



# Health & Welfare Plan

## Employee Assistance Program (EAP)

Effective June 1, 2013

### EAP Program Description

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# EMPLOYEE ASSISTANCE PROGRAM (EAP) HIGHLIGHTS

It is inevitable that all individuals will experience personal problems throughout the course of their life. Albertson's LLC recognizes that personal and work challenges can impact the well-being of valued associates. It can also be expected that problems left unattended can impact an individual's effectiveness at work. Albertson's LLC is committed to offering associates a resource to address and resolve personal and work concerns.

The Employee Assistance Program is a confidential professional program that allows you and your family members to seek assistance for personal concerns. The EAP also is available to provide resources in balancing the everyday challenges we all face in balancing work and home responsibilities.

## **Program Overview**

The EAP is a program that provides counseling and consultation for a wide range of personal, family and work related concerns. This is a benefit provided by the Company; therefore, there is no cost to you or your family members for any of the services provided by the EAP. The EAP can help with:

- Marital/Relationship Issues
- Family Problems
- Child Concerns
- Alcohol and/or Drug Abuse
- Job Stress
- Depression
- Emotional Problems
- Childcare and Parenting
- Elder Care
- Financial and Legal Issues
- Retirement Planning

This is not an exclusive list. The EAP may be available to assist with other types of issues of concern to you.

## **Confidentiality**

The EAP is completely confidential. No information regarding who accesses services and for what reasons is shared with the Company. At no time, except where mandated by law, will information discussed between you and the EAP counselor be released to any other party without a written consent. Your concerns, their source, treatment, and resolution will always be afforded the maximum confidentiality permitted by law.

## **Professional Credentials**

All EAP Counselors have a Doctorate or Master's degree in the field of behavioral health and are licensed at the highest discipline level within the state that they practice. These specialists include licensed psychologists, clinical social workers, marriage & family therapists and certified alcohol & drug counselors. Aetna Resources for Living has a national network of mental health providers, so appointments can be arranged with a counselor who is conveniently located to where you live or work.



## Introduction

Albertson's LLC offers the Employee Assistance Program (EAP) ("Program") to eligible employees of Albertson's LLC and certain affiliated companies (collectively "Employer" or "Company"). The EAP 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 EAP Program Rules document, together with your separate document entitled "Eligibility Rules Supplement" and Eligibility Rules Supplements created for other employee groups, comprise the official Plan document for the EAP Program portion of the Albertson's LLC Health & Welfare Plan as of June 1, 2013 and replace previous statements or descriptions of this Program. Because this EAP Program Rules document and the Eligibility Rules Supplement 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 EAP Program portion of the Plan. This document will be used to administer the Program and will govern the determination of benefits under the Program. This document applies to all eligible active and former employees and their dependents enrolled in the EAP.

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 work group (as described in the Eligibility Rules Supplement), you will automatically become a participant in the EAP 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 work group 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 EAP 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 EAP Program. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency or otherwise, without regard to whether Albertson's LLC agrees to the reclassification, shall make the person retroactively or prospectively eligible for benefits. However, Albertson's LLC, in

its sole discretion, may reclassify a person as benefits eligible on a prospective basis. Any uncertainty regarding an individual's classification will be resolved by excluding the person from eligibility.

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

### Health Care Fraud

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

If you obtain benefits falsely, you will be required to reimburse the EAP 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

After you have met the eligibility requirements that apply to your work group (as described in the Eligibility Rules Supplement), you will automatically be enrolled in the EAP Program.

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

### When Coverage May Be Delayed

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



## Re-qualification 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 re-qualification 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 (re-qualification) period, the employee will be treated as a newly hired employee and will be automatically covered. The employee will not need to satisfy a new waiting period.

## Who Can Be Covered by the EAP Program

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

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 EAP 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 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.

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

Albertson's LLC pays the costs of coverage to provide the EAP Program to employees, spouses and their children. The Company's contributions 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, 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, any contributions you make toward the cost of coverage must be paid on an after tax basis. In addition, Albertson's LLC's portion of the premium for your Non-Traditional Spouse's 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 W2 (in Box 1). However, the benefits your Non-Traditional Spouse receives from the 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 Program. This means that the portion of any premium you pay for coverage for your Non-Traditional Spouse's child must be paid on an after tax basis. In addition, Albertson's LLC's portion of the premium for your Non-Traditional Spouse's children's coverage will be considered income to you. However, the benefits your Non-Traditional Spouse's children receive from the Program remain tax free.



## Changing Your Coverage

### Automatic Changes to Your Benefits Elections

In the following situation, your benefit elections will be changed for you automatically:

- 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.

