Health & Welfare Plan

Flexible Spending Account (FSA) Program

Effective June 1, 2013

FSA Program Description

ALBERTSON'S LLC FLEXIBLE SPENDING ACCOUNT (FSA) PROGRAM HIGHLIGHTS

Albertson's LLC offers two benefits that you can use to save money on taxes:

Health Care tax-free "flexible spending account" (FSA)

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Dependent Daycare tax-free "flexible spending account" (FSA)

Flexible Spending Accounts

The two flexible spending accounts help you pay for many expenses for health care and for dependent daycare. FSAs extend the buying power of your dollar because they allow you to pay less in taxes.

1. Health Care Flexible Spending Account

Some eligible expenses for the Health Care FSA include:

Medical, vision and dental expenses that are not covered by your health care coverage, including deductibles and coinsurance payments

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Contact lens supplies, surgery to correct vision

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Copayments for prescription drugs

2. Dependent Daycare Flexible Spending Account

Some eligible expenses for the Dependent Daycare FSA include:

Care for children younger than 13 at a licensed daycare center, after-school care at a licensed center and care by an independent daycare provider

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In many cases, care for disabled dependent adults

This page provides only the highlights of the Albertson's LLC Flexible Spending Account Program. This Flexible Spending Account Program Rules document (including additional documents referenced in the Introduction section) governs the rules and benefits of the FSA options.

Introduction

Albertson's LLC offers the Flexible Spending Account (FSA) Program ("Program") to eligible employees of Albertson's LLC and certain affiliated companies (collectively "Employer" or "Company"). The FSA 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 FSA Program Rules document, together with your separate document entitled "Eligibility Rules Supplement" and the Eligibility Rules Supplements created for other employee groups, comprise the official Plan document for the FSA 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 FSA Program Rules document and the Eligibility Rules Supplements 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 FSA 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 FSA Program option.

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.

Albertson's LLC Flexible Spending Accounts (FSAs)

Under this Program, you are allowed to deduct money on a pre-tax basis from your paycheck to make contributions to your Flexible Spending Account (FSA). You can use funds deposited into the FSAs to pay eligible out-of-pocket medical expenses through the Health Care FSA and dependent care expenses through the Dependent Daycare FSA on a pre-tax basis. This means, FSA deductions from your paycheck are exempt from federal income taxes, Social Security taxes and, in most cases, state income taxes. These deductions reduce your taxable income reportable on your W-2 and on your income tax returns.

Both the Health Care FSA and the Dependent Daycare FSA have minimum and maximum contribution levels. Both are voluntary. You decide if you want to enroll and how much to have taken out of your paycheck.

Because these FSAs are authorized by the Internal Revenue Code, health care expenses for any family member who is a dependent for tax purposes qualifies for the tax savings under the Health Care FSA, even if the family member is not covered under one of the Company's health care options. The Dependent Daycare FSA has age and custody restrictions.

Even if you've waived Company health care coverage, you can participate in the FSAs.

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 participate in the FSA 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 FSA 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 FSA 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.

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 FSA 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 FSA Program or retroactive termination of the coverage of your spouse and/or dependents. In addition, the FSA 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 FS A 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 FSA Program in accordance with its terms.

If you obtain benefits falsely, you will be required to reimburse the FSA 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 for the Health Care FSA by the deadline, as defined in the Eligibility Rules Supplement. If you timely enroll, your Health Care FSA coverage will take effect as of your eligibility date. You may enroll in the Dependent Daycare FSA option only one time per year (during the Annual Enrollment period for an Effective Date of June 1st), provided you are still eligible for benefits at that time.

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 and deductions recalculated to meet your annual election, 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.

Benefit Plan Year Enrollment

Each Benefit Plan Year you must make a new election during Annual Enrollment to participate in either the Health Care FSA or the Dependent Daycare FSA. Your election will be effective June 1st and your payroll deductions will begin the first pay period after June 1st. Once you enroll in either of the FS As, you will not be able to change your election until the next Annual Enrollment period. This means you cannot stop, increase, or decrease your election at any time other than Annual Enrollment unless you experience a qualifying change in status such as marriage, divorce, or birth of a child. Then, the change must be consistent with the event as described in the sections titled "Changing Your Health Care FSA Election During the Year" and "Changing Your Dependent Daycare FSA Election During the Year."

If you are terminated and rehired within 60 days, you will not be treated as a new employee for purposes of this enrollment election. Instead, your prior elections will be reinstated and deductions recalculated to meet your annual election.

