Albertsons®

Health & Welfare Plan

Blue Cross of Idaho PPO Option

Effective June 1, 2013

Medical Program Description

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BLUE CROSS OF IDAHO (BCI) PPO OPTION HIGHLIGHTS

COMPREHENSIVE BENEFIT PLAN YEAR MAXIMUM	$2,000,000	
Benefit Categories	**In-Network – What You Pay**	**Out-of-Network – What You Pay**
Deductible: (per Benefit Plan Year); does not include pharmacy Copayments and certain other costs. Deductible amount is combined for In-Network and Out-of- Network Services. There are additional $100 per occurrence Deductibles for each Inpatient hospital admission and ambulance transportation service.	**Per Person Deductible** **Low Deductible Option:** $600 combined Deductible, for In- or Out-of-Network Services **Mid Deductible Option:** $850 combined Deductible, for In- or Out-of-Network Services **Family Deductible** **Low Deductible Option:** $1,800 combined Deductible (3 or more individuals), for In- or Out-of-Network Services **Mid Deductible Option:** $2,550 combined Deductible (3 or more individuals), for In- or Out-of-Network Services	
Out-of-Pocket Maximum: The amount of money an individual pays toward covered hospital and medical expense during any one Benefit Plan Year. The Deductibles, emergency room Copayment, charges for Outpatient Prescription Drugs, Prior Notification noncompliance reductions, non-covered expenses, charges in excess of the Blue Cross and Blue Shield fee schedule and certain other costs do not apply to any Out-of-Pocket Maximum.	**Low Deductible Option:** $2,600 per person, up to $5,200 per family **Mid Deductible Option:** $3,600 per person, up to $7,200 per family	**Low Deductible Option:** $6,850 per person, up to $13,700 per family **Mid Deductible Option:** $7,600 per person, up to $15,200 per family
Inpatient Hospital Services: Includes Maternity, Skilled Nursing Facility, Home Health Care and Hospice care. Room allowance based on the hospital's most common semi-private room rate. Prior Notification is required for Inpatient hospital admissions, Skilled Nursing Facility, Hospice care and coordinated Home Health Care. Failure to comply with the prior notification requirement will result in a 15% penalty, up to $5,000 maximum penalty.	$100 Inpatient admission Deductible, then 20% after Benefi t Plan Year Deductible	$100 Inpatient admission Deductible, then 40% of In-Network rate after Benefit Plan Year Deductible, subject to the Maximum Allowance Fee
Outpatient Surgery, Chronic Disease Management & Diagnostic Services: Prior Notification required for certain procedures. Failure to comply with the prior notification requirement will result in a 15% penalty, up to $5,000 maximum penalty.	20% after Deductible	40% of In-Network rate after Deductible, subject to the Maximum Allowance Fee
Emergency Room: Initial treatment in hospital emergency room for Accidental Injuries or sudden and unexpected medical conditions with severe symptoms. $200 Copayment waived if admitted to the hospital as an Inpatient, then Inpatient admission and Benefit Plan Year Deductibles apply. Copayment does not count toward Deductible. Coinsurance applies to Out-of-Pocket Maximum.	20% after $200 Copayment per visit	
Physician Office Services, Urgent Care and Laboratory: Payments are based on the Blue Cross and Blue Shield fee schedule.	20% after Deductible	40% of In-Network rate after Deductible, subject to the Maximum Allowance Fee
Preventive Care: Includes adult annual physical exams, routine or scheduled well baby/child exams, immunizations, mammograms, pap smear tests, prostate and digital rectal exams, and colorectal cancer screenings. Notwithstanding anything in this booklet to the contrary, the Medical Program will comply with health care reform for preventive care.	No cost for Covered Services.	Not Covered
Teladoc: National network of primary care physicians who provide consultations 24 hours a day, 365 days a year to diagnose routine, non-emergency health issues such as respiratory infections, bronchitis, allergies, sinus infections, urinary tract infections, flu and gastroenteritis. Visit www.Teladoc.com or call 1-800-TELADOC (835-2362)	$38 Copayment	Not Covered
Nurseline: Staffed by Registered Nurses (RN) who can help you recognize symptoms, chose appropriate care, learn to manage your health condition or connect you with other health plan resources. Call 1-888-993-7120.	No Cost	Not Covered
Infertility Treatment or Genetic Diagnostic Testing (when pre-approved by the Plan Administrator): $20,000 Lifetime Benefit Maximum, $5,000 Lifetime Benefit Maximum for infertility treatment prescriptions	20% after Deductible	40% of In-Network rate after Deductible, subject to the Maximum Allowable Fee
Chiropractor: $1,500 Benefit Plan Year maximum, subject to the Benefit Plan Year Deductible.	20% after Deductible	40% of In-Network rate after Deductible, subject to the Maximum Allowance Fee
Occupational / Physical Therapy: 25 In-Network visits per Benefit Plan Year or 12 Out-of-Network visits per Benefit Plan Year maximum, subject to the Benefit Plan Year Deductible.	20% after Deductible	40% of In-Network rate after Deductible, subject to the Maximum Allowance Fee
Rehabilitative Speech Therapy: 20 visits per Benefit Plan Year maximum, subject to the Benefit Plan Year Deductible.	20% after Deductible	40% of In-Network rate after Deductible, subject to the Maximum Allowance Fee
Behavioral Health Management: Includes treatment for Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction.	20% after Deductible	40% of In-Network rate after Deductible, subject to the Maximum Allowance Fee

***Important Note:** PPO In-Network Providers have agreed to accept the Blue Cross Blue Shield fee schedule. Out-of-Network Providers are reimbursed based on the BCI fee schedule; however, they can bill patients for any amounts that exceed BCI's fee schedule.

This chart provides only the highlights of the BlueCross of Idaho (BCI) PPO Option as of June 1, 2013. This Medical Program Rules document (including additional documents referenced in the Introduction section) governs the rules and benefits of the BCI PPO option.

PRESCRIPTION DRUG BENEFITS

COVERED EXPENSES	WHAT YOU PAY	
	Albertson's LLC Pharmacy Network Per 30-Day Supply, 90-Day Maximum	Non-Albertson's LLC Pharmacy Network Per 30-Day Supply, 90-Day Maximum
Generic Drugs	20% ($4 minimum)	50% ($4 minimum)
Formulary Brand Drugs	20% ($20 minimum)	50% ($20 minimum)
Non-Formulary Brand Drugs	30% ($40 minimum)	60% ($40 minimum)

If a brand name drug is purchased when a generic is available, the participant will pay the difference in price between the generic and brand name, in addition to the requirements above.

Out-of-Pocket Maximum: If a participant's out-of-pocket Prescription Drug expenses at an Albertson's LLC Network pharmacy reach $2,500 within the Benefit Plan Year, the participant's Copayment (amount participant pays at the pharmacy) will be reduced to a 5% Copayment for the remainder of the Benefit Plan Year.

Formulary: A list of preferred prescription drugs chosen based on the drug's efficacy, safety and cost-effectiveness.

Introduction

Albertson's LLC offers the Medical Program ("Program") to eligible employees of Albertson's LLC and certain affiliated companies (collectively "Employer" or "Company"). The Medical Program is a component program of the Albertson's LLC Health & Welfare Plan ("Plan"). The components in the Plan are the Medical Program, Dental Program, Vision Program, Employee Assistance Program, Short Term Disability Program, Long Term Disability Program, Life Insurance Program and Flexible Spending Account Program. Eligibility to participate in one component program does not guarantee or entitle you to participate in another component program in the Plan.

This Medical Program Rules document, together with your separate document entitled "Eligibility Rules Supplement" and your Rate Sheet and the Medical Program Rules documents, Eligibility Rules Supplements and Rate Sheets created for other employee groups, comprise the official Plan document for the Medical Program portion of the Albertson's LLC Health & Welfare Plan as of June 1, 2013 and replace previous statements or descriptions of this Program. (Your Rate Sheet refers to the employee contribution information and enrollment deadline in your most recent personalized Albertson's LLC Benefits Eligibility Notification or your Benefits Annual Enrollment Rate Sheet.) Because these documents are intended to provide an easily understood explanation of the rules in this Program, together these documents also serve as your summary plan description ("SPD") of the Medical Program portion of the Plan. These documents will be used to administer the Program and will govern the determination of benefits under the Program. This Medical Program Rules document applies to all eligible active and former employees and their dependents enrolled in the Blue Cross of Idaho PPO Medical Program option, but not to eligible active and former employees and dependents enrolled in another Medical Program option in the Plan.

Other component programs in the Plan are similarly documented and, in the case of programs that are subject to ERISA, those documents likewise serve as summary plan descriptions.

Eligibility and Enrollment

Eligible Employees

After you have met the eligibility requirements that apply to your workgroup (as described in the Eligibility Rules Supplement), you are eligible to enroll in the Medical Program component of the Plan. If you lose your eligibility for benefits, or if you leave the Company and are later rehired, you must complete the requirements that apply to your workgroup to regain your benefits.

In no event, will an employee in a job class covered by a collective bargaining agreement between Albertson's LLC and any labor union be eligible to participate, unless the collective bargaining agreement specifically provides for participation in the Medical Program. Temporary employees, independent contractors and leased workers are not eligible.

Albertson's LLC's classification of an individual as eligible or ineligible is conclusive for purposes of determining benefit eligibility under the Medical Program. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency or otherwise, without regard to whether Albertson's LLC agrees to the reclassification, shall make the person retroactively or prospectively eligible for benefits. However, Albertson's LLC, in its sole discretion, may reclassify a person as benefits eligible on a prospective basis. Any uncertainty regarding an individual's classification will be resolved by excluding the person from eligibility.

Because eligibility for the Program is based on your home zip code, you must promptly notify Albertson's LLC of any address changes.

Health Care Fraud

When completing and submitting any Company enrollment information, you are certifying that the information you are providing is true, accurate, and complete and you are certifying that you intend for the Plan Administrator and the Claims Administrator to rely upon the information you provide for purposes of enrollment or changes in your coverage elections under the Medical Program. In addition to being considered fraud on the Plan and an intentional misrepresentation, enrolling ineligible dependents or maintaining coverage for a person who no longer satisfies dependent eligibility rules violates Company policy. Falsification of any of the information provided to the Plan Administrator or Claims Administrator may result in your retroactive termination from coverage under the Medical Program or retroactive termination of the coverage of your spouse and/or dependents. In addition, the Medical Program reserves the right to demand reimbursement for benefits paid to you or anyone receiving benefits through you based on falsified information.

In connection with documents that are part of the Medical Program records (such as enrollment forms), it may be a criminal violation to make any false statement or representation of fact, knowing it to be false, or knowingly concealing, covering up, or failing to disclose any fact the disclosure of which is necessary to administer the Medical Program in accordance with its terms.

If you obtain benefits falsely, you will be required to reimburse the Medical Program and you may be subject to discipline, including termination of employment. In addition, state and federal law may impose criminal and civil fines and/or imprisonment.

Enrollment

You must enroll by the deadline, as defined in the Eligibility Rules Supplement. If you timely enroll, your Medical Program coverage will take effect as of your eligibility date. You are required to pay a portion of the cost for benefits of the Medical Program based on the option you choose and the eligible dependents you choose to cover. Your paycheck will reflect deductions that pay for the coverage from the date that you became eligible for coverage. Paycheck deductions are taken for any week in which you work and/or are paid. Deductions are not prorated by number of days worked in the week.

You may be able to enroll in health care coverage for any of the following, depending on your workgroup.

- Yourself only
- Yourself and your spouse or Non-Traditional Spouse (as defined in the "Who Can Be Covered by the Medical Program" section below)
- Yourself and one child (no spouse or Non-Traditional Spouse)

- Yourself and any number of children (no spouse or Non-Traditional Spouse)
- Yourself and your spouse or Non-Traditional Spouse and any number of children.

If you are terminated and rehired within 60 days, you will not be treated as a new employee for purposes of this initial enrollment election. Instead, your prior elections will be reinstated with a lapse in coverage, unless you experienced a mid-year election change event. If you are reemployed more than 60 days after your termination, you will be considered a new hire and must meet waiting period and other new hire requirements.

When Coverage May Be Delayed

On the day that your coverage would normally begin, if you are unavailable for work for reasons other than your own health condition, coverage for you and your eligible dependents may be delayed until your first day of work in an eligible job classification. In addition, if you fail to provide complete and correct information when you are enrolling for coverage, coverage can be delayed or denied, or a claim may not be paid.

Late Enrollment

If you do not enroll in the Medical Program when you first become eligible, you may not be able to participate in the Medical Program until the next Annual Enrollment period or until you have a qualifying mid-year election change event or special enrollment event, whichever comes first (as described later in these Program Rules). Annual Enrollment periods generally occur once per year.

Requalification Process

Twice per year, the Company reviews the number of hours employees are paid to determine continued benefit eligibility. Once the employee becomes eligible for benefits, the employee's hours are not reviewed until the next requalification period unless the employee has a change in eligible class. If an employee loses eligibility, they may continue benefits under COBRA (see Continuing Your Coverage Under COBRA section).

If an employee who was previously eligible for coverage, lost eligibility and then re-qualifies for benefits during a subsequent hours measurement (requalification) period, the employee will be treated as a newly hired employee and will be required to make new elections within 31 days as an eligible employee. The employee will not need to satisfy a new waiting period.

Who Can Be Covered by the Medical Program

Information in this section will help you determine who is eligible for coverage under the Medical Program. The Plan Administrator reserves the right to require proof of dependent eligibility.

Dependents

If you enroll in the Medical Program, you may also enroll eligible family members. If you have a newly eligible dependent, including a newborn child, you must notify HR Shared Services at **1-800-969-9688** to enroll your dependent before he or she can receive coverage under the Medical Program. See below for important additional information on eligible dependents, the enrollment deadline and the effective date of coverage.

The following categories of dependents are considered eligible family members:

- ***Spouse***

Your legal spouse, including a common law spouse, same sex spouse, domestic partner or civil union partner only if the marriage or partnership is legally recognized by a state and the state issued a legally recognized license or certificate. Your spouse is not eligible for coverage under the Medical Program if you are or become legally separated. References to Non-Traditional Spouse in this document refer to any eligible spouse other than a legally married opposite gender spouse (i.e., same sex spouses, domestic partners and civil union partners).

Enrolling your spouse in Albertson's LLC Medical Program may be subject to a special surcharge. An additional $25 per week will be deducted from your paycheck if your spouse is eligible for group medical coverage from his or her employer, but has declined that coverage in order to be covered by the Albertson's LLC Medical Program instead. If your spouse is enrolled for group medical coverage through his or her employer, the $25 per week surcharge does not apply.

- ***Dependent Children***

To be a dependent child, the child must be a citizen, national or resident of the United States. In addition, to be a dependent child, the child must be under 26 years of age and one of the following:

- Your biological child;
- Your adopted child or a child placed with you for adoption;
- Your stepchild, meaning your spouse's adopted or biological child or child placed for adoption with your spouse;
- Your Non-Traditional Spouse's biological or adopted child or a child placed for adoption with your Non-Traditional Spouse.

- ***Disabled Dependents***

An unmarried disabled dependent child is eligible if all of the following apply to him/her:

- Became disabled prior to turning age 26;
- Primarily dependent on you for support;
- Incapable of self sustaining employment because of medical or physical disability; and
- For whom application for extended coverage as a disabled dependent child is made within 31 days after reaching the age limit of 26. After this initial proof, the Claims Administrator may request proof again each year thereafter.

A newly eligible employee who has a disabled dependent age 26 or over may not enroll that dependent unless the Plan Administrator receives evidence of the disabled dependent's creditable coverage (with no more than a 63 day break in coverage) dating back to the disabled child's 26th birthday.

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Verification Requirements

For dependent coverage, you are also required to submit verification/proof of that family member's relationship to you before a specified deadline. The dependent will be covered under the Program during the verification period (described below) and, if satisfactory verification is timely submitted to the Verification Center, coverage will continue after the verification period. However, if the satisfactory verification is not submitted to the Verification Center on or before the last day of the verification period regardless of the reason, coverage for that dependent will be terminated at midnight of the last day of the verification period. If coverage of a dependent is terminated in these circumstances, you may not be able to enroll that dependent in the Program again until the next Annual Enrollment.

Verification Process

Notification

After you enroll a dependent in the Program, the Verification Center will send you a letter specifying the documents you must submit to verify the dependent's relationship to you.

Verification Period

You will have until the deadline stated on the letter from the Verification Center to submit the required verification. Your verification will not be considered submitted unless it is actually received by mail, fax or upload at the address given in the letter from the Verification Center.

Documentation

The Verification Center will determine in its sole discretion whether the documentation you submit is satisfactory verification of the dependent's relationship to you. Any dispute about whether the documents submitted satisfy the verification requirement will NOT extend the deadline for submitting verification and will NOT extend coverage of the dependent in the Program.

The following documents are generally required to verify a dependent's eligibility.

- ***For Children/Disabled Dependents***
  - A copy of the child's birth certificate, naming you or your spouse as the child's parent, or appropriate court order / adoption decree naming you or your spouse as the child's legal guardian OR
  - If applicable, a copy of a court-issued Qualified Medical Child Support Order (QMCSO) or other court order where you or your spouse are required to provide healthcare.
- ***For Spouse***
  - A copy of your marriage certificate AND
  - A copy of the front page of the current or prior year's filed federal tax return confirming this dependent as a spouse, OR documentation dated within the last 60 days establishing current relationship status such as a recurring monthly household bill or statement of account listing your spouse's name, the date and your mailing address.
- ***For Non-Traditional Spouse***
  - State issued license or certificate AND
  - One form of documentation dated within the last 60 days establishing current relationship status such as a recurring monthly household bill or statement of account listing your non-traditional spouse's name, the date and your mailing address.

You must also notify HR Shared Services at **1-800-969-9688** when one or more of your dependents are no longer eligible for coverage (for example, if a child is no longer eligible because he or she has had a birthday that affects age related eligibility or if you become divorced). You will not be reimbursed for any deductions that are taken from your paycheck between the time when such an event occurs and the time that you report the event. That is, refunds will not be given for delays in reporting coverage level reductions to HR Shared Services. Additionally, you will be required to pay back any claims paid for an ineligible dependent.

Qualified Medical Child Support Order (QMCSO)

In accordance with federal law, the Medical Program recognizes a Qualified Medical Child Support Order (QMCSO). A QMCSO requires you to enroll eligible children for coverage even if you do not have custody.

The QMCSO must be issued by a court of competent jurisdiction or through an appropriate state administrative process that meets the requirements of applicable law.

The Plan Administrator follows certain written procedures for determining whether an order qualifies as a QMCSO. You can obtain copies of those procedures through HR Shared Services upon request and without charge. If HR Shared Services determines that the order is a QMCSO, it will follow the terms of the order and will automatically enroll the dependent(s) named in the order, provided the Medical Program requirements are satisfied. If this happens, your dependents will be enrolled in the same Program option in which you are enrolled. If you are an eligible employee not enrolled in any Medical Program option, you and the child specified in the order will be enrolled in the option you choose (if you do not make an election, you and the child specified in the order will be defaulted into the BCI Low Deductible PPO option). All applicable employee contributions will be deducted from your paychecks.

As soon as you learn of any legal proceedings that may require you to provide health care for your children, you should notify HR Shared Services at **1-800-969-9688**.

Changing Your Coverage

Annual Enrollment

You can review personalized information each Spring that summarizes your current participation and summaries that describe the health care options and rates for the next Benefit Plan Year. It is your responsibility to review your Annual Enrollment information for accuracy.

If you are eligible for benefits, you can make any of the following choices during the Annual Enrollment period:

- Enroll for health care coverage
- Change existing health care coverage elections
- Change the dependents who you are covering
- Cancel your health care coverage

If you want to make changes, simply follow the instructions that are provided in your Annual Enrollment information. Changes are effective on the first day of the new Benefit Plan Year (June 1st) if you have completed the enrollment process correctly, in a timely manner, and you are still eligible for benefits. Your election is effective for the entire Benefit Plan Year unless you experience a permitted election change event.

If You Don't Make Changes at Annual Enrollment

In general, if you don't make changes at Annual Enrollment, the benefit elections that appear on your personalized summary continue during the following Benefit Plan Year (if these elections are still available and you are still eligible for coverage). The Plan Administrator may routinely make changes to the Medical Program, so carefully review your Annual Enrollment materials and updated Summary Plan Description (SPD).

If your existing health care plan is no longer available and you do not waive or elect other Medical Program coverage, you will automatically be enrolled in the appropriate Preferred Provider Organization (PPO) plan according to your home zip code. You will not be able to change this default election until the next annual enrollment period.

Administrative Error

It is your responsibility to make certain that the correct costs for your benefit elections are being deducted from your paychecks. If you identify an error, please contact HR Shared Services at 1-800-969-9688 immediately. HR Shared Services will make reasonable attempts to correct the error. Errors in granting coverage or deduction errors do not cause an individual who was not eligible for coverage to become eligible for coverage.

Mid-year Election Changes

You can change your Medical Program coverage during the year only when certain events occur, regardless of whether you pay for such coverage on a pretax or after tax basis.

The chart below identifies the permitted election change events and the consistency requirements that must be met in order to make a desired change. In some circumstances, the Internal Revenue Service rules related to a "spouse" may limit the ability of employees to make mid-year election changes if the employee's spouse is a Non-Traditional Spouse.

Permitted Election Change Event	Permitted Election Change
Marriage	Add or increase coverage because of new dependent(s). Cancel or decrease coverage if you and/or any dependent(s) elect coverage under spouse's group health plan. See "Special Enrollment Due to Acquiring a New Dependent" below.
Divorce, annulment, or legal separation	Add or increase coverage if you or any dependent(s) lost coverage under spouse's group health plan. Decrease coverage to drop spouse.
Death of spouse	Add or increase coverage if you and/or any dependent lost coverage under spouse's group health plan. Decrease coverage.
Change in number of dependents (because of birth, adoption, placement for adoption, death)	Add or increase coverage. Decrease coverage. See "Special Enrollment Due to Acquiring a New Dependent" below.
Dependent loses eligibility	Decrease coverage but only relating to dependent losing eligibility.
Dependent gains eligibility	Increase coverage but only relating to dependent gaining eligibility
Employment status changes of spouse or dependent, so that you, your spouse or dependent gain or lose eligibility under another group health plan. Employment status changes include only the following: • Termination or commencement of employment • A strike or lockout • Commencement of or a return from an unpaid leave • A change in your scheduled hours so that you gain or lose eligibility • Any other change in employment status that affects benefits eligibility	Add or increase coverage because of loss of other coverage (e.g., if you were covered under your spouse's group health plan and your spouse loses coverage, you, your spouse, and any other eligible dependents covered on your spouse's group health plan can enroll in the Albertson's LLC Medical Program if you and your dependents are eligible). Cancel or decrease coverage if coverage is elected under another group health plan because of gaining eligibility for coverage.
Your employment status changes (as described above) so that you gain or lose eligibility under the Albertson's LLC Medical Program	Add coverage if you have gained eligibility for yourself, your spouse and any eligible dependents. If you have lost eligibility in an employment related change, such as termination or moving from a benefit eligible to benefit ineligible job classification, your coverage will be canceled and your election will be automatically canceled as well.

Permitted Election Change Event	Permitted Election Change
Certain changes under spouse's or dependent's employer's plan	Certain prospective changes are permitted if they are due to and correspond with a permitted change made under your spouse's or dependent's employer's group health plan or if your spouse or dependent elects coverage under his or her employer's plan during the annual enrollment period of your spouse's or dependent's employer's group health plan, if it (and the plan year) are different than Albertson's LLC's annual enrollment period and Benefit Plan Year. Add or increase coverage if you are dropping coverage under spouse's or dependent's group health plan. Cancel or decrease coverage if coverage is elected under your spouse's or dependent's employer's group health plan.
Residence change	Change coverage option. If you move and your current health care coverage is no longer accessible to you (e.g., you move away from the area served by an HMO), you may change or cancel your election.
Medicare or Medicaid eligibility change	Add or increase coverage if you, your spouse or dependent loses eligibility for Medicare or Medicaid and you add coverage for the person losing entitlement. See "Special Enrollment Due to Loss of Eligibility for Medicaid or CHIP or Eligibility for a Premium Subsidy under Medicaid or CHIP." Decrease or cancel coverage if you, your spouse or dependent gain eligibility for Medicare or Medicaid and the change corresponds with cancellation of coverage for person with entitlement.
Qualified Medical Child Support Order (QMCSO)	Add or increase coverage if a QMCSO requires that you provide coverage and if as a result you need to enroll yourself and your dependent or your contribution level changes. If you are required to provide coverage pursuant to a QMCSO, Albertson's LLC will automatically make any needed changes to your cost and contribution level. Decrease coverage if another person is required to provide coverage and if as a result of the loss of the dependent your contribution level changes.
You, your spouse or your dependent lose coverage under any group health coverage sponsored by a governmental or educational institution, including the following: • A state's children's health insurance program (CHIP) • A medical care program of an Indian Tribal Government, the Indian Health Service or a tribal organization • A state health benefits risk pool • A foreign government group health plan	Add or increase coverage. See the special enrollment rules below. Note that no changes are permitted due to gain of coverage under any group health coverage sponsored by a governmental or educational institution, unless it qualifies as another Permitted Election Change (e.g. Medicaid or employment status change).
Special enrollment event	Add or increase coverage. See the special enrollment rules below.

Procedure and Deadline for Making Mid-year Election Changes

If you satisfy the requirements in this section for a mid-year election change, you must submit a written request acceptable to the Company and any supporting documentation requested by the Company to HR Shared Services within 31 days of the date you experience a permitted election change event that allows you to make an election change (within 60 days for certain Medicaid and CHIP events, as described below). Once your request is properly completed, your new election will generally be effective the date your completed request is received by HR Shared Services. For birth, adoption and placement for adoption, coverage will be effective the date of the event if you submitted a written request acceptable to the Company and any supporting documentation requested by the Company to HR Shared Services within 31 days of the date you experienced the event. Generally, for all permitted events if you submit your properly completed request prior to the date of the event, your election will be effective the date of the event. Your election remains in effect for the entire Benefit Plan Year unless you experience another permitted election change event.

The Consistency Rule

Also note that federal tax rules applicable to pre-tax health care require that your changes satisfy certain "consistency rules." If, in Albertson's LLC's judgment, the requested change does not satisfy these rules, it will not be permitted.

Please note:

You may need to provide proof of your permitted election change event or special enrollment event and the date the event occurred. Failure to do so within 31 days or 60 days (as applicable) of the event may result in denial of your change request.

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Note that if you experience a permitted election change event, you can only change your coverage level; you may not change your coverage option unless the option ceases to be available to you or you have experienced a special enrollment event.

If you have questions about changing your benefit elections during the year, please contact HR Shared Services at **1-800-969-9688**.

Here are some examples to help explain the operation of the consistency rules:

- Pat is married and has two children. Pat elects family coverage (employee plus spouse and one or more dependent children) under the Medical Program. One child turns 26 and therefore loses eligibility under the Medical Program. Even though Pat's child has experienced a permitted election change event, Pat still has two remaining eligible dependents (spouse and one child). Thus, Pat is not permitted to change her benefit election level to anything other than family coverage. Pat's child who just turned 26 will cease to be eligible, however, and will not be covered, even though Pat continues to have family coverage.
- Facts are the same as the above example except Pat only has one child. The child turns 26 and therefore loses eligibility for coverage under the Medical Program. Pat can change her election from the family coverage level (employee plus spouse and one or more dependent children) to employee plus spouse. Pat cannot, however, change from family to employee only or no coverage.
- Chris elects employee only coverage under the Medical Program. Chris marries. Chris's wife elected employee only medical coverage from her employer's health plan prior to their marriage. Chris may either cancel coverage under the Albertson's LLC Medical Program if he and his wife will be covered under her employer's plan, or his wife may cancel coverage under her plan and become covered under the Albertson's LLC Medical Program (may be subject to a $25 per week surcharge). Either change satisfies the consistency rules.

Automatic Changes to Your Benefits Elections

In some situations, your benefit elections will be changed for you automatically. You do not need to request a change to your benefit elections when the following permitted election change events occur:

- If you terminate employment or you otherwise lose eligibility, your benefit elections will terminate automatically effective on the date you terminate employment or otherwise lose eligibility.
- If your share of the cost of Medical Program coverage insignificantly increases or decreases, your payment for the coverage elected will be increased or decreased automatically, as appropriate, to equal the entire cost to you for such coverage.
- If you are an eligible employee, and you are required by a QMCSO to provide health coverage for a child, your child will be enrolled in the same health plan option in which you are enrolled. If you are an eligible employee not enrolled in any health plan option, you and the child specified in the order will be enrolled in the health plan option you choose (if you do not make an election, you and the child specified in the order will be defaulted into the BCI Low Deductible PPO option). The entire cost to you for such QMCSO coverage will be deducted from your pay automatically.