## Leaves of Absence

### EAP Coverage During an Approved Leave of Absence

During certain approved leaves of absence, your EAP coverage may be continued on the same terms as active employees.

#### *Family and Medical Leave Act (FMLA) Leave*

EAP coverage will be continued during an approved FMLA leave, provided that you do not revoke coverage during your FMLA leave.

#### *General Leave of Absence*

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

#### *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 EAP Program may be continued for a maximum period of 26 weeks. Coverage will end on the earliest date that (i) you do not re-qualify for EAP coverage under the benefit re-qualification process; or (ii) you terminate your employment including retirement; or (iii) the 26 week maximum benefit continuation period is exhausted; or (iv) for one of the events described in the When Benefits End section below. Your benefit re-qualification 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 re-qualification, 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 re-qualification 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 re-qualification, 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 re-qualification 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 do not requalify for coverage under the benefit re-qualification process in the EAP Program; or (ii) you terminate your employment including retirement; or (iii) the 26 week maximum benefit continuation period is exhausted; or (iv) one of the events described in the When Benefits End section below occur. Your benefit re-qualification 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 re-qualification, 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 re-qualification 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 re-qualification 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.

#### *EAP Coverage During an Unapproved Leave of Absence*

Your EAP 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 your return to work following this absence, your EAP coverage will be reinstated effective the date you return to work if you satisfied the previous benefits re-qualification 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.

## **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.

### **Your Coverage**

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

- Your employment ends, including retirement. (Coverage will not be extended during unused vacation time.)
- The EAP Program is terminated or amended to end coverage for employees in your work group or classification.
- You are no longer eligible for benefits.
- 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 EAP 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:

- 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 EAP Program is terminated or amended to end coverage for a work group 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:

- Your child is no longer considered an eligible dependent. (See "Who Can Be Covered by the EAP 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 EAP 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 benefits during an approved disability leave.

Your coverage may continue under the EAP Program for up to 26 weeks after the disability commenced or until you are no longer disabled (whichever occurs first).

### **Converting Coverage**

Coverage under the EAP 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 EAP Program benefits if your coverage ends for certain reasons.

Note that while COBRA itself does not apply to 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 EAP 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 EAP 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 EAP Program as a result of the covered employee's termination of employment or reduction of hours, and before the end of the 18 month period of COBRA continuation coverage.

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



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

If your qualified beneficiaries experience another qualifying event while receiving 18 or 29 months of COBRA continuation coverage, the spouse and dependent children who are qualified beneficiaries can receive up to a maximum of 36 months (including the initial 18 month period), if notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to your spouse and dependent children who are qualified beneficiaries if you die, get divorced or legally separated, or if a dependent child who is a qualified beneficiary stops being eligible under the EAP 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 EAP 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 EAP Program and does not offer any other group employee assistance 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 EAP 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 request 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 EAP Program will provide the qualified beneficiary a notice of early termination. This notice will indicate the date the coverage was terminated and the reason.

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

### **Special Second Election Period**

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

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

## Schedule of Benefits

### **How to Access the EAP**

To access EAP services just call the toll-free number, **1-888-805-4252**. The EAP is available 24 hours a day, 7 days a week.

At the time of the initial call the EAP Case Manager will gather some preliminary information and discuss with you the concerns you are experiencing. The Case Manager will then coordinate an appointment for you to meet with a counselor for a face-to-face assessment. The counselor will provide an initial assessment to determine the nature of the problem and provide treatment recommendations. Short-term counseling can be provided by the counselor to assist in resolving the problem. Up to 5 sessions are covered through the EAP Program. If long term or specialized care is indicated a referral will be made to a resource or facility that best meets your needs. The EAP will coordinate with your health benefit plan and make every effort to provide referrals to treatment providers covered under your medical plan. The goal is to recommend the best and most appropriate service at the lowest cost to you.





### **Additional Covered Services**

The EAP can also provide expanded Work Life services, which include legal and financial consultation, childcare and eldercare resources and referral-based convenience services.

To accommodate your needs in these areas Aetna Resources for Living's network also includes attorneys and consultants specializing in financial services childcare, eldercare, academic, adoption and personal care. You can access all these services through the same toll-free number, **1-888-805-4252**.

### **Legal Consultation**

The EAP can assist with a range of legal matters including family/domestic law, wills & estate planning, civil or criminal matters, motor vehicle and elder law. If you are dealing with a legal matter you can call the EAP toll-free at **1-888-805-4252** and you will be referred to a participating attorney for an in-person appointment. You are eligible for a 30 minute consultation which is at no cost to you. If you choose to retain the attorney for additional services you are eligible to receive a reduced hourly rate. The discount for retaining the attorney beyond the initial consultation is 25%.

