physical, Occupational, Speech, Chiropractic)</td>
<td>$50 Copay</td>
<td>Deductible and 40%</td>
</tr>
<tr>
<td><strong>Lab and X-Ray</strong></td>
<td>• Deductible and 20%</td>
<td>• Deductible and 40%</td>
</tr>
<tr>
<td>• Routine (Office/Clinic)</td>
<td>• Deductible and 20%</td>
<td>• Deductible and 40%</td>
</tr>
<tr>
<td>• MRI, PET, CT, Ultrasound</td>
<td>• Deductible and 20%</td>
<td>• Deductible and 40%</td>
</tr>
<tr>
<td><strong>Well-Baby Care</strong></td>
<td>0%</td>
<td>Deductible and 40%</td>
</tr>
<tr>
<td><strong>Adult Preventative Care</strong></td>
<td>0%</td>
<td>Deductible and 40%</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>Deductible and 20%</td>
<td>Deductible and 40%</td>
</tr>
<tr>
<td>(Surgical Facility)</td>
<td>Deductible and 20%</td>
<td>Deductible and 20%</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>Deductible and 20%</td>
<td>Deductible and 40%</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>Deductible and 20%</td>
<td>Deductible and 20%</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>Deductible and 20%</td>
<td>Deductible and 20%</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>Deductible and 20%</td>
<td>Deductible and 20%</td>
</tr>
<tr>
<td>(Emergency Only)</td>
<td>Deductible and 20%</td>
<td>Deductible and 20%</td>
</tr>
<tr>
<td><strong>Mental/Nervous/Substance Abuse</strong></td>
<td>• Deductible and 20%</td>
<td>• Deductible and 40%</td>
</tr>
<tr>
<td>• Inpatient</td>
<td>• Deductible and 20%</td>
<td>• Deductible and 40%</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>• Deductible and 20%</td>
<td>• Deductible and 40%</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td><strong>ACA Defined Preventative</strong></td>
<td>0%, no deductible</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Prescription Drugs</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Retail</strong></td>
<td>• Yes</td>
<td>n/a</td>
</tr>
<tr>
<td>• Prior Authorization</td>
<td>• n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>• Prescription Deductible</td>
<td>• n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>— Generic</td>
<td>Deductible and 20%</td>
<td>Not covered</td>
</tr>
<tr>
<td>— Preferred Brand</td>
<td>Deductible and 20%</td>
<td>25% Coinsurance; $25 Min up to $85 Max</td>
</tr>
<tr>
<td>— Non-Preferred Brand</td>
<td>Deductible and 20%</td>
<td>40% Coinsurance; $45 Min up to $125 Max</td>
</tr>
<tr>
<td>— Specialty Drug</td>
<td>Deductible and 20%</td>
<td>25% to $150/Script</td>
</tr>
<tr>
<td><strong>Mail Order</strong></td>
<td>Deductible and 20%</td>
<td>2x Retail Copay</td>
</tr>
<tr>
<td>Required for Maintenance</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Medications (90 Day Supply)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Important:** This chart is only a summary of the major benefits of these plans and is not intended to be used as a complete explanation of your benefits. For a complete list of covered services, including limitations and exclusions, see your Summary Plan Description.
**MEDICAL PLANS CHART**

The following comparison charts show what each plan offers.

*Note: The percentages reflect what you must pay.*

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Anthem BCBS Indemnity Plan (Out-of-Area)</th>
<th>Kaiser Permanente of California (California employees only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong> Person / Family</td>
<td>$850 / $1,700</td>
<td>No Deductible / No Deductible</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong> (includes deductible, coinsurance and copays) Person / Family</td>
<td>$4,000 / $9,700</td>
<td>$1,500 / $3,000</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Physician Office Visit</strong></td>
<td>$25 copay (includes OB/GYN)</td>
<td>$25 copay</td>
</tr>
<tr>
<td><strong>Specialist Office Visit</strong> (Physical, Occupational, Speech, Chiropractic)</td>
<td>$50 copay</td>
<td>$45 copay (includes OB/GYN)</td>
</tr>
<tr>
<td><strong>Lab and X-Ray</strong></td>
<td>0%</td>
<td>10% copay</td>
</tr>
<tr>
<td>• Routine (Office/Clinic)</td>
<td></td>
<td>• MRI, PET, CT</td>
</tr>
<tr>
<td>• MRI, PET, CT</td>
<td>$50 copay (includes OB/GYN)</td>
<td>$50 copay (includes OB/GYN)</td>
</tr>
<tr>
<td><strong>Well-Baby Care</strong></td>
<td>0%</td>
<td>No copay up to 24 months</td>
</tr>
<tr>
<td><strong>Adult Preventative Care</strong></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong> (Surgical Facility)</td>
<td>Deductible and 20%</td>
<td>$150 copay per procedure</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>$500 copay, then deductible and 20%</td>
<td>$500 copay per admission</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>Deductible &amp; 20% co-insurance</td>
<td>$100 copay (waived if admitted)</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$75 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td><strong>Ambulance</strong> (Emergency Only)</td>
<td>Deductible and 20%</td>
<td>$100 copay (must meet defined emergency criteria)</td>
</tr>
<tr>
<td><strong>Mental/Nervous/Substance Abuse</strong></td>
<td>$500 copay then deductible and 20%</td>
<td>MH: $500 copay; CD: $500 copay; Detox only; $100 copay TRRS; 120 days (every 5-year period)</td>
</tr>
<tr>
<td>• Inpatient</td>
<td></td>
<td>$25 copay</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>$25 copay</td>
<td>MH: $25 copay $12 copay for group therapy visits; CD: $5 copay for group therapy/$25 copay for individual visits</td>
</tr>
</tbody>
</table>

**Prescription Drugs**

| **ACA Defined Preventative Prescription Drugs** | n/a                        | n/a                        |
| **Retail**                                    |                           |                            |
| • Prior Authorization                         | Yes                       | n/a                       |
| • Prescription Deductible                     | $100/$300                 | n/a                       |
| — Generic                                     | $10 Copay                 | $10 Copay (generics)      |
| — Preferred Brand                             | 25% Coinsurance; $25 Min up to $85 Max | $35 Copay (formulary brand) |
| — Non-Preferred Brand                         | 40% Coinsurance; $45 Min up to $125 Max | Same as brand if medically necessary and approved by plan physician |
| — Specialty Drug                              | 25% to $150/Script        | Same as brand if medically necessary and approved by plan physician |

**Mail Order** Required for Maintenance Medications (90 Day Supply)

| 2x Retail Copay                              | Tier 1 $20 Copay; Tier 2 $70 Copay; Tier 3 & Specialty Same as brand if medically necessary and approved by plan physician |

*Important: This chart is only a summary of the major benefits of these plans and is not intended to be used as a complete explanation of your benefits. For a complete list of covered services, including limitations and exclusions, see your Summary Plan Description.*
Get Rewarded for Good Health!

Good health is priceless. Circle K wants to help you stay healthy and identify potential health risks, and our wellness incentive will reward you for taking the first steps.

**WHO IS ELIGIBLE?**

You are eligible for the Wellness Incentive if you are enrolled in the HSA, PPO Plus, Kaiser HMO or Out-of-Area Plan in 2017.

The annual Wellness Incentive is a lump-sum benefit that Circle K deposits into a Health Care Spending Account on your behalf.

**WHAT IS THE BENEFIT?**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Employee</th>
<th>Enrolled Spouse*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem BCBS HSA Medical Plan</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Anthem BCBS PPO Plus Plan</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>Kaiser Permanente HMO</td>
<td>$250</td>
<td>$250</td>
</tr>
</tbody>
</table>

* Please note that your spouse is not eligible to earn the wellness incentive if you do not have an annual physical and complete the HRA yourself.

**HOW DO I QUALIFY?**

To receive these funds, you (and your enrolled spouse) must:

• Have an annual physical.

• Have your doctor conduct the following biometric screenings: Blood pressure; fasting blood glucose level; total cholesterol, including HDL, LDL and Triglyceride levels.

• Complete an online Health Risk Assessment (HRA) that includes entering your health screening results.

Remember that routine annual physicals are covered under all our medical plans at 100%, with no deductible, copay or coinsurance.
Taking Your Health Risk Assessment

When you are ready to take the online HRA, the website you access via computer or mobile device differs depending on your medical plan.

<table>
<thead>
<tr>
<th>IF YOU'RE ENROLLED IN THE HSA, PPO PLUS OR OUT-OF-AREA PLANS...</th>
<th>IF YOU'RE ENROLLED IN THE HMO PLAN...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sign in to <a href="http://www.anthem.com">www.anthem.com</a> using the unique User ID and Password established when registering your account. Click “Health and Wellness,” then select the link to start your HRA. Your spouse must establish a separate online account to access the Health Risk Assessment. If you need assistance, contact Anthem BCBS at 1-844-453-4509 (8 a.m. to 4 p.m. EST Monday through Friday).</td>
<td>Kaiser offers a Total Health Assessment (THA) in partnership with HealthMedia®. First you'll need to register at <a href="http://www.kp.org/register">http://www.kp.org/register</a>, then you can: • Go to the <a href="http://www.kp.org">www.kp.org</a> home page and click on “total health assessment” under the My Health Manager section, or • Go to <a href="http://www.kp.org/healthylifestyles">www.kp.org/healthylifestyles</a>. If you need assistance, contact Kaiser’s Member Service Department at 1-800-464-4000. If you have questions related to the THA, contact HealthMedia at 1-866-433-9284.</td>
</tr>
</tbody>
</table>

When completing your HRA, enter the results of your biometric health screenings and answer all questions honestly. In addition, remember to keep your back up documentation in case you need to prove that you completed the HRA and qualify to receive your wellness incentive.

**QUICK FACTS**

The personal information you provide in your HRA is confidential and will not be shared with Circle K. However, we use this overall data to help us tailor our wellness programs to the needs of our employees.

**HOW DO I ACCESS THE FUNDS?**

Once you have completed the Incentive requirements, Circle K will deposit your incentive funds into a Health Care Spending Account on your behalf approximately 45 days from the completion of wellness activities.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Funds are deposited into:</th>
<th>How do I get an account?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anthem BCBS PPO Plus Plan</strong></td>
<td>PayFlex Health Care Flexible Spending Account</td>
<td>If you are not already participating in a PayFlex Health Care Flexible Spending Account, Circle K will create an account for you.</td>
</tr>
<tr>
<td><strong>Anthem BCBS HSA Medical Plan</strong></td>
<td>HealthEquity Health Savings Account</td>
<td>If you are enrolled in the Anthem BCBS Health Savings Account Medical Plan, you already have an account with HealthEquity.</td>
</tr>
<tr>
<td><strong>Kaiser Permanente HMO</strong></td>
<td>PayFlex Health Care Flexible Spending Account</td>
<td>If you are not already participating in a PayFlex Health Care Flexible Spending Account, Circle K will create an account for you.</td>
</tr>
</tbody>
</table>

PayFlex or HealthEquity will issue you a card to be used like a debit card to pay for goods and services at your care provider’s office or pharmacy. For information on how the PayFlex Health Care FSA works, see page 31. For more information on how the HealthEquity Health Savings Account works, see page 21.
Using the Health Savings Account Feature

If you enroll in the HSA Medical Plan, you’re also enrolled in a tax-advantaged Health Savings Account (HSA). As money is added to your HSA, you can use these funds to pay for eligible medical expenses – whether you incur those expenses in 2017 or in later years.

Your HSA balance can grow in three ways – with contributions from Circle K, your own contributions, and with earnings and interest.

**QUICK FACTS**

HSAs offer triple tax savings:
- Contributions are **not taxed**.
- Interest and earnings are **not taxed**.
- Money withdrawn is **not taxed** if it’s used for qualified medical expenses.

**CIRCLE K CONTRIBUTIONS**

If you enroll in the HSA Medical Plan and you receive your annual physical and complete an online Health Risk Assessment (HRA), Circle K will make a contribution to your HSA account (see Get Rewarded for Good Health on page 17).

- For Employee Only coverage: $500
- For your enrolled spouse: $500

**YOUR CONTRIBUTIONS**

You can also make voluntary, pre-tax contributions to the HSA in addition to the amount Circle K contributes. In 2017, you can contribute up to:

- For Employee Only coverage: $3,400.
- For other coverages: $6,750.
- If you’re age 55 or older: An additional $1,000 (a “catch-up” contribution) over and above your coverage limit.

Note, contribution limits include both the dollars you contribute and the dollars, if any, Circle K contributes to your account.