Special Enrollment Periods

Special enrollment periods are periods when eligible employees or dependents may enroll in the Medical Program under certain circumstances after they were first eligible for coverage. Special enrollment events are triggered by a loss of other group health plan coverage, by acquiring a new dependent, by loss of coverage due to loss of eligibility for Medicaid or Children's Health Insurance Program ("CHIP") and by eligibility for Medicaid or CHIP premium subsidy. Your written request for enrollment and any supporting documentation requested by the Company must be submitted to HR Shared Services within 31 days of the special enrollment event except if the special enrollment event is loss of coverage due to loss of eligibility for Medicaid or CHIP or eligibility for Medicaid or CHIP premium subsidy, as discussed below.

Special Enrollment Due to Loss of Other Coverage

Employees or dependents who are eligible but not enrolled in the Medical Program may enroll for coverage in the Medical Program as special enrollees upon the loss of other health plan coverage if all of the following conditions are met:

1. The employee or dependent was covered under a group health plan or other health insurance coverage at the time coverage was previously offered to the employee or dependent;
2. The employee must complete any required written waiver of coverage and state in writing that, at such time, other health insurance coverage was the reason for declining enrollment;
3. The employee's or dependent's coverage is terminated because his/her COBRA continuation has been exhausted (not due to his or her failure to pay the premium or for cause), he/she is no longer eligible for the plan due to legal separation, divorce, death of the employee, termination of employment, reduction in hours, cessation of dependent status, all employer contributions towards the coverage were terminated, the individual no longer lives or works in an HMO service area, the individual incurs a claim that would meet or exceed a lifetime limit on all benefits or the plan is changed so that the employee or dependent is no longer eligible for coverage; and
4. The employee or dependent submitted a written request for enrollment and any supporting documentation requested by the Company to HR Shared Services not later than 31 days after the date the special enrollment event occurred.

If you request coverage and provide supporting documentation within the deadline described above after the loss of other coverage, your coverage will be effective on the date your request and required documentation is submitted to HR Shared Services. If you submit a written request for coverage prior to the loss of other coverage, your coverage will be effective the date of the event if you provide any supporting documentation requested by the Company within 31 days of the date of the event.

Special Enrollment Due to Acquiring a New Dependent

Eligible employees who are either enrolled or not enrolled in the Medical Program may enroll themselves and newly acquired dependents (but not existing dependents) for coverage in the Medical Program as special enrollees. If the employee is eligible under the terms of the Medical Program, the employee and the newly acquired eligible dependent are eligible for special enrollment as a result of acquiring the new dependent through marriage, birth, adoption or placement for adoption.

Coverage is effective on the date of birth, adoption or placement for adoption, if application and supporting documentation is received prior to or within 31 days after the birth, adoption or placement for adoption.

For marriage, coverage is effective on the date the request is received, if a properly completed application is received and supporting documentation is provided within 31 days of the marriage. If notification of the marriage is provided prior to the event and supporting documentation is received within 31 days of the marriage, coverage may be effective on the date of marriage.

Special Enrollment Due to Loss of Eligibility for Medicaid or CHIP or Eligibility for a Premium Subsidy under Medicaid or CHIP

Special Enrollment Events also include loss of coverage due to loss of eligibility for Medicaid or CHIP and eligibility for Medicaid or CHIP premium subsidy. If the Special Enrollment Event you experience is either loss of coverage due to loss of eligibility for Medicaid or CHIP or becoming eligible for a premium subsidy under Medicaid or CHIP, you have 60 days to submit a written request for enrollment and provide supporting documentation requested by the Company from the date of the loss of coverage or the date that eligibility for a premium subsidy is determined.

Paying For Your Coverage

You are required to pay a portion of the cost for benefits of the Medical Program based on the option you choose and the eligible dependents you choose to cover. Your paycheck will have deductions (employee contributions) that pay for your portion of the cost of coverage from the date that you became eligible for coverage. Paycheck deductions are taken for any week in which you work and/ or are paid. Deductions are not prorated by number of days worked in the week. If pay for any week(s) is not adequate to pay your portion of the cost, deductions will be taken from subsequent pay weeks or you may be billed. If payment is not received timely, benefits will be cancelled effective on the last date for which your contributions were paid through.

Employee contributions for the Medical Program are not used to pay Albertson's LLC owned pharmacies.

Paying for Your Coverage with Pre-tax Dollars

You can make your employee contributions for Company sponsored Medical Program coverage with "pre-tax" dollars.

Under current tax law, Albertson's LLC can pay for your share of the contributions for Medical Program coverage on your behalf, and then your taxable compensation is reduced by that amount. As a result, you pay no federal income taxes, social security taxes and, in most areas, no state or local income taxes on the money that is used to pay your share of the contributions for Medical Program coverage. You do not need to complete a separate or an additional enrollment form to have health care contributions deducted on a pre-tax basis. To participate in this pre-tax employee contribution feature, you must be an active employee who is enrolled in the Medical Program. COBRA participants are not eligible to participate in the pre-tax employee contribution feature.

When you use the pre-tax employee contribution feature, your Medical Program contributions are automatically deducted from your paycheck. Even though the income on which you pay taxes is lowered, your full base earnings are used to determine other Company sponsored employee benefits that are based on pay, such as basic life insurance.

It is important to understand that the benefit under the pre-tax employee contribution feature is that your share of the contributions for health coverage are paid from your compensation before taxes are withheld. Your maximum pre-tax wage deductions are the total employee contributions for the level of coverage you selected for the year. Your pre-tax wage deductions are considered Employer contributions by the IRS.

If you do not want to participate in the pre-tax employee contribution feature, contact HR Shared Services at **1-800-969-9688** to request a pre-tax waiver form before you enroll and during each Annual Enrollment period. You must complete and return a new waiver form for each Benefit Plan Year that you choose not to participate in the pre-tax employee contribution feature.

Tax Implications of Coverage for Non-Traditional Spouse and Children of Non-Traditional Spouse

Albertson's LLC pays the majority of the costs of coverage to provide benefits to employees, spouses and their children. The Company's contributions(s) will be the same toward the cost of your Non-Traditional Spouse's coverage as for a legally married opposite gender spouse.

Under current IRS rules, if you and your eligible same-sex spouse are legally married, your employee contributions for coverage will be taken on a pre-tax basis and you will not be taxed on the Company's contribution for your same-sex spouse's coverage regardless of whether your same-sex spouse qualifies as an IRS code section 152 dependent. However, you may only receive this favorable tax treatment for your eligible common law spouse, domestic partner or civil union partner if s/he qualifies as an IRS code Section 152 dependent and you inform HR Shared Services that s/he qualifies as an IRS code Section 152 dependent. Your Non-Traditional Spouse may be an IRS code section 152 dependent if:

- Your home is the principal place of residence for your Non-Traditional Spouse;
- Your Non-Traditional Spouse is a member of your household (meaning your relationship does not violate local law);
- Your Non-Traditional Spouse is not another taxpayer's section 152 dependent; and

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- You provide more than half of the financial support for your Non-Traditional Spouse.

If your common law spouse, domestic partner or civil union partner does not qualify as an IRS code section 152 dependent, the portion of the contributions that you pay for Non-Traditional Spouse coverage under the Medical Program must be paid on an after-tax basis. In addition, the Company's portion of the contributions for your Non-Traditional Spouse coverage will be considered income to you (i.e., imputed income) and will be subject to any applicable federal, FICA, state, local or other payroll taxes. This imputed income will be reflected on your Form W-2 (in Box 1). However, the Medical Program benefits your Non-Traditional Spouse receives from the Medical Program remain tax free.

Regardless of whether your Non-Traditional Spouse is your IRS code section 152 dependent, his or her children who are not adopted by you will typically qualify only for taxable coverage under the Medical Program. This means that the portion of the contributions you pay for coverage for your Non-Traditional Spouse's child will be paid on an after-tax basis. In addition, the Company's portion of the contributions for your Non-Traditional Spouse's children's coverage will be considered income to you. However, the Medical Program benefits your Non-Traditional Spouse's children receive from the Medical Program remain tax free.

Because of these tax issues, it is important to consider with your tax advisor both the employee contribution and the additional taxes you will pay when you are evaluating the cost of covering your Non-Traditional Spouse and his or her children.

Leaves of Absence

Health Care Coverage During an Approved Leave of Absence

During certain approved leaves of absence, your health care coverage may be continued on the same terms at active employee rates. While you are on leave, you are required to make contributions for Medical Program coverage. You can make your employee contributions through automatic payroll deductions if you are receiving a paycheck. If you are on an unpaid leave or if your paid leave has not been approved or is not adequate to fully pay your share of the cost, you will be billed directly and you can pay for your benefits on an after-tax basis by submitting payment directly to HR Shared Services. Failure to make these payments timely will result in a loss of coverage.

Family and Medical Leave Act (FMLA) Leave

Health care coverage will be continued during an approved FMLA leave, for employees enrolled in and receiving health care coverage, provided that you do not revoke coverage during your FMLA leave and continue to make timely and appropriate active employee contributions, through payroll deduction from approved paid leave and/or through direct billing. If you do not timely pay your employee contributions in full, your health care coverage will be canceled on the date your paid leave ended or the last day for which you made a timely full payment, whichever is earlier (see the When Benefits End section below). Refer to the FMLA Leave Policy for premium repayment obligation information, if applicable.

General Leave of Absence

Your health care coverage will terminate on the first day of your approved General Leave of Absence.

Military Leave

During military service, health care coverage may be continued or extended as outlined below:

Coverage Continued at Active Employee Rates	Coverage Continued if Elected and Paid For under USERRA or COBRA
Employees on an approved military leave for less than 31 days may continue coverage on the same terms as when they were active employees.	Employees on an approved military leave for 31 days or longer may extend coverage, if eligible under USERRA or COBRA (for more details see below).
Employee National Guardsmen or Military Reservists called to active duty and approved for the Company's Military Activation Plan (MAP) may continue coverage on the same terms as active employees for up to 12 months.	Employees who enlist in active military service while employed by the Company may continue coverage during absences for military service 31 days or more if eligible under USERRA or COBRA (for more details see below).

Reinstatement of benefits upon return from military leave will be handled consistent with USERRA. For further information about benefits continuation after termination of benefits, refer to the USERRA and COBRA sections below.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

A federal law known as USERRA allows employees called to active military duty who lose health care coverage as a result of their military service to continue coverage for up to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Uniformed Services, which includes the Army, Air Force, Navy, Marine Corps, Reserve and National Guard (while in federal status), the commissioned corps of the Public Health Services, certain types of services in the National Disaster Medical System (NDMS) and any other category of persons designated by the President of the United States.

The election and payment procedures during a USERRA leave are the same as the COBRA procedures described in the "Continuing Your Coverage Under COBRA" section of this document except as follows:

1. You must notify the Company's COBRA administrator that your leave is for uniformed service unless this notice is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances. If you do not provide this notice, COBRA will be your only basis for continuation coverage.
2. USERRA continuation coverage can extend for up to 24 months.
3. If your leave is less than 31 days, you are only required to pay the active employee rate for such coverage (not the COBRA rate of 102% of the cost of coverage).

As with COBRA coverage, you should send all payments for USERRA continuation coverage to the Company's COBRA Administrator. If you fail to pay your

USERRA premiums on time, you will lose all continuation rights under the Medical Program unless failure to pay is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

Worker's Compensation Leaves

If you are on an approved leave of absence due to a worker's compensation injury or illness (all or a portion of which may also qualify as FMLA leave), your coverage under the Medical Program may be continued at active employee rates for a maximum period of 26 weeks. Coverage will end on the earliest date that (i) you fail to make timely payments of required employee contributions; or (ii) you do not requalify for Medical Program coverage under the benefit requalification process; or (iii) you terminate your employment including retirement; or (iv) the 26 week maximum benefit continuation period is exhausted; or (v) one of the events described in the When Benefits End section below occur. Your benefit requalification requirements are explained in this document and the Eligibility Rules Supplement. For this purpose, if you are on a worker's compensation leave during some portion or all of a 6 month measurement period for determining benefits requalification, you will be treated as though you worked the required number of hours to maintain benefits during the period you are on approved leave until the 26 week maximum benefit continuation period is exhausted.

If you exhaust the 26 week benefit continuation period during a benefit protected worker's compensation leave but are then returned to work at the conclusion of your approved leave, you will be eligible for benefits after your return to work if you satisfied the previous benefits requalification process.

Temporary Restricted Work Program for Worker's Compensation Leaves

If you are on a worker's compensation leave, you may be placed on approved Temporary Restricted Work ('TRW') for up to 90 days. The period of time when you are on TRW will not count towards the maximum 26 week period for benefit continuation during an approved disability leave. If you are on TRW during some portion of a 6-month measurement period for determining benefit requalification, you will be treated as though you worked the required number of hours to maintain benefits during the period you are on approved TRW leave. If you exhaust the 26 week benefit continuation period during a benefit protected worker's compensation leave but are later placed on TRW leave, you will be eligible for benefits during the TRW if you satisfied the previous benefits requalification process.

Short Term Disability Leave

If you are on an approved leave of absence due to a disability, and receiving short term disability payments (all or a portion of which may also qualify as FMLA leave), your coverage under the Program may be continued at active employee rates for a maximum period of 26 weeks. Coverage will end on the earliest date that (i) you fail to make timely payments of required employee contributions; or (ii) you do not requalify for Medical Program coverage under the benefit requalification process; or (iii) you terminate your employment including retirement; or (iv) the 26 week maximum benefit continuation period is exhausted; or (v) one of the events described in the When Benefits End section below occur. Your benefit requalification requirements are explained in this document and in the Eligibility Rules Supplement. For this purpose, if you are on a disability leave during some portion or all of a 6 month measurement period for determining benefits requalification, you will be treated as though you worked the required number of hours to maintain benefits during the period you are on approved leave until the 26 week maximum benefit continuation period is exhausted.

If you exhaust the 26 week benefit continuation period during a benefit protected short term disability leave but are then returned to work at the conclusion of your approved leave, you will be eligible for benefits after your return to work if you satisfied the previous benefits requalification process.

Work During Approved Short Term Disability Leave

Any period of time during an approved period of short term disability leave during which an employee works a reduced schedule will not count towards the maximum 26 week period for benefits continuation during an approved disability leave, but will be included for benefits requalification purposes.

Successive Approved Leave of Absence Periods (except involving a General Leave)

If you return to work during the 26 week benefit continuation period for a period of less than four calendar weeks and then go back out on an approved leave of absence, the 26 week benefit continuation period will continue from the point when you returned to work following the first approved leave. If the approved leave of absence periods are separated by four or more calendar weeks, the 26 week benefit continuation period will start over.

If Annual Enrollment Occurs During Your Approved Leave

While you are on approved leave, you must still review the Annual Enrollment materials and enroll by the stated deadline. If you were previously eligible for and waived coverage prior to your approved leave, then your annual enrollment elections will be effective when you return to active work, provided you meet eligibility requirements at that time.

Health Care Coverage During an Unapproved Leave of Absence

Your health care coverage will terminate the earlier of the date of your termination of employment or four weeks after the last day you actively worked, if you have not submitted documentation sufficient for your leave of absence to be approved; or on the last day you are on an approved leave, if your approved leave ends. Continuation coverage may be available under COBRA. If your employment has been maintained and you return to work following this absence, your medical coverage will be reinstated effective the date you return to work if you satisfied the previous benefit requalification process.

Collective Bargaining Agreements and Strikes

If you are absent from work due to a strike or lockout, your coverage under the Program will end on the last day worked before a full day work absence or on the first day of the work absence if hours are actually worked for a partial day during the first day of the work absence. In the event that a provision of an applicable collective bargaining agreement or applicable law

is contrary to this provision, the terms of the collective bargaining agreement or applicable law will prevail.

COBRA Coverage During a Work Absence/Reduction in Hours Worked

If you lose group health coverage during a work absence due to reduction in hours worked, you may be able to continue such coverage under COBRA. For more details about COBRA see the COBRA section below.

When Benefits End

In general, all benefits end on the date that you or your dependents are no longer eligible for benefits or that your employment terminates. It is your responsibility to call HR Shared Services within 31 days of when your spouse or children are no longer eligible for coverage under the Program. If HR Shared Services is notified after 60 days, COBRA Continuation Coverage will not be available when coverage ends.

Your Coverage

Your Medical Program coverage ends on the day on which any of the following events occurs:

- You fail to make the required contributions to the Medical Program when due. Coverage will end on the last date for which contributions were made.
- Your employment ends, including retirement. (Coverage will not be extended during unused vacation time.) Paycheck deductions are taken for any week in which you work and/or are paid. Deductions are not prorated by number of days worked in the week.
- The Medical Program is terminated or amended to end coverage for employees in your workgroup or classification.
- You are no longer eligible for benefits.
- You enter military services for duty lasting more than 31 days.
- You request that coverage be terminated (consistent with the permitted mid-year election change events).
- You die.

Your Coverage if You Transfer from Nonunion to Union Employment

If you transfer from nonunion to union employment where a collective bargaining agreement does not provide eligibility for the Plan, your Medical Program coverage will be extended until the earlier of (i) the date you become covered under the union plan; or (ii) the end of eight (8) weeks after you transfer. The Albertson's LLC Benefits Administrative Committee may, by written action, approve an extension period that is longer than eight (8) weeks.

Coverage for Your Spouse

Coverage ends for your spouse when your coverage ends, or on the day on which any of the following events occurs:

- You are no longer eligible for family level coverage. However, your covered spouse may continue coverage through the end of the month in which you die and for two consecutive months thereafter at subsidized contribution rates, as long as he or she elects COBRA and continues to satisfy the eligibility requirements.
- Your spouse is no longer considered an eligible dependent.
- You and your spouse become legally separated or divorced or the equivalent for Non-Traditional Spouses.
- The Medical Program is terminated or amended to end coverage for a workgroup or class that includes your spouse.
- Your spouse dies.

Coverage for Your Children

Coverage ends for your children when your coverage ends, or on the day on which any of the following events occurs:

- You are no longer eligible for family level coverage. However, your dependent children may continue coverage through the end of the month in which you die and for two consecutive months thereafter at subsidized contribution rates, as long as they elect COBRA and continue to satisfy the eligibility requirements.
- Your child is no longer considered an eligible dependent. (See "Who Can Be Covered by the Medical Program") If coverage ends due to an age restriction; the last day of coverage will be the day before the child's 26th birthday.
- The Medical Program is terminated or amended to end coverage for a group that includes your child.
- Your child dies.

When Coverage Ends in the Event You Become Totally and Permanently Disabled

Receipt of disability benefits does not guarantee employment. Your employment may be terminated while you receive medical benefits during an approved disability leave.

Your coverage may continue under the Medical Program with the same coverage option and at the same coverage level in effect when you became totally and permanently disabled for up to 26 weeks after the disability commenced or until you are no longer disabled (whichever occurs first). You may, however, enroll yourself or an eligible dependent during your period of disability, if you or your eligible dependent experiences a special enrollment event or a midyear election change event as previously described.

- You must pay your share of the cost of coverage on an after tax basis by personal check.
- Your payments must be sent to HR Shared Services by the due date on the billing invoice. If you fail to make the required payment within 30 days of the date due, your coverage will be terminated.

At the end of your disability extension, you may be eligible to extend medical benefits under COBRA as indicated in the "Continuing Your Coverage Under COBRA" section.

Important Notice of Your Right to Documentation of Health Coverage (Certificate of Creditable Coverage)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) can help you and your family obtain protection from pre-existing condition exclusion periods in your new medical plan if your coverage ends under another group plan or under this Medical Program. This can be done by documenting "creditable coverage".

Crediting Prior Coverage Under HIPAA

An individual receives credit (one day of credit for each day of coverage) for previous coverage that occurred without a break in coverage of 63 days or more (the time between the date coverage under the prior health plan ended and when the waiting period for the new plan began). That credit is applied to any pre-existing condition exclusion period the new plan might have. If a break of 63 or more days occurs, the prior coverage cannot be credited.

In accordance with the terms of HIPAA, Albertson's LLC must provide a Certificate of Creditable Coverage to you when you and/or your dependents stop participating in the Medical Program. The certificate is sent to you within 45 days of the date on which HR Shared Services is notified of your benefits ending date.

If you are a new Albertson's LLC employee who has previously been covered under an employer sponsored health care plan, your former employer will send a Certificate of Creditable Coverage to you if you were enrolled in that employer's health care plan at the time your employment ended.

You can present your Certificate of Creditable Coverage to a new health care plan to prove the amount of creditable coverage from your prior plan.

Certificate of Creditable Coverage

A Certificate of Creditable Coverage will be mailed to you automatically in the following situation:

- When your coverage under the Medical Program ends, whether or not you elect COBRA coverage.
- When your COBRA coverage ends, if you elected COBRA coverage.

In addition, a certificate will be provided to you upon your request.

Procedures to Request Certificates of Creditable Coverage

The Medical Program will provide the certificate as long as the request is made while you, your spouse or your dependent is covered under the Medical Program or within 24 months after coverage under the Medical Program terminates. The request can also be made by someone else on behalf of you, your spouse, or your dependent. For example, you, and your spouse or dependents who were previously covered under the Medical Program may authorize a new plan in which you, your spouse or your dependents enroll to request a Certificate of Creditable Coverage relating to prior coverage under the Medical Program. You, your spouse, and your dependents are entitled to receive a Certificate of Creditable Coverage upon request even if the Medical Program has previously provided a Certificate of Creditable Coverage to you, your spouse or your dependents.

If you, your spouse or your dependents would like to request a Certificate of Creditable Coverage, the request should be directed to HR Shared Services at **1-800-969-9688**.

The request must include the following information:

- The name of the individual for whom the Certificate of Creditable Coverage is requested;
- The last day that the individual was covered under the Medical Program, if relevant;
- The name of the participant that enrolled the individual in the Medical Program;
- Name of the person making the request and, if applicable, evidence of authority to request and receive the Certificate of Creditable Coverage on behalf of another individual;
- The address to which the Certificate of Creditable Coverage should be sent; and
- The requester's signature.

Your Certificate of Creditable Coverage includes the following information:

- The date the certificate was issued;
- The name of the Medical Program;
- The period of time that you or your dependents were enrolled in the Medical Program;
- The name of the individuals enrolled in the Medical Program;
- The name, address, and telephone number of the Claims Administrator; and
- Whom to contact for further information.

Converting Coverage

Coverage under the Medical Program cannot be converted to an individual policy.

Continuing Your Coverage Under COBRA

Under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you, your spouse, and your dependent children can continue your current Medical Program benefits if your coverage ends for certain reasons.

Note that while COBRA itself does not apply to all Non-Traditional Spouses, Albertson's LLC has determined to provide continuation coverage to Non-Traditional Spouses.

Coverage for you, your spouse, and your children can continue for up to 18 months if you lose coverage for either of the following reasons:

- Your employment ends for any reason other than gross misconduct.
- Your hours are reduced so that you are no longer eligible for benefits.

Your spouse and your children can continue coverage for up to 36 months if they lose coverage for any other qualifying event including:

- Your divorce or legal separation.
- Your death.
- Loss of dependent child status.

If you have questions regarding COBRA, please contact the COBRA Administrator. The COBRA Administrator is PayFlex Systems USA, Inc.

PayFlex Systems USA, Inc.
P.O. Box 2239
Omaha, NE 68103-2239
Telephone: 1-800-359-3921

PayFlex will decide and respond to all claims and appeals relating to an individual's eligibility for COBRA continuation coverage in the time and manner required by the Employee Retirement Income Security Act ("ERISA"), the Patient Protection and Affordable Care Act ("PPACA") and applicable regulations, as amended. PayFlex is the named claims fiduciary with respect to claims and appeals relating to eligibility for COBRA continuation coverage.

PayFlex is also a fiduciary under ERISA to the extent it handles COBRA premiums.

Notification of Continuation Rights

You, your spouse, and your children will be notified of the right to continue coverage under the Medical Program if coverage ends because your employment is terminated or your work hours are reduced.

It is your responsibility to notify HR Shared Services at **1-800-969-9688** within 60 days from the date the qualifying event occurred if you and your spouse divorce or legally separate (or the equivalent for Non-Traditional Spouses), if your children are no longer eligible for coverage, or if you or any of your dependents become eligible for Medicare. If you, your spouse or your children fail to notify HR Shared Services within this deadline, COBRA rights are forfeited. It is also your responsibility to notify HR Shared Services of any address change for your spouse, your former spouse, or other dependents if the address is different from yours.

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

Electing COBRA Coverage

You, your spouse and your children have a limited time in which to choose COBRA coverage. You must return your completed enrollment form to the address indicated within 60 days of the date of the COBRA notification letter. If you do not submit a completed enrollment form by the due date, you will lose your right to elect COBRA. Your request for continuation coverage or extension of continuation coverage may be denied if it is determined that you or your family member is not entitled to the requested continuation coverage for any reason. In such a circumstance, you will be provided with a notice of unavailability of continuation coverage after the request is received, and the notice will explain the reason for denying the request.

Special Considerations in Deciding Whether to Elect COBRA

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

Paying for COBRA Coverage

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

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

For your coverage to be effective, the first premium must be received within 45 days of the enrollment being processed. Coverage will be retroactive to the day after your termination date. After you have made the first premium payment, payments are due by the first of each subsequent month and will be accepted no later than the 30th day of the month. Payments received after the 30th day of the month will not be accepted, and coverage will be terminated on the due date.

Changing COBRA Coverage

As a COBRA participant, you have the same rights as active employees to change your coverage during the Annual Enrollment period. In addition, you can change your coverage pursuant to the special enrollment rights described earlier.

Extended COBRA Coverage

There are two ways in which the 18 month period of COBRA continuation coverage can be extended.

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1. Disability extension of 18 month period of continuation coverage.

If you or anyone in your family who is a qualified beneficiary covered under the Medical Program is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, you and your qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day after your termination of employment or reduction in hours and must last at least until the end of the 18 month period of COBRA continuation coverage. Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

You must notify the COBRA Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction in hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Medical Program as a result of the covered employee's termination of employment or reduction of hours, and before the end of the 18 month period of COBRA continuation coverage.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. You must follow the notice procedures described in the "Notification of Continuation Rights" section. If no notice is given within the required period in accordance with the notice procedures, then there will be no disability extension of COBRA continuation coverage.

2. Second qualifying event extension of 18 month period of continuation coverage.

If your qualified beneficiaries experience another qualifying event while receiving 18 or 29 months of COBRA continuation coverage, the spouse and dependent children who are qualified beneficiaries can receive up to a maximum of 36 months (including the initial 18 month period), if notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to your spouse and dependent children who are qualified beneficiaries if you die, get divorced or legally separated, or if a dependent child who is a qualified beneficiary stops being eligible under the Medical Program as a dependent child. In all of these cases, the extension is available only if the event would have caused your spouse or dependent child to lose coverage under the terms of the Medical Program had the first qualifying event not occurred. In all of these cases, the COBRA Administrator must be notified in writing of the second qualifying event within 60 days of the second qualifying event. You must follow the notice procedures described in the "Notification of Continuation Rights" section. If no notice is given within the required 60 day period, your spouse and dependent children will not receive the extension of COBRA continuation coverage.

When COBRA Coverage Ends

COBRA coverage ends as described by law, including when any of the following events occur:

- Your premium payments are not received when they are due.
- Albertson's LLC terminates the Medical Program and does not offer any other group health plan.
- The person who is receiving COBRA coverage becomes entitled to Medicare.
- The person who is receiving COBRA coverage becomes eligible for coverage under another group plan (unless the other group health care plan has an enforceable pre-existing condition clause).
- The COBRA continuation period runs out.
- On the date your disability ends if that date occurs during the time you are receiving the additional 11 months of COBRA coverage.

If you or a qualified beneficiary become covered under another group health plan, entitled to Medicare, or recover from a disability, you must immediately provide notice of this event to the COBRA Administrator (at the telephone number or address listed at the back of these Program Rules) and provide the COBRA Administrator (i) the name of this Medical Program, (ii) the type of the event, and (iii) the date of the event.

If you decide to cancel your COBRA coverage before the end of your 18 or 36 months, you must notify PayFlex in writing at the address in the back of this document. COBRA will end on the last day of the month in which you requested cancellation of coverage. Your coverage will not be canceled retroactively except for non-payment. COBRA coverage continues for a maximum of 36 months, even if multiple qualifying events occur.

Early Termination

If the Plan Administrator terminates your continuation coverage for any of the reasons listed above prior to the end of the maximum coverage period, the Medical Program will provide the qualified beneficiary a notice of early termination. This notice will indicate the date the coverage was terminated and the reason.

If you have questions about COBRA coverage, contact PayFlex at **1-800-359-3921** for assistance.