\*Employee-Employer Legal Matters are excluded.

### **Financial Consultation**

You and your family members can receive a no-cost consultation with a CPA or financial planner for a range of issues, such as debt consolidation, personal budgeting, retirement planning, mortgage & refinancing and tax planning. By calling the EAP toll-free at **1-888-805-4252**, you will be connected with a financial specialist for a 30 minute consultation, which is at no cost to you. The financial specialist will consult with you telephonically and provide referrals and information that best meets your needs.

### **Childcare**

Finding affordable, quality child care requires considerable time and energy. The EAP can assist in locating a range of childcare resources, which can include day care centers, nanny agencies, nursery schools, before & after school programs and recreational & summer camp programs. By calling the EAP toll free number (**1-888-805-4252**) you will be connected to a childcare specialist who will help to assess your specific needs. The EAP will research resources in the community you are seeking services and will mail to you a minimum of 3 qualified referrals within 5 days. A complete profile of each program will be included in your packet.

Based on your needs and/or concerns the EAP can also provide a wide range of educational materials on Parenting Issues, Special Needs Laws & Support, Adoption, and Financial Aid Programs.

### **Eldercare**

There is an increasing number of individuals who are the primary caretaker of an elderly parent. By contacting the EAP you will be referred to an Eldercare Specialist who will help identify your specific needs and those of your elderly parent. The Eldercare Specialist will locate a minimum of 3 referrals and confirm program availability. Profiles of each of the program referrals, as

well as any relevant educational materials will be mailed to your home within 5 days. The type of referrals and resources the EAP can assist in locating include Adult Day Care, Emergency & Respite Care, Home Based Services, Nursing Homes, Meal Delivery Programs, Transportation Services and Caregiver Support Groups.

### **Referral-Based Convenience Services**

Many of us are short on time when trying to balance our numerous work and family responsibilities. The EAP can assist in locating resources for many day-to-day personal chores. You can call the EAP toll free number (**1-888-805-4252**) to access these services, which are provided telephonically. You will be connected to a specialist who will research and provide you with resources for a range of services, such as tobacco cessation, home repair, automobile services, moving & relocation specialists and travel agencies. The EAP can also provide pet care resources such as boarding & grooming, kennels, pet sitters and veterinarians.

### **Web-Based Services**

As part of the EAP services you and your family members also have access to the Aetna Resources for Living website ([www.mylifevalues.com](http://www.mylifevalues.com)), which offers an array of state of the art information and services. The log-in name to the site is "Albertsons" and the password is the EAP 888# (8888054252).

If you have questions regarding the program services or would like to obtain additional information, you may call the EAP directly at **1-888-805-4252**, your local Human Resources representative or the Associate Contact Center at **1-800-969-9688**.

## **Claims Procedures for Eligibility and Plan Administrative Claims Determinations**

For a dispute concerning your eligibility to participate in the EAP Program 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 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 EAP Program and to determine all factual and legal questions under the EAP 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 EAP 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 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 EAP Program. In addition, in any legal action brought after you have exhausted administrative remedies, all determinations made by the Benefits Administrative Committee and the Benefit Plans Committee, shall be afforded the maximum deference permitted by law.

### ***Time Limits for Commencing Legal Action***

If you file a claim within the required time, complete the entire claims procedure, 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.

## **Benefit Claims Procedures**

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### **Introduction**

Because there is such broad access to Program services, it is unlikely that you will experience an event which would result in a dispute about the coverage of benefits under the Program. However, in the event that you feel that you did not receive the benefits described in this booklet for a group health care component (e.g., mental health or substance abuse) of the Program, the claims procedures below apply.

### **Initial Claim Determinations**

You should submit your claim to the Claims Administrator 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 Claims Administrator's control. In that case, the Claims Administrator 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 the Claims Administrator 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 the Claims Administrator 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 the claim denial. Send your appeal to the Claims Administrator at the address listed in the General 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. The review will be conducted by someone different from the original decision makers and without deference to any prior decision.

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. All decisions on claims and reviews of denied claims will be made by the Claims Administrator. This means the Claims Administrator has sole authority, discretion and responsibility to interpret and apply the terms of the Program and to determine all factual and legal questions under the Program. However, the Plan Administrator shall have the sole authority and responsibility to determine whether a claimant is eligible for benefits under the Program. The Claims Administrator has discretionary authority to grant or deny benefits under the Program. Benefits will only be paid if the Claims Administrator decides in its discretion that the applicant is entitled to benefits. All determinations, interpretations, rules, and decisions by the Claims Administrator or Plan Administrator shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Program.