You can make your pre-tax contributions on a per paycheck basis, or you can make the entire amount as a one-time lump-sum deduction. You can also change your HSA contribution amount at any time by contacting the Tempe Employee Service Center at 1-888-477-6583 (Circle K) or the Columbus Employee Service Center at 1-877-324-7968, option 7 (Circle K Midwest/Great Lakes/Heartland) for assistance. Please note that federal regulations do not allow you or your spouse to contribute to both an HSA and a Health Care FSA. However, you can participate in the Limited Purpose FSA, as described on page 31.
EARNINGS AND INTEREST

Once your HSA account balance reaches $1,000, that money can be invested, tax free, much like your 401(k) account. However, please note that some states do not allow tax-free contributions and/or earnings, including New Jersey, California, and Alabama. In addition, Tennessee and New Hampshire do not have state income tax, but may tax HSA dividends and/or interest or investment earnings.

KEY HSA FEATURES

There are several features that make the HSA a unique tool for saving on healthcare costs.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Benefit to You</th>
</tr>
</thead>
<tbody>
<tr>
<td>No risk of ‘Use it or lose it’</td>
<td>You can roll over unused HSA contributions from year to year, allowing you to accumulate funds for future eligible medical expenses, including eligible medical expenses in retirement.</td>
</tr>
<tr>
<td>You own your HSA funds</td>
<td>Even if you retire or leave employment with Circle K, you can take your HSA with you and continue to withdraw funds tax-free for eligible medical expenses.</td>
</tr>
<tr>
<td>It’s available for dental and vision expenses</td>
<td>Your funds don’t have to be used for just medical expenses—they can also help reduce dental or vision care expenses.</td>
</tr>
<tr>
<td>You can grow your HSA funds</td>
<td>Once your HSA reaches a minimum balance of $1,000 you may choose to transfer a portion of additional contributions from your HSA into an investment account.</td>
</tr>
</tbody>
</table>

WHAT’S AN ELIGIBLE MEDICAL EXPENSE?

You can only use your HSA to pay for eligible medical expenses. These are defined by the IRS and include:

- Office visits
- Lab tests
- Hospital charges
- Prescriptions
- Routine dental care, including braces
- Eyeglasses, contacts, or LASIK surgery
- Chiropractic services
- Acupuncture
- Hearing aids (including batteries)

Using Your HSA

It’s easy to use your HSA, and understanding how it works can help you save on healthcare costs.

1. **START IT**
   • You can deposit your own dollars into your HSA. Contributions are pre-tax through payroll deductions (up to IRS limits).

2. **BUILD IT**
   • You can change the amount you contribute any time.
   • You can also make post-tax contributions directly to your HSA.

3. **USE IT**
   • Once you enroll in the HSA Medical and complete the wellness activities, if you don’t have an HSA account open, Circle K will open an HSA account for you with Circle K contributions
   - $500 for individual coverage, and
   - $500 for your enrolled spouse if they complete the wellness activities
   • You may also choose to contribute to your HSA.

4. **GROW IT**
   • You can use the money in your HSA to pay for covered health care through an HSA debit card.
   • Withdrawals from your HSA (for qualified medical expenses) are tax-free.
   • You don’t need to provide receipts for reimbursement—you only need to save them for tax purposes.
   • You must have money in your HSA account to pay for expenses or be reimbursed.
   • Unused money in your account will rollover to the next year.
   • Your account will earn interest and grow over time.
   • Once your account reaches $1,000, you may invest your HSA account balance in available mutual funds.
   • Any interest and other investment earnings are yours to keep tax free.

5. **TAKE IT**
   • You always own the money in your HSA, including any contributions from Circle K.
   • You can take the account with you if you leave Circle K.
   • If you contributed to an HSA in 2016, remember to make a new contribution election for 2017.

For more information about the HSA, how it works and how it can benefit you, please visit HealthEquity at [healthequity.com](http://healthequity.com).
Dental Coverage

We offer two dental plan options through Cigna—the Basic Plan and the Plus Plan. Both use a Preferred Dental Provider (PDP) approach. This means you have the freedom to choose any provider for services, but you receive a higher benefit level if you use a Cigna Advantage Network dentist. If you use an out-of-network dentist, you’re subject to a deductible for covered services (except for preventive care in the Plus Plan), and you will have a higher out-of-pocket cost.

FIND A NETWORK DENTIST

To find a Cigna Advantage Network dentist in your area, visit www.mycigna.com or call 1-800-244-6224. You can also contact your dental provider and ask if they are a member of the Cigna Advantage Dental PPO Network.

HOW THE PLANS WORK

Both plans cover a broad range of dental services, including:

• Preventive care such as routine exams and cleanings, fluoride treatments, sealants and X-rays.
• Basic restorative care such as simple fillings and extractions, root canals, oral surgery and gum disease treatment.
• Major restorative care such as crowns and dentures.
• Orthodontia.

You must meet an annual deductible before the plan begins sharing in the cost of benefits. Once you meet the annual deductible, you pay coinsurance for services, up to your annual benefits maximum.

You will not receive an ID card from Cigna when you enroll. If you need to verify coverage with your provider, you can:

• Go to www.cigna.com, create a personal account, and print out an ID card.
• Direct your provider to contact Cigna at 1-800-244-6224. Use the Plan ID 3333795 when calling.
• Log on with the Cigna Mobile Application.
Dental Coverage continued...

DENTAL PLANS CHART

The following chart illustrates the Plan Design Summary for typical services. Reimbursement is based on Reasonable and Customary Charge (R&C). If you seek care from a dentist not in Cigna’s network, you will be responsible for the difference in the maximum allowable charge and your provider’s billed charges in addition to your coinsurance and deductible.

**Important:** State mandates require members in Texas, Louisiana and Mississippi to pay for services received at the same benefit level whether or not the dentist is contracted with the network. Therefore, the out-of-network benefits are the same as in-network with respect to deductible and coinsurance; however, your cost will be higher out-of-network since the dentist is not a contracted Cigna provider.

**Note:** The percentages reflect what you must pay.

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Basic Plan</th>
<th>Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person / Family</td>
<td>$50** / $150**</td>
<td>$50** / $150**</td>
</tr>
<tr>
<td></td>
<td>$25** / $75**</td>
<td>$50*** / $150***</td>
</tr>
<tr>
<td>Annual Maximum Per Person</td>
<td>$1,250</td>
<td>$1,250</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontic Lifetime Maximum Adult &amp; Child</td>
<td>60% up to $1,000</td>
<td>60% up to $1,000</td>
</tr>
<tr>
<td></td>
<td>50% up to $1,000</td>
<td>50% up to $1,000</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(oral examinations, teeth cleaning, fluoride treatments, permanent molar sealants, bitewing and full-mouth X-rays, space maintainers)*</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Basic Restorative Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(composite and amalgam fillings)</td>
<td>20%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>Periodontics, Endodontics, Surgical Removal of Teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(root canal therapy, incision and draining of abscess, scaling and root planing)*</td>
<td>50%</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>Major Restorative Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(general anesthesia/intravenous sedation, inlays and onlays, crowns, full and partial, stainless steel crowns)</td>
<td>50%</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>40%</td>
<td>50%</td>
</tr>
</tbody>
</table>

* Frequency and/or age limitations may apply to these services. These limits are described in the Summary Plan Description.

** Class I, II & III.

*** Applies to Class II & III services only.

**Important:** This chart is only a summary of the major benefits of these plans and is not intended to be used as a complete explanation of your benefits. For a complete list of covered services, including limitations and exclusions, see your Summary Plan Description.
CIGNA DENTAL ORAL HEALTH INTEGRATION PROGRAM

Research shows associations between gum disease and complications for heart disease, stroke, diabetes, preterm birth, preeclampsia and other health issues. As a result, Cigna has enhanced its program to include the following medical conditions and covered dental procedures.

MEDICAL CONDITIONS (check mark indicates covered dental service)

<table>
<thead>
<tr>
<th>Dental Service</th>
<th>Heart Disease</th>
<th>Stroke</th>
<th>Diabetes</th>
<th>Maternity</th>
<th>Chronic Kidney Disease</th>
<th>Organ Transplants</th>
<th>Head &amp; Neck Cancer Radiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodontal treatment and maintenance</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Periodontal evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency palliative treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topical application of fluoride and topical application of fluoride varnish</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topical application of fluoride – excluding varnish</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealant repair – per tooth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Eligibility, reimbursement and coverage for eligible services are subject to plan year maximums.

COST OF COVERAGE

<table>
<thead>
<tr>
<th>Premium Rates</th>
<th>Cigna Basic</th>
<th>Cigna Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WEEKLY</td>
<td>BI-WEEKLY</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$4.42</td>
<td>$8.85</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$8.04</td>
<td>$16.09</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$12.96</td>
<td>$25.92</td>
</tr>
</tbody>
</table>

FOR MORE INFORMATION

Contact CIGNA at:
- For Non-Members: www.cigna.com
- For Members: www.mycigna.com or 1-800-244-6224
Vision Coverage

We offer two vision plan options through EyeMed—the Access C Plan and Access H Plan. EyeMed provides coverage for routine eye exams, as well as benefits for glasses or contact lenses.

Under both plans, you can choose any provider for services, but you receive a higher benefit level if you use an EyeMed provider. If you don’t use an EyeMed provider, your out-of-pocket costs will be higher. In addition, you’ll be responsible for full payment to an out-of-network provider, and you must submit your receipts and an out-of-network claim form to EyeMed for reimbursement.

HOW THE PLANS WORK

How you receive care depends in which plan you select:

• **The Access C Plan** covers one yearly exam for you and your covered dependents, and saves you up to 35% on eyeglasses and 15% on conventional contact lenses. Out-of-network benefits are limited to an eye exam.

• **The Access H Plan** is a full-service plan. You can receive an exam once every 12 months, and lenses and frames (or contacts) once every 24 months.

EyeMed will provide you with an ID card after you enroll, along with complete plan details. If you need to verify coverage with your provider, you can:

• Go to [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com), create a personal account, and print out an ID card, or

• Have your eye doctor’s office call EyeMed Vision Care at 1-866-723-0513.
The following comparison chart shows what each plan offers. **Note:** The *amounts* reflect what you must pay.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exams (with dilation as necessary every 12 months)</td>
<td>$10 copay $46 per exam</td>
<td>$5 copay Up to $35</td>
</tr>
<tr>
<td>Retinal Imaging Benefit</td>
<td>Up to $39 N/A</td>
<td>Up to $39 N/A</td>
</tr>
<tr>
<td>Exam Options</td>
<td>N/A N/A</td>
<td>• Up to $55</td>
</tr>
<tr>
<td>Frames (Frequency for Plan C: unlimited, Plan H: every 24 months)</td>
<td>35% off retail* N/A</td>
<td>$100 allowance, 20% off balance over $100 Up to $50</td>
</tr>
<tr>
<td>Standard Plastic Lenses</td>
<td>• $50 • $70 • $105 • $135 N/A</td>
<td>• $15 copay • $15 copay • $15 copay • $80 copay Up to $25</td>
</tr>
<tr>
<td>Lense Options</td>
<td>• $15 copay • $15 copay • $15 copay • $40 copay • $45 copay • 20% off N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Contact Lenses (in lieu of lenses every 24 months—Plan H)</td>
<td>15% off retail N/A</td>
<td>• $115 + 15% off balance • $115 • Covered in full Up to $100 Up to $100 Up to $200</td>
</tr>
<tr>
<td>Laser Vision Correction</td>
<td>15% off retail or 5% off promotional pricing</td>
<td></td>
</tr>
</tbody>
</table>

* Frame, lenses and lens options must be purchased in the same transaction to receive full discount.

### COST OF COVERAGE

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WEEKLY</td>
<td>BI-WEEKLY</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$0.17</td>
<td>$0.35</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$0.34</td>
<td>$0.68</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$0.30</td>
<td>$0.59</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$0.47</td>
<td>$0.95</td>
</tr>
</tbody>
</table>

**FOR MORE INFORMATION**

Contact EyeMed Vision Care at [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com) or 1-866-723-0513.
Critical Illness Insurance

If you need to treat a critical illness such as cancer, heart attack and stroke, it can lead to unexpected expenses that increase your financial burden. Critical Illness Insurance helps pay for some of these expenses. This may include copays for experimental treatment, travel to and from treatment centers, or for everyday expenses like bills, groceries, rent and mortgage.

**HOW THE PLAN WORKS**

You can choose from two levels of coverage — a total benefit equal to $5,000 or $10,000. Your spouse and children are also covered, although at lower amounts:

- **Spouse:** 50% of your coverage level.
- **Children:** 25% of your coverage level.

Critical Illness insurance pays your chosen level of coverage in a lump-sum amount if you are diagnosed with one of the following conditions.

<table>
<thead>
<tr>
<th>Conditions</th>
<th>1st Occurrence</th>
<th>2nd Occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive Cancer</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Kidney Failure</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Stroke</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Coma</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td>Organ Failure</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Paralysis</td>
<td>50% (one limb)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>100% (two limbs)</td>
<td></td>
</tr>
<tr>
<td>Loss of sight, speech or hearing</td>
<td>100%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Pre-Existing Condition Limitation:** A pre-existing condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.

