Albertsons®

Health & Welfare Plan

Delta Dental PPO Option and Aetna DMO Option

Effective June 1, 2013

Dental Program Description

ALBERTSON'S LLC
DENTAL PROGRAM HIGHLIGHTS

Your Dental Options					
	Delta Dental PPO **800-356-7586** **www.deltadentalid.com**			**Aetna DMO** **877-657-9685** **www.aetna.com/docfind/custom/albertsons**	
Choosing a Dentist	You may choose any licensed dentist, but your out-of-pocket expenses will be lower when you use an in-network Delta Dental PPO dentist			When you enroll, you must choose a primary care dentist who is a member of the Aetna DMO network	
Annual Deductible	You meet the deductible for preventive services when you pay the first $25 of eligible expenses You meet the deductible for other services when you pay the first $50 of eligible expenses (including the $25 deductible for preventive services)			None	
Copayments	None			$10 per office visit	
What the Program Pays	PPO	Premier	Out-of-Network	In-Network	Out-of-Network
Maximum Annual Deductible per Family	$100	$150	$200	NA	NA
Preventive and Diagnostic Care	100%	80%	60%	100%	0%
Basic Restorative Care (fillings, simple extractions, minor surgery)	80%	70%	60%	90%	0%
Major Restorative Care (crowns, dentures, bridges)	50%	40%	30%	60%	0%
Maximum the Program Pays per Benefit Plan Year	$1,500	$1,000	$750	Unlimited	
Orthodontic Coverage					
Waiting Period for Coverage	12 Consecutive Months of Dental Coverage			None	
What the Program Pays	50% up to the $1,750 lifetime maximum benefit			You pay up to a maximum of $ 2,000 and the Program pays the rest	
Lifetime Maximum the Program Pays for Orthodontic Services	$1,750			Unlimited	

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Introduction

Albertson's LLC offers the Dental Program ("Program") to eligible employees of Albertson's LLC and certain affiliated companies (collectively "Employer" or "Company"). The Dental 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 Dental Program Rules document, together with your separate document entitled "Eligibility Rules Supplement" and your Rate Sheet and the Dental Program Rules documents, Eligibility Rules Supplements and Rate Sheets created for other employee groups, comprise the official Plan document for the Dental 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 Dental 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 Dental Program Rules document applies to all eligible active and former employees and their dependents enrolled in the Delta PPO or Aetna DMO Dental Program options, but not to eligible active and former employees and dependents enrolled in another Dental 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 Dental 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 Dental 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 Dental 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 or Insurer to rely upon the information you provide for purposes of enrollment or changes in your coverage elections under the Dental 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, Claims Administrator or Insurer may result in your retroactive termination from coverage under the Dental Program or retroactive termination of the coverage of your spouse and/or dependents. In addition, the Dental 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 Dental 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 Dental Program in accordance with its terms.

If you obtain benefits falsely, you will be required to reimburse the Dental 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 Dental Program coverage will take effect as of your eligibility date. You are required to pay a portion of the cost for benefits of the Dental 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 dental 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 Dental 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 any coverage, coverage can be delayed or denied, or a claim may not be paid.

Late Enrollment

If you do not enroll in the Dental Program when you first become eligible, you may not be able to participate in the Dental 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 Dental Program

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

Dependents

If you enroll in the Dental 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 Dental 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 Dental 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).

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 mental 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 or Insurer 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.

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 Dental 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 Dental 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 Dental 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 Delta 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 dental 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 dental 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 dental care coverage
- Change existing dental care coverage elections
- Change the dependents who you are covering
- Cancel your dental 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 Dental Program, so carefully review your Annual Enrollment materials and updated Summary Plan Description (SPD).

If your existing dental option is no longer available and you do not waive or elect other Dental 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 Dental 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.
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.
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 Dental 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 Dental 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 dental care coverage is no longer accessible to you (e.g., you move away from the area served by the DMO), 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. 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 dental coverage sponsored by a governmental or educational institution, including the following: • A state's children's health insurance program (CHIP) • A dental 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. Note that no changes are permitted due to gain of coverage under any group dental coverage sponsored by a governmental or educational institution, unless it qualifies as another Permitted Election Change (e.g. Medicaid or employment status change).

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. 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 dental 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 of the event may result in denial of your change request.

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.

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 Dental Program. One child turns 26 and therefore loses eligibility under the Dental

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 Dental 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 Dental Program. Chris marries. Chris's wife elected employee only dental coverage from her employer's health plan prior to their marriage. Chris may either cancel coverage under the Albertson's LLC Dental 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 Dental Program. 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 Dental 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 dental coverage for a child, your child will be enrolled in the same Dental Program option in which you are enrolled. If you are an eligible employee not enrolled in any Dental Program option, you and the child specified in the order will be enrolled in the Dental Program option you choose (if you do not make an election, you and the child specified in the order will be defaulted into the Delta PPO option). The entire cost to you for such QMCSO coverage will be deducted from your pay automatically.

Paying For Your Coverage

You are required to pay a portion of the cost for benefits of the Dental 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.

Paying for Your Coverage with Pre-tax Dollars

You can make your employee contribution payments for Company sponsored Dental Program coverage with "pre-tax" dollars.

Under current tax law, Albertson's LLC can pay for your share of the contributions for Dental 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 Dental Program coverage. You do not need to complete a separate or an additional enrollment form to have dental 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 Dental 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 Dental 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 dental 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
- 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 Dental 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 Dental Program benefits your Non-Traditional Spouse receives from the Dental 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 Dental 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 Dental Program benefits your Non-Traditional Spouse's children receive from the Dental 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

Dental Care Coverage During an Approved Leave of Absence

During certain approved leaves of absence, your dental 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 Dental Program coverage. You can make your employee contribution payments 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

Dental care coverage will be continued during an approved FMLA leave, for employees enrolled in and receiving dental 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 dental 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 dental care coverage will terminate on the first day of your approved General Leave of Absence.

Military Leave

During military service, dental 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 dental 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 Dental 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 Dental 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 dental coverage under the benefit requalifica-tion 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 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 dental 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.

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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.

Dental Care Coverage During an Unapproved Leave of Absence

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

- You fail to make the required contributions to the Dental 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 Dental 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 Dental 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 Dental 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 Dental 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 Dental 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 dental benefits during an approved disability leave.

Your coverage may continue under the Dental 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 mid-year 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 dental benefits under COBRA as indicated in the "Continuing Your Coverage Under COBRA" section

Converting Coverage

Coverage under the Dental 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 Dental 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 Dental 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.

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.

Extended COBRA Coverage

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

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 Dental 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 Dental 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 IS 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 Dental 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 Dental 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 Dental Program and does not offer any other group dental 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 Dental 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 Dental 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 COBRA 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**.

Claims Procedures for Eligibility, Contributions and Plan Administrative Claims Determinations

For a dispute concerning your eligibility to participate in the Dental 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.