Special Second Election Period

Special continuation rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect continuation coverage for themselves and certain family members (if they did not already elect continuation coverage) during a special second election period. This election period is the 60 day period beginning on the first day of the month in which an eligible employee becomes eligible for the health coverage tax credit, but only if the election is made within six (6) months of losing coverage. Please contact the Claims Administrator for additional information.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustments assistance. Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll free at **1-866-628-4282**.

Important Information for Women and Mothers

Coverage for Reconstructive Surgery Following a Mastectomy

The Women's Health and Cancer Rights Act of 1998 includes important protections for individuals who elect breast reconstruction in connection with a mastectomy. Under the terms of this federal act, for individuals receiving mastectomy-related benefits, coverage includes:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The coverage is subject to the same Deductible, Copayment, and Coinsurance provisions applicable to other medical benefits provided under the Medical Program.

Maternity Stay Benefits

Under a federal law called the Newborns' and Mothers' Health Protection Act of 1996, mothers and newborn children are entitled to a hospital stay of at least 48 hours for normal delivery and at least 96 hours for a Cesarean delivery. However, federal law generally does not prohibit the mother's or newborn's attending health care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

If your hospital stay is extended beyond the 48- or 96-hour period (as applicable), you must contact the Claims Administrator in advance to request approval for the expenses. You can find the contact information for the Claims Administrator in the General Plan Information at the end of these Program Rules.

Claims Procedures for Eligibility, Contributions and Plan Administrative Claims Determinations

For a dispute concerning your eligibility to participate in the Medical Program, whether your election is effective, whether you can make a change to your election, the amount of contributions due or other plan administrative matters, send your written claim to the Albertson's LLC Benefits Administrative Committee within 180 days of when you knew or reasonably should have known of the facts behind your claim, at the following address:

Albertson's LLC
Attn: Benefits Administrative Committee
PO Box 20
250 Parkcenter Blvd.
Boise, ID 83726

Initial Decision

If you have a dispute described above, within 30 days from the date your claim is received by the Benefits Administrative Committee, you will receive either: (a) notice of the decision, or (b) notice describing the need for additional time due to reasons beyond the control of the Benefits Administrative Committee to reach a decision (up to 15 additional days).

If the extension is required because you need to provide additional information in order for your claim to be decided, you will have 45 days from the date you receive such notice to provide the requested information. The time between the date notice is delivered and the date the requested information is received from you shall not count against the 30 day period (or 15 day extension, if applicable) for notifying you of any adverse decision on your claim.

Decision on Appeal

If your claim is denied and you disagree with the decision, you may appeal to the Benefit Plans Committee to review your claim. The address for the Benefit Plans Committee is listed at the end of this document in the General Plan Information section. Your appeal must be filed in writing within 180 days from the date you received the claim denial. Your appeal may (but is not required to) include issues, comments, documents, records, and other information relating to your claim that you want considered in reviewing your claim. You may request reasonable access to, and copies of, all documents, records, and other information relevant to your denied claim, without charge. You will receive notice of the decision within 60 days after the date the Benefit Plans Committee received your appeal.

If your claim involves urgent care as defined in the "Benefit Claims Review and Appeal Procedures" section, the 30-day period for notification of the initial decision and the 60-day period for notification of the decision on appeal are shortened to as soon as possible, taking into account medical exigencies, but not longer than 72 hours.

General Rules

Special Rules for Claims Relating to the Amount of Contributions Due

For claims relating to the amount of contributions due from you for coverage and only if required by health care reform rules:

- if the Benefit Plans Committee considers, relies on or generates new or additional evidence in connection with its review of your claim on appeal, you will be provided the new or additional evidence free of charge as soon as possible and with enough time before a final determination is required to be provided to you (as described above) so that you will have an opportunity to respond;

- before the Benefit Plans Committee issues a final determination on appeal based on a new or additional rationale, you will be provided the new or additional rationale free of charge as soon as possible and with enough time before the Benefit Plans Committee is required to notify you of the decision on the appeal so that you will have an opportunity to respond prior to that date;
- notices of the decision on your claim and any appeal will include the content required by health care reform rules; and
- external review will be available under the rules described in the "External Review Procedures – Health Care Reform" in the "Benefit Claims Review and Appeal Procedures" section.

If you provide any written authorization that Albertson's LLC may require, you may have a lawyer or other representative help you with any claim under the Program at your own expense.

Your casual inquiries and questions will not be treated as claims or appeals under the Program.

With respect to all claims and appeals relating to eligibility, contributions or other plan administrative matters, the Benefits Administrative Committee and the Benefit Plans Committee (as applicable) shall have the sole authority, discretion and responsibility to interpret and apply the terms of the Medical Program and to determine all factual and legal questions under the Medical Program. All determinations, interpretations, rules, and decisions by the Benefits Administrative Committee and the Benefit Plans Committee shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Medical Program.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to any denied claim.

Definition of "Relevant"

For the purpose of the claims procedures (including those in the Medical and Prescription Drug "Filing Claims" and "Benefit Claims Review and Appeals Procedures" sections), a document, record, or other information shall be considered "relevant" if such document, record, or other information: (i) was relied upon in making the benefit determination; (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (iii) demonstrates compliance with the required administrative processes and safeguards designed to ensure that the benefit claim determination was made in accordance with governing Program documents; or (iv) constitutes a statement of policy or guidance with respect to the Program concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Exhaustion of Administrative Remedies

Exhaustion of the claim and review procedure is mandatory for resolving every claim and dispute arising under the Medical Program (including those in the Medical and Prescription Drug "Benefit Claims Review and Appeal Procedures" below). In addition, in any legal action brought after you have exhausted administrative remedies, all determinations made by the Benefits Administrative Committee and the Benefit Plans Committee, shall be afforded the maximum deference permitted by law.

Time Limits for Commencing Legal Action

If you file a claim within the required time, complete the entire claims procedure (including those in the Medical and Prescription Drug "Benefit Claims Review and Appeal Procedures" below, if applicable), and your claim is denied after you request a review, you may sue over your claim (unless you have executed a release on your claim). You must, however, commence that suit within 30 months after you knew or reasonably should have known of the facts behind your claim or, if earlier, within 6 months after the claims procedure is completed.

Claims for Benefits

For disputes concerning benefits available under the Medical Program, see the Claims Procedures in the following "Filing Claims" and "Benefit Claims Review and Appeal Procedures" sections.

Other Important Information

Your ERISA Rights

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as work sites and union halls), all documents governing the Medical Program and a copy of the latest annual report (Form 5500 Series) that the Medical Program has filed with the U.S. Department of Labor, which is available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Medical Program, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Medical Program's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Care Plan Coverage

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

- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health care plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health care plan or health insurance issuer when you lose coverage under the Medical Program, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion of 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Medical Program and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Medical Program's claims procedures. In addition, if you disagree with the Medical Program's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Medical Program fiduciaries misuse the Medical Program's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay those costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Medical Program, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), (formerly the Pension and Welfare Benefits Administration) U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

Your Responsibility

You should read this booklet carefully and follow the procedures set forth in these Program Rules. If you have any questions about your benefits under the Medical Program that are not answered in this booklet, you are encouraged to contact the Claims Administrator or the Plan Administrator at the addresses shown in the General Plan Information section.

General Provisions

Plan Administration

Plan Administrator

The general administration of the Medical Program and the duty to carry out its provisions is vested in the Employer. The Chief Executive Officer of the Employer has delegated duties to the Benefits Plans Committee, which has in turn delegated certain duties to the Benefits Administrative Committee, and may from time to time revoke such authority and delegate it to another person or committee. Any delegation of responsibility must be in writing and accepted by the designated person or committee. Notwithstanding any designation or delegation of final authority with respect to claims, the Plan Administrator generally has final authority to administer the Medical Program.

Powers and Duties of the Plan Administrator

The Plan Administrator will have the authority to control and manage the operation and administration of the Medical Program. This will include all rights and powers necessary or convenient to carry out its functions as Plan Administrator. Without limiting that general authority, the Plan Administrator will have the express authority to:

1. construe and interpret the provisions of the Medical Program and decide all questions of eligibility, contributions due and Plan administrative matters;
2. prescribe forms, procedures, policies, and rules to be followed by you and other persons claiming benefits under the Medical Program;
3. prepare and distribute information to you explaining the Medical Program;
4. receive from you and any other parties the necessary information for the proper administration of eligibility requirements under the Medical Program;

5. receive, review, and maintain reports of the financial condition and receipts and disbursements of the Medical Program; and
6. to retain such actuaries, accountants, consultants, third party administration service providers, legal counsel, or other specialists, as it may deem appropriate or necessary for the effective administration of the Medical Program.

Actions of the Plan Administrator

The Plan Administrator may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the Plan Administrator shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Medical Program, except with respect to claim for benefits determinations where final authority has been delegated to the Claims Administrator.

The Plan Administrator or the Employer may contract with one (1) or more service agents, including the Claims Administrator, to assist in the handling of claims under the Medical Program and/or to provide advice and assistance in the general administration of the Medical Program. Such service agent(s) may also be given the authority to make payments of benefits under the Medical Program on behalf of and subject to the authority of the Plan Administrator. Such service agent(s) may also be given the authority to determine claims in accordance with the Program Rules.

Termination or Changes to the Medical Program

The Medical Program may be amended or terminated at any time and in any respect by action of the Albertson's LLC Benefit Plans Committee and may be amended at any time and in any respect that does not materially increase Employer costs or contributions by action of the Albertson's LLC Benefits Administrative Committee.

Funding

The Blue Cross of Idaho PPO option of the Medical Program is funded through the Employer's general assets by contributions from the Employer and/or employees.

Any funds received by the Plan, including but not limited to insurance company refunds, dividends or rebates attributable to any program in the Plan, may be expended without regard to the particular program to which they are attributable, to pay any benefits under and reasonable administrative expenses of the Plan as a whole.

Controlling Law

Except as they may be subject to federal law, including ERISA, any questions, claims, disputes, or litigation concerning or arising from the Medical Program will be governed by the laws of the State of Idaho.

Collective Bargaining Agreements

The Medical Program is maintained pursuant to the terms of various collective bargaining agreements. You and your beneficiaries can receive a copy of the collective bargaining agreement that applies to you upon written request to the Plan Administrator. A copy of the collective bargaining agreement that applies to you is also available for examination.

How the PPO Option Works

The BlueCross of Idaho (BCI) PPO option is available to all actively employed employees who are eligible for the Albertson's LLC Health & Welfare Plan. The Medical Program offers health care through a Blue Cross Blue Shield Preferred Provider Organization (PPO) network of Physicians and health care facilities that offer medical care at negotiated rates. You can choose to use a doctor or hospital who is not part of the network, but your benefits will be covered at a lower rate.

Limits to Pre-existing Conditions

When you are first covered by the Medical Program, coverage for pre-existing conditions may be limited. A pre-existing condition means a health condition for which you or your dependent has been recommended or received medical advice, diagnosis, care or treatment or services during the six months before the date that your waiting period for health care coverage began. A pregnancy is not considered a pre-existing condition.

The Medical Program will not pay charges for treatment that is related to any pre-existing condition during the first 170 days covered by the Program except as described in a preceding section titled Important Notice of Your Right to Documentation of Health Coverage (Certificate of Creditable Coverage).

Pre-existing condition limits do not apply to dependent children under age 19 or for any individual who had unrestricted coverage through another Albertson's LLC Medical Program option immediately before enrolling in this option. In addition, the pre-existing condition limit does not apply to an adult child (age 19 through 25) who was enrolled in the Medical Program effective February 1, 2011 during the special enrollment period for adult children and who was previously enrolled in an Albertson's LLC Medical Program option during the 2010 calendar year.

Your Selections Affect Levels of Benefits

You and your dependents make the decision to use PPO In-Network or Out-of-Network Providers each time you seek medical care. Your level of benefits will vary based on your decision. You receive the highest level of benefits available by using PPO In-Network Providers.

Choosing a Provider

All Providers and Facilities listed in this Medical Program Description must be licensed and/or registered by the state where the services are rendered and must be performing within the scope of their license in order for benefits to be provided.

You and your dependents must choose a PPO In-Network Provider to receive the highest level of benefits. You can all choose the same Provider or each covered person can choose a different Provider.

To locate a PPO In-Network Provider in your area, please visit the Blue Cross of Idaho (BCI) Web site at www.bcidaho.com. Click on the "Find a Provider" box to begin your Provider search. You may also call BCI's Customer Services Department at **(866) 283-6808** for assistance in locating a Provider or to obtain a free paper copy of the In-Network Provider Directory.

Albertsons

If you do not choose to receive care from a PPO In-Network Provider, you will receive the lower Out-of-Network level of benefits, including lower reimbursement levels.

Covered Providers

The following are covered Providers under this section:

- Ambulance Transportation Service
- Ambulatory Surgical Facility (Surgery Center)
- Audiologist
- Certified Nurse-Midwife
- Certified Registered Nurse Anesthetist
- Chiropractic Physician
- Clinical Nurse Specialist
- Alcoholism or Substance Abuse Treatment Facility
- Certified Speech Therapist
- Clinical Psychologist
- Electroencephalogram (EEG) Provider
- Home Intravenous Therapy Company
- Hospice
- Licensed Clinical Professional Counselor (LCPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Licensed Rehabilitation Hospital
- Lithotripsy Provider
- Psychiatric Hospital
- Dentist/Denturist
- Diagnostic Imaging Provider
- Durable Medical Equipment Supplier
- Freestanding Dialysis Facility
- Home Health Agency
- Independent Laboratory
- Licensed General Hospital
- Nurse Practitioner
- Optometrist/Optician
- Physician
- Physician Assistant
- Podiatrist
- Prosthetic and Orthotic Supplier
- Radiation Therapy Center
- Registered Dietician
- Skilled Nursing Facility
- Freestanding Diabetes Facilities

Your PPO ID Card

After you enroll in the Medical Program, you will receive a PPO identification (ID) card from the Claims Administrator. You may be required to show your PPO ID card when you visit a health care provider, including, but not limited to, any PPO In-Network Provider or an Out-of-Network Provider. You can request additional or replacement cards by calling Blue Cross of Idaho at **(866) 283-6808** or by using their Web site: **www.bcidaho.com**.

Maximum Allowance

Network Providers have agreed to provide services within the Maximum Allowance as determined by the Claims Administrator. For all services covered under the Medical Program by a PPO In-Network Provider, expenses will not exceed the Maximum Allowance. However, if you use Out-of-Network Providers, your Medical Program reimbursements will still be based on the Maximum Allowance. Therefore, you would be responsible for paying the difference between the Maximum Allowance and the Out-of-Network Provider's billed charges. The cost difference does not count towards your Out-of-Pocket Maximum.

Higher Benefits for In-Network Services

PPO In-Network Providers offer services at a preferred rate. For that reason, eligible charges from PPO In-Network Providers are reimbursed at a higher level than for Out-of-Network Providers. In addition, PPO In-Network Providers file claims to their local BlueCross BlueShield plan on your behalf and agree to not bill patients beyond the Maximum Allowance. All claims are subject to the Medical Program's Exclusions and Limitations, benefit maximums, Medical Necessity review, Maximum Allowance and prior notification requirements.

The Maximum Allowance for services is often lower than billed charges. This may reduce your portion of the cost as well as the total cost.

Lower Benefits for Out-of-Network Services

Each time you need medical care, you decide whether to use a PPO In-Network or an Out-of-Network Provider. The reimbursement rate is lower for Out-of-Network health care Providers than for In-Network Providers, so you pay a larger share of the cost if you choose to use Out-of-Network Providers.

If you use an Out-of-Network Provider, you or the Out-of-Network Provider that you choose must file claims for reimbursement of eligible expenses. When you use an Out-of-Network Provider, you or the Out-of-Network Provider that you choose must comply with the Medical Program's requirements for prior notification. (See Prior Notification Requirement for more details.)

Finally, the Out-of-Network Provider may bill you for charges in excess of the Maximum Allowance Fee under the Medical Program. You are responsible for the charges not covered by the Medical Program.

Paying Your Expenses

If you use a PPO In-Network Provider, you pay up to 20% of the Maximum Allowance for the Covered Service that is provided and any applicable Deductibles. The Medical Program is responsible for the remaining eligible expenses. If you use an Out-of-Network Provider, you may have to pay all expenses yourself. Then, you or your Out-of-Network Provider must submit a claim for a lower benefit level of reimbursement.

Benefit Plan Year Deductible

You are responsible for paying a Benefit Plan Year Deductible for yourself and each enrolled family member before the Medical Program pays for most covered expenses.

The following chart outlines the Benefit Plan Year Deductible levels available under the Medical Program.

Medical Program Option	Benefit Plan Year Deductible Per Person	Benefit Plan Year Deductible Per Family
Low Deductible	$600	$1,800 (3 or more individuals)
Mid Deductible	$850	$2,550

The Benefit Plan Year Deductible is a combined total of both In-Network and Out-of-Network eligible expenses per person.

Three individual family members must each meet their Deductible to satisfy the family Deductible.

Out-of-Pocket Maximum for In-Network Claims

During the Benefit Plan Year, you are subject to no more than the stated maximum out-of-pocket expense per individual and per family for eligible In-Network Services.

The following chart outlines the Out-of-Pocket Maximum for eligible In-Network claims:

Medical Program Option	Individual Maximum for In-Network Claims in a Benefit Plan Year	Family Maximum for In-Network Claims in a Benefit Plan Year
Low Deductible	$2,600	$5,200
Mid Deductible	$3,600	$7,200

The Benefit Plan Year Deductible, Inpatient admission Deductible and ambulance transportation Deductible do not count toward the Out-of-Pocket Maximum.

The Out-of-Pocket Maximum for In-Network claims is separate and distinct from the Out-of-Pocket Maximum for Out-of-Network claims; they are not combined.

Out-of-Pocket Maximum for Out-of-Network Claims

During the Benefit Plan Year, you are subject to no more than the stated maximum out-of-pocket expense per individual and per family for eligible Out-of-Network Services.

The following chart outlines the Out-of-Pocket Maximum for eligible Out-of-Network claims:

Medical Program Option	Individual Maximum for Out-of-Network Claims in a Benefit Plan Year	Family Maximum for Out-of-Network Claims in a Benefit Plan Year
Low Deductible	$6,850	$13,700
Mid Deductible	$7,600	$15,200

The Benefit Plan Year Deductible, Inpatient admission Deductible and ambulance transportation Deductible do not count toward the Out-of-Pocket Maximum.

The Out-of-Pocket Maximum for Out-of-Network claims is separate and distinct from the Out-of-Pocket Maximum for In-Network claims; they are not combined.

Expenses That Do Not Count Toward Your Benefit Plan Year Deductible or Out-of-Pocket Maximum

The following expenses do not count toward your Benefit Plan Year Deductible or Out-of-Pocket Maximum under the PPO option:

- Copayments
- Ambulance transportation Deductible
- Inpatient admission Deductible
- Amounts exceeding the Maximum Allowance
- Health care services or supplies that are not covered under the PPO option or are not considered Medically Necessary
- Outpatient Prescription Drugs (except as described in the Prescription Drug Coverage section)
- Charges that exceed the maximum benefit provided for a specific type of service
- Penalties you pay for failing to comply with the prior notification process when prior notification is required

Benefit Plan Year Maximum

There is a $2 million Comprehensive Benefit Plan Year Maximum per Enrolled Person for the Medical Program.

Prior Notification Requirements for Inpatient Hospital Stays, Procedures, and Diagnostic Services

In certain circumstances, the Medical Program requires that you complete a Prior Notification process, which includes calling the Medical Management Team at BCI. Your benefits may be reduced up to 15% as a penalty, up to $5,000, if the Prior Notification call is not made in advance of hospitalization or for procedures and Diagnostic Services listed below (or within two business days after an emergency hospitalization, or for Skilled Nursing, Home Health Care and Hospice care).

The Medical Program will not charge higher cost-sharing (Copayments or Coinsurance) for covered emergency services where no pre-authorization was obtained if proper notification is given within 48 hours following the

Prior Notification is required for Inpatient hospitalization, Home Health Care, Skilled Nursing, and Hospice care, except for an inpatient maternity stay of 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. Call (800) 743-1871 in advance of hospitalization or within two business days after an emergency admission. Failure to do so may result in a 15% penalty up to a maximum of $5,000.

service provided. (**Note:** Out-of-Network Providers can continue to bill you for expenses above the Maximum Allowance.)

The Prior Notification process is designed to help you receive cost-effective care. Through this process, you can arrange the Prior Notification that is required for Inpatient hospital stays, procedures and Diagnostic Services. The medical professionals who make up the Medical Management Team will review your proposed course of treatment and will contact your attending Physician, if necessary, before you are admitted to a hospital. The Medical Management Team also provides other assistance during and after your hospitalization, if necessary.

Note that when you call to meet a Prior Notification requirement, you are only receiving verification that the medical procedure or course of treatment is Medically Necessary and thus not subject to the Medical Program's Medical Necessity exclusion. You are, however, still subject to all of the Medical Program's other limitations and exclusions. Prior Notification is not a certification of benefits or a guarantee of payment. Benefits will be determined at the time the claim is submitted.

If you choose Out-of-Network Services (including hospitalization, Skilled Nursing Care, Home Health Care, or services rendered in an extended care facility), it is your responsibility to make the Prior Notification call. If you require additional services or your length of stay extends beyond the initial authorization, you are required to make an additional precertification call.

The Medical Management Team phone number is **(800) 743-1871**. This number is also listed on the back of your medical identification card.

When you call Blue Cross of Idaho, you will need the following basic information:

- Your name, identification number as it appears on your medical identification card, address, and phone number
- Your Employer's name and group number (listed on your medical identification card)
- The patient's name, birth date, and relationship to the employee
- The attending Physician's name and phone number
- The hospital's name, address, and phone number
- The reason for being admitted and/or the Surgery to be performed

Hospital Preadmission Review

Using the basic information that is supplied through prior notification, the Claims Administrator will review your proposed course of treatment before you are admitted to the hospital.

The Claims Administrator may discuss the following issues with you:

- Appropriate care: Whether care can be administered on an Inpatient or an Outpatient basis
- Weekend admission: Unnecessary weekend admissions are not covered under the Program
- Preadmission Testing: Tests conducted as an Outpatient before Surgery will reduce cost and unnecessary hospital stays
- Second opinion: If your hospital admission is for non-emergency Surgery, you may be required to obtain a second opinion to confirm the need for Surgery or to determine if an alternative course of treatment is available
- Length of hospitalization: Whether the proposed length of stay is Medically Necessary based on your particular diagnosis and health status

Procedures and Diagnostic Tests

You must call the Claims Administrator at **(800) 743-1871** to comply with the prior notification process for alternative services/Providers. These services include Home Health Care, Skilled Nursing Facilities, and Hospice care.

In addition to all Inpatient hospital stays, you must call the Medical Management Team before receiving the following tests and procedures:

Surgical Services - Inpatient or Outpatient

- Cellular, tissue and organ transplants
- Major joint replacements
- Jaw Surgery
- Nasal and sinus procedures (including but not limited to Rhinoplasty)
- Eyelid Surgery (including but not limited to Blepharoplasty)
- Spinal Surgery
- Any procedure, plastic and/or reconstructive Surgery that is deemed cosmetic (including but not limited to mammoplasty, hyperhidrosis)
- Surgery for snoring or sleep problems
- Invasive treatment of lower extremity veins (including but not limited to varicose veins)
- Cochlear implants
- Advanced imaging services: (not applicable for Emergency Room or Inpatient services)
    - Magnetic Resonance Imaging (MRI)
    - Magnetic Resonance Angiography (MRA)

- Computed Tomography Scans (CT Scan)
- Positron Emission Tomography (PET)
- Nuclear Cardiology

Other Services

- Mental Health and Substance Abuse Services including:
  - Outpatient Psychotherapy services after the tenth (10th) visit (does not include medication management services)
  - Intensive Outpatient Program (IOP)
  - Partial Hospitalization Program(PHP)
  - Residential Treatment Program
  - Psychological testing/neuropsychological evaluation testing
  - Electroconvulsive Therapy (ECT)
- Inpatient stays that originate from an Outpatient service.
- Diabetes self management education
- All Outpatient infusion therapy, including home intravenous therapy
- Non-emergent ambulance transport
- Certain Prescription Drugs including drugs that are typically administered in a hospital setting or coordinated through a Home IV provider
- Restorative Dental Services following Accidental Injury to sound natural teeth
- Hospice services
- Hospital Grade Breast Pumps
- Growth hormone therapy
- Genetic testing services
- Home Health Care, Skilled Nursing Services
- Hyperhidrosis treatment

The following services require Prior Notification when the expected charges exceed five hundred dollars ($500):

- Rental or purchase of Durable Medical Equipment, except for oxygen therapy equipment related to Durable Medical Equipment
- Prosthetic Devices
- Orthotic Devices
- Oral appliances for sleep apnea

Before receiving any of the services listed above, you or your Physician must call the Medical Management Team at **(800) 743-1871**. While your doctor or hospital will usually call on your behalf, it's ultimately your responsibility.

When you call, you may need to provide the Medical Management Team with certain information such as when you will be admitted, the date of your procedure, your diagnosis, planned treatment and length of stay. They may also contact your doctor if additional information is required.

Disease Management

Disease management programs have been developed to help Enrolled Persons manage specific chronic medical conditions. Nurse health coaches are available to provide individual guidance for chronic condition self-management through encouragement, motivation, support and reinforcement of the treating physician's treatment plan.

The Program offers disease management for the following conditions:

- **Asthma and/ or COPD:** This program provides participants with education and self-management tips to help them better understand their condition and to take a more active role in controlling it. The program helps participants adhere to the treatment plan prescribed by their physician, helps them increase their self-monitoring skills and promotes compliance with controller medications.
- **Heart Failure:** This program focuses on those with moderate to severe heart failure and is delivered primarily through nurse health coaches who assist participants through a combination of intervention, monitoring and education. There is a team focus on adhering to the treating physician's recommended treatment plan and controlling exacerbations of their condition.
- **Diabetes:** This program provides ongoing education about diabetes self-management and incorporating a healthy lifestyle to help control the participant's blood sugar. Registered nurses who have received additional training in diabetes disease management are available to answer questions and will help guide participants through understanding care guidelines for diabetes and keeping up on important lab tests and other exams that will help determine if the participant is controlling their diabetes.
- **Depression:** Clinical depression can be an ongoing, serious condition that gets in the way of work, family, and almost every aspect of life. When properly identified and treated by a healthcare professional, depression is manageable like diabetes, heart disease or any other medical illness. This program assists participants in getting the help they need.
- **Cardiometabolic Syndrome:** People with Cardiometabolic Syndrome (CMS) have a combination of distorted body measurements and abnormal biometric tests. Eligible participants for this program are identified through the results of tests shown on their *WellConnected* Health Qualification Form. While each measurement or abnormal test may signify a health risk, the presence of at least three of the following five factors indicates CMS: abnormal waist size measurement, high blood pressure, high blood sugar (prediabetes or diabetes), high triglyceride level and low HDL level. The goals for the program are to encourage a lifestyle transition from unhealthy behaviors to wellness through losing weight, being physically active, eating healthy foods, avoiding tobacco and second hand smoke and correct medication use.

WellConnected Wellness Program

Reducing Your Medical Program Contribution Rate

With *WellConnected*, you and your covered spouse, if applicable, can qualify to pay a lower Medical Program contribution rate. Information on *WellConnected* included in the benefits enrollment packet mailed to you when you are eligible to enroll in the Medical Program. If you successfully complete the *WellConnected* requirements below, you can reduce the annual cost of

your coverage in the Medical Program by up to $350 ($6.73 per weekly pay period). Your annual cost in the Medical Program will be reduced by up to $700 ($13.46 per weekly pay period) if both you and your covered spouse both successfully complete the *WellConnected* requirements. The reduction in your weekly contributions is effective approximately two weeks after you and/or your spouse complete the requirements and successfully submit them to Blue Cross of Idaho, the administrator of *WellConnected*.

Requirements You and/or Your Spouse Must Meet

Step 1: Make an appointment with your doctor to complete your Health Qualification Form (HQF).

Complete your HQF with your healthcare provider's assistance. Commit to your provider's treatment plan if needed. Total your points and make sure you and your healthcare provider sign the form.

Step 2: Send the completed HQF to Blue Cross of Idaho. Submission instructions are on the back of the HQF. Your doctor's office may submit the HQF for you, but it is your responsibility to make sure it is submitted timely.

Step 3: Take the online Personal Health Assessment (PHA) at www.bcidaho.com to learn more about your health risks and plan for better health. Enter the information from your HQF to get a more accurate picture of your health.

You need 16 points on your HQF and must take the online personal health assessment to qualify for the medical contribution discount.

Once you have completed the necessary steps, Blue Cross of Idaho will inform you and the Company of your qualification status. The information from your Personal Health Assessment and Health Qualification Form is strictly confidential and will not be shared with your Employer. Blue Cross of Idaho will only inform the Company of your qualification status.