12 month look back period.
12 month exclusion period.

**Limitations:** The policy has exclusions and limitations that may impact the eligibility for or entitlement to benefits under each covered condition. There are limitations and special requirements for each condition. See the certificate of creditable coverage located on the Benefits page of the Circle K Intranet for more information.

**CRITICAL ILLNESS REDUCTION SCHEDULE**

Benefit amounts are reduced by 50% at age 70 for those already enrolled. Your dependent’s benefit amount will be reduced on a pro rata basis when your benefit amount is reduced.

**EVIDENCE OF INSURABILITY STATEMENT**

If you are enrolling in Critical Illness coverage for you or your spouse after your initial eligibility period, or you are age 70+ and enrolling for the first time, you will be required to complete an Evidence of Insurability Statement (EOIS) form before your coverage can take effect. If an EOIS is necessary, it will be sent to you for completion. Your Critical Illness Insurance coverage will not take effect until your EOIS form is received, approved and processed.
HEALTH SCREENING BENEFIT
You and each of your covered dependents are eligible to receive a $50 Wellness/Health Screening Benefit each calendar year for completing one of the following:

- Stress test
- Glucose test
- Blood test for triglycerides
- Serum cholesterol test
- Bone marrow testing
- Breast ultrasound
- Cancer testing (CA 15-3, CA 125, CEA, PSA)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap test
- Serum Protein Electrophoresis
- Thermography

COST OF COVERAGE
Your cost of coverage depends on the coverage amount you elect. Coverage includes dependent children.

$5,000 Coverage

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000 Employee Only</td>
<td>$1.62</td>
<td>$3.24</td>
<td>$3.51</td>
</tr>
<tr>
<td>$5,000 Employee + $2,500 Spouse</td>
<td>$2.58</td>
<td>$5.16</td>
<td>$5.60</td>
</tr>
</tbody>
</table>

$10,000 Coverage

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000 Employee Only</td>
<td>$2.93</td>
<td>$5.86</td>
<td>$6.35</td>
</tr>
<tr>
<td>$10,000 Employee + $5,000 Spouse</td>
<td>$4.55</td>
<td>$9.10</td>
<td>$9.86</td>
</tr>
</tbody>
</table>

FOR MORE INFORMATION
Refer to your Benefit Summary for details on covered illnesses, amounts payable, and other plan provisions. This information will be mailed to your home after you enroll. You can also call Guardian at 1-800-268-2525.
Voluntary Accident Insurance

Like Critical Illness coverage, an accident can also lead to unexpected expenses that increase your financial burden. Voluntary Accident Insurance helps pay for some of these expenses, such as travel to and from treatment centers, child care while you recover, modifications to your home or automobile consistent with your accident or recovery needs, and for everyday expenses like bills, groceries, rent and mortgage.

HOW THE PLAN WORKS

Voluntary Accident Insurance helps offset the costs associated with both minor and major accidents. For every covered accident, you receive a benefit based on the type of injury and treatments received, regardless of what is covered by your medical insurance. You can choose from two levels of coverage — a total benefit equal to $15,000 or $30,000.

<table>
<thead>
<tr>
<th>Covered Events</th>
<th>Additional Plan 1 ($15,000)</th>
<th>Additional Plan 2 ($30,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Death</td>
<td>$15,000 employee, $15,000 spouse, $5,000 children</td>
<td>$30,000 employee, $30,000 spouse, $5,000 children</td>
</tr>
<tr>
<td>Common Carrier</td>
<td>200% of AD&amp;D</td>
<td>200% of AD&amp;D</td>
</tr>
<tr>
<td>Catastrophic Accident</td>
<td>Quadruplegia: 100%</td>
<td>Quadruplegia: 100%</td>
</tr>
<tr>
<td></td>
<td>Loss of speech &amp; hearing (both ears): 100%</td>
<td>Loss of speech &amp; hearing (both ears): 100%</td>
</tr>
<tr>
<td></td>
<td>Loss of cognitive function: 100%</td>
<td>Loss of cognitive function: 100%</td>
</tr>
<tr>
<td></td>
<td>Hemiplegia: 50%</td>
<td>Hemiplegia: 50%</td>
</tr>
<tr>
<td></td>
<td>Paraplegia: 50%</td>
<td>Paraplegia: 50%</td>
</tr>
<tr>
<td>Single Dismemberment (hand, foot, or sight in one eyes)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Multiple Dismemberment (loss of hands, feet, or sight in both eyes)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Thumb/Index Same Hand, Four Fingers Same Hand, All Toes Same Foot</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Covered Conditions/Services: Employee, Spouse and Dependent Child(ren) 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident Follow-up Treatment (six treatments per covered accident)</td>
<td>$15</td>
<td>$25</td>
</tr>
<tr>
<td>Air Ambulance</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Burns</td>
<td>Up to $12,000</td>
<td>Up to $12,000</td>
</tr>
<tr>
<td>Coma</td>
<td>$2,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>Concussion</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Dislocation</td>
<td>Up to $1,350</td>
<td>Up to $3,600</td>
</tr>
<tr>
<td>Eye Injury (requiring surgical repair)</td>
<td>$125</td>
<td>$200</td>
</tr>
<tr>
<td>Companion Lodging (max. 30 days per covered accident)</td>
<td>$50 per night</td>
<td>$100 per night</td>
</tr>
<tr>
<td>Fractures</td>
<td>Up to $2,000</td>
<td>Up to $4,500</td>
</tr>
<tr>
<td>Health Screening (one test per plan year)</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Hospital Admission (one per plan year)</td>
<td>$500</td>
<td>$750</td>
</tr>
<tr>
<td>Daily In-Hospital Benefit (hospital stay – max. 365 days per hospital stay)</td>
<td>$100 per day</td>
<td>$175 per day</td>
</tr>
<tr>
<td>Hospital Intensive Care (max. 30 days per stay)</td>
<td>$100 per day</td>
<td>$350 per day</td>
</tr>
</tbody>
</table>

Please note that these coverages increase by 20% for an eligible covered child (26 years of age or younger) who has an accident while playing organized sports.
EVIDENCE OF INSURABILITY STATEMENT

If you are enrolling in Accident Plan coverage for you or your spouse after your initial eligibility period, or you are age 70+ and enrolling for the first time, you will be required to complete an Evidence of Insurability Statement (EOIS) form before your coverage can take effect. If an EOIS is necessary, it will be sent to you for completion. Your Accident Plan Insurance coverage will not take effect until your EOIS form is received, approved and processed.

COST OF COVERAGE

Your cost of coverage depends on the coverage amount you elect.

$15,000 Coverage

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>Weekly Rates</th>
<th>Bi-Weekly Rates</th>
<th>Semi-Monthly Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$1.20</td>
<td>$2.40</td>
<td>$2.60</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$2.56</td>
<td>$5.12</td>
<td>$5.55</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$2.67</td>
<td>$5.34</td>
<td>$5.79</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$4.03</td>
<td>$8.06</td>
<td>$8.73</td>
</tr>
</tbody>
</table>

$30,000 Coverage

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>Weekly Rates</th>
<th>Bi-Weekly Rates</th>
<th>Semi-Monthly Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$2.21</td>
<td>$4.42</td>
<td>$4.79</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$4.67</td>
<td>$9.34</td>
<td>$10.12</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$4.87</td>
<td>$9.74</td>
<td>$10.55</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$7.33</td>
<td>$14.66</td>
<td>$15.88</td>
</tr>
</tbody>
</table>

FOR MORE INFORMATION

Refer to your Benefit Summary for details about the plan. You can also call Guardian at 1-800-541-7846.
Circle K offers three types of FSAs to help you save pre-tax dollars on your health and dependent care needs. These include the:

- Health Care FSA for qualified medical, dental and vision care expenses.
- Limited Purpose FSA for qualified dental and vision care expenses, if you are enrolled in the HSA Medical Plan.
- Dependent Care FSA for qualified dependent care expenses.

**HOW THE PLAN WORKS**

An FSA is an account that allows you to set aside money, before taxes, to use on eligible health care and dependent care expenses. You elect how much you want to contribute, and Circle K deducts the contribution in equal amount from your paychecks during the year.

<table>
<thead>
<tr>
<th>Difference</th>
<th>Health Care FSA</th>
<th>Limited Purpose FSA</th>
<th>Dependent Care FSA</th>
</tr>
</thead>
</table>
| Maximum Annual Contribution | $2,550 | $2,550 | • $5,000 if married and filing a joint tax return.  
• $2,550 if filing a single tax return, or if married and filing separate returns.  |
| Eligible Expenses | • Medical, vision, prescription drugs, dental copays and deductibles.  
• Other costs such as braces, eyeglasses, contacts, hearing aids and other items not covered by insurance. | • Dental and vision copays and deductibles.  
• Other costs such as braces, eyeglasses, contacts, and other items not covered by insurance. | • Dependent care expenses for children 12 years old and younger (or disabled dependents of any age).  
• This includes daycare, pre-school daycare, before- and after-school care and summer camp costs (excluding overnight camps). |
| Rules for Reimbursement | Expenses you have between January 1 and December 31, 2017, provided they are medically necessary, not reimbursable under any other plan and tax deductible under IRS rules. | Expenses you have between January 1 and December 31, 2017, provided the dependent care is necessary and both you and your spouse are actively working, a full-time student or actively seeking work. |
IMPORTANT FSA RULES

Remember that all the following rules apply to the Health Care, Limited Purpose and Dependent Care FSAs:

• **Expense Deadline:** Your eligible expenses are reimbursable for any expenses you incur between January 1 and December 31, 2017.

• **Reimbursement Deadline:** You have until March 31, 2018 to submit claims for eligible 2017 expenses.

• **Forfeited Amounts:** Any amounts left in your FSAs after March 31, 2018 that exceed $500 will be forfeited under IRS rules. That’s why you should estimate your FSA your expenses carefully - contribute only what you will use!

FSAs are strictly governed by IRS regulations. For more details and a list of eligible expenses, visit the PayFlex website at [www.payflex.com](http://www.payflex.com) or call PayFlex at 1-844-PAYFLEX (1-844-729-3539) Monday through Friday, 7 AM - 7 PM CST, and on Saturday from 9 AM - 2 PM CST.

USING YOUR FSA FUNDS

PayFlex wants to make using your FSA as easy and convenient as possible. That’s why we offer you choices when using your funds:

• **PayFlex Health Care Debit Card (for the Health Care and Limited Purpose FSAs only)**
  — Debit card preloaded with your annual election amount.
  — Use it at providers or merchants with an industry-standard approval system at the checkout (most drug stores, pharmacies and big-box retailers).
  — Learn more about the approval system and find stores near you at [www.sigis.com](http://www.sigis.com).

• **You can pay yourself back** for an eligible out-of-pocket expense, or you can pay your provider directly from your PayFlex account.

• **You can file FSA claims online** using our free* PayFlex Mobile application or via the PayFlex Member Portal.

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**FOR MORE INFORMATION**

Contact PayFlex at [www.payflex.com](http://www.payflex.com) or 1-844-PAYFLEX (1-844-729-3539), Monday – Friday, 7 AM – 7 PM CST and on Saturday from 9 AM – 2 PM CST.
Life and Accidental Death and Dismemberment (AD&D) Insurance

When thinking about life and accident insurance, it’s important to give some thought to what expenses and income needs your dependents would have if something happened to you. To make sure you have protection, we offer you a variety of insurance choices through Aetna to help you meet those needs.

BASIC LIFE AND AD&D COVERAGE

Circle K provides you with a basic level of protection at no cost to you.

• Basic Life Insurance coverage provides a lump-sum payment to your beneficiary if you die. Your coverage amount equals your base annual salary, rounded to the next $1,000, to certain maximums. (A combined basic and voluntary coverage maximum of $1,500,000; $750,000 without medical questions for new hires).

• Basic AD&D Insurance coverage provides a lump-sum payment to you or your beneficiary if you die or are injured in an accident. Your coverage amount equals your base annual salary, rounded to the next $1,000. The amount payable to you depends on the extent of your injuries, as shown in the following table:

<table>
<thead>
<tr>
<th>If bodily injuries result in the following:</th>
<th>Your benefit amount will be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of any combination of two: hands, feet or eyesight; loss of speech and hearing; quadriplegia</td>
<td>100%</td>
</tr>
<tr>
<td>Third-degree burns covering 75% or more of the body</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia, hemiplegia, loss of one hand, one foot, sight in one eye, speech, or hearing, third-degree burns covering 50% – 74% of the body</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia, loss of thumb and index finger of the same hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

Please note that if you die, AD&D benefits are paid in addition to any Life Insurance your beneficiary is eligible to receive.