General Rules

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 Dental Program and to determine all factual and legal questions under the Dental 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 Dental 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 Benefit Claims Procedures below), 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 Dental Program (including those in the Benefit Claims Procedures below). In addition, in any legal action brought after you have exhausted administrative remedies, all determinations made by the Benefits Administrative Committee, the Benefit Plans Committee, the Claims Administrator or the Insurer 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 Benefit Claims 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 Dental Program, see the Benefit Claims Procedures in the following sections.

Other Important Information

Your ERISA Rights

As a participant of the Dental Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Dental 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 Dental Program and a copy of the latest annual report (Form 5500 Series) that the Dental 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 Dental 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 Dental 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 Dental 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 Dental Program on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Dental Program participants, ERISA imposes duties upon the people who are responsible for the operation of the Dental Program. The people who operate your Dental Program, called "fiduciaries" of the Dental Program, have a duty to do so prudently and in the interest of you and other Dental 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 Dental 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 Dental Program's claims procedures. In addition, if you disagree with the Dental 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 Dental Program fiduciaries misuse the Dental 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 Dental 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 Dental Program that are not answered in this booklet, you are encouraged to contact the Claims Administrator, Insurer 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 Dental 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 Dental 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 Dental 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 Dental 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 Dental Program;
3. prepare and distribute information to you explaining the Dental Program;
4. receive from you and any other parties the necessary information for the proper administration of eligibility requirements under the Dental Program;
5. receive, review, and maintain reports of the financial condition and receipts and disbursements of the Dental 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 Dental 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 Dental Program, except with respect to claim for benefits determinations where final authority has been delegated to the Claims Administrator or Insurer, as applicable.

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

The Dental 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 Delta Dental PPO option of the Dental Program is funded through the Employer's general assets by contributions from the Employer and/or employees. The Aetna DM0 option of the Dental Program is fully insured and the Employer and employees contribute toward the cost of coverage.

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 Dental Program will be governed by the laws of the State of Idaho.

Collective Bargaining Agreements

The Dental 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.

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How the Dental Program Works

Highlights

This Dental Program Description explains two dental options: Delta Dental PPO and Aetna DMO.

Delta Dental's PPO option pays a percentage of eligible services after you meet a deductible and you may use any licensed dentist. However you will generally save money by using dentists who are members of the Delta Dental's PPO network because these dentists have agreed to accept Delta Dental's payment and the patient's copayment as payment in full for covered services. You may utilize dentists who are members of the Delta Dental's Premier network and obtain lower in-network level of benefits. If your dentist is not a member of the Delta Dental's PPO or Premier networks, you will receive the lowest, out-of-network benefit level and the dentist may charge you more than the network negotiated fee schedule.

The Aetna DMO (dental maintenance organization) option is similar to a Dental HMO. It provides a high level of coverage, but you must receive all your care from a primary care dentist who is a member of the Aetna DMO. Care from a dentist who is not a member of the Aetna DMO will not be covered. The Aetna DMO may not be available in some zip code areas.

Both dental options offer the following:

- Preventive care
- Most necessary dental services
- An identification card, which should be presented to providers to obtain benefits

Keep in mind that benefits under either option are covered only for the most cost-effective treatment that produces a professionally adequate result. If you incur charges for more expensive treatment than accepted dental standards require, only the amount for the less costly treatment will be paid. To be covered, services and supplies must be dentally necessary, in keeping with accepted dental practice, and provided by a licensed dentist or other licensed practitioner acting under the direction of a licensed dentist.

Dentally necessary means a service or supply as determined by Delta Dental or Aetna that meets established criteria, including but not limited to the following:

- It is consistent with and appropriate for the diagnosis or treatment of the patient's condition.
- It is of proven value.
- It is not primarily for the convenience of the provider or patient.

Your dental benefits are subject to coordination or benefits and right of reimbursement provisions. (See "Benefit Claims Procedures")

About the Delta Dental PPO Option

If you enroll in the Delta Dental PPO option, you may choose any licensed dentist that you prefer. This is a preferred provider organization plan (you choose the dentist for services), so you should keep in mind that your choice of dentist will affect your Dental Program benefits.

Your out-of-pocket costs are likely to be the least if you go to a Delta Dental PPO Participating dentist (an in-network PPO dentist). PPO dentists have agreed to accept payment according to the PPO dentist schedule, and in most cases this results in a reduction of their fees. By using PPO dentists you will have the lowest family maximum deductible, will receive the highest reimbursement rates for covered services and will have the highest annual maximum that the Dental Program will pay for covered services.

If you go to a non-PPO dentist who participates with Delta Dental's Premier program, the fee reduction may not be as great as with the PPO dentists. However, Premier participating dentists agree to accept Delta Dental's payment and your copayment as payment in full. If you use a Delta Premier dentist, your family maximum deductible is higher, the reimbursement rates for covered services are lower and the annual maximum the Dental Program will pay for covered services is lower than the amounts for PPO dentists.

If you choose an out-of-network dentist who isn't participating in either program, you will be responsible for any difference between Delta Dental's allowed fee and the nonparticipating dentist or the out-of-country dentist submitted fee, in addition to any copayment. By using out-of-network dentists you are subject to the highest family maximum deductible, the lowest reimbursement rates for covered services and the lowest annual maximum that the Plan will pay for covered services.

See the chart on the inside cover of this Dental Program description for details on coverage differences between PPO dentists, Premier dentists and the out-of-network dentists.

Choice of Provider

You choose your provider. Four types of dentists are available to you.

1) Delta Dental's PPO Dentist

- Is a dentist who has signed an agreement with Delta Dental in his or her state to participate in the PPO network
- Has agreed to accept the PPO dentist fee schedule
- Has agreed to accept direct payment from Delta Dental, the Claims Administrator
- Will submit claims for you and charge you only for copayments, deductibles, and services that are not covered by the Dental Program
- Will explain services that aren't covered before the service is provided so that you or your dependents will not be surprised by the charges

2) Delta Dental's Premier Dentist

- Is a dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in the DeltaPremier network
- Has agreed to accept direct payment from Delta Dental, the Claims Administrator
- Has agreed to accept Delta Dental's maximum approved fee
- Will submit claims for you and charge you only for copayments, deductibles, and services that are not covered by the Dental Program
- Will explain services that aren't covered before the service is provided so that you or your dependents will not be surprised by the charges

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3) Nonparticipating or out-of-network Dentist

- Is a dentist who has not signed an agreement with Delta Dental to participate in any network
- Will charge you according to his or her normal practice fees, which may be more than the nonparticipating dentist fee
- May or may not submit the charges to the Dental Program for you
- May not accept payment directly from Delta Dental
- All payments for a nonparticipating dentist will be based on the lesser of the submitted fee or the nonparticipating dentist fee. The payments are sent to you.

4) Out-of-Country Dentist

- Is a dentist whose office is located outside of the United States and its territories
- Out-of-country dentists are not eligible to sign participating agreements with Delta Dental.
- Payment is based on the lesser of the submitted fee or the out-of-country dentist fee
- Payment will usually be sent to you

For more information regarding Delta Dental's PPO network dentists and Delta Dental's Premier network dentists, call Delta Dental member services at **(800) 356-7586** or visit the Delta Dental Website at www.deltadentalid.com. Provider lists are furnished automatically, without charge, upon request.