If it is unreasonably difficult due to a medical condition or medically inadvisable for you to meet the requirements of this program, Blue Cross of Idaho and your employer will work with you to develop another way to qualify. Please submit a waiver with your healthcare provider's certification and signature. Contact Blue Cross of Idaho to request a waiver.

In no event, will an individual in a job class covered by a collective bargaining agreement between Albertson's LLC and any labor union, be eligible to participate in *WellConnected*, unless the collective bargaining agreement specifically provides for participation in *WellConnected* and the Program.

Expenses Covered Under the PPO Option

To determine if your treatment or expense is covered under the Medical Program, first review the information that is contained in this Medical Program description. If you can't find an answer, call Blue Cross of Idaho at **(866) 283-6808** in advance of having the treatment performed or incurring the expense.

Eligible Medical Expenses

The Medical Program covers a wide range of medical services. However, certain services are not covered. Eligible medical expenses for Covered Services, subject to certain exclusions and limitations, include, but are not limited to, the following:

- Diagnosis or treatment of a sickness, Illness, injury, or symptoms that result from a physical or Mental Condition.
- Charges that do not exceed the Maximum Allowance for the area.
- Charges for Medically Necessary services that meet professionally accepted, national standards of practice or quality and that are consistent with the conclusions of prevailing medical research.
- Charges for services or supplies that are not experimental, Investigational, or unproven.

To determine the amount of coverage for your procedures, contact the Claims Administrator, Blue Cross of Idaho – (866) 283-6808.

Professional Services

The following professional service expenses are covered under the Medical Program:

- Physician office visits.
- Allergy injections and serum treatment.
- Diagnostic Services, laboratory, and x-ray expenses.
- Outpatient Surgery and therapeutic treatments.

Preventive Care

You pay nothing, including no Coinsurance or Deductible, for covered preventive care services and immunizations when you use PPO In-Network Providers. Preventive Care services are not covered if you use an Out-of-Network Provider. Notwithstanding anything in this booklet to the contrary, the Medical Program will comply with health care reform for preventive care.

Covered preventive care services can be found on the website www.healthcare.gov and include:

- Alcohol misuse assessment;
- Adult annual physical examinations;
- Routine or scheduled well-baby/child examinations;
- Aortic aneurysm ultrasound;
- Bone density screening;
- Chemistry panels;
- Cholesterol screening;
- Colorectal cancer screening (Colonoscopy, Sigmoidoscopy and Fecal Occult Blood Tests);
- Complete Blood Count (CBC) test;

- Diabetes screening;
- Dietary counseling (up to 3 visits per person per Benefit Plan Year);
- Genetic counseling for high risk family history of breast or ovarian cancer;
- Health risk assessment for depression;
- Lipid disorder screening;
- Newborn metabolic screening (PKU, thyroxine, sickle cell);
- Newborn hearing test;
- Pap test;
- PSA test;
- Rubella test;
- Screening EKG;
- Screening mammogram;
- Smoking cessation counseling visit;
- Thyroid Stimulating Hormone(TSH);
- Transmittable diseases screening (including chlamydia, gonorrhea, human immunodeficiency virus (HIV), human papillomavirus (HPV), syphilis, and tuberculosis(TB);
- Sexually transmitted infections assessment;
- HIV assessment;
- Screening and assessment for interpersonal and domestic violence;
- Prescribed contraceptive services (oral contraceptives covered under Prescription Drug benefit);
- Urinalysis (UA);
- For Pregnant Women: urine culture, Hepatitis B virus screening, iron deficiency screening, Rh(D) incompatibility screening and diabetes screening;
- Breastfeeding support and supply services.

The specifically listed preventive care services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.

Immunizations that the Medical Program currently covers include: vaccines for accellular pertussis, diphtheria, haemophilus influenzae type B (Hib), hepatitis A, hepatitis B, human papilloma virus (HPV), influenza, measles, meningococcal, mumps, pneumococcal, poliomyelitis (polio), rotavirus, rubella, tetanus, varicella (chicken pox) and zoster (shingles). Serum, supplies and travel vaccines are not covered benefits.

Hospital Services

Prior Notification is required for Inpatient stays (see Prior Notification Requirement).

You are responsible for paying a $100 Inpatient admission Deductible each time an Enrolled Person is admitted to a hospital. This Inpatient admission Deductible is in addition to any applicable Benefit Plan Year Deductible and Coinsurance.

The following hospital services expenses are covered under the Medical Program:

- Semiprivate room and board charges, and intensive care, cardiac care, and newborn care.
- A private room, if your Physician recommends one because of your condition and if the request is approved by the Claims Administrator in advance. If it is not recommended and you have not received approval as described in the prior notification requirement section earlier in this Medical Program description, you pay the difference between the private room rate and the rate for a semiprivate room. Approval will be given only if you have severely compromised defenses against infection, a contagious Disease, or for protection of your life.
- Outpatient Preadmission x-ray or laboratory Testing performed within seven days before the scheduled admission or Surgery. These services are not covered if the testing is repeated after you are admitted.
- Operating room, recovery room, intravenous feedings, x-rays, laboratory tests, blood-transfusion services, and Inpatient Prescription Drugs.
- Services at an approved Inpatient facility for the treatment of nonacute Illnesses or injuries that require Skilled Nursing Care and physical restoration. Benefits are available only for the care or treatment of an injury or sickness that would otherwise require confinement in a hospital.
- Pregnancy-related medical expenses of the employee or the employee's enrolled dependent in connection with childbirth or miscarriage. The Claims Administrator, through Prior Notification, must approve in advance a hospital stay that extends beyond the stay permitted by law.

Maternity Stay Benefits

Newborns' and Mothers' Act of 1996. Under federal law, mothers and newborn children are entitled to a hospital stay of at least 48 hours for normal delivery and at least 96 hours for a cesarean delivery. However, federal law generally does not prohibit the mother's or newborn's attending health care Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

If your hospital stay is extended beyond the 48- or 96-hour period (as applicable), you must contact the Claims Administrator in advance to request approval for the expenses. You can find the contact for the Claims Administrator in the "General Program Information" at the end of this Medical Program Description.

Prenatal Education Program

Bright Beginnings is a prenatal program designed to promote healthy prenatal care through education to expectant mothers. Blue Cross of Idaho provides this program to any employee, or their spouse, who is pregnant. Prenatal program members are provided with nutrition, exercise, prenatal care, and child care information to help maintain a healthy pregnancy and to deliver a healthy baby.

Enrolling in the Prenatal Program

An expectant woman who wishes to participate in the Bright Beginnings program must enroll during the first three (3) months (the first trimester) of her pregnancy. Simply call Bright Beginnings at **(800) 741-1871**.

The Prenatal Program Includes

Upon enrollment, the expectant mother will receive a book on pregnancy care as a gift from Blue Cross of Idaho. The gift will be mailed to the expectant mother along with a prenatal card, which is used for the incentive portion of the program. The Physician must sign the prenatal card at each prenatal visit and the six (6) week postpartum examination. When the card is completed, the mother has 60 days to return the card to Blue Cross of Idaho and indicate which of the following she would like to receive as her incentive gift:

1. A $100 U.S. Savings Bond in the mother's name; or
2. Reimbursement up to $50 toward the purchase of a car seat (if this gift is selected, the purchase receipt for the car seat should be mailed with the completed prenatal card to Blue Cross of Idaho).

Remember

The first step is to call Bright Beginnings at **(800) 741-1871**. The expectant mother must register for the program and see her Physician during the first three (3) months of her pregnancy in order to be eligible for the selected incentive gift.

Important Note

This prenatal program should not be construed to replace prenatal medical care. All treatment decisions about medical care rest exclusively with the expectant mother and her Physician. The Bright Beginnings program does not grant, or change, any health care coverage. All claims submitted to Blue Cross of Idaho will be administered in accordance with the Medical Program.

Surgical Services

Prior Notification is required for certain procedures. See Prior Notification Requirements for Inpatient Hospital Stays, Procedures and Diagnostic Services. The following surgical service expenses are covered under the Medical Program:

- Surgeon's fees.
- Assistant Surgeon's Fees, if an assistant surgeon is required by standard protocol. The fee is limited to no more than 20% of the fee that is approved for the primary surgeon. A nonphysician surgical assistant's fee is limited to no more than 10% of that amount. No assistant fees are payable if the facility makes a qualified employee available for that purpose.
- Repair of Congenital Anomalies or birth defects that cause a functional defect, as certified by a Physician.
- Cosmetic Surgery that is necessary for the timely repair of an Accidental Injury.
- Charges for Surgery and services for the treatment of Tempomandibular Joint Dysfunction (TMJ) or orthognathic, limited to $2,000 per Enrolled Person per lifetime.
- Newborn circumcisions.
- Treatment or Surgery for eye refractions that is required as a result of Accidental Injury, and the initial pair of eyeglasses (up to $145 for frames) and contact lenses or scleral lenses when required following Surgery, Accidental Injury, or the treatment of Illness.
- Sterilization procedures, including vasectomies and tubal ligations.
- Multiple surgical procedures – If you are having more than one surgical procedure performed at the same time, the secondary (and any additional) procedures are covered at a reduced reimbursement rate because surgical preparation and other fees are included in the fee for the primary Surgery.
- Reconstructive breast Surgery in connection with a covered mastectomy, including mammoplasty, reconstruction of the breast on which the mastectomy was performed, Surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and treatment of physical complications at all stages of the mastectomy including lymphedemas.

To determine the amount of coverage for your procedures, contact the Claims Administrator at Blue Cross of Idaho at **(866) 283-6808**.

Coverage for Reconstructive Surgery Following a Mastectomy

The Women's Health and Cancer Rights Act of 1998 includes important protections for individuals who elect breast reconstruction in connection with a mastectomy. Under the terms of this federal act, for individuals receiving mastectomy-related benefits, coverage includes:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to the same Deductible, Copayment, and Coinsurance provisions applicable to other medical benefits provided under the Medical Program.

Human Organ and Tissue Transplants

Medical expenses for organ or tissue Transplant are covered when Blue Cross of Idaho's transplant coordinator approves the transplantation.

To determine the Transplant coverage for your procedures, contact the Claims Administrator (Blue Cross of Idaho) Member Services, at **(866) 283-6808**.

The Medical Program's coverage excludes transplantation services that are determined to be experimental, Investigational, or unproven services, even if the services are performed at a Transplant facility that the Claims Administrator designates.

In-Network and Out-of-Network: Organ and tissue Transplant Covered Services are subject to Deductible and Coinsurance.

If the Transplant involves a heart, lung, heart and lung, liver, pancreas, or pancreas and kidney, it is strongly recommended that you use the Blue Distinction

Centers for Transplants (BDCT) network in order to secure the highest level of benefits available. The BDCT are major hospitals and research institutions (Recognized Transplant Centers) located throughout the United States.

These facilities are required to meet outcomes-oriented quality criteria that have been developed by panels of nationally recognized Transplant surgeons and Physicians. When you contact Blue Cross of Idaho for preapproval, you can work with the BCI transplant coordinator to decide which BDCT facility is best for you.

All other organ and tissue Transplants can be conducted at any network hospital if you receive preapproval from Blue Cross of Idaho.

Transplant Donor Charges

Donor charges for Organ Procurement are subject to these provisions:

- When both the recipient and donor are Medical Program members, each is entitled to the benefits of this Medical Program.
- When only the recipient is a Medical Program member, both the donor and the recipient are entitled to the benefits of this Medical Program to the extent that these benefits are not available to the donor from any other source. (Benefits used by the donor will count toward the recipient's coverage under this Medical Program.)
- When only the donor is a Medical Program member, the donor is entitled to the benefits of this Program to the extent that these benefits are not available from any other source. No benefits are provided to the Transplant recipient.

Transplant Travel Benefit

Travel benefits are only available for Transplants listed above, when using the BDCT network. The Medical Program will pay up to 100% of the travel expenses (up to $5,000) that you or your covered dependent incurs for transportation, lodging, and food costs that are associated with a preapproved organ Transplant at a BDCT facility. Transplant travel benefits are not subject to any individual or family Deductibles. If you or your covered dependent receives preapproved Transplant related services during evaluation, candidacy, the Transplant event, or post-Transplant care, you are eligible for reimbursement through the transplant travel benefit. This benefit does not count toward the Comprehensive Benefit Plan Year Maximum.

24 Hour Nurseline

You may access a toll-free Nurseline 24 hours a day, 7 days a week by calling **1-888-993-7120**. When calling the Nurseline you speak to a Registered Nurse to receive health advice and information. Nurse advice is available for reasons such as:

- Determining the need to seek medical care
- Asking questions about medications, tests or procedures
- Obtaining information on care of a new or chronic condition
- Getting tips on more effective communication with your healthcare providers
- Inquiring about staying healthy and keeping fit

Teladoc

Teladoc is a national network of physicians who are state licensed and U.S. board certified in internal medicine, pediatrics, family medicine and emergency medicine, available for consultations 24 hours a day, 365 days a year. Teladoc physicians diagnose routine, non-emergency medical problems, recommend treatment and prescribe medication when appropriate by calling a prescription into your local pharmacy. Prescriptions will not be provided for DEA controlled substances. The Teladoc benefit is not available to residents of or in the state of Oklahoma until July 1, 2013.

The fee for a telephone consultation is $38. You are required to pay this fee at the time of consultation. A claim will then be submitted to the Claims Administrator to be applied to your Deductible or Coinsurance. Any applicable reimbursement will be paid directly to you.

If eligible for this benefit, you will be sent a Teladoc ID card at your home address. Once you receive the ID card you will need to complete the Teladoc registration process through the website www.Teladoc.com. Additional instructions will be included with the ID card. Once your registration is finished, you will also need to complete the Teladoc Medical History Disclosure. The Medical History Disclosure must be done prior to requesting a physician consultation. Call Teladoc at **1-800-TELADOC (835-2362)** with any questions.

Emergency Care

Emergency care is covered 24 hours a day, seven days a week. The emergency room is designed to treat acute emergency conditions, and as a result is more expensive than treatment provided in a doctor's office or at an urgent care center.

When emergency care results in an Inpatient hospital admission, you or a family member must call the Claims Administrator at **1-800-743-1871** within two business days of the date the confinement begins, or as soon as reasonably possible, to be covered at the In-Network level. When emergency care has ended, you must use PPO In-Network Providers to receive the higher level of benefits.

If you receive treatment for an Emergency Medical Condition or Accidental Injury of sufficient severity to necessitate immediate medical care, eligible Emergency Medical Condition expenses (including hospital services, doctor's fees, x-rays and lab work) will be covered at the in-network level, subject to the Maximum Allowance, after the applicable Copayment or Deductible. If Out-of-Network Providers provide service, you would also be responsible for paying the difference between the Maximum Allowance and the Out-of-Network Provider's billed charges. The cost difference for using Out-of-Network Providers does not count towards your Out-of-Pocket Maximum. If follow-up care is needed, you must coordinate that care with PPO In-Network Providers to be covered at the in-network benefit level. If you are admitted to the hospital from the emergency room, the $200 Emergency Room Copayment is waived and you are required to pay a $100 Inpatient admission Deductible and your Benefit Plan Year Deductible, if not already met.

What Is an Emergency Medical Condition?

A condition in which sudden and unexpected symptoms are sufficiently severe to necessitate immediate medical care. Emergency Medical Conditions, include but are not limited to, heart attacks, cerebrovascular accidents, poisonings, loss of consciousness or respiration, and convulsions.

Ambulance Transportation

When you have an Emergency Medical Condition, expenses for eligible emergency transportation by ambulance, air ambulance, or other Medically Necessary transportation are covered. The transportation must be from the place where you became ill or were injured to the nearest facility that can provide the necessary care. Medically Necessary transportation is covered between hospitals when special treatment will be provided at the receiving hospital.

Eligible ambulance transportation expenses are covered at the in-network level, subject to the Maximum Allowance, after you pay a $100 Deductible per ambulance transportation service and your Benefit Plan Year Deductible. For Out-of-Network Providers, you would also be responsible for paying the difference between the Maximum Allowance and the Out-of-Network Provider's billed charges. The cost difference for using Out-of-Network Providers does not count towards your Out-of-Pocket Maximum.

Emergencies

The emergency room is designed for the treatment of acute emergency conditions, and as a result is more expensive than treatment provided in a doctor's office or at an urgent care center.

Other Covered Services

The following professional service expenses are covered under the Program:

- Diabetes education covered at 50% up to $300 per Enrolled Person per lifetime.
- Dental services which are rendered by a Physician or Dentist and required as a result of Accidental Injury to the jaw, sound natural tooth, mouth, or face. Injuries as a result of chewing or biting and Temporomandibular Joint (TMJ) Disorder are not considered accidental injuries. No benefits are available under this section for Orthodontia or Orthognathic services. Benefits are provided for repair of damage to a sound natural tooth, lips, gums, and other portions of the mouth, including fractures of the maxilla or mandible. Repair or replacement of damaged dentures, bridges, or other dental appliances is not covered, unless the appliance must be modified or replaced due to Accidental Injury to a sound natural tooth which are abutting the bridge or denture. Benefits for dental services under this provision shall be secondary to dental benefits available to an Enrolled Person under a dental policy of insurance, contract, or underwriting plan.
- IV therapy, radiation therapy, and chemotherapy (if it is prescribed by a Physician and Medically Necessary, as determined by the Claims Administrator).
- Chiropractic services, up to $1,500 per Enrolled Person per Benefit Plan Year.
- Physical Therapy if the therapy meets all of the following requirements:
  - It is expected to result in significant improvement in bodily function that is lost or impaired.
  - It is prescribed by a Physician who directs and controls the treatment.
  - It is performed by a licensed physical therapist.
  - It is not related to a myofacial pain disorder.
  - Outpatient: Physical Therapy Covered Services are subject to Deductible and In-Network and Out-of-Network Coinsurance.
  - In-Network: When all services are In-Network, there is a 25 visit maximum benefit for Outpatient Occupational and Physical Therapy combined, per Enrolled Person, per Benefit Plan Year.
  - Out-of-Network: When all services are Out-of-Network, there is a 12 visit maximum benefit for Outpatient Occupational and Physical Therapy combined per Enrolled Person, per Benefit Plan Year.
  - Not to exceed 25 visits maximum benefit for Outpatient Occupational and Physical Therapy combined per Enrolled Person, per Benefit Plan Year. The 12 visit maximum Out-of-Network benefit wil be reduced by visits already accumulated toward the In-Network 25 visit benefit maximum.
- Rehabilitative speech therapy if such therapy is for loss of speech for a person who previously had the ability to speak and if the therapy meets all of the following requirements:
  - It is performed by a certified speech therapist.
  - It is prescribed by a Physician who directs and controls the treatment.
  - The patient has the facility to make verbal sounds and the mental and physical capacity to communicate verbally.

  The combined total of In and Out-of-Network visits can not exceed 20 visits per Enrolled Person per Benefit Plan Year.
- Infertility treatment or Genetic Diagnostic testing (when pre-approved by the Plan Administrator) when a history of serious genetic disorders has been demonstrated that is used to determine the presence of hereditary Illnesses or Diseases (including, but not limited to Fanconi Anemia, Tay-Sachs Disease, Cystic Fibrosis, Huntington Disease or Sickle Cell Anemia).
  - $20,000 Lifetime Benefit Maximum
  - $5,000 Lifetime Benefit Maximum for infertility treatment prescriptions
- Medically Necessary nutritional supplements/products and specialized formula for the condition of PKU may be covered under the medical provisions of the Program.

Additional Health Care Services

You must call the Claims Administrator at **(800) 743-1871** to comply with the prior notification process for Home Health Care, Skilled Nursing Facilities, and Hospice care. Custodial Care is not covered through any of these services and is a Medical Program exclusion.

- Home Health Care, Skilled Nursing Care Services – Professional nursing services provided to a Homebound Enrolled Person that can only be rendered by a licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.), provided such nurse does not ordinarily reside in the Enrolled Person's household or is not related to the Enrolled Person by blood or

marriage. The services must be Medically Necessary and preauthorized by BCI and the patient's Physician and must not constitute Custodial Care. Services must be provided by a Medicare certified Home Health Agency and limited to intermittent Skilled Nursing Care. The patient's Physician must review the care at least every thirty (30) days. No benefits are provided during any period of time in which the Enrolled Person is receiving Hospice Covered Services.

Benefits for Home Health Care, Skilled Nursing Care Services are limited to 25 visits per Benefit Plan Year when you do not use a PPO In-Network Provider.

- Skilled Nursing Facility care, which provides for comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate authority to provide such services.
  - In-Network: When all services are In-Network, benefits are limited to 100 days per Enrolled Person, per Benefit Plan Year.
  - Out-of-Network: When all services are Out-of-Network, benefits are limited to 60 days per Enrolled Person, per Benefit Plan Year.
  - Not to exceed a total combined limit of 100 days per Enrolled Person, per Benefit Plan Year. The 60-day Out-of-Network Maximum benefit will be reduced by days already accumulated toward the In-Network 100-day benefit maximum.
- Hospice care, which provides benefits to a terminally ill patient and emotional support for family members during the last six months of an Enrolled Person's life. The coverage usually includes the following items:
  - Semiprivate room and board
  - Other services and supplies that are made by the Hospice care agency, or the physical or occupational therapist of the Home Health Agency
  - Part-time or intermittent nursing care by a registered nurse (R.N.) or a Home Health Aide
  - Respite Care
  - Psychological and dietary counseling for the patient

  The Home Health Care, Skilled Nursing Care services coverage (described in a preceding section of this Medical Program description) does not apply to Hospice patients. To receive Hospice care under the Medical Program, the Physician must certify that the patient is terminally ill and has six months or less to live.

Prosthetics and Supplies

- Initial charges for braces, trusses, crutches, casts, splints, artificial limbs or eyes, or any other Prosthetic Devices to replace lost physical organs or parts, or to aid in their functions when impaired. Replacement prosthetics must be prior authorized and may be allowed based on criteria established by the Claims Administrator.
- The initial pair of orthopedic or corrective shoes, arches, braces, or Orthotic Devices and later charges for additional orthopedic or corrective shoes if a change in the condition occurs (other than patient growth)
- Injectable medications, medical and surgical supplies such as colostomy bags, catheters, dressings, syringes and hypodermic needles

Durable Medical Equipment

The Medical Program covers the purchase or rental (whichever is the most economical) of Durable Medical Equipment, including the following items:

- Oxygen and equipment for oxygen
- Hospital beds
- Mechanical equipment for respiratory paralysis
- Wheelchairs

Call the Claims Administrator in advance at **(866) 283-6808** to determine whether the equipment you are considering purchasing or renting is covered. Durable Medical Equipment is reviewed based on Medical Necessity. Prior notification is required for all equipment with a purchase price of $500 or more.

Behavioral Health Management

Psychiatric Care Services

Covered Psychiatric Care services include Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), Residential Treatment Program, psychological testing/neuropsychological evaluation testing and Electroconvulsive Therapy (ECT).

Payments for Inpatient or Outpatient Psychiatric Services apply to Covered Services furnished by any of the following:

- Licensed General Hospital
- Alcoholism or Substance Abuse Treatment Facility
- Psychiatric Hospital
- Licensed Clinical Social Worker (LCSW)
- Licensed Clinical Professional Counselor (LCPC)
- Licensed Marriage and Family Therapist (LMFT)
- Clinical Psychologist
- Physician

Inpatient Psychiatric Care

The benefits provided for Inpatient hospital services and Inpatient medical services in this Medical Program Description are also provided for the care of Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or any combination of these.

Outpatient Psychiatric Care

The benefits provided for Outpatient Hospital Services and Outpatient Medical Services in this Medical Program Description are also provided for Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or any combination of these. The use of Hypnosis to treat an Enrolled Person's Mental or Nervous Condition is a Covered Service.

Outpatient Psychotherapy Services

Covered Services include professional office visit services, family, individual and/or group therapy.

Prior Notification

The following services require Prior Notification (see Prior Notification section starting on page 22):

- Outpatient Psychotherapy services after the tenth (10th) visit (does not include medication management services)
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Residential Treatment Program
- Psychological Testing/neuropsychological evaluation testing
- Electroconvulsive Therapy (ECT)

Exclusions and Limitations

For Acute Care, rehabilitative care, diagnostic testing except as specified as a Covered Service in this Medical Program; for Mental or Nervous Conditions and Substance Abuse or Addiction services not recognized by the American Psychiatric and American Psychological Associations.

Expenses Not Covered Under the PPO Option

To determine whether your treatment or expense is covered under the Program, check this Medical Program Description first. If you require additional information, call the Claims Administrator at **(866) 283-6808** before having the treatment performed or incurring the expense.

Sometimes more than one effective treatment is available. Be sure to ask your health care Provider why a particular course of treatment is recommended. The Medical Program may not cover all possible methods of treatment. Don't be afraid to research all your treatment alternatives before you make a decision.

The Medical Program does not cover certain medical expenses. Expenses that are not covered include, but are not limited to, the following:

- Not Medically Necessary services, supplies or other charges
- Out-of-Network charges that are higher than the Maximum Allowance
- Services, supplies, or treatments that do not meet the definition of a covered health service even if they are prescribed, recommended, or approved by a Physician
- Devices, drugs, procedures, services, supplies, or treatments determined as experimental, Investigational, or unproven by the Claims Administrator
- Ambulance transportation that is not Medically Necessary
- Preventive care services that are not listed as covered expenses or that exceed any limits for such services
- Services that are not recommended or prescribed by a Physician or Dentist
- Services, supplies, or treatments that are covered by another plan that the Company offers or to which the Company makes contributions
- Services that are covered by the Dental Program, except as noted in this Medical Program Description
- Expenses that an Enrolled Person is entitled to receive without charge under any Workers' Compensation, state disability, or municipal, state, or federal program or due to any injury arising out of or in the course of any occupation or employment for wage or profit
- Expenses that are covered by other insurance, including, but not limited to, auto insurance, homeowner's insurance, and business risk insurance
- Expenses for any services or supplies that were provided before the individual was covered or after the individual ceased participation in the Medical Program
- Cosmetic services, supplies or surgery, except as necessary for the timely repair of Accidental Injury or of birth defects of covered children
- Treatment for any military-service-related injury, Illness, or Disease in a hospital facility that is operated by the United States government, or for services or supplies for medical care while on active duty as a member of the armed forces of any state or country or resulting from a war, whether declared or undeclared, or international armed conflict, except for expenses resulting from acts of terrorism
- Treatment or confinement in a hospital that does not charge patients
- Treatment or confinement in any institution, or any part of an institution, that is not a hospital, an extended-care facility, a Hospice care facility, or an Inpatient residential Substance Abuse rehabilitation facility
- Treatment or examinations ordered by a court in connection with legal proceedings, unless the treatment or examinations qualify as covered expenses
- Breast enlargement/reduction-except when Medically Necessary
- Scar revision
- Personal comfort, hygiene, or entertainment items, such as a television, radio or other listening devices, or telephone
- Charges for completing claim forms
- Expenses for an injury or Illness resulting from or sustained as a result of being engaged in an illegal occupation or the commission of or attempted commission of an assault or illegal act or participation in a civil insurrection and/or riot (whether or not your participation results in a conviction)
- Confinement in a facility that primarily provides educational or Custodial Care
- Bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, and homemaker or caretaker services
- Hypnosis, unless approved to treat a Mental or Nervous Condition
- Marriage counseling
- Acupuncture, except when used within the scope of the Physician's (M.D. or D.O.) license instead of anesthesia

- Services related to gender change or alterations
- Eyeglasses, contact lenses, and eye exercise therapy, except as noted under Vision Services
- Services related to any eye Surgery such as Lasik, radial keratotomy or laser keratotomy performed to correct refractive errors
- Stop-smoking programs, except as specifically provided by the Medical Program
- Weight-control or weight-loss programs or procedures including, but not limited to, health services and associated expenses for surgical and non-surgical treatment (including bariatric/gastric bypass Surgery, liposuction, abdominoplasty, special foods, food supplements, liquid diets, enteral feedings, and other nutritional and electrolyte supplements, diet plans, and related products)
- Sensitivity training, educational training therapy, or treatment for an education requirement
- Elective abortions, unless the mother's life is in danger
- Sterilization reversals (such as reversal of a tubal ligation or vasectomy)
- Physical, psychiatric, or psychological exams, tests, vaccinations, immunizations, or treatments that are not otherwise available under the Medical Program, when services:
  - Are for purposes of obtaining, maintaining, or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage, or adoption;
  - Relate to judicial or administrative proceedings or orders; or
  - Are conducted for purposes of medical research
- Holistic testing and treatment, including dietary counseling and herbal medicine
- Ecological or environmental medicine, diagnosis, and/or treatment
- Incidental procedures that are performed at the same time as a primary procedure but that require no additional physician resources
- Services that are considered an integral and essential part of another, separately billed service
- Transfer of medical records
- Expenses for not keeping an appointment
- Expenses that the patient is not legally required to pay
- Expenses that are made because medical coverage exists
- Chiropractic hospital expense
- Services subject to a pre-existing condition limitation (contact Blue Cross of Idaho for specific information at **(866) 283-6808**)
- Medical and surgical treatments for snoring, except if you have documented obstructive sleep apnea (oral appliances for snoring are also excluded)
- Devices used specifically as safety items or to affect performance primarily in sports-related activities
- All expenses related to physical conditioning programs, such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation
- Expenses for Inpatient private duty nursing that is not deemed Medically Necessary but provided because of an inadequately staffed hospital, provided for the Custodial Care of the patient, or provided for the convenience or luxury of a patient even if the private duty nursing is recommended by a Physician
- Telephone consultations, except as provided through Teladoc
- Acute-level expenses for special non-acute areas of a hospital
- Membership costs for health clubs
- Membership fees at facilities open to the public
- Expenses incurred by a dependent if the dependent is covered as an employee for the same services under the Medical Program
- Orthodontic appliances, autorepositioning appliances, occlusal rehabilitation, Physical Therapy, or equilibration for treatment of TMJ or other disorders
- Medical supplies or treatment for Substance Abuse, organic brain syndrome, mental retardation, senile deterioration, or any other mental disorder while in an extended-care facility
- Equipment that can be used for reasons other than medical purposes, such as air conditioners, air purifiers, and humidifiers
- Routine hearing examinations, except for Newborn hearing exams
- Hearing aids, except the initial devices when they are necessary as the result of an Accidental Injury
- Home Health Care services that are not included in a Physician's written treatment plan; Home Health Care services that are provided by a person who ordinarily resides in the participant's home, or by a member of the participant's family or the participant's spouse's family; Home Health Care services of a social worker; or transportation services
- Over-the-counter products
- Therapeutic devices or appliances that perform Diagnostic tests such as for cholesterol, blood pressure, ovulation, or fertility
- Over-the-counter vitamins, megavitamin therapy, and nutritional-based therapy, whether or not prescribed by a Physician (except prenatal vitamins)
- Growth hormone therapy, unless the Plan Administrator determines that it is Medically Necessary
- Acupressure, Rolfing, massage therapy, aromatherapy, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institute of Health
- Routine foot, hand, or skin care
- Wigs, toupees, hair transplants, hair weaving, or any drug used for baldness including chemotherapy

- Except for Medicare, services that are provided by, or upon application would be provided by, the U.S. government, any state or local government, or the government of any country
- Expenses related to complications from or otherwise arising out of procedures which are not covered under the Medical Program
- Expenses incurred in a foreign country, unless the covered person is a resident of such country or is traveling on business or vacation and cannot otherwise avoid such expense. Services provided outside the United States, would not be Covered Service under this Medical Program.
- Travel, whether or not prescribed
- Inpatient care when such care could properly be provided on an Outpatient basis
- Expenses for services or supplies by a Provider who is the covered person or any person who is the spouse, child, sibling (whether such relationship exists by blood or law) of the covered person
- Expenses for any Illness, or condition for which a third party may be liable or legally responsible, unless the Plan Administrator directs otherwise pursuant to the terms of the Medical Program

Annual Vision Exam

When you enroll in the Medical Program, the Company automatically provides you with an annual vision exam through VSP with a $20 Copayment. You must use a provider that is in the VSP network to receive your annual vision exam at the $20 Copayment level. If you see a Non-VSP Provider you may receive up to $45 in reimbursement for the exam. You can locate a VSP Network Doctor in your area at www.vsp.com or by calling **(800) 877-7195**.

