BENEFITS ENROLLMENT

Open Enrollment 2027 BENEFITS

ENROLL | ONLINE AT **WORKDAY.GFS.COM** OR VIA THE WORKDAY MOBILE APP

NOVEMBER 12–DECEMBER 2, 2026

OPEN ENROLLMENT SUMMARY

This is your opportunity to review and update your benefits for the 2027 calendar year.

Must Actively Enroll	Optional Changes and Enrollment	No Enrollment Required
Healthcare FSA	HSA Weekly Contributions	Employee Assistance Program (EAP)
Limited Purpose FSA	Medical/Prescription	Employee Tuition Reimbursement
Dependent Care FSA	Dental	
	Vision	
	Supplemental Life	
	Long-Term Disability	
	Short-Term Disability	
	Identity Protection	
	Accident, Critical Illness, Hospitalization	

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BENEFIT RESOURCES

1	**Total Rewards website** Open Enrollment Information & Video ***gfsstoretotalrewards.com***
2	**Alex** Interactive Plan Decision Support ***start.myalex.com/gfs/ftsa***
3	**Gordon Food Service Benefit Team** (616) 717-6800 ***HRBenefits@gfs.com***

TIMELINE

Don't delay!	Visit the Total Rewards Website at ***gfsstoretotalrewards.com*** for details about 2027 plans
November 12	Open Enrollment begins
December 2	Open Enrollment ends
December 10	Deadline to email dependent verification documents to ***HRBenefits@gfs.com*** only if you **added** a child or spouse to the medical, dental or vision plans
January 1	The new plan year begins
Mid-January	Monthly HSA company contribution will be deposited to your account

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HEALTH PLAN WEEKLY PREMIUMS

Weekly Insurance Premiums

	EMP	EMP/SP	EMP/CH	EMP/SP/CH(REN)
CORE PPO PLAN *Medical/Prescription*	$5.00	$55.72	$48.94	$67.30
HEALTH INVESTMENT PLAN *Medical/Prescription*	$16.84	$110.60	$97.15	$133.58
PREMIER PPO PLAN *Medical/Prescription*	$36.10	$179.33	$156.51	$244.76
DENTAL	$4.21	$8.85	$8.01	$12.64
VISION	$1.19	$2.26	$2.38	$3.50

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HEALTH PLAN COMPARISON

	CORE PPO PLAN				HEALTH INVESTMENT PLAN				PREMIER PPO PLAN			
Weekly Premiums	EMP	EMP/SP	EMP/CH	EMP/SP/CH	EMP	EMP/SP	EMP/CH	EMP/SP/CH	EMP	EMP/SP	EMP/CH	EMP/SP/CH
Medical/Prescription	$5.00	$55.72	$48.94	$67.30	$16.84	$110.60	$97.15	$133.58	$36.10	$179.33	$156.51	$244.76
Deductible	**In-Network**				**In-Network**				**In-Network**			
Individual	$4,250				$2,300				$1,200			
2 Individuals	$8,500				$3,800				$2,400			
3+ Individuals	$8,500				$4,600				$2,400			
Out-of-Pocket Max (includes deductible)												
Individual	$7,000				$4,000				$4,000			
2 Individuals	$14,000				$7,000				$8,000			
3+ Individuals	$14,000				$8,000				$8,000			
Office Visits & Specialist												
Preventive-Care Visit	Covered 100%				Covered 100%				Covered 100%			
PCP Office Visit	$40 copay				80% after deductible				$25 copay			
CVS Virtual PCP Visit	Covered 100%				Covered 100%				Covered 100%			
Specialist Office Visit	$60 copay				80% after deductible				$40 copay			
Emergency & Hospitalization												
Inpatient Hospital	70% after deductible				80% after deductible				80% after deductible			
Emergency Room	70% after deductible				80% after deductible				80% after deductible			
Urgent Care	$75 copay				80% after deductible				$50 copay			
Prescriptions												
Preventive Medications (Blood Pressure and Cholesterol Lowering)	Subject to copay below				Covered 100%				Subject to copay below			
Generic	$10 copay				$10 copay after deductible				$10 copay			
Preferred	30% - $25/$75				30% - $25/$75 after deductible				30% - $25/$75			
Non-Preferred	50% - $50/$100				50% - $50/$100 after deductible				50% - $50/$100			
Specialty Medications	50% to $250 copay				50% to $250 copay after deductible				50% to $250 copay			
Retail 90-Day Supply and Mail Order 90-Day Supply												
Preventive Medications (Blood Pressure and Cholesterol Lowering)	Subject to copay below				Covered 100%				Subject to copay below			
Generic	$25 copay				$25 copay after deductible				$25 copay			
Preferred	30% - $62.50 min/$187.50 max				30% - $62.50 min/$187.50 max after deductible				30% - $62.50 min/$187.50 max			
Non-Preferred	50% - $125 min/$250 max				50% - $125 min/$250 max after deductible				50% - $125 min/$250 max			

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PRE-TAX SAVINGS ACCOUNTS

HEALTH PLAN	PREMIER PPO CORE PPO	HEALTH INVESTMENT PLAN (HIP)	
ACCOUNT TYPE	**FSA**	**LIMITED PURPOSE FSA**	**HSA**
Contribution	$3,500	$3,500	S - $4,500 F - $9,000
Eligible Expenses	Medical	Dental	Medical
	Prescription	Vision	Prescription
	Dental		Dental
	Vision		Vision

HEALTH INVESTMENT PLAN (HIP)			
HSA	**IRS LIMIT**	**COMPANY CONTRIBUTION**	**EMPLOYEE CONTRIBUTION MAXIMUM**
1 Individual	$4,500	$500 $41.67 deposited monthly	$4,000
2 Individuals	$9,000	$750 $62.50 deposited monthly	$8,250
3+ Individuals	$9,000	$1,000 $83.33 deposited monthly	$8,000
Age 55+	Additional $1,000 catch-up contributions allowed		

DEPENDENT CARE FSA		
IRS LIMIT	**COMPANY CONTRIBUTION**	**EMPLOYEE MAXIMUM**
$7,500	500	$7,000
Contribute up to $7,000 annually in pretax dollars to pay for eligible childcare expenses. Receive a dollar for dollar company match up to $500. Plan carefully, the DC FSA follows the 'use it or lose it' rule.		