Maximum Approved Fees

The Maximum Approved Fee is established in a system that Delta Dental uses to determine the approved fee for a given procedure for a given Delta Dental Premier network dentist. A fee meets Maximum Approved Fee requirements if it is the lowest of:

- The Submitted Amount.
- The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service, irrespective of Dentist's contractual agreement with another dental benefits organization.
- The maximum fee that the local Delta Dental Plan approves for a given procedure in a given region and/or specialty, under normal circumstances.

Delta Dental may also approve a fee under unusual circumstances. Participating Dentists are not allowed to charge Delta Dental patients more than the Maximum Approved Fee for the Covered Service. In all cases, Delta Dental will make the final determination about what is the Maximum Approved Fee for the Covered Services.

What the Delta Dental PPO Option Covers

The schedule that follows shows covered items in the left-hand column. Limitations apply to covered items and are shown in the right-hand column. Coverage is excluded for certain services and supplies, regardless of whether they are considered necessary by you or your provider (see "What the Delta Dental PPO Option Does Not Cover").

Covered Items	Limitations
Preventive and Diagnostic	
Oral exam, including cleaning and scaling of teeth	Maximum of 2 times in a Benefit Plan Year (Employees with Type II Diabetes are eligible to receive 4 cleanings in a Benefit Plan Year)
Dental x-rays — full mouth (includes bitewings and panograhic	Once every 5 years
Supplemental bitewing x-rays	Maximum of 1 time every 24 months
Fluoride treatment	Maximum of 1 time in a Benefit Plan Year; for children under age 19 only (does not include fluoride rinses, self-applied fluorides, or desensitizing medicaments)
Sealants (applies to all posterior teeth occlusal surfaces, including bicuspids)	Sealants are payable once in a 3-year period
Fitting and installing initial space maintainer, including adjustments after 6 months	To replace prematurely lost teeth for children under age 18 only, repairs and duplicates not covered.
Emergency or urgent treatment to temporarily relieve pain	None

Covered Items	Limitations
Basic	
Extractions of teeth, including preoperative and postoperative care	None
Oral surgery, including preoperative and routine postoperative care	None
Osseous surgery	Once per quadrant per 3-year period
Minor restorations, including amalgam, acrylic, synthetic porcelain, and composite fillings for diseased or accidentally broken teeth	Once per surface in any 24-month period
Endodontic treatment (root canal and pulp infection therapy)	None
Periodontics — treatment of gum disease and gingival curettage	Once in 3-year period
Periodontal scaling and root planing	Once per quadrant in a 24-month period
Repair and recementing of crowns, onlays	More than 6 months after installation or 12 months after recementation
Dental treatment for temporomandibular joint disorder (TMJ)	Medical services or supplies for TMJ are not covered by the Dental Program
Occlusal guard	Once every 24 months, bruxism only, repairs, relines, replacements, or adjustments are not covered.
Occlusal adjustment	Not Covered
Major	
Stayplate if done within one month of extractions	To replace missing permanent anterior teeth during healing process or for children under age 16 only
Crowns	Prefabricated crowns not covered as final restoration of a permanent tooth
Initial installation of onlays or crown restorations to restore diseased teeth	If extensive decay prevents successful use of direct fi lling (porcelain, porcelain substitute, and cast restoration not covered for children under age 12)
Replacement of onlays, gold fi llings, or crown restorations	If existing crown cannot be made serviceable and if it is at least 5 years old
Porcelain crowns on posterior teeth	Dental Program will pay only the applicable amount that it would have paid for a porcelain fused to metal crown
All porcelain bridge	Covered as the porcelain fused to metal equivalent
Veneers	Covered by review if crown criteria is met
Dentures	
Initial installation of partial or full removable dentures	Limited to once in a 5-year period.
Repair and adjustment of a complete denture	More than 6 months after installation of an initial or replacement denture (reline or replacement of denture base limited to once every 24 months)
Replacement of partial or complete denture	Only if denture is at least 5 years old and cannot be made serviceable
Bridgework	
Initial installation of fixed or removable bridgework, including crowns as abutments to replace one or more natural teeth. Please note that the cost towards the implant is applicable to the patient's annual maximum amount.	Limited to once in a 5-year period.
Replacement of fixed or removable bridgework	Only if the existing bridgework cannot be made serviceable and the bridge is at least 5 years old
Implants	An implant body, implant abutment, and the prosthesis placed on the implant are a covered benefit. The implant body and implant abutment will have a lifetime benefit per implant. All implants placed in an edentuloous will have a lifetime benefit per arch. All prosthesis placed on an implant will be covered up to the cost of a standard prosthetic. Removal of implant or repair to an implant abutment is Not Covered. All procedures directly related to the implant will be benefited at 50% up to a maximum of $900 per lifetime per implant. The $900 allowance will go against the Program's annual maximum. All implant procedures are subject to all waiting periods for major (class III) services.
Orthodontics*	
For preventing tooth irregularities or malocclusion of the jaw, including appliance therapy * Wait period required. Eligibility based on 12 consecutive months of dental coverage.	**Limited to procedures required for:** • Correction of overbite or overjet • Maxillary and mandibular arches in either protrusive or retrusive relation • Cross bite • An arch length discrepancy in either the maxillary or mandibular arch • Bimaxillary protrusion

Limitations of the Delta Dental PPO Option

The benefits for the following services are limited as follows. All charges for the following services will be the responsibility of the employee:

- A crown or onlay is a covered benefit only for extensive loss of tooth structure due to caries and/or fracture.
- An individual crown over an implant is payable at the prosthodontic benefit level.
- Orthodontic (Class IV) benefit limitations:
  a. If the treatment plan is terminated before completion of the case for any reason, the Dental Program's obligation will cease with payment to the date of termination.
  b. The dentist may terminate treatment, with written notification to Delta Dental and to the patient, for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment of benefits ends on the last day of the month in which the patient was last treated.
- The Dental Program's obligation for payment of benefits ends on the last day of employment, but will make payment for covered services provided on or before the last day of termination, as long as it receives a claim for those services within one year in which the services were completed.
- When services in progress are interrupted and completed later by another dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each dentist.
- Care terminated due to the death of an employee or eligible dependent will be paid to the limit of the Dental Program's liability for the services completed or in progress.
- Optional treatment: If you select a more expensive service than is customarily provided or for which Delta Dental does not determine a valid dental need is shown, the Dental Program can make an allowance based on the fee for the customarily provided service.

For example, if a tooth can be satisfactorily restored with a regular filling and you choose to have the tooth restored with a more costly material or an inlay, the Dental Program will pay only the amount that it would have paid to restore the tooth with regular filling material. You are responsible for the difference in cost.