Eligibility Requalification Rules

If Albertson's LLC determines, as a result of the eligibility requalification process, that your average hours have dropped so that you are no longer eligible to participate in the Plan, you will be able to continue to participate in the FSA Program for the remainder of the Benefit Plan Year. You will not be eligible to participate in the FSA Program during the next Benefit Plan Year, unless you meet the eligibility requirements to participate in the next Annual Enrollment.

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 call the Associate Contact Center at **1-800-969-9688**, option **2** 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.

How Flexible Spending Accounts Work

When you enroll in the FSAs, you estimate the amount of eligible expenses you will have during the Benefit Plan Year (June 1 – May 31). That total amount will be deducted from your paychecks in equal amounts throughout the year. Although your actual wages remain the same, your taxable wages as reported to the government are reduced by the amount you put into your FSA, as they are considered salary reductions in lieu of a benefit. When you have incurred an eligible expense, you are reimbursed with funds from the applicable FSA. An expense is incurred when you receive the treatment or service, purchase the supply, or order the item - not when you receive the bill or make payment.

The FSA Pre-tax Advantage

Because Health Care FSA and/or Dependent Daycare FSA deductions are taken out of your paychecks before federal income taxes, Social Security taxes, and before state and local income taxes in most states, 100% of each dollar you deposit in these FSAs goes toward eligible expenses. You may pay 15¢ or more of every dollar you earn for federal income tax and 7.65¢ for Social Security taxes. By participating in the Albertson's LLC FSAs, you may save more than 20¢ on every $1 applied to the FSAs. Keep in mind that since Social Security taxes (FICA) are not withheld on the amount set aside in your FSAs, the earnings used to calculate your Social Security benefits may also be reduced. This reduction in earnings may reduce the Social Security benefits to which you will be entitled. It is recommended that you consult a tax advisor for more information.

The "Use It or Lose It" Rule

Under Internal Revenue Service (IRS) rules, you have 2½ months after the end of the Benefit Plan Year – up to and including August 15 – to receive services that are considered eligible health care expenses. If you don't use all the money in your Health Care FSA by August 15, those funds will no longer be available to you. All deposits in a Health Care FSA must be used to reimburse eligible health care expenses incurred by the end of the Benefit Plan Year or within 2½ months following the end of the Benefit Plan Year that the deposits are taken from your paycheck or they will be forfeited. All deposits in a Dependent Daycare FSA must be used to reimburse eligible dependent daycare expenses incurred by the end of the Benefit Plan Year that the deposits are taken from your paycheck or they will be forfeited (the 2½ month grace period following the end of the Benefit Plan Year does not apply to the Dependent Daycare FSA). This is known as the "Use It or Lose It" rule.

Make sure you don't contribute more money to your FSAs than you know your expenses will total. To help you plan how much to contribute to your Health Care FSA and/or Dependent Daycare FSA, we have provided planning worksheets in the SPD under the sections "Planning Your Health Care FSA Election Amount" and "Planning Your Dependent Daycare FSA Election Amount."

You have until September 30 to submit claims for the previous Benefit Plan Year's expenses. However, all services or expenses must be incurred by August 15 for the Health Care FSA or by the end of the Benefit Plan Year for the Dependent Daycare FSA to be eligible for reimbursement. You cannot submit claims for expenses that were incurred before your FSAs became active.

Annual Contributions

Under the Health Care FSA, you can elect the annual minimum of $260, the annual maximum of $2,500, or any amount greater than $260 and less than $2,500.

Health Care FSA Contribution Limits	
	Per Benefit Plan Year
Minimum contribution	**$260**
Maximum total contribution	**$2,500**

Under the Dependent Daycare FSA, you can elect the minimum of $1,300, the annual maximum $5,000, or any amount greater than $1,300 and less than $5,000.

Dependent Care FSA Contribution Limits	
	Per Benefit Plan Year
Minimum contribution	**$1,300**
Maximum total contribution	**$5,000** ($2,500 if you are married and file a separate tax return)

Remember, you cannot change your deduction amount until the next Annual Enrollment period unless you experience a qualifying change in status. We encourage you to seek tax advice for help in determining your yearly contributions.

FSA Limits for Highly Compensated Employees

To qualify for and maintain the tax-preferred status of the Program, the Company must conduct and successfully pass a non-discrimination test each year. The IRS requires this test to ensure that the Program benefits all participants, regardless of the level of compensation. It may be necessary at some point during the year to limit or stop the contributions of highly compensated employees (as defined by the IRS) if it appears the Program may not pass the non-discrimination test.