Quick Fact

Federal tax law requires Circle K to report the cost of company-paid insurance in excess of $50,000 as imputed income.
VOLUNTARY LIFE INSURANCE COVERAGE

If you want additional life insurance for you, your spouse or your dependent child(ren), you can purchase Voluntary Life Insurance coverage.

You must enroll in Voluntary coverage for yourself if you also want to enroll your spouse and/or child(ren) in coverage. When you purchase Voluntary Life Insurance coverage for yourself, these amounts are in addition to the basic coverage provided by Circle K.

<table>
<thead>
<tr>
<th>Covered Individual</th>
<th>Voluntary Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youself</td>
<td>You can elect 1-5 times your salary in coverage, up to a maximum of $1.5 million (combined with Company Paid Life).</td>
</tr>
</tbody>
</table>
| Your spouse        | • You can elect coverage in $10,000 increments, up to a maximum of $50,000.  
• Spouse coverage may not exceed 50% of the combination of your own Basic & Voluntary life coverage(s). |
| Your child(ren)    | $10,000 per eligible child. |

EVIDENCE OF INSURABILITY STATEMENT

If you are first enrolling in or increasing Voluntary Life Insurance coverage for you or your spouse after your initial eligibility, you will be required to complete an Evidence of Insurability Statement (EOIS) form before your coverage can take effect. If an EOIS is necessary, it will be sent to you for completion.

Your Voluntary Life Insurance coverage will not take effect until your EOIS form is received, approved and processed.

COST OF COVERAGE

To determine the monthly cost of Voluntary Term Life coverage for Employee and Spouse, please refer to your online enrollment event for details. The online event will calculate the premium cost for these benefits for you.

FOR MORE INFORMATION

Contact Aetna at 1-800-523-5065, or call:
• **Tempe Employee Service Center:** 1-888-477-6583  
• **Columbus Employee Service Center:** 1-877-324-7968, option 7
VOLUNTARY AD&D INSURANCE

If you want additional AD&D insurance for you, your spouse or your dependent child(ren), you can purchase Voluntary AD&D Insurance coverage.

You must enroll in Voluntary coverage for yourself if you also want to enroll your spouse and/or child(ren) in coverage. When you purchase Voluntary AD&D Insurance coverage for yourself, these amounts are in addition to the basic coverage provided by Circle K.

You may elect voluntary coverage in an amount from $25,000 to $500,000, in $25,000 increments. If you elect coverage for your family, the benefit amount for family members will be a percentage of the amount you elect.

<table>
<thead>
<tr>
<th>Family Option Benefits</th>
<th>Voluntary AD&amp;D Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee + Spouse Only</td>
<td>• Spouse would be covered for 50% of employee benefit amount.</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>• Each Child would be covered for 15% of employee benefit amount.</td>
</tr>
<tr>
<td>Employee, Spouse + Child(ren)</td>
<td>• Spouse covered for 40% of employee benefit amount.</td>
</tr>
<tr>
<td></td>
<td>• Each Child covered for 10% of employee benefit amount.</td>
</tr>
</tbody>
</table>

Please note that the maximum age for a covered spouse is age 74. Spouses 75 years of age and older are not eligible for Voluntary AD&D Insurance coverage.

COST OF COVERAGE

The cost of Voluntary AD&D Insurance is based on your elected coverage amount. To determine the monthly cost, multiply the cost per $1,000 of coverage by the amount of coverage you’re electing for you and your family.

<table>
<thead>
<tr>
<th>Your Coverage Option</th>
<th>Monthly Cost Per $1,000 of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$0.03</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$0.04</td>
</tr>
</tbody>
</table>

REDUCTION SCHEDULE

Your benefits under the Basic Life, Basic AD&D, and Voluntary Employee Life Insurance will be reduced depending on your age. The reduced amount becomes effective January 1 of the following year in which you reach the following ages:

- **At age 65**: 65% of covered amount.
- **At age 70**: 45% of covered amount.
- **At age 75**: 30% of covered amount.
- **At age 80**: 20% of covered amount.
Disability Insurance

Our disability insurance, provided through Aetna Disability Services, consists of two types of plans that protect your income if you are unable to work due to illness or injury. Circle K provides you with basic Short-Term Disability (STD) at no cost. In addition, you have the option of purchasing Voluntary Long-Term Disability (LTD) coverage for an additional cost.

For both STD and LTD, benefits are provided only to you. Your spouse and other dependents are not eligible for coverage.

**WHEN ARE YOU CONSIDERED DISABLED?**

A disability is a condition that is caused by a sickness or injury that prevents you from working. For STD, only non-occupational disabilities are covered, while LTD covers both occupational and non-occupational disabilities. Your health care provider will need to evaluate your condition and determine whether or not you are disabled under the terms of the plan.

**SHORT-TERM DISABILITY**

Your STD benefits begin on the eighth day of a disability due to illness. You receive up to $1,800 per week (to a maximum of 66 \(\frac{2}{3}\) % of your covered income per week) for up to 26 weeks. Your covered income is determined using your gross weekly earnings just prior to the onset of your disability. There is no pre-existing condition clause for Short-Term Disability.

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Plan Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly Benefit % — Maximum of 26 Weeks</td>
<td>66 (\frac{2}{3}) %</td>
</tr>
<tr>
<td>Weekly Maximum Benefit</td>
<td>$1,800 per week</td>
</tr>
<tr>
<td>Waiting Periods</td>
<td>Accident = 7 Days / Sickness = 7 Days</td>
</tr>
</tbody>
</table>

Please note that if you live in California, Hawaii, New Jersey, New York, Puerto Rico or Rhode Island, the STD payments you receive from Circle K will be offset by any disability benefits you’re also eligible to receive from a state-sponsored disability plan.
VOLUNTARY LONG-TERM DISABILITY

If you elect Voluntary LTD coverage, benefits begin after you have been disabled for more than 26 weeks and have exhausted your STD benefits. Like STD, you receive a specified percentage of your weekly pay. You are not eligible for an LTD benefit if you become disabled within 180 days after you initially elect coverage.

You can choose from four different Voluntary LTD options. You can elect coverage equal to 50% or 60% of your salary for 5 years of maximum benefit (refer to LTD Certificate for details) or elect coverage to Age 65/Social Security Normal Retirement Age (SSNRA) (refer to LTD Certificate for details).

- **Option 1** = 50% of weekly pay for maximum of 5 years duration.
- **Option 2** = 60% of weekly pay for maximum of 5 years duration.
- **Option 3** = 50% of weekly pay until you reach your SSNRA.
- **Option 4** = 60% of weekly pay until you reach your SSNRA.

BENEFIT DURATION

As long as you remain disabled under the terms of the plan, your LTD payments will continue to either a 5-year maximum benefit duration (for Option 1 and Option 2), or until the calendar month in which you reach your SSNRA (Option 3 and Option 4).

However, if your disability starts on or after the date you reach age 61, benefit payments will continue as shown in the following chart:

<table>
<thead>
<tr>
<th>Age at Disability</th>
<th>Duration of Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to age 61</td>
<td>Options 1 or 2:</td>
</tr>
<tr>
<td></td>
<td>5 year maximum duration</td>
</tr>
<tr>
<td></td>
<td>Options 3 or 4:</td>
</tr>
<tr>
<td></td>
<td>To Normal Retirement Age</td>
</tr>
<tr>
<td>61</td>
<td>48 months</td>
</tr>
<tr>
<td>62</td>
<td>42 months</td>
</tr>
<tr>
<td>63</td>
<td>36 months</td>
</tr>
<tr>
<td>64</td>
<td>30 months</td>
</tr>
<tr>
<td>65</td>
<td>24 months</td>
</tr>
<tr>
<td>66</td>
<td>21 months</td>
</tr>
<tr>
<td>67</td>
<td>18 months</td>
</tr>
<tr>
<td>68</td>
<td>15 months</td>
</tr>
<tr>
<td>69 and over</td>
<td>12 months</td>
</tr>
</tbody>
</table>

PRE-EXISTING CONDITION LIMITATIONS

A pre-existing condition is an illness, injury or pregnancy-related condition for which during the 6 months before your coverage became effective you were diagnosed, treated or you received diagnostic treatment by a health care provider.

You are not eligible to receive an LTD benefit for a disability caused by a pre-existing condition (or to which the pre-existing condition contributes), if that disability starts within the first 12 months after your coverage becomes effective. After you have been covered for 12 months, any pre-existing condition limitations no longer apply.
Disability Insurance *continued...*

**EVIDENCE OF INSURABILITY STATEMENT**

If you are first enrolling in or changing your Voluntary LTD coverage after your initial eligibility, you will be required to complete an Evidence of Insurability Statement (EOIS) form before your coverage can take effect. If an EOIS is necessary, it will be sent to you for completion.

**COST OF COVERAGE**

Your cost of coverage depends on the LTD option you choose.

<table>
<thead>
<tr>
<th>Your Coverage Option</th>
<th>Monthly Cost Per $100 of Covered Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1 - 50%/5 year maximum</td>
<td>$0.467</td>
</tr>
<tr>
<td>Option 2 - 60%/5 year maximum</td>
<td>$0.713</td>
</tr>
<tr>
<td>Option 3 - 50% up to age 65</td>
<td>$0.705</td>
</tr>
<tr>
<td>Option 4 - 60% up to age 65</td>
<td>$1.123</td>
</tr>
</tbody>
</table>

**FOR MORE INFORMATION**

- Contact Aetna to file an STD or LTD claim at 1-877-832-8241.
- For plan information, call:
  - Circle K Tempe Employee Service Center: 1-888-477-6583
  - Circle K Midwest/Great Lakes/Heartland Columbus Employee Service Center: 1-877-324-7968, option 7
Circle K offers a 401(k) Plan to help you save money for retirement. You're eligible to participate if you are age 18 or older and have completed 45 or more days of service. Once eligible, you can enroll in the 401(k) Plan effective with the first day of the following month.

THE 401(k) PLAN MAKES SAVING FOR RETIREMENT EASY
- **It’s automatic** — Your contributions are automatically deducted from your paycheck.
- **It’s free money** — Circle K matches a portion of your pre-tax contributions.
- **It’s tax-deferred** — If you contribute on a pre-tax basis, this lowers your taxable income.
- **It’s your decision** — You decide how to invest your funds based on your goals and the amount of risk you’re willing to take.

ROTH CONTRIBUTIONS NOW AVAILABLE
Starting in 2017, our plan now allows Roth contributions. This feature allows you to save on an after-tax basis now, but any investment growth on your contributions is completely tax-free when you withdraw the money at a later date, assuming certain requirements are met. (Your Roth 401(k) account must be at least five years old when you withdraw it, and you must take the money after you reach age 59½ to qualify for this tax savings.)

Together, the sum of your Roth 401(k) and pre-tax 401(k) contributions cannot exceed the maximum IRS annual contribution limit. Certain IRS rules apply to the use of the Roth 401(k), so make sure you understand them completely before choosing this option. You can find more information on Roth 401(k) in IRS Publication 4530 [http://www.irs.gov/pub/irs-pdf/p4530.pdf](http://www.irs.gov/pub/irs-pdf/p4530.pdf).
HOW THE PLAN WORKS

<table>
<thead>
<tr>
<th>Your Contributions</th>
<th>You can contribute 1% to 100% of your total salary on a pre-tax, after-tax, or Roth basis (excluding bonuses, severance pay, commissions and incentive pay), up to certain annual IRS limits.</th>
</tr>
</thead>
</table>
| Circle K Matching Contributions | After you’ve completed one year of service with Circle K, the matching contribution you’re eligible to receive will depend on your total years of service with the company:  
• If you have less than three years service, your company match will be 50% of the first 4% of pay you contribute on a pre-tax and Roth (combined) basis.  
• If you have three or more years of service, your company match will be 50% of the first 6% of pay you contribute on a pre-tax and Roth (combined) basis.  
If you make after-tax contributions to the 401(k) Plan, please note that these amounts are not eligible for a match. |
| Investments | The plan offers a broad range of investment options to respond to a wide array of investor preferences and to provide different levels of investment risk and return. Options are available across most investment categories, including stock, bond and real estate funds. The plan also contains target date funds as an investment choice. |
| Loans and Withdrawals | While the primary purpose of the plan is to help you save for retirement, loans and early withdrawal options may be available in certain circumstances. Please refer to the full Plan Document or contact Principal for further information |

VESTING SCHEDULE

You’re always 100% vested in the contributions you make to the 401(k) Plan. This means these amounts are yours if you retire or leave employment with Circle K at any time.

You’re 100% vested in the Circle K matching contributions you receive after you complete three years of employment. If you leave employment with Circle K before you complete three years, you’ll forfeit any matching contributions credited to your account.