Listed below are some other examples of common optional services. Remember that you are responsible for the difference in cost for any optional treatment.

- Porcelain crowns on posterior teeth — the Program will pay only the applicable amount that it would have paid for a porcelain fused to metal crown.
- Overdentures — the Program will pay only the applicable amount that it would have paid for a conventional denture.
- Porcelain/ceramic onlay — the Program will pay only the applicable amount that it would have paid for a porcelain fused to metal crown.
- Inlay — the Program will pay only the applicable amount that it would have paid for an amalgam or resin restoration (depending on the tooth being restored).
- Amalgam and resin restorations are payable once within a 24-month period, regardless of the number or combination of restorations placed on a surface.
- Core build-ups and other substructures are benefits only when needed to retain a crown on a tooth with excessive breakdown due to caries and/or fractures.
- Recementing a crown, onlay, space maintainer, or bridge within 6 months of the seating date or within 12 months of payment for recementing by the same dentist or dental office.
- Retention pins are covered benefits once in a 24-month period. Only one substructure per tooth is a covered benefit.
- Benefits for root planing are payable once in any 2-year period. Periodontal surgery, including subgingival curettage, is payable once in any 3-year period by the same dentist or dental office.
- Tissue conditioning is not a covered benefit more than once per arch in 24 months.
- The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
- Prophylaxes (cleanings) and oral examinations. These services are payable twice in a Benefit Plan Year, except when medically necessary following specified periodontal procedures. In these cases, prophylaxes (including periodontal prophylaxes) may be provided up to four times in the 12 consecutive months immediately following the completion date of the periodontal treatment plan.

  Delta Dental determines payment eligibility by researching the patient's history for the 12 months previous to the current date of service.
- Brush Biopsy oral cancer detection is covered as a diagnostic service under this Program. Note, the biopsy service the dentist performs is covered under the Dental Program while the lab fee would be a medical expense.

The limitations above apply to services provided by PPO, Premier and out-of-network dentists.

All charges from nonparticipating (out-of-network) dentists for services above the nonparticipating dentist fee will be the responsibility of the employee.

What the Delta Dental PPO Option Does Not Cover

Delta Dental will not pay for the following services. All charges for the following services are the employee's responsibility (though the employee's payment obligation may be satisfied by other insurance or some other arrangement for which the employee is eligible):

- Services or appliances received or started before becoming covered under the Dental Program

- Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion; or for implantology techniques or periodontal splinting. If orthodontic benefits have been selected, this exclusion will not apply to those benefits as limited by the terms and conditions of the Dental Program.
- Services that are not in accordance with accepted dental practice or appropriate for treatment of the patient's condition
- Veneers, unless crown criteria is met through review
- Prescription drugs and medicines, premedications, medicaments/solutions, and relative analgesia or charges that are covered by a healthcare plan
- Services that are covered by workers' compensation or employer disability programs or for services provided by governmental agencies (other than Medicaid)
- Items that you are not legally obligated to pay for or for which no charge would be made in the absence of coverage
- Services or supplies that are experimental
- Services that are needed as a result of war or an act of war, riots, civil disobedience, intentionally self-inflicted injury, criminal acts, or atomic or thermoneuclear explosion or resulting radiation
- Plaque-control programs, education, training, supplies, or counseling on diet, nutrition, or personal oral hygiene
- Dental services for cosmetic reasons, personalization, or characterization of dentures for precision attachments, temporary dental procedures, replacement of any lost, missing, or stolen appliances, or other services or supplies that are not listed under "What the Delta Dental PPO Option Covers" earlier in this booklet
- Claims that are not submitted within one year following the year services were rendered.
- Charges for missed appointments or for completing claim forms
- Services for correction of congenital or developmental malformations, cosmetic surgery, or dentistry for aesthetic reason
- Charges for hospitalization, laboratory tests, and histopathologic examinations
- Services, as determined by Delta Dental, for which no valid dental need can be demonstrated, that are specialized techniques, or that are investigational in nature as determined by the standards of generally accepted dental practice
- Treatment by other than a dentist, except for services performed by a licensed dental hygienist under the scope of his or her license
- Those benefits excluded by the policies and procedures of Delta Dental, including the processing policies
- Services that are covered under a hospital, surgical/medical, or prescription drug program
- A space maintainer, for maintaining space due to the premature loss of the anterior primary teeth
- Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers
- Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position
- A prefabricated crown used as a final restoration on a permanent tooth
- A substructure to a single/abutment crown over an implant
- A paste-type root canal filling on a permanent tooth
- Chemical curettage
- Services associated with overdentures
- A metal base on a removable prosthesis
- The replacement of teeth beyond the normal complement of teeth
- Temporary appliances
- A posterior bridge in conjunction with a partial denture in the same arch
- Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ)
- Diagnostic photographs and cephalometric films, unless done for orthodontics.
- Myofunctional therapy
- Mounted case analysis
- The fee for a consultation that is part of the fee for the examination and/or diagnostic procedure(s)
- Local anesthesia
- Acid etching, cement bases, cavity liners, and a base or temporary filling
- Infection control
- Temporary crowns
- Gingivectomy as an aid to the placement of a restoration
- The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces
- Diagnostic casts are allowed only when done in conjunction with orthodontics. They are considered to be a part of the fee for restorative or prosthodontic procedures.
- Palliative treatment, when any other service is provided on the same date except x-rays and tests necessary to diagnose the emergency condition
- Postoperative radiographs, when done following any completed service or procedure

- Periodontal charting
- A pulp cap when done with a sedative filling or any other restoration. A sedative or temporary filling when done with the opening and drainage of a tooth or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done on the same day a root canal is initiated.
- A pulpotomy on a permanent tooth, except on a tooth with an open apex
- A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed
- Retreating a root canal by the same dentist or dental office within 24 months of the original root canal treatment
- A prophylaxis, when done on the same day as root planing. Root planing, when done on the same day as subgingival curettage.
- An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard. Replacement, repair, refines, or adjustments of occlusal guards
- Refine, rebase or any adjustment or repair within six (6) months of the delivery of a partial denture
- Tissue conditioning, when performed on the same day as the delivery of a denture or the refine or rebase of a denture

About the Aetna DMO Option

The Aetna Dental Maintenance Organization (the Aetna DMO) is similar to a medical HMO, and eligibility depends upon your home zip code.

This coverage option allows for many of the charges for the preventive and corrective dental care that you and your dependents receive. Not all charges are eligible, and some charges are eligible only to a limited extent. There is no annual or lifetime maximum.

If you enroll in the Aetna DMO option, you select your primary care dentist (PCD) from those who have contracted with Aetna DMO in your area. Under the Aetna DMO option, the services provided are determined between you and your dentist. Aetna has arranged for primary care dentists and participating specialist dentists to furnish the necessary dental services under this coverage. This is similar to an HMO in that you will then use your primary dentist for all services unless he or she refers you to another Aetna DMO dentist for specific services.

If you want to change from one Aetna DMO primary dentist to another, you may do so by notifying Aetna on or before the 15th day of the month. Your change is effective on the first day of the following month.