You can also enroll in the voluntary vision coverage which helps pay the costs of materials such as glasses and contacts. This voluntary coverage is separate from your medical coverage and his its own employee contribution. See your Vision Program description for more details on both the exam and voluntary vision coverage.

Filing Claims

When you use a PPO In-Network Provider for treatment, the health care Provider will submit the claim information on your behalf to the local Blue Cross Blue Shield plan. You will receive an explanation of benefits notice (EOB) from the Claims Administrator. The EOB shows the amount paid to the Provider and the amount you may owe.

When you use an Out-of-Network health care Provider for treatment, you may be required to submit claims yourself. You can obtain claim forms from Blue Cross of Idaho Customer Service at **1-866-283-6808** or you can download them directly from the Blue Cross of Idaho, (BCI) Web site at www.bcidaho.com.

The Claims Administrator has the full discretionary power to interpret and apply the terms of the Program. All decisions of the Claims Administrator as to the facts of the case, interpretation of any provision of the Program or its application to any case and any other interpretative matter, determination or question under the Program will be final and binding on all affected parties.

Deadline for Filing Claims

Claims must be submitted within twelve (12) months of the date of service and must be for services that were performed during the period that you or your dependents were covered under this Program. Claims submitted later than twelve (12) months after the date of service will not be accepted or reviewed.

Procedures for Claims Concerning Coverage Denials

In some cases, the Claims Administrator may determine that a service is not eligible for coverage under the Program before you have received the service in question. If Prior Notification (or other prior approval by the Program) is required before you can obtain coverage for the service, and such coverage is denied, the request for coverage will be treated as a Pre-Service Claim for benefits, and you will receive written notification of its denial. If you disagree with the coverage decision, you can then, if you wish, pursue the internal appeal and external review processes for denied Pre-Service Claims outlined later in this section. In other cases, the Program may not require Prior Notification or other prior approval for a particular service, but you or your Provider may have inquired about the status of coverage before obtaining the service and have been informed that the service is not covered. If you wish to bring a claim relating to this type of coverage decision (where prior notification or approval is not required and you have not yet received the medical services) it will be treated as a "Post-Service" Claim as outlined later in this section.

Notification of Benefit Determinations

The Claims Administrator will notify you or your authorized representative of its benefit determinations as follows:

Urgent Care Claims:

An urgent care claim is a Pre-Service Claim where the prescribing Provider or treating Provider notifies the Claims Administrator that a delay in medical treatment or supplies might jeopardize the life or health of the claimant or jeopardize the ability to regain maximum function or, in the opinion of the claimant's health care Provider, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Notice of a benefit determination on an urgent care claim will be provided as soon as possible, taking into account the medical circumstances, but not later than seventy-two (72) hours after receipt of the claim. However, if the Claims Administrator gives you notice of an incomplete claim, the notice will include a time period of not less than forty-eight (48) hours for you to respond with the requested specified information. The Claims Administrator will then provide you with the notice of benefit determination within forty-eight (48) hours after the earlier of: that date you provide the requested information, or the end of the period of time given you to provide the information.

If the urgent care claim involves a concurrent care decision, notice of the benefit determination will be provided as soon as possible, but not later than twenty-four (24) hours after receipt of your claim for extension of treatment or care, as long as the claim is made at least twenty-four (24) hours before

the prescribed period of time expires or the prescribed number of treatments ends.

Other Pre-Service Claims:

A Pre-Service Claim is a claim that requires prior authorization or other notification or approval prior to receiving the medical services or supplies. For Pre-Service Claims other than urgent care claims, notice of a benefit determination will be provided in writing within a reasonable period appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim. However, this period may be extended one time by the Claims Administrator for up to an additional fifteen (15) days if the Claims Administrator both determines that such an extension is necessary due to matters beyond its control and provides you written notice, prior to the end of the original fifteen (15) day period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given at least forty-five (45) days from your receipt of the notice to provide the information.

Notice of an Adverse Benefit Determination regarding a concurrent care decision will be provided sufficiently in advance of any termination or reduction of benefits to allow you to appeal and obtain a determination before the benefit is reduced or terminated.

Post-Service Claims:

Notice of Adverse Benefit Determinations will be provided in writing within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. However, this period may be extended one time by the Claims Administrator for up to an additional fifteen (15) days if the Claims Administrator both determines that such an extension is necessary due to matters beyond its control and provides you written notice, prior to the end of the original fifteen (15) day period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given at least forty-five (45) days from your receipt of the notice to provide the information.

The applicable time period for the benefit determination begins when your claim is filed in accordance with the claim filing procedures of the Claims Administrator, even if you haven't submitted all the information necessary to make a benefit determination. However, if the time period for the benefit determination is extended due to your failure to submit information necessary to decide a claim, the time period for making the benefit determination will be suspended from the date the notice of extension is sent to you until the earlier of: (a) the date on which you respond to the request for additional information, or (b) the date established by the Claims Administrator for the furnishing of the requested information (at least forty-five (45) days).

Adverse Benefit Determinations

If your claim is subject to an Adverse Benefit Determination, you will receive a notification that includes:

- information about your claim (including, for example, date of service, Provider and claim amount) and the specific reason(s) for the denial;
- the Program provisions on which the denial is based;
- a description of additional material (if any) needed to perfect the claim;
- an explanation of your right to request an appeal;
- a statement of your right to file a civil action under section 502(a) of ERISA if your claim is denied upon appeal;
- a statement indicating whether an internal rule, guideline, protocol or other similar criterion was relied on in deciding your claim and information explaining your right to request such information, free of charge;
- for urgent care claims only, a description of the expedited review process applicable to such claims;
- description of the Program's standard, if any, used in denying the claim
- description of available internal appeals and external review processes; and
- disclosure of availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Health and Human Services, if any, to assist in internal claims, appeals and external review process.

Reimbursement of Benefits Paid By Mistake

If the Claims Administrator mistakenly pays benefits on behalf of an Enrolled Person that the Enrolled Person is not entitled to under this Program, the Enrolled Person must reimburse the erroneous benefits to the Claims Administrator, on behalf of the Plan Administrator.

The reimbursement is due and payable as soon as the Claims Administrator notifies the Enrolled Person and requests reimbursement. The Claims Administrator, on behalf of the Plan Administrator, may also recover such erroneous benefits from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, the Claims Administrator, on behalf of the Plan Administrator, may reduce benefits or reduce an allowance for benefits as an offset toward reimbursement or pursue any other method of recovery permissible under law.

Even though the Claims Administrator, on behalf of the Plan Administrator, may elect to continue to provide benefits after mistakenly paying benefits, the Claims Administrator, on behalf of the Plan Administrator, may still enforce this provision. This provision is in addition to, not instead of, any other remedy the Claims Administrator, on behalf of the Plan Administrator, may have at law or in equity.

Benefit Claims Review and Appeal Procedures

Inquiry and Appeals Procedures

You have the right to appeal any denied claim. Your appeal must be filed with the Claims Administrator in writing, within 180 days after you receive the written notice of the reduction or denial. Upon request, the Claims Administrator

will provide documents, records, and other information that is relevant to your claim for benefits. This information will be provided free of charge. If the Claims Administrator considers, relies on or generates new or additional evidence in connection with its review of your claim on appeal, you will be provided the new or additional evidence free of charge as soon as possible and with enough time before a final determination is required to be provided to you (as described above) so that you will have an opportunity to respond. The Claims Administrator will notify you of a decision within 30 days of when it receives the appeal unless the appeal is an appeal of an adverse determination concerning a claim involving urgent care or a Pre-Service Claim. The decision will be sent to you in writing and will include specific reasons for the decision and specific references to the Program provisions on which the decision is based.

If you have followed these procedures and you still do not agree with the Claims Administrator's decision about your claim, you can file suit in federal court. These claims and appeals procedures (except any external review described below) must be exhausted before any legal action is commenced.

Appeals that concern a claim involving urgent care or a Pre-Service Claim are subject to federal regulations that set forth specific time frames for the review process. For that reason, under some circumstances, the regular claims review procedures that are explained above might not be adequate. You might need an accelerated claims review procedure. For example, if your request for prior notification of a hospital admission is not approved, the request would generally be subject to the prior notification/pre-service time frames shown in the table below. However, a request for prior notification could be considered an urgent claim (for example, care for a life-threatening condition). The request would then be subject to the urgent-care time frames shown in the table below.

A. *Informal Inquiry*

For any initial question concerning a claim, an Enrolled Person should call or write Blue Cross of Idaho's (BCI) Customer Services Department. Blue Cross of Idaho's (BCI) phone numbers and addresses are listed on the Explanation of Benefits (EOB) forms and in the "General Plan Information" section of this Medical Program Description.

B. *Formal Appeal*

An Enrolled Person who wishes to formally appeal a Pre-Service Claim decision by the Claims Administrator may do so through the following process:

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals, may be submitted by phone or facsimile. The appeal should set forth the reasons why the Enrolled Person contends the Claims Administrator's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

   Appeal should be sent to:

   Blue Cross of Idaho
   Appeals and Grievance Coordinator
   PO Box 7408
   Boise, ID 83707-1408
   Phone: (866) 283-6808
   Fax: (208) 331-8857

2. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by someone different than the original decision maker and not a subordinate of the initial decision maker. If the Claims Administrator considers, relies on or generates new or additional evidence in connection with its review of your claim on appeal, you will be provided the new or additional evidence free of charge as soon as possible and with enough time before a final determination is required to be provided to you (as described above) so that you will have an opportunity to respond. For non-urgent claim appeals, the Claims Administrator will mail a written decision to the Enrolled Person within fifteen (15) days after receipt of the written appeal. You will be notified orally within seventy-two (72) hours after receipt of the appeal by the decision maker on an urgent claim appeal. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based including:

- information about your claim and the reason(s) the denial was upheld;
- the Program provisions on which the denial is based;
- an explanation of your right to request reasonable access to and copies of the relevant documents, records, and information used in the claims process without charge;
- a description of any voluntary appeal procedures offered by the Program;
- a statement of your right to file a civil action under section 502(a) of ERISA if your claim is denied upon appeal;
- a statement indicating whether an internal rule, guideline, protocol or other similar criterion was relied on in deciding your claim and information explaining your right to request such information, free of charge;
- description of the Program's standard, if any, used in denying the claim;
- description of available internal appeals and external review processes; and
- disclosure of availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Health and Human Services, if any, to assist in internal claims, appeals and external review process.

Each appeal will be processed as quickly as possible taking into account the medical exigencies of each claim.

3. Furthermore, the Enrolled Person or their authorized representative has the right to reasonable access to, and copies of all documents, records and other information that are relevant to the appeal.
4. If the original, non-urgent claim decision is upheld upon reconsideration, the Enrolled Person may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. The appeal will be conducted by someone different than the prior decision makers and not a subordinate of the prior decision makers. If the Claims Administrator considers, relies on or generates new or additional evidence in connection with its review of your claim on appeal, you will be provided the new or additional evidence free of charge as soon as possible and with enough time before a final determination is required to be provided to you (as described above) so that you will have an opportunity to respond. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of the Claims Administrator's mailing of the initial reconsideration decision. The Appeals and Grievance Coordinator will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made and you will be notified within fifteen (15) days of its receipt. The final decision will include:

- information about your claim and the reason(s) the denial was upheld;
- the Program provisions on which the denial is based;
- an explanation of your right to request reasonable access to and copies of the relevant documents, records, and information used in the claims process without charge;
- a description of any voluntary appeal procedures offered by the Program;
- a statement of your right to file a civil action under section 502(a) of ERISA if your claim is denied upon appeal;
- a statement indicating whether an internal rule, guideline, protocol or other similar criterion was relied on in deciding your claim and information explaining your right to request such information, free of charge;
- description of the Program's standard, if any, used in denying the claim;
- discussion of the decision;
- description of available internal appeals and external review processes; and
- disclosure of availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Health and Human Services, if any, to assist in internal claims, appeals and external review process.

C. Post-Service Claims Appeal

An Enrolled Person who wishes to formally appeal a Post-Service Claims decision by the Claims Administrator may do so through the following process (a rescission of coverage is also considered a claim denial that can be appealed):

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. This written appeal should set forth the reasons why the Enrolled Person contends the Claims Administrator's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

Appeal should be sent to:

Blue Cross of Idaho
Appeals and Grievance Coordinator
PO Box 7408
Boise, ID 83707-1408
Phone: (866) 283-6808

2. After receipt of the written appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by someone different than the original decision maker and not a subordinate of the initial decision maker. If the Claims Administrator considers, relies on or generates new or additional evidence in connection with its review of your claim on appeal, you will be provided the new or additional evidence free of charge as soon as possible and with enough time before a final determination is required to be provided to you (as described above) so that you will have an opportunity to respond. The Claims Administrator shall mail a written decision to the Enrolled Person within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list:

- the reason(s) the denial was upheld;
- the Program provisions on which the denial is based;
- an explanation of your right to request reasonable access to and copies of the relevant documents, records, and information used in the claims process without charge;
- a description of any voluntary appeal procedures offered by the Program;
- a statement of your right to file a civil action under section 502(a) of ERISA if your claim is denied upon appeal;
- a statement indicating whether an internal rule, guideline, protocol or other similar criterion was relied on in deciding your claim and information explaining your right to request such information, free of charge;
- description of the Program's standard, if any, used in denying the claim;
- description of available internal appeals and external review processes; and
- disclosure of availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Health and Human Services to assist in internal claims, appeals and external review process.

3. Furthermore, the Enrolled Person or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.
4. If the original decision is upheld upon reconsideration, the Enrolled Person may send an additional written appeal to the Appeals and

Grievance Coordinator requesting further review. The appeal will be conducted by someone different than the prior decision makers and not a subordinate of the prior decision makers. If the Claims Administrator considers, relies on or generates new or additional evidence in connection with its review of your claim on appeal, you will be provided the new or additional evidence free of charge as soon as possible and with enough time before a final determination is required to be provided to you (as described above) so that you will have an opportunity to respond. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of the Claims Administrator's mailing of the initial reconsideration decision. The Appeals and Grievance Coordinator will have a final decision after consideration of all relevant information. A final decision on the appeal will be made and you will be notified within thirty (30) days of its receipt. The final decision will include:

- information about your claim and the reason(s) the denial was upheld;
- the Program provisions on which the denial is based;
- an explanation of your right to request reasonable access to and copies of the relevant documents, records, and information used in the claims process without charge;
- a description of any voluntary appeal procedures offered by the Program;
- a statement of your right to file a civil action under section 502(a) of ERISA if your claim is denied upon appeal;
- a statement indicating whether an internal rule, guideline, protocol or other similar criterion was relied on in deciding your claim and information explaining your right to request such information, free of charge;
- description of the Program's standard, if any, used in denying the claim;
- discussion of the decision;
- description of available internal appeals and external review processes; and
- disclosure of availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Health and Human Services, if any, to assist in internal claims, appeals and external review process.

D. Special Rules for Claims Related to Rescissions

A rescission is a cancellation of coverage with retroactive effect. However, some retroactive cancellations of coverage are not rescissions. Cancellation of coverage for failure to pay required employee contributions toward the cost of coverage on time is not a rescission. If your coverage is rescinded, you will receive written notice 30 days before the coverage will be cancelled. A rescission will be considered a claim denial that can be appealed according to the rules described above for Post-Service Claim denials.

E. External Review Procedures - Health Care Reform

If your claim is still denied after the second level of appeal and you disagree with the Claims Administrator's decision, you may submit your claim to the external appeal process described below only if (i) your claim relates to rescission of coverage; or (ii) your claim involves medical judgment (including, but not limited to, the Program's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit or a determination that a treatment is experimental or investigational), as determined by the external reviewer. This step is not mandatory. Note, however, that if a denial, reduction, termination, or refusal to provide payment for a benefit is based on a determination that a participant is not eligible under the Program, no external review is available.

In most circumstances, before you may submit your claim to the external appeal process, you must first follow the claims procedures outlined above by filing an initial claim and two appeals of a denied claim with the Claims Administrator. However, in certain circumstances (described below), you may receive an expedited external review. In this case, you may not have to exhaust the internal claims process before filing a request for external review.

If the Claims Administrator fails to strictly adhere to the internal ERISA claims procedures described above and claims and appeals guidance issued by the Department of Labor, you will be deemed to have exhausted the internal claims and appeals process and you may initiate an external review or bring suit under section 502 of ERISA, except that de minimus violations that do not cause, and are not likely to cause, prejudice or harm to you will not result in deemed exhaustion as long as the Program demonstrates that the violation was for good cause or due to matters beyond its control and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the Program. You may request written explanation of the violation from the Program and it will provide such an explanation, including a specific description of any bases for asserting that the violation should not result in deemed exhaustion within 10 days. If an external reviewer or court denies your request for immediate review because of this exception, you have the right to resubmit your claim for internal appeal. You will receive notification of this right within 10 days after your request for external review was denied.

Within 4 months of the date you receive notice that, after the second level of appeal, your claim continues to be denied, you may submit your claim to the external appeal process by writing to:

Blue Cross of Idaho
PO Box 7408
Boise, ID 83707-1408
Phone: (866) 283-6808

Your written external appeal may include issues, comments, documents, records, and other information relating to your claim that you want considered in reviewing your claim.

Under the following circumstances, you can request an expedited external review:

- If you have received an initial claim determination that denied your claim, you may request expedited external review if (1) you filed a request for an urgent care appeal AND (2) the time for completing the internal review process would seriously jeopardize life, health, or ability to regain maximum function.
- If you appealed your initial claim denial and received a final internal claim denial and (1) the time for completing the standard external

review process would seriously jeopardize life, health, or ability to regain maximum function OR (2) the denial of the internal appeal concerned the admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility.

1. Preliminary Review of Standard (Not Expedited) External Claims.

Within 5 business days of receipt of the external review request, the Claims Administrator will complete a preliminary review of your request to determine if your claim is eligible for external review. Your claim is eligible for external review if:

- you are or were covered under the Program when the item or service was requested or provided,
- the claim or appeal denial does not relate to your failure to meet the Program's eligibility requirements (except in the case of rescissions),
- you have exhausted the internal appeal process (unless you are not required to exhaust the internal claims procedures), and
- you have provided all information and forms required to process external review.

Within 1 business day after completion of the preliminary review, the Claims Administrator will notify you in writing regarding whether your claim is eligible for external review. If your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the 4 month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.

2. External Review Process. If the Claims Administrator determines your claim is eligible for external review, your claim will be assigned to an independent review organization. The independent review organization will notify you that your claim is eligible for external review and that the review process is beginning. The notice will also inform you that you have 10 business days following receipt of the notice to provide additional information to the independent review organization for it to consider.

The independent review organization will not defer to the decisions made during the internal review process and will look at your claim anew. The independent review organization will consider all the information and documents that it receives in a timely manner when making its decision.

The independent review organization will provide written notice of the final external review decision within 45 days after it receives the request for external review.

If the independent review organization reverses the Claims Administrator's denial of your claim, the decision will be final and the Program must immediately provide coverage or payment.

The period during which your external appeal is brought and decided will not count against the time period permitted for you to bring a lawsuit (e.g., any applicable statute of limitations will be tolled). Submitting your claim to the external appeal process is not a prerequisite and does not prevent you from filing a civil action under section 502(a) of ERISA once the claim and review procedure has been completed.

3. Expedited External Review Process. In general, the same rules that apply to standard external review apply to expedited external review, except that the timeframe for decisions and notifications is shorter. An expedited external review is initiated when the prescribing Provider or treating Provider notifies the Claims Administrator the the Enrolled Person's life or health is in jeopardy.

Expedited Preliminary Review: The Claims Administrator will immediately conduct a preliminary review to determine if your claim is eligible for external review. After the preliminary review is completed the Claims Administrator will immediately notify you of the determination. If your request was not complete, the notice will describe information or materials needed to complete the request. You will have until the end of the 4 month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request.

Expedited External Review: If your claim is eligible for expedited external review, your claim will be assigned to an independent review organization. The independent review organization will provide you its final decision as expeditiously as your medical condition or circumstances require, but in no event will the notification be provided later than 72 hours after the independent review organization receives the request for expedited external review. If the notice of the decision is not provided in writing, then the independent review organization must provide you with written confirmation of the decision within 48 hours after the notice of decision was first provided to you by other means.

F. General Rules

- Your initial claim, any request for review of an Adverse Benefit Determination, and any request for external appeal must be made in writing, except for requests for review of Adverse Benefit Determinations relating to urgent care claims, which may also be made orally.
- You must follow the claim-and-review procedure contained in this booklet carefully and completely and you must file your claim before any applicable deadlines. If you do not do so, you may give up important legal rights.
- Your casual inquiries and questions will not be treated as claims or requests for a review or submissions to the external appeal process.
- You may have a lawyer or other representative help you with your claim at your own expense (the Claims Administrator or the Plan Administrator may require written authorization to verify that an individual has been authorized to act on your behalf, except that for urgent care claims a health care professional with knowledge of the claimant's medical condition will be permitted to act as an authorized representative).

- You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to any Adverse Benefit Determination. You will also be allowed to review all documents, records and other relevant information and present evidence and written testimony as part of the internal claims process.
- You must comply with any additional requirements for filing a claim (e.g., using a specific claim form) imposed by the Claims Administrator.

Determination for the Type of Service	Urgent Care Pre-Service	Prior Notification (Nonurgent)	Post-Service
The Claims Administrator will notify you of the initial determination within	72 hours	15 days (*depending on the medical situation*)	30 days
The Claims Administrator may ask for extension of	None	15 days	15 days
The Claims Administrator must request any needed information within	24 hours	15 days	30 days
You may respond to request for additional information within	48 hours	45 days	45 days
You have to request an appeal within	180 days	180 days	180 days
The Claims Administrator will notify you of the determination on an appeal within	72 hours (*depending on the medical situation*)	15 days (*for each level*)	30 days (for each level)

Coordination of This Program's Benefits with Other Benefits

This Maintenance of Benefits (MOB) provision applies when an Enrolled Person has health care coverage under more than one (1) Plan or Policy. Plan or Policy is defined below.

The Order of Benefit Determination Rules governs the order in which each Plan or Policy will pay a claim for benefits. The Plan or Policy that pays first is called the Primary Plan or Policy. The Primary Plan or Policy must pay benefits in accordance with its Plan or Policy terms without regard to the possibility that another Plan or Policy may cover some expenses. The Plan or Policy that pays after the Primary Plan or Policy is the Secondary Plan or Policy.

A. Definitions

1. A **Plan or Policy** is any of the following that provides benefits or services for medical or dental care or treatment. If separate Plans or Policies are used to provide coordinated coverage for members of a group, the separate Plans or Policies are considered parts of the same Plan or Policy and there is no MOB among those separate Plans or Policies.

   a) Plan or Policy includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   b) Plan or Policy does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefit for non-medical components of long-term care policies; Medicare supplement policies; Medicare or any other federal governmental plans, unless permitted by law.

   Each Plan or Policy for coverage under a) or b) is a separate Plan or Policy. If a Plan or Policy has two (2) parts and MOB rules apply only to one (1) of the two (2), each of the parts is treated as a separate Plan or Policy.

2. **This Plan** means the Medical Program under the Albertson's LLC Health & Welfare Plan.
3. This **MOB provision** means the part of the Plan or Policy providing the health care benefits to which the MOB provision applies and which may be reduced because of the benefits of other Plans or Policies. Any other part of the Plan or Policy providing health care benefits is separate from this plan. A Plan or Policy may apply one (1) MOB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply under MOB provision to coordinate other benefits.
4. The **Order of Benefit Determination Rules** determine whether This Plan is a Primary Plan or Secondary Plan when the Enrolled Person has health care coverage under more than one (1) Plan or Policy. When This Plan is primary, it determines payment for its benefits first before those of any other Plan or Policy without considering any other Plan or Policy's benefits. When This Plan is secondary, it determines its benefits after those of another Plan or Policy and will reduce the benefits it pays when the benefits payable under the Primary Plan or Policy equal or exceed the benefits which would have been payable under This Plan had benefits payments under This Plan been determined first.
5. **Primary/Secondary Plan or Policy** is determined by the Order of Benefits Determination Rules.
6. **Allowable Expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan or Policy covering the Enrolled Person. When a Plan or Policy provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit

paid. An expense that is not covered by any Plan or Policy covering the Enrolled Person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

a) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans or Policies provides coverage for private hospital room expenses.

b) If an Enrolled Person is covered by two (2) or more Plans or Policies that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

c) If an Enrolled Person is covered by two (2) or more Plans or Policies that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

d) If an Enrolled Person is covered by one (1) Plan or Policy that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan or Policy that provides its benefits or services on the basis of negotiated fees, the Primary Plan's or Policy's payment arrangement shall be the Allowable Expense for all Plans or Policies. However, if the provider has contracted with the Secondary Plan or Policy to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's or Policy's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan or Policy to determine its benefits.

e) The amount of any benefit reduction by the Primary Plan or Policy because a covered person has failed to comply with the Plan or Policy provisions is not an Allowable Expense. Examples of these types of Plan or Policy provisions include second surgical opinions, pre-certification of admissions, and preferred provider arrangements.