HOW TO ENROLL

When you’re ready to enroll, please have your Social Security number and Circle K’s Contract ID number (611072) handy. You can then enroll:

• By Phone at 1-800-547-7754, or

FOR MORE INFORMATION

Contact the Principal Financial Group Client Contact Center at 1-800-547-7754 or www.principal.com.
Employee Stock Purchase Plan

Alimentation Couche-Tard offers you the opportunity to participate in the company’s Employee Stock Purchase Plan (ESPP). The ESPP allows you to purchase company stock through easy and convenient payroll deductions. The Alimentation Couche-Tard stock ticker is ATD.B, and trades on the Toronto Stock Exchange.

You’re eligible for the ESPP after you’ve completed one year of service. There are two enrollment windows each year in which you can join the plan—May 1 and November 1.

HOW THE PLAN WORKS

Once eligible, you can elect to make after-tax payroll contributions to the ESPP, up to a maximum of 5% of pay. Your contributions are matched by the company at 25%, to a maximum annual matching contribution of $1,250. This match is made in two ways:

• 15% of your contribution is matched immediately.

• 10% of your contribution is matched in January of the following year. This is provided you’re still employed with Circle K and you haven’t sold your shares.

Any fees associated with purchasing the stock are paid by the company.

HOW TO ENROLL

If you’re eligible for the ESPP, you’ll receive an email before each of the two enrollment windows with details on how to enroll.

FOR MORE INFORMATION

Contact your HR Representative at:

• Circle K Tempe Employee Service Center: 1-888-477-6583
• Circle K Midwest/Great Lakes/Heartland Columbus Employee Service Center: 1-877-324-7968, option 7
Employee Assistance Program

The EAP helps you balance work and life through confidential and easily accessible services. It puts free, convenient resources within your reach and that helps you and your family stay healthy.

The EAP is offered through Anthem BCBS. It is a company-provided benefit for you, your dependent family members (living with you or not), and any member of your household. You do not have to be enrolled in a Circle K medical plan to use the EAP.

HOW THE PLAN WORKS

Services offered through the EAP include:

• **Face-to-face counseling:** Up to 3 visits with an EAP network clinician for each personal situation, at no cost. Just call the EAP 24/7 to get a referral or you can start the process directly on the EAP website.

• **EAP website:** The EAP’s state of the art website includes a full suite of health and wellness resources. These include an EAP clinician search feature, a library of health articles, monthly well-being webinars, a self-assessment tool, skill builder courses and more.

• **Dependent care resources:** Get information and resources on a wide range of child and elder care services, including adoption, summer camps, day care, support groups and more.

• **Legal and financial consultation:** One free legal or financial consultation per issue. In addition the EAP website provides a variety tools related to legal/financial needs, including access to identity theft protection services.

• **Tobacco cessation:** The EAP website offers an online education program to help you learn how to break the tobacco habit. In addition, you’ll have access to a tobacco cessation coach by telephone or through instant messaging.

FOR MORE INFORMATION

Contact Anthem 24/7 at 1-800-865-1044 or log in at www.anthemEAP.com and enter “Circle K.”

Tuition Reimbursement

At Circle K, we encourage you to continue building your knowledge and skills. That’s why we provide the Tuition Reimbursement Program for job-related courses and degrees at most accredited colleges and universities. The program reimburses for a variety of eligible expenses, including tuition, books, registration and course fees. If your job-related course or degree is approved, you’re eligible for 100% reimbursement of expenses up to a maximum of $5,000 per year.
Sonic Boom promotes healthy behaviors and lifestyles with a fun, energizing new program. Every day you'll receive challenges — they revolve around physical activity, nutrition, weight management, and stress reduction. They're all different — some are wacky, others are intriguing — others will teach you things you didn't know — but all of them will get you thinking about — and doing — healthier behaviors.

We'll also be doing a fun activity challenge called Sonic Striding. You can wear your Fitbit, Jawbone, Garmin, Misfit, or Boomerang+ to measure your activity — duration, intensity, calories burned — and it wirelessly transmits that information to your personal Sonic Boom website. That’s fun - but the fun really begins when we start the competition. Circle K will be running a few fun contests throughout the year, and you can compete as an individual or a team - and you can be anonymous or be bold and brag! There are prizes on the line, so get ready to get moving. You’ll earn Prize points for participating in all the different activities in the program, and you’ll even be able to reward each other points for engaging in healthy behaviors. These points will get you status in the program and cool prizes!

For more information, refer to the Tuition Reimbursement policy on the Circle K Intranet Site.

The Sonic Boom Wellness Program

For more information, to enroll in Sonic Boom get started at https://circlek.app.sbwell.com.
Time Off Benefits

Circle K recognizes that you may need time away from work. That's why we offer you several types of paid and unpaid time off.

BEREAVEMENT TIME OFF
If you have a death in the immediate family, you'll receive a maximum of three days of paid leave so you can attend the funeral. This paid leave depends on whether you were scheduled to work during the days you will be absent. In addition, your pay is based on scheduled straight time hours per day. You may be required to provide appropriate documentation as to your need for bereavement leave. Under our bereavement policy, your “immediate family” includes your current spouse, children, father, mother, brothers, sisters, grandparents, grandchildren, in-laws and step-relatives.

LEAVE OF ABSENCE
Circle K offers time off for personal and family obligations through our leave of absence program. Leave of absence benefits are available for Family Medical Leave Act (FMLA) leave, medical leave, military leave and personal leave.

FOR MORE INFORMATION
Contact your HR Representative at:
• Circle K Tempe Employee Service Center: 1-888-477-6583
• Circle K Midwest/Great Lakes/Heartland Columbus Employee Service Center: 1-877-324-7968, option 7

HOLIDAY PAY
Circle K recognizes six paid holidays per year, including:
• Memorial Day
• Independence Day (4th of July)
• Labor Day
• Thanksgiving Day
• Christmas Day
• New Year’s Day

Hourly store associates who are scheduled to work these holidays will be paid one and a half times their normal hourly rate. See the Policy Manual for your Division located on the Circle K Intranet site for more information on Holiday Pay.

PERSONAL DAYS
Store Managers, QSR Supervisors, Managers in Training & Non-Store Associates are entitled to a maximum of seven sick/personal days per year, beginning each January 1. New associates are eligible for one sick/personal day after each 45-day service period (to a maximum of seven days) during their first calendar year of service.

Note: California, Oregon & Washington Non-Store employees receive 5 Personal Days, with the number of eligible paid sick days determined by the state laws within each of these states. Contact your local HR Representative for more specific details if you work in one of these states. State laws more stringent than the terms contained in this document shall take precedence.
VACATION
Circle K offers paid vacation to eligible store managers, QSR supervisors, and non-store associates who were actively employed for at least 40 weeks in the prior year. In general, the maximum amount of vacation available to use in any calendar year can never exceed the total vacation days available to you on January 1 of each year, based on your length of service. If you are promoted during the year, your vacation time earned will be based on your years of service and the vacation policy for your new position. If demoted during the year, you will continue to have the vacation you earned. Then, beginning the following January, your vacation earned will be based on your years of service and the vacation policy for your new position. You will not be paid for vacation time not taken. Please note that if you’re a non-exempt manager in training, your paid vacation time will be up to a maximum of 50 hours per week at your current rate of pay.

IF YOU LEAVE THE COMPANY
If you leave Circle K’s employment, you will be paid for any earned (but unused) vacation. This will occur as soon administratively possible after your separation date. However, if you were originally hired by The Pantry/Kangaroo Express and your separation is:

- **Voluntary:** you can receive \( \frac{1}{12} \) of your annual vacation benefit for each month worked after January 1 in the year you terminated (less any vacation time already taken). You must provide two weeks advance notice, and you may not use vacation time during this two-week period.

- **Involuntary:** you will forfeit all vacation time unless state or local laws provide otherwise. If your employment ends for business reasons (a store closing or job elimination) and you work until your specified last day, you can receive \( \frac{1}{12} \) of your annual vacation benefit for each month worked after January 1 in the year your employment terminates (less any vacation time already taken).

EARNING VACATION IN YOUR FIRST YEAR OF EMPLOYMENT
If you’re an exempt or non-exempt store manager, QSR Supervisor, Manager in Training, or non-store associate, during your first year of employment you earn one day of vacation per month based on your hire date.

<table>
<thead>
<tr>
<th>Month Hired</th>
<th>Days Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>10</td>
</tr>
<tr>
<td>February</td>
<td>10</td>
</tr>
<tr>
<td>March</td>
<td>9</td>
</tr>
<tr>
<td>April</td>
<td>8</td>
</tr>
<tr>
<td>May</td>
<td>7</td>
</tr>
<tr>
<td>June</td>
<td>6</td>
</tr>
<tr>
<td>July</td>
<td>5</td>
</tr>
<tr>
<td>August</td>
<td>4</td>
</tr>
<tr>
<td>September</td>
<td>3</td>
</tr>
<tr>
<td>October</td>
<td>2</td>
</tr>
<tr>
<td>November</td>
<td>1</td>
</tr>
<tr>
<td>December</td>
<td>0</td>
</tr>
</tbody>
</table>

If you leave the company for any reason before the end of your first calendar year, you are not eligible for a vacation payment for the partial year worked unless mandated by state law.

EARNING VACATION IN SUBSEQUENT YEARS
After your first year of employment, store managers and non-store associates will earn vacation each January 1 based on length of service. Please note that your length of service for vacation purposes will be calculated based on the calendar year rather than an anniversary year basis.

<table>
<thead>
<tr>
<th>Length of Service</th>
<th>Vacation Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 - 4 years</td>
<td>10 days</td>
</tr>
<tr>
<td>5 - 14 years</td>
<td>15 days</td>
</tr>
<tr>
<td>15 or more years</td>
<td>20 days</td>
</tr>
</tbody>
</table>

Note: Any State laws more stringent than the terms contained in this document shall take precedence.
Coinsurance: How you and your medical plan share costs after you meet the plan’s annual deductible (if applicable). For example, your plan may cover 80% of charges for a covered hospitalization, leaving you responsible for the other 20%. This 20% is known as the coinsurance.

Copay: A fixed amount (for example, $20) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of service you receive.

Deductible: The amount you owe for health care services before your plan begins to pay. For example, if your annual deductible is $3,000, your plan won’t pay anything until you’ve reached that amount first. The exception is preventive care, which is fully covered so you pay nothing.

Dependent Care Flexible Spending Account (FSA): An optional arrangement you may set up to pay for eligible dependent care expenses — including child and elder care — with tax-free dollars. You contribute to your FSA through automatic, before-tax payroll deductions. For a full list of eligible expenses, refer to IRS Publication 503, available at www.irs.gov.

Health Care Flexible Spending Account (FSA): An optional arrangement you may set up to pay for eligible health care expenses — including deductibles, coinsurance, and copays for medical, dental, and vision care — with tax-free dollars. You contribute to your FSA through automatic, before-tax payroll deductions. You can roll over up to $500 of unused funds at the end of the plan year to use the following year; amounts above $500 will be forfeited. By law, you cannot participate in a Health Care FSA and a Health Savings Account (HSA) at the same time. For a full list of eligible expenses, refer to IRS Publication 502, available at www.irs.gov.

Health Savings Account (HSA): A medical savings account that, by law, is only available to participants in a qualified high-deductible health plan, such as the Anthem BCBS HSA Medical Plan. An HSA allows you to pay for eligible medical expenses — including deductibles, coinsurance, and copays for medical, dental, and vision care — with tax-free dollars. Unlike a Flexible Spending Account (FSA), all of the money in your HSA rolls over from year to year and is always yours to keep. For example, you may use the money in your HSA to pay for eligible health expenses in retirement. For a full list of eligible expenses, refer to IRS Publication 502, available at www.irs.gov.

Limited Purpose Flexible Spending Account (LPFSA): Available to Anthem BCBS HSA Medical Plan participants only, the LPFSA is designed to work together with an HSA to provide additional tax-saving opportunities. This account can be used to reimburse deductibles, coinsurance, and copayments for dental and vision care only (your HSA covers your out-of-pocket medical expenses). Eyeglasses and contact lenses, prescription sunglasses, Lasik surgery, and adult orthodontia are included.

Out-of-pocket maximum: The most you’ll ever pay in a plan year for covered expenses. Once you meet your out-of-pocket maximum, your plan pays 100% of covered services for the rest of the year.

Premiums: A fixed amount that you automatically contribute from each paycheck for coverage under a medical plan. Premiums can vary widely by the type of plan you choose.

Preventive care: In-network preventive care is fully covered under all of Circle K’s medical plans, so you pay nothing. Preventive care includes routine care designed to prevent illness or disease, including annual physicals, immunizations, and cancer screenings. If the same tests are done to diagnose an illness or treat a known condition, they are not considered preventive care and your plan’s normal charges will apply.
COBRA Benefits

If your employment with Circle K ends, your benefits end the last day of your last pay period in which you paid for benefits. Under certain circumstances, you may continue your health care coverage under COBRA when it would otherwise end.

COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA contains provisions giving certain former employees, retirees, spouses and dependent children the right to temporary continuation of health coverage at group rates. However, this coverage is available only in specific instances. Group health coverage for COBRA participants is more expensive than health coverage for active employees. A COBRA participant pays the entire coverage expense plus 2%. COBRA applies to your Medical, Dental and Vision coverage. In addition, you have access to benefits under the Employee Assistance Program and may continue participating in the Health Care Flexible Spending Account for the remainder of the benefit plan year in which you experienced your qualifying event.

WHEN YOU LEAVE

After you terminate employment, PayFlex will send COBRA information to your home address. If you submitted claims for services provided after your termination date but before you elected COBRA, you may need to contact the appropriate health care insurance providers to have the claims reprocessed.

WHEN COBRA ENDS

The following charts illustrate how long you and your dependents can continue COBRA coverage.

<table>
<thead>
<tr>
<th>If You Lose Coverage/ Eligibility Due to:</th>
<th>Then You Can Continue Coverage for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination of employment</td>
<td>18 months</td>
</tr>
<tr>
<td>Termination of employment and either you (or a dependent) are disabled at any time during the first 60 days of COBRA coverage</td>
<td>29 months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If Your Dependent Loses Coverage/ Eligibility Due to:</th>
<th>Then Your Dependent Can Continue Coverage for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your death</td>
<td>36 months</td>
</tr>
<tr>
<td>You (employee) become entitled to Medicare after your COBRA election</td>
<td>36 months</td>
</tr>
<tr>
<td>You and your spouse divorce</td>
<td>36 months</td>
</tr>
<tr>
<td>No longer being considered a dependent (because of their age or their marriage)</td>
<td>36 months</td>
</tr>
</tbody>
</table>
COBRA Benefits continued...

COBRA coverage will end before the end of the eligibility period if:

- You don’t make premium payments on time.
- You become entitled to Medicare.
- All Circle K group health plans are discontinued.
- You become covered under another group health plan after you elect COBRA coverage, unless the plan has a pre-existing conditions limitation that affects you. If the new plan complies with HIPAA regulations, a pre-existing conditions limitation likely will not affect termination of COBRA coverage.

CONTINUING COVERAGE THROUGH THE HEALTH INSURANCE MARKETPLACE

Rather than continue coverage through COBRA, you may find the health insurance marketplace provides you with more cost-effective coverage for you and your family, especially if you are eligible for a government tax break (subsidy).

To learn more about your marketplace options, visit Mercer Marketplace at www.insurance.mercermarketplace.com or call 1-800-713-2859 between 8:00 am to 5:30 pm Eastern Time to speak to a licensed Mercer Marketplace customer service agent.

? FOR MORE INFORMATION
Contact PayFlex at www.payflex.com or the COBRA Call Center at 1-888-678-7835.
Required Legal Notices

Circle K reserves the right to change, amend, or terminate any benefits plan at any time for any reason. Participation in a benefit plan is not a promise or guarantee of future employment. Receipt of benefits documents does not constitute eligibility.

The Open Enrollment Guide, combined with these legal notices, provides an overview of the benefits available to you and your family. In the event of a discrepancy between the information presented in the Open Enrollment Guide and official plan documents, the official plan documents will govern.

STATEMENT OF MATERIAL MODIFICATIONS (ERISA PLANS)

This Open Enrollment Guide constitutes a Summary of Material Modifications (SMM) to the Circle K Health Care Plan and Cafeteria Plan year ending 12/31/2016. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

CIRCLE K HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Circle K health plans. This information, known as protected health information (PHI), includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the medical plans. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan’s duties with respect to health information about you

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing “behind the scenes” plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH CIRCLE K

The Plan, or its health insurer, may disclose your health information without your written authorization to Circle K for plan administration purposes. Circle K may need your health information to administer benefits under the Plan. Circle K agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources are the only Circle K employees who will have access to your health information for plan administration functions.

Here’s how additional information may be shared between the Plan and Circle K, as allowed under the HIPAA rules:

- The Plan, or its insurer, may disclose “summary health information” to Circle K, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants’ claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer, may disclose to Circle K information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option offered by the Plan.
HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH CIRCLE K

In addition, you should know that Circle K cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Circle K from other sources— for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers’ compensation programs—is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You’ll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you’re not present or if you’re incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers’ compensation</td>
<td>Disclosures to workers’ compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws</td>
</tr>
<tr>
<td>Necessary to prevent serious threat to health or safety</td>
<td>Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.</td>
</tr>
<tr>
<td>Public health activities</td>
<td>Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects</td>
</tr>
<tr>
<td>Victims of abuse, neglect, or domestic violence</td>
<td>Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you’ll be notified of the Plan’s disclosure if informing you won’t put you at further risk)</td>
</tr>
<tr>
<td>Judicial and administrative proceedings</td>
<td>Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)</td>
</tr>
<tr>
<td>Law enforcement purposes</td>
<td>Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the plan’s premises</td>
</tr>
<tr>
<td>Decedents</td>
<td>Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties</td>
</tr>
<tr>
<td>Organ, eye, or tissue donation</td>
<td>Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death</td>
</tr>
<tr>
<td>Research purposes</td>
<td>Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project</td>
</tr>
</tbody>
</table>
YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right.

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE PLAN'S RIGHT TO REFUSE

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you’re notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.
Required Legal Notices continued...

### Right to Receive Confidential Communications of Your Health Information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

### Right to Inspect and Copy Your Health Information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a “designated record set.” This may include medical and billing records maintained for a health care provider, enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. The Plan may provide you with a summary or explanation of the information instead of a copy, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage.

If the Plan doesn’t maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan’s cost.

### Right to Amend Your Health Information That Is Inaccurate or Incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

### Right to Receive an Accounting of Disclosures of Your Health Information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an “accounting of disclosures.” You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations.
- To you about your own health information.
- Incidental to other permitted or required disclosures.
- Where authorization was provided.
- To family members or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a “limited data set” (health information that excludes certain identifying information).
RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION continued...

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE PLAN UPON REQUEST

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

CHANGES TO THE INFORMATION IN THIS NOTICE

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2017. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed.

If changes are made to the Plan’s privacy policies described in this notice, you will be provided with a revised privacy notice that will be posted to the Circle K Intranet Site.

CONTACT

For more information on the Plan’s privacy policies or your rights under HIPAA contact Doryce Norwood, Privacy Officer, at 1-888-477-6583.

COMPLAINTS

If you’re concerned that your privacy rights have been violated, or believe your Plan has not followed its legal obligations under HIPAA, or you disagree with a decision we made about access to your records, you may contact the Privacy Officer at 1-888-477-6583 (Circle K) or 1-877-324-7968, option 7 (Circle K Midwest/Great Lakes/Heartland). Once Circle K is notified of a potential violation, a formal process is set in motion. The Privacy Officer will:

• Send you written documentation requesting specific information relating to the alleged incident.

• Once the written complaint is received from you, the Privacy Officer will determine whether the allegation is with merit, and report back to you within 30 days.

• If the complaint is without merit, the Privacy Officer will send a responsive letter to the individual who submitted the complaint.

• If the complaint is valid, the Privacy Officer will send a letter to the individual explaining what steps will be taken to correct any future improper disclosures.

• Determine whether there is any harm to be mitigated.

• Consider whether sanctions should be imposed.

• Ensure future violations do not occur.

• If you’re still not satisfied, the appeal can continue to the U.S. Department of Health and Human Services.

You will not be retaliated against for filing a complaint. Circle K can provide you with the appropriate address upon request, or you may visit www.hhs.gov/ocr for further information.

This notice supersedes all previous Notice of Privacy Practices issued by us and is effective January 1, 2017.

Doryce Norwood, Privacy Officer
Circle K Stores Inc. Employee Benefit Plan
1130 W. Warner Rd., Bldg. B, DC-33
Tempe, AZ 85284
1 -888-477-6583; hrsolve@circlek.com
HIPAA SPECIAL ENROLLMENT NOTICE

Notice of special enrollment rights for health plan coverage

If you decline enrollment in a Circle K health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Circle K health plan without waiting for the next Annual Benefits Enrollment Period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Circle K medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for special enrollment rights, you may add the dependent to your current coverage or change to another health plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

CHIP/MEDICAID NOTICE

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

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

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

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

CHIP/MEDICAID NOTICE continued...

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016 You should contact your state for further information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Type</th>
<th>Website</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA - Medicaid</td>
<td><a href="http://myalhipp.com/">Website</a></td>
<td><a href="http://myalhipp.com/">Website</a></td>
<td><a href="1-855-692-5447">Phone</a></td>
</tr>
<tr>
<td>ALASKA - Medicaid</td>
<td><a href="http://myakhipp.com/">Website</a></td>
<td><a href="http://myakhipp.com/">Website</a></td>
<td>[Phone](Outside of Anchorage: 1-800-780-9972)</td>
</tr>
<tr>
<td>ARKANSAS - Medicaid</td>
<td><a href="http://myakhipp.com/">Website</a></td>
<td><a href="http://myakhipp.com/">Website</a></td>
<td><a href="1-855-MyARHIPP" title="855-692-7">Phone</a></td>
</tr>
<tr>
<td>COLORADO - Medicaid</td>
<td><a href="http://www.colorado.gov/hcpf">Website</a></td>
<td><a href="http://www.colorado.gov/hcpf">Website</a></td>
<td><a href="1-800-221-3943">Phone</a></td>
</tr>
<tr>
<td>FLORIDA - Medicaid</td>
<td><a href="http://flmedicaidtplrecovery.com/hipp/">Website</a></td>
<td><a href="http://flmedicaidtplrecovery.com/hipp/">Website</a></td>
<td><a href="1-877-357-3268">Phone</a></td>
</tr>
<tr>
<td>KENTUCKY - Medicaid</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">Website</a></td>
<td><a href="http://chfs.ky.gov/dms/default.htm">Website</a></td>
<td><a href="1-800-635-2570">Phone</a></td>
</tr>
<tr>
<td>LOUISIANA - Medicaid</td>
<td><a href="http://dhhs.louisiana.gov/index.cfm/subhome/I/n/331">Website</a></td>
<td><a href="http://dhhs.louisiana.gov/index.cfm/subhome/I/n/331">Website</a></td>
<td><a href="1-888-695-2447">Phone</a></td>
</tr>
<tr>
<td>MASSACHUSETTS - Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/MassHealth">Website</a></td>
<td><a href="http://www.mass.gov/MassHealth">Website</a></td>
<td><a href="1-800-462-1120">Phone</a></td>
</tr>
<tr>
<td>MAINE - Medicaid</td>
<td><a href="http://www.maine.gov/dhsof/publicassistance/index.html">Website</a></td>
<td><a href="http://www.maine.gov/dhsof/publicassistance/index.html">Website</a></td>
<td><a href="1-800-442-6003" title="TTY: Maine relay 711">Phone</a></td>
</tr>
<tr>
<td>NEVADA - Medicaid</td>
<td><a href="http://dwss.nv.gov/">Website</a></td>
<td><a href="http://dwss.nv.gov/">Website</a></td>
<td><a href="1-800-992-0900">Phone</a></td>
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<td>GEORGIA - Medicaid</td>
<td><a href="http://dch.georgia.gov/medicaid">Website</a></td>
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<td><a href="404-656-4507">Phone</a></td>
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<tr>
<td>INDIANA - Medicaid</td>
<td><a href="http://www.in.gov/fssa/hip/">Website</a></td>
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<td><a href="1-877-438-4479">Phone</a></td>
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<tr>
<td>IOWA - Medicaid</td>
<td><a href="http://www.dhs.state.ia.us/hipp/">Website</a></td>
<td><a href="http://www.dhs.state.ia.us/hipp/">Website</a></td>
<td><a href="1-888-346-9562">Phone</a></td>
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<td>KANSAS - Medicaid</td>
<td><a href="http://www.kdheks.gov/hcf/">Website</a></td>
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<td>GEORGIA - Medicaid</td>
<td><a href="http://dch.georgia.gov/medicaid">Website</a></td>
<td><a href="http://dch.georgia.gov/medicaid">Website</a></td>
<td><a href="404-656-4507">Phone</a></td>
</tr>
<tr>
<td>INDIANA - Medicaid</td>
<td><a href="http://www.in.gov/fssa/hip/">Website</a></td>
<td><a href="http://www.in.gov/fssa/hip/">Website</a></td>
<td><a href="1-877-438-4479">Phone</a></td>
</tr>
<tr>
<td>IOWA - Medicaid</td>
<td><a href="http://www.dhs.state.ia.us/hipp/">Website</a></td>
<td><a href="http://www.dhs.state.ia.us/hipp/">Website</a></td>
<td><a href="1-888-346-9562">Phone</a></td>
</tr>
<tr>
<td>KANSAS - Medicaid</td>
<td><a href="http://www.kdheks.gov/hcf/">Website</a></td>
<td><a href="http://www.kdheks.gov/hcf/">Website</a></td>
<td><a href="1-800-792-4884">Phone</a></td>
</tr>
<tr>
<td>MASSACHUSETTS - Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/MassHealth">Website</a></td>
<td><a href="http://www.mass.gov/MassHealth">Website</a></td>
<td><a href="1-800-462-1120">Phone</a></td>
</tr>
<tr>
<td>MAINE - Medicaid</td>
<td><a href="http://www.maine.gov/dhsof/publicassistance/index.html">Website</a></td>
<td><a href="http://www.maine.gov/dhsof/publicassistance/index.html">Website</a></td>
<td><a href="1-800-442-6003" title="TTY: Maine relay 711">Phone</a></td>
</tr>
<tr>
<td>NEVADA - Medicaid</td>
<td><a href="http://dwss.nv.gov/">Website</a></td>
<td><a href="http://dwss.nv.gov/">Website</a></td>
<td><a href="1-800-992-0900">Phone</a></td>
</tr>
</tbody>
</table>
## Required Legal Notices continued...