With the Aetna DMO, you do not need to submit claim forms. Your dentist will charge you only for the copayment. Claims for services and supplies must meet one of the following conditions:

- They must be provided by the person's primary care dentist at the dental office location.
- They must be given by a participating specialist dentist for a dental condition that requires specialized care if the care is not available from the person's primary care dentist, and if the primary care dentist referred the covered person to the participating specialist dentist, and provided Aetna approves coverage for the treatment. This care is called referral care.
- In most cases, if a nonparticipating dental provider gives the services and supplies, they are covered only in the case of out-of- area emergency dental care. Rules for payment of services provided by a nonparticipating dental provider may differ depending on where you are located. Contact Aetna member services for more information.

Services that are not covered by the DMO will not be provided unless you receive specific prior approval.

Your dental benefits are subject to coordination of benefits and right of reimbursement provisions explained in "Benefit Claims Procedures."

More information regarding the Aetna DMO is available through Aetna DMO member services at **(877) 657-9685** or on the Web at www.aetna.com.docfind/custom/albertsons.

What the Aetna DMO Option Covers

This coverage pays benefits to designated primary care dentists and participating specialist dentists for covered dental expenses.

Aetna DMO Dental Care Schedule

The following schedule shows the frequency of covered services that the DMO pays for when provided by designated primary care dentists and participating specialist dentists.

Primary Care Dentist Services

Preventive, Diagnostic, and Basic Services

Generally, preventive and diagnostic services are paid at 100%. Basic services are generally paid at 90%.

Visits and Exams

- Office visit for oral examination (limited to 4 visits per calendar year)
- Emergency palliative treatment
- Prophylaxis (cleaning) (limited to 2 treatments per calendar year)
- Topical application of fluoride (limited to 1 treatment per calendar year and to covered persons under age 16)
- Oral hygiene instruction
- Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to covered persons under age 16)
- Pulp vitality test
- Diagnostic casts

X-Rays and Pathology

- Bitewing x-rays (limited to 1 set per calendar year)
- Entire series, including bitewings, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing x-rays (limited to 1 set every 3 years)
- Periapical x-rays
- Intra-oral, occlusal view, maxillary, or mandibular Extra-oral upper or lower jaw
- Biopsy and histopathologic examination of oral tissue

Space Maintainers

Includes all adjustments within 6 months after installation

- Fixed, band type
- Removable acrylic with round wire clasp

Basic Services

Generally, the following services are paid at 90%:

Endodontics

- Pulp capping
- Pulpotomy
- Surgical exposure for rubber dam isolation
- Root canal therapy, including necessary x-rays (anterior, bicuspid)

Restorations and Repairs

- Amalgam restoration
  - — 1 surface
  - — 2 surfaces
  - — 3 or more surfaces
- Resin restoration other than for molars
  - — 1 surface
  - — 2 surfaces
  - — 3 or more surfaces or incisal angle
- Retention pins
- Sedative fillings
- Stainless-steel crowns
- Prefabricated resin crowns (excluding temporary crowns)
- Recementing inlays, crowns, bridges, space maintainers
- Tissue conditioning for dentures

Periodontics

- Emergency treatment (abscess, acute periodontitis, etc.)
- Scaling and root planing (limited to 4 separate quadrants, every 2 years)
- Periodontal maintenance procedures following surgical therapy (limited to 2 per calendar year)

Oral Surgery

Includes local anesthetics and routine postoperative care

- Extractions, uncomplicated
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissue)
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Incision and drainage of abscess
- Crown exposure to aid eruption
- Removal of foreign body from soft tissue
- Suture of soft-tissue injury

Major Services

Generally, these services are paid at 60%.

Restorations

- Inlays
  - — 1 surface
  - — 2 surfaces
  - — 3 or more surfaces
- Onlays
  - — 2 surfaces
  - — 3 surfaces
  - — 4 or more surfaces
- Crowns (including buildups when necessary)
  - — Resin
  - — Resin with noble metal
  - — Resin with base metal
  - — Porcelain
  - — Porcelain with noble metal
  - — Porcelain with base metal
  - — Base metal (full cast)
  - — Noble metal (full cast)
  - — Metallic (3/4 cast)
  - — Post and core
- Pontics
  - — Base metal (full cast)
  - — Noble metal (full cast)
  - — Porcelain with noble metal

— Porcelain with base metal

— Resin with noble metal

— Resin with base metal

- Dentures and Partials (includes relines, rebases, and adjustments within 6 months after installation)

— Full (upper and lower)

— Partial

— Stress breakers (per unit)

— Stayplates

— Crown and bridge repairs

— Adding teeth to an existing denture

— Full and partial denture repairs

— Relining/rebasing dentures including adjustments within 6 months after installation)

— Occlusal guard (for bruxism only) limited to 1 every 3 years

Participating Specialist Dentist Services

Generally, these services are paid at 90%.

Endodontics

Includes local anesthetics where necessary

- Apexification/recalcification
- Apicoectomy (per tooth) - first root
- Apicoectomy (per tooth) - each additional root
- Retrograde filling
- Root amputation
- Hemisection

Oral Surgery

Includes local anesthetics where necessary and postoperative care

- Removal of residual root
- Removal of odontogenic cyst
- Closure of oral fistula
- Removal of foreign body from bone
- Sequestrectomy
- Frenectomy
- Transplantation of tooth or tooth bud
- Alveoplasty in conjunction with extractions - per quadrant
- Alveoplasty not in conjunction with extractions - per quadrant
- Removal of exostosis
- Sialolithotomy; removal of salivary calculus
- Closure of salivary fistula

Periodontics

- Gingivectomy or gingivoplasty - per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy or gingivoplasty - per tooth (limited to 1 per site, every 3 years)
- Gingival flap procedure - per quadrant
- Occlusal adjustment (other than with an appliance or by restoration)
- Full mouth debridement (limited to once per lifetime)

Generally, these services are paid at 60%.

Endodontics

Includes local anesthetics where necessary

- Molar root canal therapy, including necessary x-rays

Intravenous Sedation and General Anesthesia Oral Surgery

Includes local anesthetics where necessary and postoperative care

- Surgical removal of impacted teeth
- Partially bony
- Completely bony
- Completely bony with unusual surgical implications

Periodontics

- Osseous surgery (including flap entry and closure), per quadrant, limited to 1 per quadrant, every 3 years

Orthodontics

- Orthodontic screening exam after $30 copayment
- Orthodontic diagnostic records after $150 copayment
- Comprehensive orthodontic treatment of adult or adolescent dentition after $1,545 copayment
- Orthodontic retention after $275 copayment

There is a total copayment of $2,000. Following this copayment, orthodontic services are covered at 100%.

The schedule that follows shows covered items and the percentage that the DMO pays. Limitations apply to some covered items, and coverage is excluded for certain services and supplies, regardless of whether they are considered necessary by you or your provider (see "*What the Aetna DMO Option Does Not Cover*").