7. **Closed Panel Plan** is a Plan or Policy that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan or Policy, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

8. **Custodial Parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. Order of Benefit Determination Rules

When an Enrolled Person is covered by two (2) or more Plans or Policies, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan or Policy pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan or Policy.
2. A Plan or Policy may consider the benefits paid or provided by another Plan or Policy in calculating payment of its benefits only when it is secondary to that other Plan or Policy.
3. Each Plan or Policy determines its order of benefits using the first of the following rules that apply:

a) Non-Dependent or Dependent. The Plan or Policy that covers the Enrolled Person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan or Policy and the Plan or Policy that covers the Enrolled Person as a dependent is the Secondary Plan or Policy. For special rules concerning an Enrolled Person who is Medicare Eligible or a Non-Traditional Spouse, please see paragraphs F and G. below.

b) Dependent Child Covered Under More Than One Plan or Policy. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan or Policy the order of benefits is determined as follows:

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Plan or Policy of the parent whose birthday falls earlier in the calendar year is the Primary Plan or Policy; or if both parents have the same birthday, the Plan or Policy that has covered the parent the longest is the Primary Plan or Policy.

(2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan or Policy of that parent has actual knowledge of those terms, that Plan or Policy is primary. This rule applies to the Benefit Plan Year commencing after the Plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) shall determine the order of benefits;

iii. If a court decree states both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Plan or Policy covering the Custodial Parent;
2. The Plan or Policy covering the spouse of the Custodial Parent;
3. The Plan or Policy covering the non-Custodial Parent; and then
4. The Plan or Policy covering the spouse of the non-Custodial Parent.

For a dependent child covered under more than one Plan or Policy of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

c) Active Employee or Retired or Laid-off Employee. The Plan or Policy that covers an Enrolled Person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan or Policy. The Plan or Policy covering that same Enrolled Person as a retired or laid-off employee is the Secondary Plan or Policy. The same would hold true if an Enrolled Person is a dependent of an active employee and that same Enrolled Person is a dependent of a retired or laid-off employee. If the other Plan or Policy does not have this rule, and as a result, the Plans or Policies do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 3.a) can determine the order of benefits.

d) COBRA or State Continuation Coverage. If an Enrolled Person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan or Policy, the Plan or Policy covering the Enrolled Person as an employee, member, subscriber or retiree or covering the Enrolled Person as a dependent of an employee, member, subscriber or retiree is the Primary Plan or Policy and the COBRA or state or other federal continuation coverage is the Secondary Plan or Policy. If the other Plan or Policy does not have this rule, and as a result, the Plans or Policies do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 3.a) can determine the order of benefits.

e) Longer or Shorter Length of Coverage. The Plan or Policy that covered the Enrolled Person as an employee, member, policyholder, subscriber, or retiree longer is the Primary Plan or Policy and the Plan or Policy that covered the Enrolled Person the shorter period of time is the Secondary Plan or Policy.

f) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans or Policies meeting the definition of Plan or Policy. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

g) If you are covered under This Plan and TRICARE: This Plan will comply with the TRICARE provisions of federal law, rather than the Order of Benefit Rules in this section, to determine which plan is a Primary Plan or Policy and which is a Secondary Plan or Policy. TRICARE will be primary and This Plan will be secondary only to the extent permitted by TRICARE rules.

C. Effect on The Benefits of This Plan

1. When This Paragraph Applies. This Paragraph C. applies when, in accordance with Paragraph B., "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one (1) or more other Plans or Policies. If the benefits of This Plan may be reduced under this paragraph, such an Other Plan or Policy or Plans or Policies are referred to as "the other Plans or Policies" in subparagraph 2. immediately below.

2. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when:

a) The benefits payable under the Other Plan or Policy equal or exceed the benefits which would have been payable under This Plan had benefits payment under This Plan been determined first, then there is no benefit payable under This Plan.

*EXAMPLE:	Other Plan or Policy benefit	- $960 or 80%
	This Plan benefit	- $960 or 80%

No benefits available under This Plan. Other Plan or Policy benefits as determined first are equal to benefits under This Plan.

and,

b) The benefits payable for Covered Services under the Other Plan or Policy are less than the benefits which would have been payable under This Plan had benefits been determined first, then the benefits shall equal those benefits payable under This Plan, less the benefits payable under the Other Plan or Policy.

*EXAMPLE:	Other Plan or Policy benefit	- $840 or 70%
	This Plan benefit	- $960 or 80%

Benefits payable under This Plan must equal 80% or (960–840 = $120).

* The above examples do not necessarily reflect the benefits payable under This Plan and are used only to show how

benefits would be determined under This Plan and an Other Plan or Policy.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

D. Facility of Payment

A payment made under another Plan or Policy may include an amount that should have been paid under This Plan. If it does, BCI may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. BCI will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

E. Right of Recovery

If the amount of the payments made by BCI is more than it should have paid under this MOB provision, it may recover the excess from one or more of the Enrolled Persons it has paid or for whom it has paid; or any other Enrolled Person or organization that may be responsible for the benefits or services provided for the covered Enrolled Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

F. Medicare Eligibles

This Plan will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

(a) a former employee (including a disabled employee who is not a former employee but who is in inactive status) who is eligible for Medicare and whose coverage is continued for any reason as provided in This Plan;

(b) a former employee's Dependent, or a former Dependent spouse, who is eligible for Medicare and whose coverage is continued for any reason as provided in This Plan;

(c) an employee, retired employee, employee's Dependent or retired employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

This Plan will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount they would receive if they had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount they would receive if they were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount they would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for them.

This reduction will not apply to any employee and their Dependent(s) or any former employee and their Dependent(s) unless they are listed under (a) through (c) above.

G. Non-Traditional Spouses

Under federal law, the Medicare Secondary Payer Rules generally do not apply to Non-Traditional Spouses covered under a group health plan. Therefore, unless otherwise required by law, Medicare is always the Primary Plan for a person covered as a Non-Traditional Spouse, and This Plan is the Secondary Plan.

Auto Insurance, Homeowner's, or Other Insurance

Any auto, homeowner's, or other insurance that you have is considered primary for any injury-related expenses resulting from an accident. If injuries are the result of an auto accident, any auto insurance is primary, even when the auto insurance is "no fault" coverage required by law.

Workers' Compensation

The Program excludes coverage for any Illness or injury incurred while working for any employer for wage or profit or for which workers' compensation benefits or benefits under any similar law are available.

Subrogation and Reimbursement Rights

The benefits of this Program will be available to an Enrolled Person when he or she is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as "third party"). To the extent that such benefits for Covered Services are provided or paid for by Blue Cross of Idaho, on behalf of the Plan Administrator under this Program or any other Blue Cross of Idaho plan, agreement, certificate, contract or plan, the Plan shall be subrogated and succeed to the rights of the Enrolled Person or, in the event of the Enrolled Person's death, to the rights of his or her heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Enrolled Person or his or her personal representative shall furnish Blue Cross of Idaho in writing with the names and addresses of the third party or parties that caused or are responsible, or may have caused or may be responsible for such injury, harm or loss, and all facts and information known to the Enrolled Person or his or her personal representative concerning the injury, harm or loss.

The Plan may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Enrolled Person's right to receive payments from other parties. The Enrolled Person or his or her legal representative will transfer to the Plan any rights he or she may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Enrolled Person. Thus, the Plan may initiate litigation at its sole discretion, in

the name of the Enrolled Person, against any third party or parties. Furthermore, the Enrolled Person shall fully cooperate with the Plan and Blue Cross of Idaho in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Plan's subrogation rights and efforts. The Plan will be reimbursed in full for all benefits paid even if the Enrolled Person is not made whole or fully compensated by the recovery. Moreover, the Plan is not responsible for any attorney's fees, other expenses or costs incurred by the Enrolled Person without the prior written consent of the Plan and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Enrolled Person hires regardless of whether amounts recovered are used to repay benefits paid by the Plan.

Additionally, the Plan may at its option elect to enforce its right of reimbursement from the Enrolled Person, or his or her legal representative, of any benefits paid from monies recovered as a result of the injury, harm or loss. The Enrolled Person shall fully cooperate with Blue Cross of Idaho and the Plan in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Plan's reimbursement rights and efforts.

The Enrolled Person shall pay the Plan as the first priority, and the Plan shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party's or parties' insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by the Plan under this Program, regardless of how the recovery is allocated (i.e., pain and suffering) and whether the recovery makes the Enrolled Person whole. Thus, the Plan will be reimbursed by the Enrolled Person, or his or her legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Enrolled Person is not made whole or fully compensated by the recovery. Moreover, the Plan is not responsible for any attorney's fees, other expenses or costs incurred by the Enrolled Person without the prior written consent of the Plan and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Enrolled Person hires regardless of whether amounts recovered are used to repay benefits paid by the Plan.

To the extent that the Plan provides or pays benefits for Covered Services, the Plan's rights of subrogation and reimbursement extend to any right the Enrolled Person has to recover from the Enrolled Person's insurer, or under the Enrolled Person's "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions, and workers' compensation benefits.

The Plan shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Enrolled Person, the Enrolled Person's personal representative, a special needs trust, or any trust, person or vehicle that holds any payment or recovery from or on behalf of the Enrolled Person including the Enrolled Person's attorney.

The Plan's subrogation and reimbursement rights shall take priority over the Enrolled Person's rights both for expenses already incurred and paid by the Plan for Covered Services, and for benefits to be provided or payments to be made by the Plan in the future on account of the injury, harm or loss giving rise to the Plan's subrogation and reimbursement rights. Further, the Plan's subrogation and reimbursement rights for incurred expenses and/or future expenses yet to be incurred are primary and take precedence over the rights of the Enrolled Person, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Enrolled Person and the Plan.

Collections or recoveries made in excess of such incurred Plan expenses shall first be allocated to such future Plan expenses, and shall constitute a special Deductible applicable to such future benefits and services under this or any subsequent plan. Thereafter, the Plan shall have no obligation to make any further payment or provide any further benefits until the benefits equal to the special Deductible have been incurred, delivered, and paid by the Enrolled Person.

Prescription Drug Coverage

Rx.com Pharmacy Benefit Coalition (PBC) is the Pharmacy Benefit Administrator and named claims fiduciary for prescription care. Call Rx.com PBC at **(800) 772-8593** or log on to their website at www.rx.com for questions regarding:

- Albertson's LLC Pharmacy Network
- Coverage of specific prescription drugs
- Mail order program
- Prior Authorizations for certain medications
- Step Therapy

Covered drugs are those that are necessary for the treatment of a Disease or Illness, and that are widely accepted as effective, appropriate, and essential, based on the recognized standards of the medical community.

Prescriptions are considered necessary when they are prescribed in conjunction with a Medically Necessary service or supply. Drug therapy must be prescribed by a licensed Physician and must be in accordance with guidelines pertaining to type, frequency, and duration-of-treatment that have been established by national medical, research, and governmental agencies. The fact that your Physician prescribes, orders, recommends, or approves a prescription or supply does not mean it is an eligible expense under the prescription drug provisions.

As new drugs become available (including generics) or become available over-the-counter (OTC), the Pharmacy Benefit Administrator decides whether they are considered an eligible expense under the prescription drug provisions of the Medical Program.

Albertsons

Covered Expenses	Albertson's LLC Pharmacy Network You Pay	Non-Albertson's LLC Pharmacy Network You Pay
Tier 1 – Generic Drugs	20% Copayment for each 30-day supply, with a $4 minimum	50% Copayment for each 30-day supply, with a $4 minimum
Tier 2 – Formulary Brand-Name Drugs If you choose a brand name drug when a generic is available, you are responsible for the difference in the cost between the generic and brand drug, in addition to your copayment.	20% Copayment for each 30-day supply, with a $20 minimum	50% Copayment for each 30-day supply, with a $20 minimum
Tier 3 – Non-Formulary Brand-Name Drugs If you choose a brand name drug when a generic is available, you are responsible for the difference in the cost between the generic and brand drug, in addition to your copayment.	30% Copayment for each 30-day supply, with a $40 minimum	60% Copayment for each 30-day supply, with a $40 minimum

Preventive Care

Certain preventive care drugs are covered at 100% when there is a prescription provided from your health care provider and the prescription is obtained at an Albertson's LLC network pharmacy.

- Aspirin for men age 45-79 and women age 55-79
- Vitamin D use for men and women over age 65 to prevent falls in community dwelling adults who are increased risk for falls.
- Immunization vaccines for adults, including Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus (HPV), Influenza, Measles, Mumps, Rubella (MMR), Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella
- Folic Acid supplements for women who may become pregnant
- FDA-approved generic contraceptive medications
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Immunization vaccines for children to age 18 including Diphtheria, Tetanus, Pertussis, Haemophilus Influenzae Type B, Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Inactivated Poliovirus, Influenza, Measles, Mumps, Rubella (MMR), Meningococcal, Pneumococcal, Rotavirus
- Iron supplements for children age 6 to 12 months at risk for anemia

The specifically listed preventive care services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.

How to Purchase Prescription Drugs

You can purchase Prescription Drugs from any Albertson's LLC-owned or network pharmacy or by mail order to receive the highest level of benefit. Your prescription drug benefit has built-in incentives to encourage you to consider the most cost-effective treatments. There are three tiers or levels of Copayments which allows you to pay different amounts depending on whether the drug you use is a generic, a formulary brand-name drug (preferred), or a non-formulary brand-name drug (non-preferred). OTC drugs are not covered.

Tier 1: If a generic drug is available and you choose the generic, you'll pay the lowest Copayment. If you choose a brand name drug when a generic is available, you will pay the difference between the price of the generic and the brand name drug, plus any applicable Copayment, even if your doctor prescribes the brand name.

Tier 2: The second tier is made up of formulary brand-name drugs. A formulary brand-name drug is a drug that is selected by a committee of health care professionals for its combination of effectiveness, availability and cost. Formulary brand-name drugs are generally more expensive than available generic drug options, but are less expensive than the non-formulary brand name drugs. Since you pay a percentage of the cost of a drug, using generics and formulary brand-name drugs can save you money.

Tier 3: If you do choose to use a non-formulary brand-name drug, you pay a higher Copayment.

When you fill a prescription, provide your ID card to the pharmacy. As an Enrolled Person in a Blue Cross medical option, use your combination medical/prescription drug ID card sent to you by Blue Cross of Idaho.

If your Physician so prescribes, you can fill prescriptions for up to a 90-day supply at a network pharmacy. You will be responsible for the applicable copayment for each 30-day supply. Specialty medications are limited to a 30-day supply. Certain specialty medications may be limited to a 15-day supply for the first time the prescription is filled. You may be required to present your medical ID card at the time of purchase. If you do not present your card when you purchase your prescription, you might have to make full payment and submit a claim to be reimbursed.

You can obtain claim forms from Rx.com PBC by calling **(800) 772-8593**.

Copayments and Maximums

Copayments do not count toward Medical Program Deductibles, however if a participant's Pharmacy Network out-of-pocket Prescription Drug expenses reach $2,500, the participant's Copayment (the amount the participant pays at the pharmacy) will be reduced to 5% for the remainder of the Benefit Plan Year. There is no Coinsurance maximum for Out-of-Network pharmacy expenses. Reimbursements you receive or charges paid by the Program for Prescription Drugs count toward the Medical Program's $2 million Comprehensive Benefit Plan Year Maximum. There is a $5,000 Lifetime Benefit Maximum for the use of Prescription Drugs for treatment of infertility.

The Albertson 's LLC Pharmacy Network

The Albertson's LLC Pharmacy Network consists of many pharmacies nationwide. The network includes Albertsons, Jewel-Osco, Acme, Sav-On Drugs, Osco Drugs, Shaw's, and Star Markets locations.

Most employees live in an area that is served by the Albertson's LLC Pharmacy Network. If you need assistance in locating a pharmacy near your home, you can call Rx.com PBC at **(800)-772-8593** or log in to your account at

www.rx.com. If you are accessing this website for the first time, you must create a personal account to utilize the pharmacy locator tool.

Mail-Order Purchases

Prescriptions can be filled by mail order through the Prescription Drug Mail Order Program. If prescribed by your Physician, you can purchase up to a 90-day supply of drugs. You will be responsible for the applicable copayment for each 30-day supply. Specialty medications are limited to a 30-day supply. Certain specialty medications may be limited to a 15-day supply for the first time the prescription is filled. Certain "controlled" substances are limited to 30-day supply or less, with no refills. Call Rx.com PBC at **(800) 772-8593** to request a supply of mail order forms and additional information.

Disease Management

You may be invited to participate in voluntary disease management programs to help you manage specific chronic medical conditions, such as diabetes. Enrolled Persons identified by the Claims Administrator as having diabetes and who live in an area supported by Albertson's LLC pharmacists who are trained in diabetes management may be invited to participate in the Albertson's LLC Diabetes Management Program. The disease management programs may provide education, testing and incentives through enhanced benefits if you participate. Participants in the Albertson's LLC Diabetes Management Program are eligible for 100% coverage of certain generic prescription drugs by completing the program requirements. The generic prescription drugs included in the Diabetes Management Program are medically necessary oral medications to treat diabetes, medications to control conditions related to diabetes, such as high blood pressure and cholesterol, and supplies such as test strips and lancets. Insulin will continue to be covered, as medically necessary, through the standard prescription benefit under the Medical Program. These disease management programs may not be available in all areas. The Program may have additional requirements and limitations.

Prior Authorization and Step Therapy

Certain prescription drugs require Pharmacy Benefit Administrator authorization before they are covered by the Program. The prior authorization process makes sure that medications are being dispensed for the appropriate reason, in the appropriate quantities, and at the appropriate time.

The following are examples of situations in which a prescription would require prior authorization:

- Specialty prescription drugs to treat rare or serious medical conditions, such as, but not limited to, Multiple Sclerosis, Hemophilia, genetic disorders, Rheumatoid Arthritis, and prescriptions used to treat enzyme disorders or immune deficiencies
- Prescription medication that may be used for cosmetic purposes
- Prescriptions for tobacco cessation
- Prescriptions for growth hormones
- Prescriptions for certain pain medications
- Prescriptions for anabolic steroids
- Prescriptions for asthma and allergy medications
- Prescriptions for treatment of sexual dysfunction (approved only for post-surgical conditions)
- Prescriptions for an additional vacation supply beyond the one annual vacation override

Step therapy is a requirement to use one or more medications before benefits for the use of another medication can be authorized. Through step therapy, treatment for a medical condition generally begins with the most cost-effective and safest drug therapy and progresses to other more costly or risky therapy, only if necessary. The following are examples of drug classes that may require step therapy

- Injectable anti-diabetic agents other than insulin
- Certain lipid-lowering (cholesterol) medications
- Certain Multiple Sclerosis drugs
- Certain asthma and allergy medications

You will need to contact the Pharmacy Benefit Administrator at **(800) 772-8593** and provide additional information for prior authorizations and step therapy.

Your attempt to obtain benefits for these drugs may be denied. Your Physician can mail or fax the appropriate medical documentation to support Medical Necessity to the Pharmacy Benefit Administrator at Rx.com PBC, 101 Jim Wright Freeway South, Suite 200, Fort Worth, Texas 76108 or fax (877) 246-3291. After receiving the documentation, the Pharmacy Benefit Administrator will verify if the condition falls within the appropriate medical guidelines, based on both medical judgment and current medical literature. In addition, some drugs may be subject to quantity limitations in response to safety and cost concerns. In most cases, if the Pharmacy Benefit Administrator receives the appropriate documentation in a timely manner, you will not experience a delay in obtaining your medicine.

Prior Authorization of Prescriptions Requiring Additional Medical Services

Some drugs require medical services in conjunction with the drug. In those cases, you will need to obtain prior authorization through Blue Cross of Idaho (your medical Claims Administrator) before your prescription or services are covered by the Program. The prior authorization process makes sure that medications are being dispensed for the appropriate reason, in the appropriate quantities, and at the appropriate place and time. The following are examples of situations in which a prescription would require prior authorization through Blue Cross of Idaho:

- The prescription is for growth hormones
- The drug will be administered by a provider in the office or hospital setting
- The drug will be coordinated through a Home IV provider

In these instances, you will need to contact Blue Cross of Idaho Customer Service at **(866) 283-6808** to provide additional information.

Your physician can mail or fax the appropriate medical documentation to support the Medical Necessity of the prescription to the Claims Administrator at Blue Cross of Idaho, Attn: Pharmacy Management, PO Box 7408, Boise, Idaho, 83707 or fax (208) 387-6969. After receiving the documentation, Blue Cross of Idaho will verify if the condition falls within the appropriate

medical guidelines, based on both medical judgment and current medical literature. In addition, some drugs may be subject to quantity limitations in response to safety and cost concerns. In most cases, you will not experience a delay in obtaining your medicine. You may experience a delay, however, if Blue Cross of Idaho does not receive the appropriate documentation in a timely manner. Blue Cross of Idaho may deny coverage of some prescriptions based on their review of the documentation.

Utilization Review

Prescription drug benefits include utilization review of Prescription Drug usage for the Enrolled Person's health and safety. If there are patterns of over-utilization or misuse of drugs, the Enrolled Person's Physician and Pharmacist will be notified. The Program reserves the right to limit benefits to prevent over-utilization or misuse of Prescription Drugs.

Prescription Drugs That Are Not Covered

The prescription drug program does not cover expenses for the following circumstances or types of drugs:

- Prescriptions that are not Medically Necessary or not covered by the Program, as determined by the Pharmacy Benefit Administrator
- Prescriptions that an Enrolled Person is entitled to receive without charge under any state's Workers' Compensation law, any state or municipal programs, or any federal program
- Prescription charges that are covered by other insurance, including, but not limited to, auto insurance, homeowner's insurance, and business risk insurance
- Drugs intended for use in a hospital
- Therapeutic devices, supplies, or appliances, such as diagnostic tests for cholesterol (although diabetic supplies such as test strips, syringes, and lancets are covered)
- Support garments and other non-medical substances
- Drugs to treat sexual dysfunction, unless prior authorized for post-surgical conditions
- Abortifacient medications not limited to RU 486 (Mifepristone)
- Non-legend drugs (over-the-counter) other than insulin
- Over-the-counter vitamins (pre-natal vitamins prescribed for pregnancy and generic legend vitamins may be covered)
- Contraceptive devices including injectables, implants and intrauterine devices (may be covered under the medical provisions of the Program)
- Proton Pump Inhibitors and H2 Blockers
- Non-sedating antihistamines
- Investigational or unproven drugs, or drugs prescribed for Investigational, or unproven (non-FDA approved/unlabeled) indications or purposes as determined by the Pharmacy Benefit Administrator
- Charges for administration/injection of any drug
- Drugs, services, supplies, and pharmaceuticals that are used for cosmetic purposes, including, but not limited to Renova
- Drugs to treat hair loss, replacement or enhancement (for example, Rogaine, Minoxidil, and Propecia)
- Ostomy supplies (expenses for these items may be covered under the medical provisions of the Program)
- Drugs for diet or weight control
- Nutritional supplements/products and specialized formulas (expenses for Medically Necessary products for the condition PKU, as determined by the medical Claims Administrator, may be covered under the medical provisions of the Program)
- Blood and blood plasma (expenses for these items may be covered under the medical provisions of the Program)
- Tobacco cessation products/deterrents in excess of the 12-week supply limit for Chantix or 6-month supply limit for Bupropion per Benefit Plan Year
- Extemporaneously prepared combinations of federal legend drugs in a non-FDA approved dosage form (for example, capsules made from progesterone and estrogen powder)
- Newly FDA-approved or -indicated drugs, unless approved by the Pharmacy Benefit Administrator
- DEA Class I drugs (controlled substances)

Note: Lost, destroyed, or stolen prescriptions will not be replaced and must be paid for in full by the Enrolled Person, unless the Enrolled Person elects to use the one annual vacation override, if it has not been used within the prior twelve (12) months.

Filing Prescription Drug Claims

When you use an In-Network Pharmacy they will submit the claim information on your behalf to Rx.com PBC. When you use an Out-of-Network Pharmacy you may be required to submit a paper claim yourself. You can obtain claim forms from Rx.com PBC Pharmacy Help Desk at **(800) 772-8593**.

The Pharmacy Benefit Administrator has the full discretionary power to interpret and apply the terms of the Program. All decisions of the Pharmacy Benefit Administrator as to the facts of the case, interpretation of any provision of the Program or its application to any case and any other interpretative matter, determination or question under the Program will be final and binding on all affected parties.

Deadline for Filing Claims

Claims must be submitted within twelve (12) months from the date of service and must be for services that were performed during the period that you or your dependents were covered under this Program. Claims submitted later than twelve (12) months after the date of service will not be accepted or reviewed.

Procedures for Claims Concerning Coverage Denials

In some cases, the Pharmacy Benefit Administrator may determine that a pharmacy benefit is not eligible for coverage under the Program until a prior authorization has been provided. If Prior Authorization (or other prior approval by the Program) is required before you can obtain coverage for the service, and such coverage is denied, the request for coverage will be treated as a Pre-Service Claim for benefits, and you will receive written notification of its denial. If you disagree with the coverage decision, you can then, if you wish, pursue the internal appeal and external review processes for denied

Pre-Service Claims outlined later in this section. In other cases, the Program may not require Prior Notification or other prior approval for a particular pharmacy benefit, but you or your Provider may have inquired about the status of coverage before obtaining the pharmacy benefit and have been informed that the service is not covered. If you wish to bring a claim relating to this type of coverage decision (where prior notification or approval is not required) it will be treated as a "Post Service" Claim as outlined later in this section.

Notification of Benefit Determinations

The Pharmacy Benefit Administrator will notify you or your authorized representative of its benefit determinations as follows:

Urgent Care Claims:

An urgent Pharmacy claim is defined as where the prescribing provider or treating provider notifies the Pharmacy Benefit Administrator that the member's life or health is in jeopardy. Notice of a benefit determination on an urgent care claim will be provided as soon as possible, taking into account the medical circumstances, but not later than seventy-two (72) hours after receipt of the claim. However, if the Pharmacy Benefit Administrator gives you notice of an incomplete claim, the notice will include a time period of not less than forty-eight (48) hours for you to respond with the requested specified information. The Pharmacy Benefit Administrator will then provide you with the notice of benefit determination within forty-eight (48) hours after the earlier of: (a) that date you provide the requested information, or (b) the end of the period of time given you to provide the information.

Other Pre-Service Claims:

A Pre-Service claim is a claim that requires prior authorization or other notification or approval prior to receiving the pharmacy benefit. For Pre-Service Claims other than urgent care claims, notice of a benefit determination will be provided in writing within a reasonable period appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim. However, this period may be extended one time by the Pharmacy Benefit Administrator for up to an additional fifteen (15) days if the Pharmacy Benefit Administrator both determines that such an extension is necessary due to matters beyond its control and provides you written notice, prior to the end of the original fifteen (15) day period, of the circumstances requiring the extension and the date by which the Pharmacy Benefit Administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given at least forty-five (45) days from your receipt of the notice to provide the information.

Post-Service Claims:

Notice of Adverse Pharmacy Benefit Determinations will be provided in writing within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. However, this period may be extended one time by the Pharmacy Benefit Administrator for up to an additional fifteen (15) days if the Pharmacy Benefit Administrator both determines that such an extension is necessary due to matters beyond its control and provides you written notice, prior to the end of the original fifteen (15) day period, of the circumstances requiring the extension and the date by which the Pharmacy Benefit Administrator expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given at least forty-five (45) days from your receipt of the notice to provide the information.

The applicable time period for the Pharmacy benefit determination begins when your claim is filed in accordance with the claim filing procedures of the Pharmacy Benefit Administrator, even if you haven't submitted all the information necessary to make a benefit determination. However, if the time period for the benefit determination is extended due to your failure to submit information necessary to decide a claim, the time period for making the benefit determination will be suspended from the date the notice of extension is sent to you until the earlier of: (a) the date on which you respond to the request for additional information, or (b) the date established by the Pharmacy Benefit Administrator for the furnishing of the requested information (at least forty-five (45) days).

Adverse Pharmacy Benefit Determinations

If your claim is subject to an Adverse Pharmacy Benefit Determination, you will receive a notification that includes:

- information about your claim (including, for example, date of service, Provider and claim amount) and the specific reason(s) for the denial;
- the Program provisions on which the denial is based;
- a description of additional material (if any) needed to perfect the claim;
- an explanation of your right to request an appeal;
- a statement of your right to file a civil action under section 502(a) of ERISA if your claim is denied upon appeal;
- a statement indicating whether an internal rule, guideline, protocol or other similar criterion was relied on in deciding your claim and information explaining your right to request such information, free of charge;
- for urgent care claims only, a description of the expedited review process applicable to such claims;
- description of the Program's standard, if any, used in denying the claim;
- description of available internal appeals and external review processes; and
- disclosure of availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Health and Human Services, if any, to assist in internal claims, appeals and external review process.

Reimbursement of Pharmacy Benefits Paid By Mistake

If the Pharmacy Benefit Administrator mistakenly pays benefits on behalf of an Enrolled Person that the Enrolled Person is not entitled to under this Program, the Enrolled Person must reimburse the erroneous benefits to the Pharmacy Benefit Administrator, on behalf of the Plan Administrator.