### CHIP/MEDICAID NOTICE continued...

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW HAMPSHIRE - Medicaid</td>
<td></td>
<td><a href="http://www.dhhs.nh.gov/oii/documents/hippapp.pdf">Website</a></td>
<td>603-271-5218</td>
</tr>
<tr>
<td>MISSOURI - Medicaid</td>
<td></td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">Website</a></td>
<td>573-751-2005</td>
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<tr>
<td>MONTANA - Medicaid</td>
<td></td>
<td>[Website](<a href="http://dphhs.mt.gov/MontanaHealthcare">http://dphhs.mt.gov/MontanaHealthcare</a> Programs/CHIP)</td>
<td>1-800-694-3084</td>
</tr>
<tr>
<td>NEBRASKA - Medicaid</td>
<td></td>
<td><a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">Website</a></td>
<td>1-855-632-7633</td>
</tr>
<tr>
<td>SOUTH DAKOTA - Medicaid</td>
<td></td>
<td><a href="http://dss.sd.gov">Website</a></td>
<td>1-800-597-1603</td>
</tr>
<tr>
<td>UTAH - Medicaid and CHIP</td>
<td></td>
<td>Medicaid: <a href="http://health.utah.gov/medicaid">Website</a></td>
<td>1-877-543-7669</td>
</tr>
<tr>
<td>VERMONT - Medicaid</td>
<td></td>
<td><a href="http://www.greenmountaincare.org/">Website</a></td>
<td>1-800-250-8427</td>
</tr>
<tr>
<td>VIRGINIA - Medicaid and CHIP</td>
<td></td>
<td>Medicaid: <a href="http://www.coverva.org/programs_premium_assistance.cfm">Website</a></td>
<td>1-855-242-8282</td>
</tr>
<tr>
<td>WASHINGTON - Medicaid</td>
<td></td>
<td><a href="http://www.hca.wa.gov/free-or-low-cost-healthcare/program-administration/premium-payment-program">Website</a></td>
<td>1-800-562-3022 ext. 15473</td>
</tr>
</tbody>
</table>

To see if any more states have added a premium assistance program since July 31, 2016 or for more information on special enrollment rights, you can contact either:

**U.S. Department of Labor**
Employee Benefits Security Administration
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
1-866-444-EBSA (3272)

**U.S. Department of Health and Human Services**
Centers for Medicare & Medicaid Services
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565
NOTICE REGARDING THE CIRCLE K WELLNESS INCENTIVE PROGRAM

Circle K Wellness Program is a voluntary wellness program available to all full-time employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health assessment or “HA” that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for total cholesterol, HDL, LDL, TC/DHL ration, Triglycerides, Glucose, Biometrics: Height, Weight, Blood Pressure and Body Mass Index (BMI) calculation. You are not required to complete the HA or to participate in the biometric screening, only employees who do so will receive the incentive.

However, employees who choose to participate in the wellness program will receive an incentive of $250 - $500 for an individual or $500 - $1000 if the employee and spouse complete both the health assessment and biometric screening. Although you are not required to complete the HA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional Employee Wellness Incentives of up to $150 in gift cards with varying increments may be available for employees who participate in certain health-related activities through Sonic Boom by earning points for participating in daily challenges, daily steps/time goals, Sonic Boom Health Trackers, Sonic Boom’s “Caught Ya’” recognition program, biometric screening, health assessment, preventive exams, and other activities as listed on Sonic Boom’s Rewards page.

The information from your health assessment, the results from your biometric screening, and information obtained through the Sonic Boom programs, will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as recommended global daily challenges, education, and invitations to company-wide contests.

You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Circle K may use aggregate information it collects to design a program based on identified health risks in the workplace, Circle K, Kroger Health Screenings and Sonic Boom will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law.

Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Doryce Norwood, Director and General Counsel, at 1-888-477-6583.
Required Legal Notices continued...

**IMPORTANT COBRA NOTICE**

**Introduction**
This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

**What is COBRA Continuation Coverage?**
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:
• Your hours of employment are reduced; or
• Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:
• Your spouse dies;
• Your spouse’s hours of employment are reduced;
• Your spouse's employment ends for any reason other than his/her gross misconduct;
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
• You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:
• The parent-employee dies;
• The parent-employee’s hours of employment are reduced;
• The parent-employee’s employment ends for any reason other than his/her gross misconduct;
• The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the plan as a “dependent child.”

**When Is COBRA Coverage Available?**
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee continues until 36 months after the date of Medicare entitlement.
Required Legal Notices continued...

IMPORTANT COBRA NOTICE continued...

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). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA’s website.)

IMPORTANT COBRA NOTICE continued...

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

Plan Contact Information
PayFlex
PayFlex Systems USA, Inc.
Benefits Billing Department
P.O. Box 953374
St. Louis, MO, 63195-3374
Toll Free: (888) 678-7835

IMPORTANT NOTICE FROM CIRCLE K ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE
The purpose of this notice is to advise you that the prescription drug coverage listed below under the Circle K medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2017. This is known as “creditable coverage.”

Why this is important: if you or your covered dependent(s) are enrolled in any prescription drug coverage during 2017 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren’t currently covered by Medicare and won’t become covered by Medicare in the next 12 months, this notice doesn’t apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Circle K and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.
Notice of creditable coverage
You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Circle K prescription drug plans listed below, you’ll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2017. This is called Credible Coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

The Circle K Stores Employee Benefit Plan has determined that the prescription drug coverage offered on average for all plan participants, is expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Credible Coverage.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary, as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Circle K coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Circle K plan.

You should know that if you waive or leave coverage with Circle K and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You’ll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this Circle K coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here’s how to get more information about Medicare prescription drug plans:

Call your state Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number).

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For More Information About This Notice or Your Current Prescription Drug Coverage
Contact the Circle K Employee Service Center at 1-888-HR-SOLVE.

PHYSICIAN DESIGNATION NOTICE (THIS ONLY APPLIES IN CA)
The Kaiser plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan designates a primary care provider automatically, insert: Until you make this designation, Kaiser designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser directly.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Kaiser plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser at 1-800-464-4000.
YOUR RIGHTS UNDER USERRA

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.

Health Insurance Protection

• If you leave your job to perform military service, you may 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 the military service, you have the right to be reemployed, generally without any waiting periods or exclusions (i.e., pre-existing condition exclusions) except for service-connected illnesses or injuries.

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.

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.

WOMEN’S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

• All stages of reconstruction of the breast on which the mastectomy was performed.

• Surgery and reconstruction of the other breast to produce a symmetrical appearance.

• Prostheses.

• Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your health plan directly.

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT (NMHPA OR “NEWBORNS’ ACT”) NOTICE

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your health plan directly.

HEALTH INSURANCE MARKETPLACE COVERAGE

Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employer-based health coverage offered by your employer.

What Is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November of every year for coverage starting as early as the following January.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings Through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.
Required Legal Notices continued...

HEALTH INSURANCE MARKETPLACE COVERAGE continued...

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.*

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact your HR Benefits Representative at 1-888-477-6583 (Circle K) or 1-877-324-7968, option 7 (Circle K Midwest/Great Lakes/Heartland).

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

• An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information about Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Circle K
3. Employer name: Circle K Stores Inc.
4. Employer Identification Number (EIN): 74-1149540
6. Employer phone number: 1-888-477-6583
7. City: Tempe
8. State: AZ
9. ZIP code: 85284
10. Who can we contact about employee health coverage at this job? Tempe Arizona Employee Services Center
11. Phone number (if different than above)
12. Email address: hrsolve@circlek.com

Circle K Midwest/Great Lakes/Heartland
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Macs Convenience Stores, LLC
4. Employer Identification Number (EIN): 98-0349427
5. Employer address: P.O. Box 347
6. Employer phone number: 1-877-324-7968, option 7
7. City: Columbus
8. State: IN
9. ZIP code: 47202
10. Who can we contact about employee health coverage at this job? Columbus Indiana Employee Services Center
11. Phone number (if different than above)
12. Email address: benefits@circlek.com

Here is some basic information about health coverage offered by this employer:

• As your employer, we offer a health plan to:
  — All employees.

✓ Some employees. Eligible employees are:
  Full-time employees working more than 30 hours.

• With respect to dependents:

✓ We do offer coverage. Eligible dependents must meet the eligibility requirements and include spouse, registered domestic partner, children under age 26 or disabled children of any age who rely on you for financial support.

— We do not offer coverage.

✓ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, Health care.gov will guide you through the process. Here’s the employer information you’ll enter when you visit Health care.gov to find out if you can get a tax credit to lower your monthly premiums.

The information on the following page corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.
HEALTH INSURANCE MARKETPLACE COVERAGE  
continued...

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?
Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)
No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
Yes (Go to question 15)
No (STOP and return this form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

   a. How much would the employee have to pay in premiums for this plan? $
   
   b. How often?

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
— Employer won’t offer health coverage
— Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

   a. How much will the employee have to pay in premiums for that plan? $
   
   b. How often?

INVESTMENT OPTION DEFAULT

If you have not provided complete, up to date direction as to how the account set up for you under the retirement plan is to be invested, the account will be directed under automatic rules. You need to understand these rules and make sure that you are comfortable with them or that you take action to direct the investment of the account according to your preferences. These rules state that, if we do not have complete investment directions from you, the retirement funds in the account and new contributions for which we do not have direction will be directed to the applicable Principal TrustSM Target Date Fund (Principal Management Corporation provides nondiscretionary advisory services to Principal Trust regarding these funds) based on your current age and the definition of normal retirement date under the plan.

RIGHT TO DIRECT

If you do not want retirement funds to be directed as indicated above, then you may elect to direct the retirement funds to investment options under the retirement plan by visiting The Principal website at www.principal.com and logging into the account or by calling 1-800-547-7754.

You may make changes to your investment direction as allowed under the retirement plan. This includes transferring any contributions from the applicable investment option default to another.

FEES AND EXPENSES

Plan administrative expenses are paid from the total investment expense of one or more of the Plan’s investment options. Plan administrative expenses typically include items such as recordkeeping, participant website access, participant statements, Plan compliance services and financial professional services.

From time to time, Plan expenses may be incurred in the course of normal Plan operation for Plan services such as legal, auditing, third-party administration, consulting, investment advice to the Plan, etc. If allowed by the Plan document, the Plan Fiduciary may direct that these expenses be paid by the Plan. If such expenses are charged to participant accounts, the dollar amount of such expenses will be disclosed on the secure www.principal.com website and on participant statements (if applicable) for the quarter in which they are paid.

The following participant-level services have additional fees. These participant transaction fees will be charged to your account balance for the services you elect to use. Participant transaction fees for the Plan include:

• Distributions (eligible withdrawals): $40
• Loan Maintenance fee for new loans: $12 per quarter
• Loan Setup fee: $50
• QDRO (Qualified Domestic Relations Order) processing: $350

Please see the Investment Option Summary for fees and expenses that may be charged against your account based on investment-level transactions. This information can be obtained by visiting www.principal.com or by calling 1-800-547-7754.
HEALTH CARE REFORM GLOSSARY

Affordable Care Act; Health Care Reform Law
The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) is a law that was passed in March 2010 to improve access to affordable health insurance for many Americans.

Cost-Sharing Discounts
Reduced dollar amounts for health plan features like annual deductibles and copays that are available to some people who get their health insurance through the health insurance marketplace. To be eligible for these reduced dollar amounts, the person buying the coverage must qualify based on the amount of his or her household income. These discounts generally are not available if you are eligible to enroll in a Circle K health plan.