Covered Items	Percentage Paid
Visits and Exams	
Visit for oral examination	100%
Prophylaxis, including scaling and polishing	100%
Fluoride	100%
Oral hygiene instruction	100%
Molar sealants	100%
X-Rays	
Bitewing x-rays	100%
Full mouth series	100%
Periapical x-rays	100%
Endodontics	
Pulpotomy (employee responsible for 10%)	90%
Root canal therapy, anterior or bicuspid tooth (employee responsible for 10%)	90%
Apicoectomy (employee responsible for 10%)	90%
Root canal therapy, molar teeth (employee responsible for 40%)	60%
Minor Restorations	
Amalgam (silver fillings) (employee responsible for 10%)	90%
Composite fillings (anterior teeth) (employee responsible for 10%)	90%
Stainless steel crowns (employee responsible for 10%)	90%
Periodontics	
Scaling and root planing (employee responsible for 10%)	90%
Gingevectomy (employee responsible for 10%)	90%
Osseous surgery (employee responsible for 40%)	60%
Oral Surgery	
Incision and drainage or abscess (employee responsible for 10%)	90%
Uncomplicated extractions (employee responsible for 10%)	90%
Surgical removal of erupted tooth (employee responsible for 10%)	90%
Surgical removal of impacted tooth (soft tissue) (employee responsible for 10%)	90%
Surgical removal of impacted tooth - full or bony impaction (employee responsible for 40%)	60%
Prosthodontics/Major Restorations	
(preexisting vacancies of natural teeth or in a denture are not covered)	
Inlays/onlays (employee responsible for 40%)	60%
Crowns (employee responsible for 40%)	60%
Full or partial dentures (employee responsible for 40%)	60%
Denture repairs (employee responsible for 40%)	60%
Pontics (employee responsible for 40%)	60%
Anesthesia	
General anesthesia/IV sedation (only if medically necessary) (employee responsible for 40%)	60%
Space Maintainer	100%
Orthodontics	
(after a total copayment of $ 2,000)	100%
(see Dental Care Schedule for details)	

Limitations as to frequency of services may apply. Check with your Aetna DMO dentist before having services performed to avoid disappointments.

Aetna DMO Copayments

A copayment applies to some dental services. You are responsible for making the copayment to the dentist.

Copayment: Primary Care Provided by Primary Care Dentists

A copayment applies to primary care services that are shown on the preceding dental care schedule. The copayment is a percent of the primary care dentist's usual fee for that service, which Aetna has reviewed for reasonableness. The copayment percent that applies is shown on the Covered Items schedule.

"Usual fee" means the fee the primary care dentist charges to patients in general. Your primary care dentist can give you a copy of the usual fee schedule. It is not a part of this Dental Program description, and it can change from time to time. It is used only for the purpose of calculating a copayment and is not the basis for compensation to the primary care dentist. Aetna compensates a primary care dentist based on separate, negotiated agreements that may be less than or unrelated to the primary care dentist's usual and customary charges. These agreements can vary among primary care dentists.

Copayment: Specialty Services Provided by Participating Specialist Dentists

A copayment applies to specialty services that are shown on the preceding dental care schedule. The copayment is a percent of the participating specialist dentist's fee for that service.

The fee may be a fee negotiated with the participating specialist dentists and approved by Aetna. In that case, the copayment is based on the actual, negotiated fee.

If Aetna compensates participating specialist dentists on another basis, the fee is the participating specialist dentist's usual fee, which Aetna has reviewed for reasonableness. "Usual fee" means the fee participating specialist dentists charge to patients in general. It is not a part of this Dental Program description, and it can change from time to time. Then, it is used only for the purpose of calculating a copayment and is not the basis for compensation to the participating specialist dentists. Aetna compensates a participating specialist dentist based on separate, negotiated agreements that may be less than or unrelated to the participating specialist dentist's usual and customary charges. These agreements can vary among participating specialist dentists.

You will be informed of the fee when you visit the participating specialist dentists. The copayment percent that applies is shown on the preceding dental care schedule.

In the case of orthodontic services, the amount of copayment is shown on the dental care schedule.

What the Aetna DMO Option Does Not Cover

Some items are excluded from coverage under the DMO option, whether or not considered necessary by you or your dentist. An Aetna DMO dentist will not charge for items that aren't covered without your prior consent. Items not covered include charges for:

- Those for services or supplies, which are covered in whole or in part under any other part of this Program, or under any other plan of group benefits provided by or through the Employer.
- Those for services and supplies furnished to diagnose or treat a disease or injury that is not a nonoccupational disease or nonoccupational injury.

- Those for services not listed in the dental care schedule, unless otherwise specified.
- Those for replacement of a lost, missing, or stolen appliance and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons — except to the extent needed to repair an injury. Surgery must be performed in the benefit year of the accident, which causes the injury or in the next benefit year. *(The preceding time limit does not apply to members in CA, TX and AZ)*
  - Facings on molar crowns and pontics will always be considered cosmetic.
- Those for or in connection with services, procedures, drugs, or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
- Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion, or erosion.
- Those for any of the following services:
  - An appliance, or modification of one, if an impression for it was made before the person became a covered person
  - A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person
  - Root canal therapy, if the pulp chamber for it was opened before the person became a covered person.

(The preceding exclusion does not apply to members in TX.)

- Those for services that Aetna defines as not necessary for the diagnosis, care, or treatment of the condition involved. This applies even if they are prescribed, recommended, or approved by the attending physician or dentist.
- Those for services intended for treatment of any jaw joint disorder, unless otherwise specified.
- Those for space maintained, except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Those for orthodontic treatment, unless otherwise specified.
- Those for general anesthesia and intravenous sedation, unless done in conjunction with another necessary covered service.
- Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
- Those in connection with a service given to a person age 5 or more if that person becomes a covered person other than: (i) during the first 60 days the person is eligible for this coverage; or (ii) as prescribed for any period of An nual Enrollment agreed to by the Employer and Aetna. This does not apply to charges incurred:
  - after the end of the twelve month period starting on the date the person became a covered person; or
  - as a result of accidental injuries sustained while the person was a covered person; or
  - for a service in the dental care schedule under the headings Visits and Exams, and x-rays and Pathology.

(The preceding exclusion does not apply to members in TX.)

- Those for a crown, cast, or processed restoration unless:
  - it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
  - the tooth is an abutment to a covered partial denture or fixed bridge
- Those for pontics, crowns, cast, or processed restorations made with high noble metals, unless otherwise specified.
- Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified.
- Those for services needed solely in connection with non-covered services.
- Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

Alternate Treatment Rule

If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a more cost-effective service, provided that all of the following terms are met:

- The service must be listed on the dental care schedule;
- The service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- The service selected must meet broadly accepted national standards of dental practice.

If a participating dental provider is providing the services and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of the copayment for the approved less costly service; plus the difference in cost between the approved less costly service and the more costly covered service.