## 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 EAP Program will be governed by the laws of the State of Idaho.

## Other Important Information

### Your ERISA Rights

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

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for EAP Program participants, ERISA imposes duties upon the people who are responsible for the operation of the EAP Program. The people who operate your EAP Program, called "fiduciaries" of the EAP Program, have a duty to do so prudently and in the interest of you and other EAP 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 EAP 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 EAP Program's claims procedures. In addition, if you disagree with the EAP 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 EAP Program fiduciaries misuse the EAP 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 EAP 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 EAP Program that are not answered in this booklet, you are encouraged to contact the Claims Administrator, or the Plan Administrator at the addresses shown in the General Plan Information section.

## General Provisions

### Plan Administration

#### *Plan Administrator*

The general administration of the EAP 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 of delegation of final authority with respect to claims, the Plan Administrator generally has final authority to administer the EAP 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 EAP 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 EAP 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 EAP Program;
3. prepare and distribute information to you explaining the EAP Program;
4. receive from you and any other parties the necessary information for the proper administration of eligibility requirements under the EAP Program;
5. receive, review, and maintain reports of the financial condition and receipts and disbursements of the EAP 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 EAP 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 EAP Program, except with respect to claim for benefits determinations where final authority has been delegated to the Claims Administrator.

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

The EAP 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**

This EAP Program is fully insured and funded through the Employer's general assets.

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

### **Collective Bargaining Agreements**

The EAP 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.

### **Grandfathered Notice**

Albertson's LLC believes the EAP Program is a grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the EAP Program may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the address listed in the General Plan Information section. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or **[www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

### **Qualified Medical Child Support Order (QMCSO)**

In accordance with federal law, the Program recognizes a Qualified Medical Child Support Order (QMCSO). A QMCSO requires you to cover eligible children 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 the Plan Administrator without charge. If the Plan Administrator determines that the order is a QMCSO, it will follow the terms of the order and will automatically cover the dependent(s) named in the order, provided the Program requirements are satisfied.



## General Plan Information

<b>PLAN NAME</b>	<p>Albertson's LLC Health &amp; Welfare Plan</p> <p>The Employee Assistance Program (EAP) is one component of the Plan.</p> <p>The Albertson's LLC Health &amp; 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.</p>
<b>PLAN NUMBER</b>	650
<b>TYPE OF PROGRAM</b>	Employee Assistance Program
<b>TYPE OF PROGRAM</b>	Fully-Insured
<b>CONTRIBUTION SOURCE</b>	Company paid
<b>EMPLOYER/PLAN SPONSOR/NAMED FIDUCIARY, EXCEPT WITH RESPECT TO CLAIMS</b>	<p>Albertson's LLC  P.O. Box 20  Boise, ID 83726  Telephone: (208) 395-6200</p>
<b>EMPLOYER IDENTIFICATION NUMBER</b>	82-0184434
<b>AGENT FOR SERVICE OF PROCESS</b>	<p>Albertson's LLC  c/o CT Corporation System Inc.  100 South Fifth Street, Suite 1075  Minneapolis, MN 55402  (612) 333-4315</p> <p>(legal process may also be served on the Plan Administrator)</p>
<b>PLAN ADMINISTRATOR</b>	<p>Albertson's LLC  P.O. Box 20  Boise, ID 83726  Telephone: 1-800-969-9688</p>
<b>ALBERTSON'S LLC BENEFITS ADMINISTRATIVE COMMITTEE AND/OR ALBERTSON'S LLC BENEFIT PLANS COMMITTEE</b>	<p>Albertson's LLC  Attn: Director of Employee Benefits  P.O. Box 20  Boise, ID 83726</p>
<b>PLAN YEAR (Benefit Plan Year)</b>	June 1 through May 31
<b>CLAIMS ADMINISTRATOR AND NAMED CLAIMS FIDUCIARY FOR THE EMPLOYEE ASSISTANCE PROGRAM</b>	<p>Aetna Resources for Living  4300 Centreway Place  Arlington, TX 76018  Telephone: 1-888-805-4252  TDD: 1-800-327-1833  (for hearing-impaired people)</p>
<b>TYPE OF ADMINISTRATION</b>	Insurer Administration
<b>COBRA ADMINISTRATOR</b>	<p>PayFlex Systems USA, Inc.  P.O. Box 2239  Omaha, NE 68103-2239  Telephone: 1-800-359-3921</p>