The reimbursement is due and payable as soon as the Pharmacy Benefit Administrator notifies the Enrolled Person and requests reimbursement. The

Pharmacy Benefit Administrator, on behalf of the Plan Administrator, may also recover such erroneous benefits from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, the Pharmacy Benefit Administrator, on behalf of the Plan Administrator, may reduce benefits or reduce an allowance for benefits as an offset toward reimbursement or pursue any other method of recovery permissible under law.

Even though the Pharmacy Benefit Administrator, on behalf of the Plan Administrator, may elect to continue to provide benefits after mistakenly paying benefits, the Pharmacy Benefit Administrator, on behalf of the Plan Administrator, may still enforce this provision. This provision is in addition to, not instead of, any other remedy the Pharmacy Benefit Administrator, on behalf of the Plan Administrator, may have at law or in equity.

Prescription Drug Benefit Claims Review and Appeal Procedures

Inquiry and Appeals Procedures

You have the right to appeal any denied claim. Your appeal must be filed with the Pharmacy Benefit Administrator in writing, within 180 days after you receive the written notice of the reduction or denial. Upon request, the Pharmacy Benefit Administrator will provide documents, records, and other information that is relevant to your claim for benefits. This information will be provided free of charge. If the Pharmacy Benefit Administrator considers, relies on or generates new or additional evidence in connection with its review of your claim on appeal, you will be provided the new or additional evidence free of charge as soon as possible and with enough time before a final determination is required to be provided to you (as described above) so that you will have an opportunity to respond. The Pharmacy Benefit Administrator will notify you of a decision within 30 days of when it receives the appeal unless the appeal is an appeal of an adverse determination concerning a claim involving urgent care or a pre-service claim. The decision will be sent to you in writing and will include specific reasons for the decision and specific references to the Program provisions on which the decision is based.

If you have followed these procedures and you still do not agree with the Pharmacy Benefit Administrator's decision about your claim, you can request external review of your claim or file suit in federal court. These claims and appeals procedures (except any external review described below) must be exhausted before any legal action is commenced.

Appeals that concern a pharmacy claim involving urgent care are subject to federal regulations that set forth specific time frames for the review process. For that reason, under some circumstances, the regular claims review procedures that are explained above might not be adequate. You might need an accelerated claims review procedure. For example, if your request for prior notification of a prescription benefit is not approved, the request would generally be subject to the prior notification/pre-service time frames shown in the table below. However, a request for prior notification could be considered an urgent claim (for example, care for a life-threatening condition). The request would then be subject to the urgent-care time frames shown in the table below.

A. Informal Inquiry

For any initial question concerning a prescription claim, an Enrolled Person should call Rx.com PBC at **(800) 772-8593** or send a written inquiry to 101 Jim Wright Freeway South, Fort Worth, Texas 76108-2202. The phone number and address are also listed on the Explanation of Benefits (EOB) forms and in the "General Plan Information" section of this Medical Program Description.

B. Formal Appeal

An Enrolled Person who wishes to formally appeal a Pharmacy Claim decision by the Pharmacy Benefit Administrator may do so through the following process:

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals, may be submitted by phone or facsimile. The appeal should set forth the reasons why the Enrolled Person contends the Pharmacy Benefit Administrator's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

   Appeal should be sent to:
   Rx.com PBC
   Attn: Appeals
   101 Jim Wright Freeway South
   Suite 200
   Fort Worth, Texas 76108
   Phone: 1-800-772-8593

2. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by someone different than the original decision maker and not a subordinate of the initial decision maker. If the Pharmacy Benefit Administrator considers, relies on or generates new or additional evidence in connection with its review of your claim on appeal, you will be provided the new or additional evidence free of charge as soon as possible and with enough time before a final determination is required to be provided to you (as described above) so that you will have an opportunity to respond. For non-urgent Pharmacy Claims Pre-Service appeals, the Pharmacy Benefit Administrator will mail a written decision to the Enrolled Person within fifteen (15) days after receipt of the written appeal. For an urgent claim appeal, you will be notified as soon as possible taking into account your medical condition, but no later than seventy-two (72) hours after receipt of the appeal by the decision maker. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based including:

   - information about your claim and the reason(s) the denial was upheld;

- the Program provisions on which the denial is based;
- an explanation of your right to request reasonable access to and copies of the relevant documents, records, and information used in the claims process without charge;
- a statement of your right to file a civil action under section 502(a) of ERISA;
- a statement indicating whether an internal rule, guideline, protocol or other similar criterion was relied on in deciding your claim and information explaining your right to request such information, free of charge;
- description of the Program's standard, if any, used in denying the claim;
- description of available internal appeals and external review processes; and
- disclosure of availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Health and Human Services, if any, to assist in internal claims, appeals and external review process.

Each appeal will be processed as quickly as possible taking into account the medical exigencies of each claim.

3. Furthermore, the Enrolled Person or their authorized representative has the right to reasonable access to, and copies of all documents, records and other information that are relevant to the appeal.

C. Post-Service Claims Appeal

An Enrolled Person who wishes to formally appeal a Post-Service Claims decision by the Pharmacy Benefit Administrator may do so through the following process (a rescission of coverage is also considered a claim denial that can be appealed):

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. This written appeal should set forth the reasons why the Enrolled Person contends the Pharmacy Benefit Administrator's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

   Rx.com PBC
   Attn: Appeals
   101 Jim Wright Freeway South
   Suite 200
   Fort Worth, Texas 76108
   Phone: 1-800-772-8593

2. After receipt of the written appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by someone different than the original decision maker and not a subordinate of the initial decision maker. If the Pharmacy Benefit Administrator considers, relies on or generates new or additional evidence in connection with its review of your claim on appeal, you will be provided the new or additional evidence free of charge as soon as possible and with enough time before a final determination is required to be provided to you (as described above) so that you will have an opportunity to respond. The Pharmacy Benefit Administrator will mail a written decision to the Enrolled Person within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list:

- the reason(s) the denial was upheld;
- the Program provisions on which the denial is based;
- an explanation of your right to request reasonable access to and copies of the relevant documents, records, and information used in the claims process without charge;
- a description of any voluntary appeal procedures offered by the Program;
- a statement of your right to file a civil action under section 502(a) of ERISA;
- a statement indicating whether an internal rule, guideline, protocol or other similar criterion was relied on in deciding your claim and information explaining your right to request such information, free of charge;
- description of the Program's standard, if any, used in denying the claim;
- description of available internal appeals and external review processes; and
- disclosure of availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Health and Human Services to assist in internal claims, appeals and external review process.

3. Furthermore, the Enrolled Person or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

D. Special Rules for Claims Related to Rescissions

A rescission is a cancellation of coverage with retroactive effect. However, some retroactive cancellations of coverage are not rescissions. Cancellations of coverage for failure to pay required employee contributions toward the cost of coverage on time are not rescissions. If your coverage is rescinded, you will receive written notice 30 days before the coverage will be cancelled. A rescission will be considered a claim denial that can be appealed according to the rules described above for Post Service Claim denials.

E. External Review Procedures— Health Care Reform

If your claim is still denied after appeal and you disagree with the Pharmacy Benefit Administrator's decision, you may submit your claim to the external appeal process described below only if (i) your claim relates to rescission of coverage; or (ii) your claim involves medical judgment (including, but not limited to, the Program's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit or a deter-

mination that a treatment is experimental or investigational), as determined by the external reviewer. This step is not mandatory. Note, however, that if a denial, reduction, termination, or refusal to provide payment for a benefit is based on a determination that a participant is not eligible under the Program, no external review is available.

In most circumstances, before you may submit your claim to the external appeal process, you must first follow the claims procedures outlined above by filing an initial claim and an appeal of a denied claim with the Pharmacy Benefit Administrator. However, in certain circumstances (described below), you may receive an expedited external review. In this case, you may not have to exhaust the internal claims process before filing a request for external review.

If the Pharmacy Benefit Administrator fails to adhere to the internal ERISA claims procedures described above and claims and appeals guidance issued by the Department of Labor, you may be deemed to have exhausted the internal claims and appeals process. If so, you may initiate an external review or bring suit under section 502 of ERISA, except that de minimus violations that do not cause, and are not likely to cause, prejudice or harm to you will not result in deemed exhaustion as long as the Program demonstrates that the violation was for good cause or due to matters beyond its control and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the Program. You may request written explanation of the violation from the Program and it will provide such an explanation, including a specific description of any bases for asserting that the violation should not result in deemed exhaustion within 10 days. If an external reviewer or court denies your request for immediate review because of this exception, you have the right to resubmit your claim for internal appeal. You will receive notification of this right within 10 days after your request for external review was denied.

Within 4 months of the date you receive notice that, after the second level of appeal, your claim continues to be denied, you may submit your claim to the external appeal process by writing to:

Rx.com PBC
Attn: External Review
101 Jim Wright Freeway South
Suite 200
Fort Worth, Texas 76108
Phone: 1-800-772-8593

Your written external appeal may include issues, comments, documents, records, and other information relating to your claim that you want considered in reviewing your claim.

Under the following circumstances, you can request an expedited external review:

- If you have received an initial claim determination that denied your claim, you may request expedited external review if (1) you filed a request for an urgent appeal AND (2) the time for completing the internal review process would seriously jeopardize life, health, or ability to regain maximum function.
- If you appealed your initial claim denial and received a final internal claim denial and the time for completing the standard external review process would seriously jeopardize life, health, or ability to regain maximum function.

1. **Preliminary Review of Standard (Not Expedited) External Claims.** Within 5 business days of receipt of the external review request, the Pharmacy Benefit Administrator will complete a preliminary review of your request to determine if your claim is eligible for external review. Your claim is eligible for external review if:

   - you are or were covered under the Program when the item or service was requested or provided,
   - the claim or appeal denial does not relate to your failure to meet the Program's eligibility requirements (exept in the case of rescissions),
   - you have exhausted the internal appeal process (unless you are not required to exhaust the internal claims procedures), and
   - you have provided all information and forms required to process external review.

   Within 1 business day after completion of the preliminary review, the Pharmacy Benefit Administrator will notify you in writing regarding whether your claim is eligible for external review. If your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the 4 month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.

2. **External Review Process.** If the Pharmacy Benefit Administrator determines your claim is eligible for external review, your claim will be assigned to an independent review organization. The independent review organization will notify you that your claim is eligible for external review and that the review process is beginning. The notice will also inform you that you have 10 business days following receipt of the notice to provide additional information to the independent review organization for it to consider.

   The independent review organization will not defer to the decisions made during the internal review process and will look at your claim anew. The independent review organization will consider all the information and documents that it receives in a timely manner when making its decision.

   The independent review organization will provide written notice of the final external review decision within 45 days after it receives the request for external review.

   If the independent review organization reverses the Pharmacy Benefit Administrator's denial of your claim, the decision will be

final and the Program must immediately provide coverage or payment.

The period during which your external appeal is brought and decided will not count against the time period permitted for you to bring a lawsuit (e.g., any applicable statute of limitations will be tolled). Submitting your claim to the external appeal process is not a prerequisite and does not prevent you from filing a civil action under section 502(a) of ERISA once the claim and review procedure has been completed.

3. **Expedited External Review Process.** In general, the same rules that apply to standard external review apply to expedited external review, except that the timeframe for decisions and notifications is shorter. An expedited external review is initiated when the prescribing provider or treating provider notifies the Pharmacy Benefit Administrator that the Enrolled Person's life or health is in jeopardy.

   Expedited Preliminary Review: The Pharmacy Benefit Administrator will immediately conduct a preliminary review to determine if your claim is eligible for external review. After the preliminary review is completed the Pharmacy Benefit Administrator will immediately notify you of the determination. If your request was not complete, the notice will describe information or materials needed to complete the request. You will have until the end of the 4 month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request.

   Expedited External Review: If your claim is eligible for expedited external review, your claim will be assigned to an independent review organization. The independent review organization will provide you its final decision as expeditiously as your medical condition or circumstances require, but in no event will the notification be provided later than 72 hours after the independent review organization receives the request for expedited external review. If the notice of the decision is not provided in writing, then the independent review organization must provide you with written confirmation of the decision within 48 hours after the notice of decision was first provided to you by other means.

F. General Rules

- Your initial claim, any request for review of an Adverse Benefit Determination, and any request for external appeal must be made in writing, except for requests for review of Adverse Benefit Determinations relating to urgent claims, which may also be made orally.
- You must follow the claim and review procedure contained in this booklet carefully and completely and you must file your claim before any applicable deadlines. If you do not do so, you may give up important legal rights.
- Your casual inquiries and questions will not be treated as claims or requests for a review or submissions to the external appeal process.
- You may have a lawyer or other representative help you with your claim at your own expense (the Pharmacy Benefit Administrator or the Plan Administrator may require written authorization to verify that an individual has been authorized to act on your behalf, except that for urgent claims a health care professional with knowledge of the claimant's medical condition will be permitted to act as an authorized representative).
- You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to any Adverse Benefit Determination. You will also be allowed to review the claim file and present evidence and written testimony as part of the internal claims process.
- You must comply with any additional requirements for filing a claim (e.g., using a specific claim form) imposed by the Pharmacy Benefit Administrator.

Determination for the Type of Service	Urgent Care Pre-Service	Prior Notification (Nonurgent)	Post-Service
The Pharmacy Benefit Administrator will notify you of the initial determination within	72 hours	15 days *(depending on the medical situation)*	30 days
The Pharmacy Benefit Administrator may ask for extension of	None	15 days	15 days
The Pharmacy Benefit Administrator must request any needed information within	24 hours	15 days	30 days
You can provide additional information within	48 hours	45 days	45 days
You have to request an appeal within	180 days	180 days	180 days
The Pharmacy Benefit Administrator will notify you of the determination on an appeal within	72 hours (*depending on the medical situation*)	15 days	30 days

Albertsons

Definitions

For reference, most terms defined in this section are capitalized throughout this Medical Program description. Other terms may be defined where they appear in this Medical Program Description. All Providers and Facilities must be licensed and/or registered by the state where the services are rendered and must be performing within the scope of license in order for the Program to provide benefits. Definitions in this Medical Program Description shall control over any other definition or interpretation unless the context clearly indicates otherwise.

Accidental Injury— an objectively demonstrable impairment of bodily function or damage to part of the body caused by trauma from a sudden, unforeseen external force or object, occurring at a reasonably identifiable time and place, and without an Enrolled Person's foresight or expectation, which requires medical attention at the time of the accident. The force may be the result of the injured party's actions, but must not be intentionally self-inflicted unless caused by a medical condition or domestic violence. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden.

Acute Care— Medically Necessary Inpatient treatment in a Licensed General Hospital or other Facility Provider for sustained medical intervention by a Physician and Skilled Nursing Care to safeguard an Enrolled Person's life and health. The immediate medical goal of Acute Care is to stabilize the Enrolled Person's condition, rather than upgrade or restore an Enrolled Person's abilities.

Adverse Benefit Determination— any denial, reduction, rescission or termination of coverage, or the failure to provide payment for services or ongoing treatment under this Medical Program.

Alcoholism— a behavioral or physical disorder manifested by repeated excessive consumption of alcohol to the extent that it interferes with an Enrolled Person's health, social, or economic functioning.

Alcoholism or Substance Abuse Treatment Facility— a Facility Provider that is primarily engaged in providing detoxification and rehabilitative care for Alcoholism, or Substance Abuse, or Addiction.

Ambulatory Surgical Facility (Surgery Center)— a Medicare Certified Facility Provider, with a staff of Physicians, which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis.
2. Provides treatment by or under the supervision of Physicians and provides Skilled Nursing Care while the Enrolled Person is in the facility.
3. Does not provide Inpatient accommodations appropriate for a stay of longer than twelve (12) hours.
4. Is not primarily a facility used as an office or clinic for the private practice of a Physician or other Professional Provider.

American Psychiatric Association— an organization composed of medical specialists who work together to ensure effective treatment for all persons with a mental disorder.

American Psychological Association— a scientific and professional organization that represents psychology in the United States.

Benefit Plan Year— the specified period of time in which an Enrolled Person's benefits for incurred Covered Services accumulate toward annual benefit limits, Deductible amounts and Out-of-Pocket Limits. The Benefit Plan Year begins June 1 and ends May 31.

Blue Cross of Idaho Health Services, Inc. (Blue Cross of Idaho or BCI)— a nonprofit mutual insurance company and Claims Administrator.

Claims Administrator— Blue Cross of Idaho and its affiliates, who provide certain claims administration services for the Medical Program.

Coinsurance— the percentage of the Maximum Allowance or the actual charge, whichever is less, an Enrolled Person is responsible to pay Out-of-Pocket for Covered Services after satisfaction of any applicable Deductibles or Copayments, or both.

Comprehensive Benefit Plan Year Maximum— the greatest aggregate amount payable by the Program on behalf of an Enrolled Person for all Covered Services during each Benefit Plan Year in which the Enrolled Person has been continuously enrolled or covered under the Program. Payments applied toward specific Lifetime Benefit Maximums also apply toward the applicable Comprehensive Benefit Plan Year Maximum.

Congenital Anomaly— a condition existing at or from birth, which is a significant deviation from the common form or function, whether caused by a hereditary or a developmental defect. In this Program, Congenital Anomalies include cleft lips, cleft palates, birthmarks, webbed fingers or toes, and other conditions that BCI may determine to be Congenital Anomalies. In no event will the term Congenital Anomaly include conditions relating to the teeth or intraoral structures supporting the teeth.

Copayment— a designated dollar and/or percentage amount, separate from Coinsurance, that an Enrolled Person is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered.

Covered Service— when rendered by a covered Provider, a service, supply, or procedure specified in this Program for which benefits will be provided to an Enrolled Person.

Custodial Care— care designated principally to assist an Enrolled Person in engaging in the activities of daily living; or services which constitute personal care, such as help in walking and getting in and out of bed, assistance in eating, dressing, bathing, and using the toilet; preparation of special diets; and supervision of medication, which can usually be self-administered and does not require the continuing attention of trained medical or paramedical personnel. Custodial Care is normally, but not necessarily, provided in a nursing home, convalescent home, rest home, or similar institution.

Deductible— the amount an Enrolled Person is responsible to pay Out-of-pocket before the Program begins to pay benefits for Covered Services. The amount credited to the Deductible is based on the Maximum Allowance or the actual charge, whichever is less. The Deductible starts over for each Benefit Plan Year, beginning June 1 and ending May 31.

Dental Services— the treatment of teeth and supporting structures, including but not limited to, the replacement of teeth.

Diagnostic Service— a test or procedure performed on the order of a Physician or other Professional Provider because of specific symptoms, in order to identify a particular condition, Disease, Illness, or Accidental Injury. Diagnostic Services, include but are not limited to:

1. Radiology services.
2. Laboratory and pathology services.
3. Cardiography, encephalography, and radioisotope tests.

Disease— any alteration in the body or any of its organs or parts that interrupts or disturbs the performance of vital functions, thereby causing or threatening pain, weakness, or dysfunction. A Disease can exist with or without an Enrolled Person's awareness of it, and can be of known or unknown cause(s).

Durable Medical Equipment— items which can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of Accidental Injury, Disease or Illness, and are appropriate for use in the Enrolled Person's home.

Effective Date— the date when coverage for an Enrolled Person begins under this Program.

Electroconvulsive Therapy (ECT)— Electroconvulsive Therapy (ECT) is a treatment for severe forms of depression, bipolar disorder, schizophrenia and other serious mental illnesses that uses electrical impulses to induce a convulsive seizure.

Emergency Medical Condition— a condition in which sudden and unexpected symptoms are sufficiently severe to necessitate immediate medical care. Emergency Medical Conditions, include but are not limited to, heart attacks, cerebrovascular accidents, poisonings, loss of consciousness or respiration, and convulsions.

Enrolled Person— an eligible employee or an eligible dependent covered under this Medical Program.

Formulary— A list of preferred prescription drugs chosen based on the drug's efficacy, safety and cost-effectiveness.

Homebound— confined primarily to the home as a result of a medical condition. The term connotes that it is "a considerable and taxing effort" to leave the home due to a medical condition and not because of inconvenience.

Home Health Agency— any agency or organization that provides Skilled Nursing Care services and other therapeutic services.

Home Health Aide— an individual employed by a contracting Hospice, under the direct supervision of a licensed registered nurse (R.N.), who performs and trains others to perform, intermittent Custodial Care services which include but are not limited to, assistance in bathing, checking vital signs, and changing dressings.

Home Health Care— the delivery of Skilled Nursing services under the direction of a Physician to a Homebound patient in their home on an intermittent basis. Home Health Care is generally intended to transition a Homebound patient from a hospital setting to a home or prevent a hospital stay.

Hospice— a Medicare Certified public agency or private organization designated specifically to provide services for care and management of terminally ill patients, primarily in the home.

Illness— a deviation from the healthy and normal condition of any bodily function or tissue. An Illness can exist with or without an Enrolled Person's awareness of it, and can be of known or unknown cause(s).

In-Network Services— Covered Services provided by a PPO In-Network Provider.

Inpatient— an Enrolled Person who is admitted as a bed patient in a Licensed General Hospital or other Facility Provider and for whom a room and board charge is made.

Intensive Outpatient Program— Intensive Outpatient Program (IOP) is a treatment program that includes extended periods of therapy sessions, several times a week for a minimum of three (3) hours per day, a minimum of three (3) days per week and a minimum of nine (9) hours per week. It is an intermediate setting between traditional therapy sessions and partial hospitalization.

Investigational— Any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational if, as determined by BCI, it fails to meet any one of the following criteria:

- The technology must have final approval from the appropriate government regulatory body. This applies to drugs, biological products, devices, and other products/procedures that must have approval from the U.S. Food and Drug Administration (FDA) or another federal authority before they can be marketed. Interim approval is not sufficient. The condition for which the technology is approved must be the same as that BCI is evaluating.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological changes related to a Disease, injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives.
- The technology must show improvement that is attainable outside the investigational setting. Improvements must be demonstrated when used under the usual conditions of medical practice.

If a technology is determined to be investigational, all services specifically associated with the technology, including but not limited to associated procedures, treatments, supplies, devices, equipment, facilities or drugs will also be considered investigational.

In determining whether a technology is investigational, BCI considers the following source documents: Blue Cross Blue Shield Association Technology Evaluation Center (TEC) assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by BCI, and Blue Cross of Idaho Medical Policies. BCI also considers, at its discretion, current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

BCI reserves the right to interpret the meaning of the terms used in this definition and any policies or procedures, which support this definition.

Licensed General Hospital— a short term, Acute Care, general hospital that:

1. Is an institution licensed in the state in which it is located and is lawfully entitled to operate as a general, Acute Care hospital.
2. Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians, for compensation from and on behalf of its patients.
3. Has functioning departments of medicine and Surgery.
4. Provides twenty-four (24)-hour nursing service by or under the supervision of licensed registered nurses (R.N.s).
5. Is not predominantly a:
    a. Skilled Nursing Facility
    b. Nursing home
    c. Custodial Care home
    d. Health resort
    e. Spa or sanatorium
    f. Place for rest
    g. Place for the aged
    h. Place for the treatment or rehabilitative care of Mental or Nervous Conditions
    i. Place for the treatment or rehabilitative care of Alcoholism or Substance Abuse or Addiction
    j. Place for Hospice care
    k. Residential Treatment Facility
    l. Transitional Living Center

Licensed Rehabilitation Hospital— a Facility Provider principally engaged in providing diagnostic, therapeutic, and physical rehabilitation services to Enrolled Persons on an Inpatient basis.

Lifetime Benefit Maximum— the greatest aggregate amount payable by the Medical Program on behalf of an Enrolled Person for specified Covered Services during all periods in which the Enrolled Person has been continuously enrolled or covered under the Medical Program. Payments applied toward specific Lifetime Benefit Maximums also apply toward the all-inclusive Comprehensive Benefit Plan Year Maximum.

Maximum Allowance— for Covered Services under the terms of this Medical Program, Maximum Allowance is the lesser of the billed charge or the amount established as the highest level of compensation for a Covered Service. If the Covered Services are rendered outside the state of Idaho by a Provider contracting with a Blue Cross and/or Blue Shield affiliate in the location of the Covered Services, the Maximum Allowance is the lesser of the billed charge or the amount established by the affiliate as compensation. If the Covered Services are rendered outside the state of Idaho by a Provider not contracting with a Blue Cross and/or Blue Shield affiliate in the location of the Covered Service, the Maximum Allowance is the lesser of the billed charge or the amount established by BCI as compensation for a Covered Service.

The Maximum Allowance is determined using many factors, including pre-negotiated payment amounts; diagnostic related groupings (DRGs); a resource based relative value scale (RBRVS); ambulatory payment classifications (APCs); the Provider's charge(s); the charge(s) of Providers with similar training and experience within a particular geographic area; Medicare reimbursement amounts; and/or the cost of rendering the Covered Service. Moreover, Maximum Allowance may differ depending on whether the Provider is PPO In-Network or Out-of-Network.

In addition, Maximum Allowance for Covered Services provided by contracting or noncontracting Dentists is determined using many factors, including pre-negotiated payment amounts, a calculation of charges submitted by contracting Idaho Dentists, and/or a calculation of the average charges submitted by all Idaho Dentists.

Medically Necessary (or Medical Necessity)— the Covered Services or supplies required to identify or treat an Enrolled Person's condition, Disease, Illness or Accidental Injury and which, as recommended by the treating Physician or other Covered Provider and as determined by BCI, are:

1. The most appropriate supply or level of service, considering potential benefits and harms to the Enrolled Person.
2. Proven to be effective in improving health outcomes:
    a. For new treatments, effectiveness is determined by peer reviewed scientific evidence;
    b. For existing treatments, effectiveness is determined first by peer reviewed scientific evidence, then by professional standards, then by expert opinion.
3. Not primarily for the convenience of the Enrolled Person or Covered Provider.
4. Cost-effective for this condition, compared to alternative treatments, including no treatment. Cost-effectiveness does not necessarily mean lowest price.

When applied to the care of an Inpatient, it further means that the Enrolled Person's medical symptoms or condition are such that the services cannot be safely and effectively provided to the Enrolled Persons an Outpatient.

The fact that a Covered Provider may prescribe, order, recommend, or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under this Program.

The term Medically Necessary as defined and used in this Program is strictly limited to the application and interpretation of this Program, and any determination of whether a service is Medically Necessary hereunder is made solely for the purpose of determining whether services rendered are Covered Services.

In determining whether a service is Medically Necessary, BCI considers the medical records and, the following source documents: Blue Cross Blue Shield Association Technology Evaluation Center (TEC) assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by BCI, and Blue Cross of Idaho Medical Policies. BCI also considers current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

Medicare— Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

Mental or Nervous Conditions— means and includes mental disorders, mental Illnesses, psychiatric Illnesses, mental conditions, and psychiatric conditions (whether organic or inorganic, whether of biological, nonbiological, chemical or nonchemical origin and irrespective of cause, basis, or Inducement). Mental and Nervous Conditions, include but are not limited to: psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

Non-Traditional Spouse— An individual to whom you certify that you have been issued a valid marriage license/certificate or civil union license/ certificate by a state that legally recognizes common law marriages, same sex marriages, domestic partner marriages or civil unions.

Occupational Therapy— treatment that employs constructive activities designed and adapted for a physically disabled Enrolled Person to help him or her satisfactorily accomplish the ordinary tasks of daily living and tasks required by the Enrolled Person's particular occupational role.

Organ Procurement— Diagnostic Services and medical services to evaluate or identify an acceptable donor for a recipient and a donor's surgical and hospital services directly related to the removal of an organ or tissue for such purpose. Transportation for a donor or for a donated organ or tissue is not an Organ Procurement service.

Orthotic Devices— any rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or Diseased body part.

Out-of-Nerwork Provider— a Professional Provider or Facility Provider that has not entered into an agreement with Blue Cross Blue Shield regarding payment for Covered Services rendered to an Enrolled Person under this PPO program.

Out-of-Nerwork Services— any Covered Services rendered by an Out-of-Network Provider.

Out-of-Pocket Maximum— The most each Enrolled Person must pay each applicable Benefit Plan Year toward the Maximum Allowance for Covered Services. After an Enrolled Person reaches the Out-of-Pocket Maximum, the Medical Program pays 100% of the Maximum Allowance for Covered Services for that Enrolled Person for the rest of the applicable Benefit Plan Year. The Highlights chart at the beginning of this document lists the Out-of-Pocket Maximum amounts.