Replacement Rule

The replacement of, addition to, or modification of:

- Existing dentures;
- Crowns;
- Casts or processed restorations;
- Removable bridges; or
- Fixed bridgework

is covered only if one of the following terms is met:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. Coverage under the Aetna DM0 must have been in force for the covered person when the extraction took place.
- The existing denture, crown, cast, or processed restoration, removable bridge, or bridgework cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Tooth Missing but Not Replaced Rule

Coverage for the first installation of removable dentures, removable bridges, and fixed bridgework is subject to the requirements that such dentures, removable bridges, and fixed bridgework are (i) needed to replace one or more natural teeth that were removed while coverage under the Aetna DM0 was in force for the covered person; and (ii) are not abutments to a partial denture, removable bridge, or fixed bridge installed during the prior 5 years. *(Not applicable to members in CA and TX.)*

Aetna DMO Orthodontic Treatment

Coverage for orthodontic treatment is limited to those services and supplies listed on the dental care schedule that applies.

Aetna has arranged for participating specialist dentists to furnish the orthodontic procedures. A copayment applies to the orthodontic procedures done on a covered person.

Comprehensive orthodontic treatment is limited to a lifetime maximum of 24 months of active, usual and customary orthodontic treatment on permanent dentition; plus an extra 24 months of posttreatment retention.

Coverage for services and supplies are not provided for any the following:

- Replacement of broken appliances;
- Retreatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;
- Treatment of primary dentition;
- Treatment of transitional dentition; or
- Lingually placed direct-bonded appliances and arch wires (also known as "invisible braces").

Coverage is not provided for any charges for an orthodontic procedure if an active appliance for that orthodontic procedure has been installed before the first day on which the person became a covered person for the benefit.

(The preceding paragraph does not apply to members in TX and AZ.)

Coverage is not provided for any charges for an orthodontic procedure for which an active appliance has been installed within the 2 years starting with the date the person became a covered person for the benefit. This applies only to a person who does not become such a covered person by the 30th day after the first day the person is eligible to become such a covered person.

(The preceding paragraph does not apply to members in TX)

Extended Treatment

Benefits After Termination of Coverage

Dental services given after the covered person's coverage terminates are not covered. However, ordered inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures, fixed bridgework, and root canals will be covered when ordered, if the item is installed or delivered no later than 30 days after coverage terminates.

(The preceding paragraph does not apply to members in AZ.)

"Ordered" means that prior to the date coverage ends:

- As to a denture: impressions have been taken from which the denture will be prepared.
- As to a root canal: the pulp chamber was opened.
- As to any other item listed above: the teeth which will serve as retainers or support, or which are being restored, have been fully prepared to receive the item and impressions have been taken from which the item will be prepared.

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Benefit Claims Procedures

Highlights

- Explains how to file dental claims
- Includes details of how coordination of benefits and right of reimbursement affect the processing of your claim
- Provides information about how you can request a review and appeal the decision on a claim

How to File a Dental Claim

You and your enrolled dependents should use your dental identification card when you receive services or supplies covered under the Dental Program.

Here's how the claims process works for Delta Dental:

If you or your enrolled dependents receive care from a Delta PPO dentist or a DeltaPremier dentist, the following events occur:

- Your dentist (see Delta PPO and DeltaPremier providers in the "How the Dental Program Works" chapter) will submit the claim to Delta Dental.
- Payment for covered items is based on the following:

1. If the dentist is a PPO dentist and a DeltaPremier dentist, Delta Dental will base payment on the lesser of:
   a. The submitted amount;
   b. The PPO dentist schedule; or
   c. The Maximum Approved Fee.

Delta Dental will send payment to the PPO dentist and the subscriber will be responsible for any copayment and/or the amount the dentist charged for any noncovered services.

2. If the dentist is a PPO dentist, but not a DeltaPremier dentist, Delta Dental will base payment on the lesser of:
   a. The submitted amount; or
   b. The PPO dentist schedule.

Delta Dental will send payment to the PPO dentist and the subscriber will be responsible for any copayment and/or the amount the dentist charged for any noncovered services.

3. If the dentist is a non-PPO dentist but is participating in DeltaPremier, Delta Dental will base payment on the lesser of:
   a. The submitted amount; or
   b. The Maximum Approved Fee.

Delta Dental will send payment to the DeltaPremier dentist and the subscriber will be responsible for any copayment and/or the amount the dentist charged for any noncovered services.

- Coordination of benefits with another plan and right of reimbursement considered, if applicable. (See the information later in this booklet.)
- Your dentist will charge you only for copayments, deductibles, and services that the Program does not cover. See the "How the Dental Program Works" section for a description of what is and is not covered.
- You will receive an Explanation of Benefits that details the items mentioned above.
- Your Delta PPO or DeltaPremier dentist will receive direct payment.

If you or your enrolled dependents receive care from a nonparticipating dentist:

- Your provider may submit a claim for services for you or you may need to submit it yourself.
- Coordination of benefits with another plan and right of reimbursement are considered, if applicable.
- Payment for covered items will be based on the lesser of the submitted amount or the nonparticipating dentist fee.
- Payment may be made to you, and will include an explanation of how benefits are calculated.
- You may be responsible for paying your provider in full.
- Dental claim forms are available from Delta Dental of Idaho.

If you or your enrolled dependents receive care from an out-of-country dentist:

- You will have to submit a claim for services.
- Coordination of benefits with another plan and right of reimbursement are considered, if applicable.
- Payment for covered items will be based on the lesser of the submitted amount or the out-of-country dentist fee.
- Payment will usually be sent to you, and will include an explanation of how benefits are calculated.
- You will be responsible for paying your provider in full.
- Dental claim forms are available from Delta Dental of Idaho.

Here's how the claims process works for the Aetna DMO:

- There are no claim forms to submit for services provided by providers who have contracted with Aetna DMO. Claim forms may be required for out-of-area emergency care or out-of-network care required by some states. Contact Aetna member services for details.
- You make arrangements with your dentist for payment of your copayment for any covered charges or for services not covered.
- You will not receive an explanation of benefits because there is no claims process.
- If you disagree with the decision of Aetna DMO, you have the right to request a review.

Initial Claim Determinations

You should submit your claim to Delta Dental of Idaho or Aetna DM0, as applicable, at the address listed in the General Plan Information section. An initial benefit determination on your claim will be made and you will be notified in writing within 30 days after receipt of your claim. The 30 day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond the control of Delta Dental of Idaho or Aetna DM0. In that case, Delta Dental of Idaho or Aetna DM0, as applicable, will notify you prior to the expiration of the initial 30 day period of the circumstances requiring an extension and the date by which it expects to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information needed, and you will have 45 days from the receipt of the notice to provide the information. If you fail to provide the required information within 45 days, your claim may be denied. If Delta Dental of Idaho or Aetna DMO, as applicable, denies your claim in whole or in part, you will receive a notice specifying the reasons, the Program provisions on which it is based, a description of additional material (if any) needed to perfect the claim, your right to file a civil action under section 502(a) of ERISA if your claim is denied upon review, and it will also explain your right to request a review.