Essential Health Benefits
These are a set of services that must be covered by certain health plans. These services include:
- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitative and habilitative services and devices.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.

All health insurance plans offered through the health insurance marketplace must cover these services. State Medicaid plans must cover them too. Circle K health plans cover many of these benefits as well, though not required under the Affordable Care Act.

In addition, health plans cannot put a lifetime or annual dollar limit on benefits that are available for these services. Circle K health plans do not include lifetime or annual dollar limits on these benefits.

Federal Poverty Level (FPL)
The FPL is a measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits that are available as a result of the Affordable Care Act. The 2015 Poverty Guidelines can be located at: http://aspe.hhs.gov/poverty/15poverty.cfm

Health Insurance Marketplace/Affordable Insurance Exchanges
This is a service set up in each state where individuals and small businesses can buy affordable and qualified health insurance plans. The marketplaces will offer a choice of health plans that provide different levels of benefits and have different costs.

Individual Mandate
The rule under the Affordable Care Act that says you must have Minimum Essential health insurance that meets basic minimum standards on or after January 1, 2014. If not, a tax penalty may apply to you. Enrollment in a Circle K health plan satisfies the individual mandate.

Minimum Essential Coverage
This is the type of coverage an individual needs to have to meet the individual mandate under the Affordable Care Act. You can get it from individual market policies, job-based coverage (excluding a Circle K Excepted Indemnity Medical health plan), Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Public Exchanges

Subsidy
This is a form of financial assistance provided by the federal government. Under the Affordable Care Act, those who qualify can receive this assistance in the form of an advanced tax credit or cost-sharing discount when purchasing health insurance through a health insurance marketplace.

Tax Penalty
This is the amount you may owe starting January 1, 2014, for every month you do not have health insurance. If you have a tax penalty, you will need to pay it to the IRS when filing your annual tax return. For instance, if you went without coverage from January through March in 2016 you would add up the monthly penalty for the three months you didn’t have coverage and pay it in 2017 when filing your 2016 tax return.

HCR State Exchange Info
Please visit www.healthcare.gov for more information.

SUMMARY ANNUAL REPORT FOR CIRCLE K STORES

This is a summary of the annual report of the Circle K Stores Employee Benefit Plan, EIN 74-1149540, Plan No. 501, for the period January 1, 2015 through December 31, 2015. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Circle K Stores, Inc. has committed itself to pay certain health claims incurred under the terms of the plan.

Insurance Information
The plan has contracts with Aetna Life Insurance Co., Anthem Insurance Companies, Inc., Cigna Health and Life Insurance Company and affiliates, Fidelity Security Life Insurance Company, HM Life Insurance Company and Kaiser Foundation Health Plan Inc to pay health, dental, vision, life insurance, temporary disability, long-term disability, prescription drug, accidental death and dismemberment and employee assistance program claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2015 were $7,629,654.
SUMMARY ANNUAL REPORT FOR CIRCLE K STORES EMPLOYEE BENEFIT PLAN continued...

Your Rights To Additional Information
You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

• insurance information, including sales commissions paid by insurance carriers

To obtain a copy of the full annual report, or any part thereof, write or call the office of Circle K Stores, Inc. at 1130 W. Warner Road, Tempe, AZ 85284-2816, or by telephone at (602) 728-4925.

You also have the legally protected right to examine the annual report at the main office of the plan ( Circle K Stores, Inc., 1130 W. Warner Road, Tempe, AZ 85284-2816) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

SUMMARY ANNUAL REPORT FOR MACS CONVENIENCE STORES, LLC EMPLOYEE BENEFIT PLAN

This is a summary of the annual report of the Macs Convenience Stores, LLC Employee Benefit Plan, EIN 98-0349427, Plan No. 501, for the period January 1, 2015 through December 31, 2015. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Macs Convenience Stores, LLC has committed itself to pay certain health claims incurred under the terms of the plan.

Insurance Information
The plan has contracts with Aetna Life Insurance Co., Anthem Insurance Companies, Inc., Cigna Health and Life Insurance Company and affiliates, Fidelity Security Life Insurance Company and HM Life Insurance Company to pay health, dental, vision, life insurance, temporary disability, long-term disability, business travel accident and accidental death and dismemberment and employee assistance program claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2015 were $2,607,223.

Your Rights To Additional Information
You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

• insurance information, including sales commissions paid by insurance carriers

To obtain a copy of the full annual report, or any part thereof, write or call the office of Macs Convenience Stores, LLC at P.O. Box 347, Columbus IN 47202, or by telephone at (877) 324-7968.

You also have the legally protected right to examine the annual report at the main office of the plan (Macs Convenience Stores, LLC, 4080 W. Jonathon Moore Pike, Columbus, IN 47201) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.
Required Legal Notices  continued...

SUMMARY ANNUAL REPORT FOR THE PANTRY, INC. 
EMPLOYEE ASSISTANCE PLAN
This is a summary of the annual report of the The Pantry, Inc. Employee Assistance Plan, EIN 56-1574463, Plan No. 511, for the period January 1, 2015 through December 31, 2015. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information
The plan has a contract with Health and Human Resource Center, Inc. to pay employee assistance program claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2015 were $158,825.

Your Rights To Additional Information
You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

• insurance information, including sales commissions paid by insurance carriers

To obtain a copy of the full annual report, or any part thereof, write or call the office of The Pantry, Inc. at 1801 Douglas Drive PO Box 1410, Sanford, NC 27331-1410, or by telephone at (919) 774-6700.

You also have the legally protected right to examine the annual report at the main office of the plan (The Pantry, Inc., 1801 Douglas Drive PO Box 1410, Sanford, NC 27331-1410) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

SUMMARY ANNUAL REPORT FOR CIRCLE K STORES RETIREMENT PLAN
This is a summary of the annual report for Circle K Retirement Plan, EIN 74 1149540, for January 1, 2014, through December 31, 2014. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement
Benefits under the plan are provided by a combination of funding arrangements. Plan expenses were $7,595,222. These expenses included $115,507 in administrative expenses and $7,479,715 in benefits paid to participants and beneficiaries, and $0 in other expenses. A total of 20,991 persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

The value of plan assets, after subtracting liabilities of the plan, was $89,723,833 as of December 31, 2014, compared to $83,632,991 as of January 1, 2014. During the plan year, the plan experienced an increase in its net assets of $6,090,842. This increase includes unrealized appreciation or depreciation in the value of the plan assets; that is, the difference between the value of the plan’s assets at the end of the year and the value of the assets at the beginning of the year or cost of assets acquired during the year.

The plan had total income of $13,686,064, including employer contributions of $2,196,300, employee contributions of $6,045,294, gains of $0, from the sale of assets, and earnings from investments of $4,853,958.

Your Rights to Additional Information
You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

• An accountant’s report
• Financial information and information on payments to service providers
• Assets held for investment
• Fiduciary information, including non-exempt transactions between the plan and parties in-interest.
• Insurance information including sales commissions paid by insurance carriers.
• Information regarding any common or collective trusts, pooled separate accounts; master trusts or 103 12 investment entities in which the plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call:

• Circle K
  The Circle K Retirement Plan
  1130 W Warner Rd., Tempe AZ 85284-2816
  1-602-728-8000

• Circle K Midwest/Great Lakes/Heartland
  Circle K HR/Benefits Department
  P.O. Box 347, Columbus IN 47202
  1-877-324-7968, option 7

The charge to cover copying costs will be $1.00 for the full annual report, or $.10 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge. You also have the legally protected right to examine the annual report at the main office of the plan at:

• Circle K
  1130 W Warner Rd, Tempe, AZ 85284-2816

• Circle K Midwest/Great Lakes/Heartland
  Circle K HR/Benefits Department
  4080 W. Jonathan Moore Pike, Columbus IN 47201

• The U.S. Department of Labor in Washington, D.C.

You may also obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.
Important Contacts

Please contact the companies listed here to learn more about a specific benefit plan. We also invite you to speak with your HR Representative.

<table>
<thead>
<tr>
<th>When you have questions about</th>
<th>Contact</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical: Anthem BCBS • 24 hour Nurseline</td>
<td>Anthem Blue Cross Blue Shield</td>
<td>1-844-453-4509 1-800-700-9184</td>
<td><a href="http://www.anthem.com">www.anthem.com</a></td>
</tr>
<tr>
<td>Medical: Kaiser Permanente</td>
<td>Kaiser</td>
<td>1-800-464-4000</td>
<td></td>
</tr>
<tr>
<td>Critical Illness Insurance</td>
<td>Guardian</td>
<td>1-800-268-2525</td>
<td><a href="http://www.guardiananytime.com">www.guardiananytime.com</a></td>
</tr>
<tr>
<td>Accident Insurance Plan</td>
<td>Guardian</td>
<td>1-800-541-7846</td>
<td><a href="http://www.guardiananytime.com">www.guardiananytime.com</a></td>
</tr>
<tr>
<td>Dental</td>
<td>Cigna Dental</td>
<td>1-800-244-6224</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
</tr>
<tr>
<td>Life and AD&amp;D Insurance</td>
<td>Aetna</td>
<td>1-800-523-5065</td>
<td>N/A</td>
</tr>
<tr>
<td>Life Portability and/or Conversion</td>
<td>Aetna</td>
<td>1-877-503-3448</td>
<td>N/A</td>
</tr>
<tr>
<td>Disability Insurance</td>
<td>Aetna</td>
<td>1-877-832-8241</td>
<td>N/A</td>
</tr>
<tr>
<td>401(k)</td>
<td>Principal</td>
<td>1-800-547-7754</td>
<td><a href="http://www.principal.com">www.principal.com</a></td>
</tr>
<tr>
<td>Employee Stock Purchase Plan</td>
<td>HR Benefits Representative</td>
<td>1-888-477-6583 (Circle K) 1-877-324-7968, option 7 (Circle K Midwest/Great Lakes/Heartland)</td>
<td><a href="mailto:hrsolve@circlek.com">hrsolve@circlek.com</a> <a href="mailto:benefits@circlek.com">benefits@circlek.com</a></td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>PayFlex</td>
<td>1-844-729-3539 (M-F, 7a.m. – 7 p.m CT and Sat 9 a.m – 2 p.m. CT)</td>
<td><a href="http://www.payflex.com">www.payflex.com</a></td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td>Anthem Blue Cross Blue Shield</td>
<td>1-800-865-1044</td>
<td><a href="http://www.anthemeap.com">www.anthemeap.com</a> (Log in: Circle K)</td>
</tr>
<tr>
<td>Tuition Reimbursement</td>
<td>HR Benefits Representative</td>
<td>1-888-477-6583 (Circle K) 1-877-324-7968, option 7 (Circle K Midwest/Great Lakes/Heartland)</td>
<td><a href="mailto:hrsolve@circlek.com">hrsolve@circlek.com</a> <a href="mailto:benefits@circlek.com">benefits@circlek.com</a></td>
</tr>
<tr>
<td>Circle K Employee Service Center</td>
<td>HR Benefits Representative</td>
<td>1-888-477-6583 (Circle K) 1-877-324-7968, option 7 (Circle K Midwest/Great Lakes/Heartland)</td>
<td><a href="mailto:hrsolve@circlek.com">hrsolve@circlek.com</a> <a href="mailto:benefits@circlek.com">benefits@circlek.com</a></td>
</tr>
<tr>
<td>COBRA</td>
<td>PayFlex</td>
<td>1-888-678-7835</td>
<td><a href="http://www.payflex.com">www.payflex.com</a></td>
</tr>
<tr>
<td>Medical Coverage through the Exchange</td>
<td>Mercer Marketplace</td>
<td>1-800-713-2859</td>
<td><a href="http://www.insurance.mercermarketplace.com">www.insurance.mercermarketplace.com</a></td>
</tr>
</tbody>
</table>

This document provides a very brief description of the important features of your coverage. This is not the insurance contract, but only a summary of coverage. Only the policy and the certificate of insurance issued by the carrier contain the actual provisions, including exclusions and limitations, which control the terms of the coverage. This means that the policy or certificate of insurance set forth in detail the rights and obligations of both you and Circle K.
Circle K
Tempe Employee Service Center
1130 W. Warner Rd., Bldg. B, DC-33
Tempe, AZ 85284
Phone: 1-888-HR-SOLVE (1-888-477-6583)
Fax: 1-602-728-5275
Email: hrsolve@circlek.com

Circle K Midwest/Great Lakes/Heartland
Columbus Employee Service Center
P.O. Box 347
Columbus, IN 47202
Phone: 1-877-324-7968, option 7
Secured Fax: 1-812-314-3284
Email: benefits@circlek.com