The following expenses do not count toward your Benefit Plan Year Deductible or Out-of-Pocket Maximum:

- Copayments
- Ambulance transportation Deductible
- Inpatient admission Deductible
- Amounts exceeding the Maximum Allowance
- Health care services or supplies that are not covered under the Program or are not considered Medically Necessary
- Outpatient Prescription Drugs (except as described in the Prescription Drug Coverage section)
- Charges exceeding the maximum benefit provided for a specific type of service
- Penalties you pay for failing to comply with the prior notification process when prior notification is required

Outpatient— an Enrolled Person who receives services or supplies while not an Inpatient.

Partial Hospitalization Program— Partial Hospitalization Program (PHP) is a treatment program that provides interdisciplinary medical and psychiatric services. Partial Hospitalization Program (PHP) involves a prescribed course of psychiatric treatment provided on a predetermined and organized schedule and provided in lieu of hospitalization for a patient who does not require full-time hospitalization.

Pharmacy Benefit Administrator— Rx.com Pharmacy Benefit Coalition (PBC), and its affiliates, who provide certain claims administration services for the prescription care benefit in the Medical Program.

Physical Therapy— treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiologies principles, or devices to relieve pain, restore maximum function, or prevent disability following a condition, Disease, Illness, Accidental Injury, or loss of a body part.

Physician— a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine.

Plan— Albertson's LLC Health & Welfare Plan

Plan Administrator— Albertson's LLC

Post-Service Claim— any claim for a benefit under this Program that does not require Prior Notification before services are rendered.

PPO— Preferred Provider Organization

PPO In-Network Provider— a Provider that has entered into an agreement with Blue Cross Blue Shield regarding payment for Covered Services rendered to an Enrolled Person.

Preadmission Testing— tests and studies required in connection with an Enrolled Person's Inpatient admission to a Licensed General Hospital that are rendered or accepted by the Licensed General Hospital on an Outpatient basis. Preadmission tests and studies must be done prior to a scheduled Inpatient admission to the Licensed General Hospital, provided the services would have been available to an Inpatient of that hospital. Preadmission Testing does not include tests or studies performed to establish a diagnosis.

Prescription Drugs— drugs, biologicals, and compounded prescriptions that can be dispensed only according to a written prescription given by a Physician, that are listed with approval in the United States Pharmacopoeia, National Formulary or AMA Drug Evaluations published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription."

Pre-Service Claim— any claim for a benefit under this Program that requires Prior Notification before services are rendered.

Primary Care Giver— a person designated to give direct care and emotional support to an Enrolled Person as part of a Hospice Plan of Treatment. A Primary Care Giver may be a spouse, relative, or other individual who has personal significance to the Enrolled Person. A Primary Care Giver must be a volunteer who does not expect or claim any compensation for services provided to the Enrolled Person.

Prosthetic Devices— devices that replace all or part of an absent body organ, including contiguous tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body organ.

Provider— a person or entity that is licensed, where required, to render Covered Services. For the purposes of this Program, Providers include only the following:

1. Facility Providers
   a. Ambulatory Surgical Facility (Surgery Center)
   b. Contracting Alcoholism or Substance Abuse Treatment Facility
   c. Contracting Electroencephalogram (EEG) Provider
   d. Contracting Hospice
   e. Contracting Home Intravenous Therapy Company
   f. Contracting Licensed Rehabilitation Hospital
   g. Contracting Lithotripsy Provider
   h. Contracting Psychiatric Hospital
   i. Diagnostic Imaging Provider
   j. Freestanding Diabetes Facility
   k. Freestanding Dialysis Facility
   l. Home Health Agency
   m. Independent Laboratory
   n. Licensed General Hospital
   o. Prosthetic and Orthotic Supplier
   p. Radiation Therapy Center
   q. Skilled Nursing Facility
2. Professional Providers
   a. Ambulance Transportation Service
   b. Audiologist
   c. Certified Nurse-Midwife
   d. Certified Registered Nurse Anesthetist
   e. Chiropractic Physician
   f. Clinical Nurse Specialist
   g. Contracting Certified Speech Therapist
   h. Contracting Clinical Psychologist
   i. Contracting Licensed Clinical Professional Counselor (LCPC)
   j. Contracting Licensed Clinical Social Worker (LCSW)
   k. Contracting Licensed Marriage and Family Therapist (LMFT)
   l. Contracting Licensed Occupational Therapist
   m. Contracting Licensed Physical Therapist
   n. Dentist/Denturist
   o. Durable Medical Equipment Supplier
   p. Licensed Pharmacist
   q. Nurse Practitioner
   r. Optometrist/Optician
   s. Physician
   t. Physician Assistant
   u. Podiatrist
   v. Registered Dietician

Psychiatric Hospital— a Facility Provider principally engaged in providing diagnostic and therapeutic services and Rehabilitation Services for the Inpatient treatment of Mental or Nervous Conditions, Alcoholism or Substance Abuse or Addiction. These services are provided by or under the supervision of a staff of Physicians, and continuous nursing services are provided under the supervision of a licensed registered nurse (R.N.). A Psychiatric Hospital provides these services for compensation from and on behalf of its patients.

Recognized Transplant Center— a Licensed General Hospital that meets any of the following criteria:

1. Is approved by the Medicare program for the requested Transplant Covered Services.
2. Is included in the Blue Cross and Blue Shield System's National Transplant Networks.
3. Has an arrangement(s) with another Blue Cross and/or Blue Shield plan for the delivery of the requested Transplant Covered Services, based on appropriate approval criteria established by that plan.
4. Is approved by BCI based on the recommendation of BCI's Medical Director.

Residential Treatment Program — a twenty-four (24) hour level of care that provides Enrolled Person with long-term or severe mental disorders or Substance Abuse-related disorders with residential care. Care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs.

Respite Care — care provided to a Homebound Enrolled Person as part of a Hospice plan of treatment. The purpose of Respite Care is to provide the Primary Care Giver a temporary period of rest from the stress and physical exhaustion involved in caring for the Enrolled Person at home.

Rx.com Pharmacy Benefit Coalition (PBC) — Pharmacy Benefit Administrator and named claims fiduciary for prescription care.

Skilled Nursing Care— nursing service that must be rendered by or under the direct supervision of a licensed registered nurse (R.N.) to maximize the safety of an Enrolled Person and to achieve the medically desired result according to the orders and direction of an attending Physician. The following components of Skilled Nursing Care distinguish it from Custodial Care that does not require professional health training:

1. The observation and assessment of the total medical needs of the Enrolled Person.
2. The planning, organization, and management of a treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired result.
3. Rendering to the Enrolled Person, direct nursing services that require specialized training.

Skilled Nursing Facility— a licensed facility Provider primarily engaged in providing Inpatient Skilled Nursing Care to patients requiring convalescent care rendered by or under the supervision of a Physician. Other than incidentally, a Skilled Nursing Facility is not a place or facility that provides minimal care, Custodial Care, ambulatory care, or part-time care services; or care or treatment of Mental or Nervous Conditions, Alcoholism, or Substance Abuse or Addiction.

Substance Abuse or Addiction — a behavioral or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with an Enrolled Person's health, social, or economic functioning.

Surgery — within the scope of a Provider's license, the performance of:

1. Generally accepted operative and cutting procedures.
2. Endoscopic examinations and other invasive procedures using specialized instruments.
3. The correction of fractures and dislocations.
4. Customary preoperative and postoperative care.

Transplant — surgical removal of a donated organ or tissue and the transfer of that organ or tissue to a recipient.

Albertsons

GENERAL PLAN INFORMATION	
PLAN NAME	Albertson's LLC Health & Welfare Plan The Medical Program is one component of the Plan. The Albertson's LLC Health & Welfare Plan includes the Medical Program, Dental Program, Vision Program, Employee Assistance Program, Short Term Disability Program, Long Term Disability Program, Life Insurance Program and Flexible Spending Account Program.
PLAN NUMBER	650
TYPE OF PROGRAM	Medical
PROGRAM FUNDING	Self-Insured
CONTRIBUTION SOURCE	Company and employee contributions
EMPLOYER/PLAN SPONSOR	Albertson's LLC P.O. Box 20 Boise, ID 83726 Telephone: (208) 395-6200
EMPLOYER IDENTIFICATION NUMBER	82-0184434
AGENT FOR SERVICE OF PROCESS	Albertson's LLC c/o CT Corporation System Inc. 100 South Fifth Street, Suite 1075 Minneapolis, MN 55402 (612) 333-4315 (legal process may also be served on the Plan Administrator)
PLAN ADMINISTRATOR/NAMED FIDUCIARY EXCEPT WITH RESPECT TO CLAIMS	Albertson's LLC P.O. Box 20 Boise, ID 83726 Telephone: (800) 969-9688
ALBERTSON'S LLC BENEFITS ADMINISTRATIVE COMMITTEE AND/OR ALBERTSON'S LLC BENEFIT PLANS COMMITTEE	Albertson's LLC Attn: Director of Employee Benefits P.O. Box 20 Boise, ID 83726
PLAN YEAR (Benefit Plan Year)	June 1 through May 31
CLAIMS ADMINISTRATOR AND NAMED CLAIMS FIDUCIARY FOR MEDICAL CARE	BlueCross of Idaho P.O. Box 7408 Boise, ID 83707-1408 Telephone: (866) 283-6808
PHARMACY BENEFIT ADMINISTRATOR AND NAMED CLAIMS FIDUCIARY FOR PRESCRIPTION CARE	Rx.com PBC 101 Jim Wright Freeway South, Suite 200 Fort Worth, TX 76108-2202 Telephone: (800) 772-8593
TYPE OF ADMINISTRATION	Contract Administration
COBRA ADMINISTRATOR	PayFlex Systems USA, Inc. P.O. Box 2239 Omaha, NE 68103-2239 Telephone: (800) 359-3921

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Appendix A

ALBERTSON'S LLC

HEALTH & WELFARE PLAN

HIPAA PRIVACY AND SECURITY PROVISIONS

SECTION 1

INTRODUCTION

The Health Insurance Portability and Accountability Act of 1996, Public Law 104 191 ("HIPAA") and the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E ("Privacy Rule") provide that a covered health plan can only disclose protected health information to the sponsor of the plan if the plan's terms and provisions restrict the use and disclosure of the protected health information by the sponsor. HIPAA and the Security Standards and Implementation Specifications at 45 C.F.R. part 160 and part 164, subpart C ("Security Rule") provide that a covered health plan can only disclose electronic protected health information to the sponsor of the plan if the plan's terms require the sponsor to safeguard the electronic protected health information. Albertson's LLC ("Plan Sponsor"), sponsors the Albertson's LLC Health & Welfare Plan ("Plan"), to provide health care and a variety of other welfare benefits to eligible employees of Albertson's LLC.

SECTION 2

DEFINITIONS AND HYBRID ENTITY DESIGNATION

2.1. Definitions. When the following terms are used in these HIPAA provisions with initial capital letters, they shall have the meanings set forth below. Capitalized terms which are not specifically defined in these HIPAA provisions shall have the same meaning as those terms in the Privacy Rule, the Security Rule, or the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"):

2.1.1. Administrative Functions — shall include, but are not limited to, the following uses and disclosures:

(a) for the purposes of "payment," as that term is defined under 45 C.F.R. § 164.501 of the Privacy Rule;

(b) for "health care operations," as that term is defined under 45 C.F.R. § 164.501 of the Privacy Rule;

(c) to a Business Associate who has signed a contract limiting its ability to use and disclose PHI and requiring it to implement appropriate safeguards;

(d) to a covered health care provider, a covered healthcare clearinghouse, or another covered health plan for payment activities of such covered entity receiving the information;

(e) to another group health plan sponsored by the Plan Sponsor, which, with the Covered Entity, form an organized health care arrangement;

(f) to provide participants with information about treatment alternatives or other health related benefits and services that may be of interest;

(g) as Required By Law;

(h) to respond to court or administrative order, subpoena, discovery request or other lawful process if (i) the information sought is relevant and material to a legitimate law enforcement inquiry, (ii) the request is specific and limited in scope reasonably practicable in light of its purpose, and (iii) de-identified (as defined in the Privacy Rule) information could not reasonably be used;

(i) to public health authority, law enforcement officials or other appropriate government authority for public health activities; to lessen a serious and imminent threat to individual or public health or safety; to report abuse, neglect or domestic violence or other law enforcement purposes;

(j) to the extent authorized by and necessary to comply with workers' compensation laws or similar programs;

(k) to a health oversight agency for health oversight activities authorized by law;

(l) to the Secretary of the Department of Health and Human Services for the purpose of determining compliance with the Privacy Rule; and

(m) any other activities considered administrative functions under the Privacy Rule.

If Covered Entity is permitted or required to use or disclose Protected Health Information or Summary Health Information to a third party in accordance with the Privacy Rule, and an Identified Person is required to act on behalf of Covered Entity, then such use or disclosure by an Identified Person shall be considered an Administrative Function unless the Privacy Rule expressly provides that such use or disclosure is not considered an Administrative Function.

Administrative Functions shall not include: (i) employment related functions or functions in connection with any other benefits or benefit plan; and (ii) enrollment functions performed by the Plan Sponsor on behalf of its employees.

2.1.2. Business Associate — any entity or person who, on behalf of the Covered Entity, performs or assists in the performance of a function or activity involving the use or disclosure of PHI or uses PHI to provide services to the Covered Entity including legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services. It does not include any Identified Person or other member of the Employer's workforce.

2.1.3. Covered Entity — the self funded health care components of the Plan and, if applicable, any health insurance issuer or HMO with respect to a health care component.

2.1.4. Electronic Protected Health Information ("ePHI") — "Electronic Protected Health Information" shall mean information that comes within paragraph l(i) or l(ii) of the definition of "protected health information," as defined in 45 C.F.R. § 160.103.

2.1.5. HITECH Act — Title XIII of the American Recovery and Reinvestment Act of 2009, otherwise known as the Health Information Technology for Economic and Clinical Health Act.

2.1.6. Identified Persons — employees or classes of employees or other persons under Plan Sponsor's control identified in Schedule A to the extent they are performing Administrative Functions for or on behalf of Covered Entity. The Benefit Plans Committee, a member thereof, or the Director of Employee Benefits shall have the authority to amend Schedule A from time to time to add or remove Identified Persons from Schedule A.

2.1.7. Individually Identifiable Health Information or IIHI — health information including demographic information collected from an individual, that:

(a) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(b) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that either identifies the individual or with respect to which there is a reasonable basis to believe the information can be sued to identify the individual.

2.1.8. Privacy Rule — the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E. A reference to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.

2.1.9. Protected Health Information or PHI — Individually Identifiable Health Information ("IIHI"); provided that Protected Health Information shall not include IIHI contained in: (i) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) health care records of post secondary degree students, as described at 20 U.S.C. 1232g(a)(B)(iv); and (iii) employment records held or maintained by the Employer.

2.1.10. Required By Law — a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law. Required By Law includes, but is not limited to, court orders and court ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

2.1.11. Security Incident — "Security Incident" shall have the same meaning as the term "security incident" in 45 C.F.R. § 164.304.

2.1.12. Security Rule — the Security Standards and Implementation specifications at 45 C.F.R. part 160 and part 164, subpart C. A reference to a section in the Security Rule means the section as in effect or as amended, and for which compliance is required.

2.1.13. Summary Health Information ("SHI") — Individually Identifiable Health Information that summarizes the claims history, claims experiences, or type of claims experienced by individuals for whom benefits have been provided under the Covered Entity and from which certain identifiers have been deleted, except that geographic information may only be aggregated to the level of a five digit zip code.

2.2. Hybrid Entity Designation. The Plan is a "hybrid entity" (as that term is defined in the Privacy Rule) and is comprised, in part, of the following self funded "health care components" (as that term is defined in the Privacy Rule):

1. Medical Program;
2. Health Flexible Spending Account Program; and
3. Dental Program.

SECTION 3

USE AND DISCLOSURE OF PHI

3.1. Disclosure of PHI to Identified Persons Without Authorization. Subject to the minimum necessary requirement set forth in Section 3.5 and the Plan Sponsor certifying to the implementation of the requirements set forth in Section 4, Covered Entity may disclose PHI to Identified Persons to use and disclose for the purpose of performing Administrative Functions.

3.2. Disclosure of PHI to Plan Sponsor Without Authorization. Covered Entity may disclose PHI to Plan Sponsor for purposes of determining whether an individual is participating in the Covered Entity or, in the case of an insured health plan or HMO, is enrolled in or disenrolled from the Covered Entity.

3.3. Disclosure of SHI to Plan Sponsor Without Authorization. Without an authorization from the subject of the PHI, Covered Entity and Identified Persons may disclose SHI to Plan Sponsor only for purposes of:

(a) obtaining premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Covered Entity; or

(b) modifying, amending, or terminating the Covered Entity, any health care component of the Covered Entity, or the Plan.

3.4. Pursuant to an Authorization. Pursuant to an authorization that satisfies the requirements of the Privacy Rule and the HITECH Act, if and when applicable, Covered Entity may disclose PHI to Plan Sponsor, to an Identified Person, or to any other person identified in the authorization ("recipient") and such recipient may further use or disclose such PHI for any purpose

specified in the authorization. The terms of these HIPAA provisions (including but not limited to Sections 3 and 4) shall not apply to disclosures of PHI made pursuant to an authorization.

3.5. Minimum Necessary Use and Disclosure. Covered Entity shall make reasonable efforts to limit the disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure as required by the HITECH Act and any further guidance issued under the HITECH Act.

SECTION 4

CERTIFIED OBLIGATIONS OF PLAN SPONSOR

4.1. Certification. Plan Sponsor certifies that it has adopted and implemented the terms and provisions set forth in these HIPAA provisions.

4.2. PHI Certification. With respect to any PHI (other than enrollment/disenrollment information and SHI which are not subject to these restrictions) created, received, maintained, used or disclosed by the Plan Sponsor and/or any Identified Person from or on behalf of the Covered Entity, Plan Sponsor agrees to the following requirements and limitations:

(a) Prohibition on Unauthorized Use or Disclosure. Plan Sponsor and/or any Identified Person will not use or further disclose such PHI, except as permitted or required by these HIPAA provisions or as Required By Law.

(b) Subcontractors and Agents. Plan Sponsor will ensure that any agents, including a subcontractor, to whom such PHI is provided agree to the same restrictions and conditions that apply to Plan Sponsor.

(c) Prohibition on Employment Related Actions. Plan Sponsor and/or any Identified Person will not use or disclose such PHI for employment related actions and decisions in connection with any other benefit or employee benefit plan sponsored by Plan Sponsor.

(d) Duty to Report Violations. To the extent Plan Sponsor and/or an Identified Person becomes aware of any use or disclosure that is inconsistent with the uses or disclosures permitted under these HIPAA provisions, Plan Sponsor and/or the Identified Person will report such inconsistent uses or disclosures to Covered Entity.

(e) Access to PHI. Upon a request by a Participant, Plan Sponsor and/or any Identified Person responsible for handling requests for access will provide Participant with access to his or her PHI, in accordance with Covered Entity's privacy policies and procedures.

(f) Amendment of PHI. Upon a request by a Participant, Plan Sponsor and/or any Identified Person responsible for handling requests for amendment will respond to Participant's request and incorporate any approved amendments to such PHI, in accordance with the Covered Entity's privacy policies and procedures.

(g) Accounting of Disclosures. Upon a request by a Participant, Plan Sponsor and/or any Identified Person responsible for accounting for disclosures of PHI will provide such Participant with an accounting of disclosures, in accordance with the requirements of the Privacy Rule and the HITECH Act, if and when applicable.

(h) Inspection of Books and Records. Plan Sponsor will make internal practices, books, and records relating to the use and disclosure of such PHI available to the Secretary of the Department of Health and Human Services for purposes of determining Covered Entity's compliance with the Privacy Rule.

(i) Retention of PHI. Plan Sponsor and/or any Identified Person will, if feasible, return or destroy all such PHI that is maintained in any form and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made. If such return or destruction is not feasible, Plan Sponsor and/or any Identified Person will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) Firewall. Plan Sponsor will ensure that adequate separation between Covered Entity, Identified Persons, and Plan Sponsor is satisfied in accordance Section 5.

4.3. ePHI Certification. With respect to any ePHI (other than enrollment/disenrollment information and SHI which are not subject to these restrictions) created, received, maintained or transmitted by Plan Sponsor and/or any Identified Person from or on behalf of Covered Entity, Plan Sponsor agrees to the following requirements and limitations:

(a) Subcontractors and Agents. Plan Sponsor will ensure that any agents, including independent contractors and subcontractors, to whom ePHI is provided from the Covered Entity, agree to implement reasonable and appropriate security measures to protect the ePHI.

(b) Safeguards. Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity.

(c) Duty to Report Violations. Plan Sponsor will report to the Covered Entity any Security Incident of which it becomes aware, except that, for purposes of this reporting requirement, the term "Security Incident" shall not include inconsequential incidents that occur on a daily basis such as scans or "pings" that are not allowed past Plan Sponsor's firewall.

SECTION 5

ADEQUATE SEPARATION

5.1. Adequate Separation of Covered Entity, Identified Persons and Plan Sponsor. Covered Entity shall allow only the Identified Persons listed on Schedule A (as amended from time to time) to have access to or use of PHI.

5.2. Compliance Requirements.

5.2.1. Access and Use. Identified Persons shall have access to and use of PHI only for the purposes of performing Administrative Functions for the Covered Entity and certain other functions Required By Law. Plan Sponsor will ensure the adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures to the extent that Identified Persons have access to ePHI.

5.2.2. Compliance. For purposes of performing any Administrative Function, an Identified Person shall comply with the requirements of Section 4 and the privacy and security policies and procedures of the Covered Entity.

5.2.3. Resolution of Any Issues of Noncompliance. Identified Persons shall be sanctioned or disciplined up to and including termination of employment for failure to comply with the privacy and security policies and procedures of the Covered Entity.

SCHEDULE A

IDENTIFIED PERSONS

1. The person designated as the Privacy Officer: General Counsel
2. The person designated as the Security Officer: Chief Information Officer
3. The persons designated as the Albertson's LLC Benefit Plans Committee
4. The persons designated as the Albertson's LLC legal
5. The persons designated as the Albertson's LLC Human Resources and/or Labor Relations

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Appendix B

BridgeHealth Medical, Inc.

Surgery Benefit Management Program

The Medical Program component of the Albertson's LLC Health & Welfare Plan provides Enrolled Persons or Covered Persons access to the BridgeHealth Network when their treating physicians recommend certain covered medical procedures ("Covered Services") and they elect to receive treatment from medical providers participating in the BridgeHealth Network ('Providers"). BridgeHealth Medical, Inc. is a Surgery Benefit Management company offering access to Centers of Excellence for medically necessary cardiovascular surgeries, joint replacements, spinal surgeries, shoulder surgeries, Cyberknife, and many other procedures that can be scheduled and are approved by BridgeHealth.

The following types of cases are ideal for the Surgery Benefit Management (SBM) Program:

- Heart Bypass and Valve Surgery
- Knee and Hip Joint Replacement
- Shoulder Reconstruction
- Spinal Decompression
- Spinal Fusion
- Prostate Surgery
- CyberKnife® for discreet tumors

Eligibility

The BridgeHealth SBM Program is available to Enrolled Persons in Blue Cross of Idaho medical options (Low Deductible, Mid Deductible, Basic PPO, EPO or High Deductible Health Plan) or Covered Persons in Humana HMO.

To be eligible for the SBM Program, the following conditions must be satisfied:

- Albertson's LLC Medical Program coverage must be primary coverage for the Enrolled or Covered Person;
- The procedure must be a Covered Service under the Medical Program and determined to be medically necessary by the applicable Medical Program Claims;
- The service is approved by a BridgeHealth Network Provider and BridgeHealth;
- Use of the SBM Program for a particular Covered Service must be financially beneficial to both the Enrolled or Covered Person and the Medical Program, as determined by BridgeHealth.

Benefits of the Program

Enrolled or Covered Persons who have a qualifying Covered Service with a BridgeHealth Network Provider that has been approved by BridgeHealth for coverage under the SBM Program will have 100% coverage for the approved Episode of Care, without having to meet the Benefit Plan Year Deductible if it has not already been met. For the Blue Cross High Deductible Health Plan option, the Enrolled Person will be responsible for the Benefit Plan Year Deductible before the 100% coverage takes effect, so that they will not lose eligibility for health savings account contributions.

Covered Services may include the costs for the Episode of Care (defined below) for medically necessary (as determined by the applicable Claims Administrator) surgeries as well as the Travel Costs (defined below) for the Enrolled or Covered Person and a necessary companion. Travel Costs include transportation and lodging between the Enrolled or Covered Person's home location and the location where treatment is to be performed, hotel accommodations near the Provider, and a per diem for meals and incidental expenses related to medical travel. All transportation and lodging must be reserved and scheduled through BridgeHealth Medical.

Travel Costs

Travel costs for airfare and lodging include the following, as applicable:

- Round trip coach tickets for both the Enrolled or Covered Person and a necessary companion;
- Mileage will be provided instead of airfare in situations where the Enrolled or Covered Person's scheduled procedure is less than 100 miles from their home;
- One hotel room will be provided for the Enrolled or Covered Person and necessary companion during the duration of their stay that is deemed medically necessary by the Provider (if the Enrolled or Covered Person and necessary companion decide to arrive earlier or stay longer than is deemed medically necessary by the Provider, this will be at the Enrolled or Covered Person's and companion's expense and if an additional room is requested, this must be booked for and paid by the Enrolled or Covered Person or the companion and is not the responsibility of BridgeHealth or the Medical Program).

Meals and Incidentals

The per diem for meals and incidentals is calculated at $50 per person per day for the first 14 days of approved Travel. If the approved stay is 15 days or longer, the allowance will be $125 per person per week. The number of days that the Enrolled or Covered Person is required to be in-patient at a network facility will be deducted from the final calculation of the allowance. Allowances for meals and incidentals are only for the Enrolled or Covered Person and a necessary companion and are to be used for travel expenses such as meals, tips, taxis, rental car, checked baggage fees or other travel expenses incurred.

Episode of Care

The Episode of Care is the period of time from when the Enrolled or Covered Person first meets with their BridgeHealth destination Provider to the time the Enrolled or Covered Person is released to return home by the BridgeHealth Provider. During the Episode of Care, the SBM Program covers all approved physician fees, hospital fees, implants and lab work. Not included in the Episode of Care are:

- Any lab work, tests, x-rays or other images needed prior to the Episode of Care;
- Any rehabilitation that will be done once the Enrolled or Covered Person returns home;
- Any prescription that is written by the BridgeHealth Provider to be taken on the flight home or afterwards (e.g., blood thinners); and
- Any durable medical equipment that the patient takes home.

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Conditions for Receipt of Benefits

The Enrolled or Covered Person must agree to provide BridgeHealth with medical records it needs to determine eligibility for the BridgeHealth SBM Program. The Enrolled or Covered Person must also sign a consent form to participate in the Program.

Claims Procedures

When you use a BridgeHealth Network Provider for treatment, the Provider will submit the claim information on your behalf to BridgeHealth. BridgeHealth will provide payment for the Episode of Care directly to the Network Provider.

Tax Implications of Benefits

Certain portions of the BridgeHealth SBM Program benefits can be provided tax-free to Enrolled or Covered Persons, while other costs will be considered taxable income. See the chart below for additional information. You may wish to consult a tax expert with any specific questions.

Benefit Category	Details of Benefit	Tax Implications
Transportation	Round trip coach airplane ticket for Enrolled or Covered Person	Tax free if the transportation for the Enrolled or Covered Person is primarily for and essential to medical care
	Round trip coach airplane ticket for companion	Tax free (if companion's presence is necessary for medical reasons)
	Mileage in situations where the Enrolled or Covered Person's scheduled procedure is less than 100 miles from their home	Tax free when traveling to obtain medical care. The IRS announces the standard medical mileage rate each year.
Lodging	One room will be provided for the Enrolled or Covered Person and companion during their stay. If an additional room is requested this must be paid for by the Enrolled or Covered Person or the companion. If the Enrolled or Covered Person and companion decide to arrive earlier or stay longer than is deemed medically necessary by the provider, this will be at the Enrolled or Covered Person's and companion's expense.	Tax free ($50 per night for Enrolled or Covered Person and $50 per night for necessary companion) while away from home primarily for and essential to medical care if (1) the medical care is provided by a physician in a licensed hospital or medical care facility that is related to or the equivalent of a licensed hospital; and (2) there is no significant element of personal pleasure, recreation or vacation in the travel away from home. In other words, depending on the price of the room, you may be imputed with additional taxable income.
Allowance for meals and incidentals	You will receive an allowance for meals, taxis, tips, rental car, checked baggage fees, etc. The standard amount calculated for the first 14 days is $50 per day per person (including the Enrolled or Covered Person and up to one companion). For stays of 15 days or more the allowance will be $125 per person (including the Enrolled or Covered Person and up to one companion) per week. Days the patient is required to stay in-patient are deducted from the final calculation for the allowance.	You will be taxed on this meals and incidentals allowance.