Appeals

In the event that Delta Dental of Idaho or Aetna DMO, as applicable, denies a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted within 180 days from your receipt of the claim denial. Send your appeal to Delta Dental of Idaho or Aetna DMO, as applicable, at the address listed in the General Plan Information section.

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight. For Delta Dental of Idaho, the review will be conducted by someone different from the original decision makers and not by a subordinate of the original decision makers and without deference to any prior decision. For Aetna DMO, a Dental Consultant who participated in the initial decision review may review the appeal if new and/or additional information is provided. That Dental Consultant may either reverse their original determination and allow the appeal or find that the appeal review cannot be fully reversed. Appeals that cannot be fully reversed, or those that contain no new or additional information, will be reviewed by a Dental Consultant who did not participate in the initial decision review.

Within 60 days after the date your request for review is received, you will receive written notice of the decision. If we affirm the denial of your claim, in whole or in part, you will receive a notice specifying the reasons, the Program provisions on which it is based, notice that upon request you are entitled to receive free of charge reasonable access to and copies of the relevant documents, records, and information used in the claims process, and your right to file a civil action under section 502(a) of ERISA. If an internal rule, guideline, protocol or similar criterion was relied on in deciding your claim or request for review, you have the right to request such information free of charge, and the denial notice will contain a statement informing you of this right.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. The authorization must be in writing. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

Deadline to Commence a Lawsuit

If you file your claim within the required time, complete the entire claims procedure, and your appeal is denied, you may sue over your claim (unless you have executed a release of 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 complete.

Controlling Law

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

Coordination of Benefits

If you or any of your dependents are covered by more than one group dental option, reimbursement is coordinated between the plans so that benefits are not duplicated.

When you are covered by more than one group dental plan, the plan that pays first is called the "primary plan." The primary plan pays its benefits without considering what the other plan may pay. The other plan (the "secondary plan") may pay additional benefits depending on its coordination of benefits (COB) provisions. When the Dental Program is secondary, your reimbursement is adjusted so that the total reimbursement from both plans is not more than the amount paid by the plan with the highest reimbursement level. This way, neither plan pays more than it would have without coordination of benefits.

Determining Which Plan Is Primary

The following rules determine which plan will pay benefits first:

- If one of the plans has no COB provision, that plan is always primary.
- When both plans have a COB provision, the plan covering the person as an employee is the primary plan. The Dental Program is primary for all enrolled employees.
- If you and your spouse both cover your children and you are not separated or divorced, the plan of the parent whose birthday (month and day) occurs first in the calendar year is primary. This is called the "birthday rule." If one plan does not have the birthday rule, the father's plan is primary.

When you are covered by more than one group dental plan, the plan that pays first is called the "primary plan." The primary plan pays its benefits without considering what the other plan may pay.

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Coordination With Medicare

Medicare provides additional types of insurance coverage: Medicare Part A, Medicare Part B, Medicare Part D and Medicare Advantage Plans. These types of coverage are available to actively employed and retired individuals age 65 and older who are entitled to Social Security retirement benefits. They also are available to disabled people of any age who have been entitled to Social Security disability benefits for at least 24 months. If you continue working past age 65, the Dental Program will be the primary plan for you and your covered dependents, including your spouse (even if the spouse is eligible for Medicare).

Third-Party Subrogation and Reimbursement

By participating in the Program, you agree that if you and your enrolled dependents are injured by a third party (including, but not limited to, an injury caused by an auto accident or by the use of a product), the Dental Program will be subrogated to your rights against the third party or the third party's insurance carrier and will be entitled to reimbursement for any benefits paid that are related to the injury.

This means that the Program can recover from the third party and/or its insurance carrier (in the event of subrogation where the Program recovers from the third party or its insurance carrier) any amount up to the total amount it has paid or may pay for expenses that you or your dependent incurred as a result of the injury, without any reduction for attorney fees or court costs, without regard to whether you or your enrolled dependents would be fully compensated or made whole by the amount recovered, whether the third party admits to causing the injury, or whether the amount is specifically awarded for medical and/or dental expenses.

This also means that you and your attorney hold any amounts recovered from a third party in constructive trust to satisfy the Program's lien. The Program can recover from you and/or your attorney (in the event of reimbursement where you or your enrolled dependents recover from the third party or its insurance carrier) any amount up to the total amount it has paid or may pay for expenses that you or your dependent incurred as a result of the injury, without regard to whether you or your enrolled dependents would be fully compensated by the amount recovered, whether the third party admits to causing the injury, or whether the settlement payment is specifically awarded for medical and/or dental expenses.

You and any covered dependent (or a person who is authorized by law to represent the dependent) must execute and deliver a subrogation and reimbursement agreement and any other documents that the Plan Administrator and Program may require in connection with its subrogation and reimbursement rights.

The Program's subrogation and reimbursement rights do not limit your right and that of your enrolled dependents to take legal action against the person who caused your injury. You can pursue legal action to recover medical and/or dental expenses and other damages. However, you and your enrolled dependents must immediately obtain the Plan Administrator's consent before you settle any claim or release any third party from liability. Albertson's LLC and the Program will not be responsible for attorney's fees or court costs that you may incur and will not reduce the amount of required reimbursement by the amount of your attorney's fees or court costs.

If a potential subrogation situation arises, you must cooperate with the Program to assist in this recovery. You must provide information about the facts surrounding your injury and your future medical and/or dental needs, and you must assist in the efforts to recover from the party who is responsible for your injuries.

If a potential reimbursement situation arises, you must provide the Plan Administrator with information about any claim or settlement that you or your enrolled dependents may have against a third party (or a third party's insurance company) as the result of an accident caused by a third party. If you do not reimburse the Program, the Program may pursue appropriate legal action and/or reduce, refuse, or offset future benefit payments until the reimbursement amount is recovered.

Immediately contact the Plan Administrator if you or your enrolled dependent is involved in an accident or sustains an injury that might create a subrogation or reimbursement situation.

General Plan Information

PLAN NAME	Albertson's LLC Health & Welfare Plan The Dental 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	Dental
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 BENEFIT 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
CLAIMS ADMINISTRATOR AND NAMED CLAIMS FIDUCIARY FOR DELTA DENTAL	Delta Dental of Idaho P.O. Box 2870 Boise, ID 83701 Telephone: (800) 356-7586
TYPE OF ADMINISTRATION FOR DELTA DENTAL	Contract Administration
INSURER AND NAMED CLAIMS FIDUCIARY FOR AETNA DMO	Aetna DMO P.O. Box 14094 Lexington, KY 40512-4094 Telephone: (877) 657-9685
TYPE OF ADMINISTRATION FOR AETNA DMO	Insurer Administration
PLAN YEAR (Benefit Plan Year)	June 1 through May 31
COBRA ADMINISTRATOR	PayFlex Systems USA, Inc. P.O. Box 2239 Omaha, NE 68103-2239 Telephone: 800-359-3921

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 inconsquential 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