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DELTA DENTAL®

DENTAL & ORTHODONTIA PLAN

The Gordon Food Service Dental Plan is administered by Delta Dental of Michigan. This Plan is purchased separately from the medical coverage. To locate an in-network dentist, visit ***deltadentalmi.com*** and click on "Find a Dentist".

Dental Coverage

ANNUAL DENTAL MAXIMUM
$1,700 all dental services

PREVENTIVE DENTAL SERVICES
- 100% coverage
- Cleanings/exams and bitewing x-rays
- Twice per year

ANNUAL DEDUCTIBLE (Minor & Major Restorative Procedures)
$50 per person per year

MINOR RESTORATIVE DENTAL PROCEDURES
- 20% Co-Insurance (Plan covers 80%)
- Fillings, crowns, root canals, extractions, etc.

MAJOR RESTORATIVE DENTAL PROCEDURES
50% Co-Insurance (Plan covers 50%) Bridges, dentures, etc.

EMP	EMP/SP	EMP/CH	EMP/SP/CH
$4.21	$8.85	$8.01	$12.64

Orthodontic Coverage

ORTHODONTIA MAXIMUM
$1,500 per course of treatment

COURSE OF TREATMENT
24 month lapse between services for new treatment to be payable (benefit renews)

COVERAGE DETAILS
- Services covered at 50%
- Includes initial banding and periodic visits
- No age limit

DELTA DENTAL ID CARDS PROVIDED BUT NOT REQUIRED TO ACCESS COVERAGE

When you seek services from an in-network Delta Dental provider, they can verify coverage with the following information:
- Employee Social Security Number
- Plan 1800
- (800) 524-0149

Benefits of Using In-network Dentists

To maximize the benefits available under the plan, Gordon Food Service has partnered with Delta Dental of Michigan to offer services for a reduced fee if an in-network dentist is used. The dental network consists of Delta Dental PPO and the Delta Dental Premier networks. Dentists outside the network may be used with the same dental benefit coverage; however, you will not receive a reduced rate for those services and may be billed for services over what the plan covers.

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VISION PLAN

The Vision Plan is administered by EyeMed. To locate a provider near you, visit ***eyemedvisioncare.com***.
This plan is purchased separately from the medical coverage.

	MEMBER COST	REIMBURSEMENT
Annual Exam	**In-Network**	**Out-of-Network**
	Covered 100%	Covered 100%
Contact Lens Fit		
Standard	Up to $40	N/A
Premium	10% off retail price	N/A
Frames		
	$150 allowance 80% off balance over $150	Up to $80
Standard Plastic Lenses		
Single Vision	$15	Up to $70
Bifocal	$15	Up to $80
Trifocal	$15	Up to $90
Standard Progressive Lens	$50	Up to $80
Premium Progressive Lens	$50	Up to $80
	$120 allowance is combined for standard and contact lenses	
Lens Options		
Tint (Solic and Gradient)	$15	N/A
UV Coating	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Polycarbonate <19	Covered 100%	N/A
Standard Anti-Reflective	$45	N/A
Contact Lenses		
Conventional	$120 allowance 15% off balance over $120	Up to $120
Disposables	$120 allowance	Up to $120
	$120 allowance is combined for standard and contact lenses	
Frequency		
Exam	Once every calendar year	
Frames	Once every calendar year	
Standard Plastic Lenses OR Contact Lenses	Once every calendar year	
Additional Discounts & Secondary Purchase:		
Once you have used all of your vision benefits based on the chart above, you can continue to receive a discount on additional purchases.		

EMP	EMP/SP	EMP/CH(REN)	FAMILY
$1.19	$2.26	$2.38	$3.50

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UNUM VOLUNTARY PLANS

Unum Voluntary plans can help offset out-of-pocket medical or household expenses. Receive direct cash payments to help pay copays or deductibles. Or use the cash payment for everyday expenses. Review plan details for the Accident, Critical Illness and Hospital plans to decide which plans are right for you.

GROUP ACCIDENT INSURANCE	GROUP CRITICAL ILLNESS INSURANCE	GROUP HOSPITAL INSURANCE
Accident insurance provides a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.	Critical Illness will pay a lump sum benefit payment if you are diagnosed with an illness that is covered by this insurance. Eligible diagnoses include but not limited to: • Heart attack • Stroke • Major organ failure • Cancer • ALS • Multiple Sclerosis Critical Illness will not pay a wellness benefit in 2027.	Group Hospital Insurance helps covered employees and their families manage the financial impacts of a hospitalization. You can receive benefits when you are admitted to the hospital for a covered accident, illness or childbirth.

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Allstate IDENTITY PROTECTION

ALLSTATE IDENTITY PROTECTION

Allstate Identity Protection offers coverage to help protect you and your family from increased Scam and Fraud attempts. Enroll in Comprehensive Identity, Scam and Cyber Protection for an affordable weekly premium.

Comprehensive Identity, Scam, and Cyber Protection.

Benefits Include:

- Allstate Scam Protection
- Family protection features
- Identity restoration support
- Data removal

2026 WEEKLY PREMIUMS	
EMP	EMP/SP
$1.83	$3.22

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