Unclaimed Reimbursements

Any unclaimed reimbursements (e.g., uncashed checks) that remain unclaimed by you for 18 months forfeit to the Employer.

No Transfers Between Spending Accounts

Tax laws do not allow you to use money in the Health Care FSA for dependent daycare expenses and vice versa. Because of these tax rules, it is important to carefully estimate the amount of eligible health care and dependent daycare expenses you are likely to have during the year. It's better to underestimate your expenses than risk losing some of your FSA contributions at the end of the Benefit Plan Year.

Other Things to Consider

If you participate in an FSA, your Social Security benefit calculations will be based on your lower taxable earnings figures. You can check with your local Social Security office about any impact this may have on your benefits, although this is usually very minor. You cannot claim deductions or credits on your income tax return for the same expenses used to claim FSA benefits. Amounts reimbursed under this Program will reduce the amount of deductible health care expenses and dependent care expenses you can claim for tax credit purposes. It is recommended that you consult a tax advisor for more information.

When Participation Ends

Your participation ends on the earliest of the following dates:

- the date of your death;
- the date your employment ends;
- the date you are no longer eligible to participate;
- the date you miss four consecutive weekly deposits;
- the date you fail to make any required payments or contributions;
- the date you request that your election be terminated as a result of, and consistent with, a permitted election change event or leave of absence rule;
- the last day of the Benefit Plan Year for which you have a benefit election in effect (however, you may still be entitled to submit eligible health care expenses for reimbursement incurred during the 2½ month period following the end of the Benefit Plan Year as described in the "How the Health Care FSA Works" section)
- the date the Program is terminated or amended such that you are no longer eligible for coverage.

Although your deposits stop when your participation ends, you have up to 90 days to request reimbursement for any eligible expenses that were incurred before your participation ended.

Health Care FSA

The Health Care FSA allows you to save money spent on some health care services for yourself and your family that are not fully covered or are ineligible for coverage by your health care or dental plans. A special feature of this benefit allows you to be reimbursed for eligible health care expenses without waiting for the contributions to accumulate in your account.

Generally, eligible health care expenses are expenses not covered by any health care or dental plan. You may use the Health Care FSA for eligible expenses incurred by you, your spouse and any other person who is your dependent, as defined in Section 152 of the IRS Code ("152 Dependent"). Your eligible dependent must also be a U.S. Citizen or national, or a resident of the United States, Canada or Mexico.

How the Health Care FSA Works

1. You decide whether to participate in the Health Care FSA and how much to contribute to your account. There is a minimum of $260 per year and a maximum of $2,500 per year for the Benefit Plan Year from June 1 to May 31.
2. Contributions are deducted from your paycheck each week and put into your FSA before payroll taxes are calculated.

When you make your election in MIO, you also will elect one of the three reimbursement options (see below).

Choose one of the three Reimbursement Options:	PayFlex Mastercard Debit Card	Auto-Claims Submission	Neither
3. You pay for eligible health care services and products when you or a qualified family member receives or purchases them.	Yes, with your PayFlex Mastercard Debit Card	Yes, out-of-pocket	Yes, out-of-pocket
4. Payment process	Present your card for payment of eligible expenses and select "credit" (if applicable). The system will then validate that you have funds available to cover the transaction and automatically deduct the amount from your PayFlex account. You can use your card at qualified merchants where MasterCard is accepted, including pharmacies, physician and dental offices, hospitals and hearing and vision care providers.*	Your eligible expenses associated with your Blue Cross of Idaho medical claims, prescription drug claims, Delta Dental of Idaho dental claims or VSP vision services claims to be automatically paid from your PayFlex Health Care FSA. After the respective claims administrator processes claims, they will notify PayFlex of your FSA-eligible out-of-pocket expenses.	You may choose neither if you would like to control when your FSA claims are submitted and reimbursed. Claims may be submitted to PayFlex online through **www.healthhub.com**, by fax or mail. You must include receipts and (if applicable) the "explanation of benefits" from any other health plan that processed a claim for the service along with your signed claim form.
5. PayFlex reimburses you or your provider for eligible health care expenses	No, since the eligible expenses are automatically deducted from your FSA. Be sure to save your receipts, as you may be required to submit documentation to PayFlex that verifies you used your card to pay for an eligible item or service.	Yes, PayFlex will process the FSA claim and generate a reimbursement to you for the amount that you are responsible for, such as deductible or coinsurance, via check or direct deposit.	Yes
6. Under Internal Revenue Service (IRS) rule, you have 2-1/2 months after the end of the Benefit Plan Year, up to and including August 15, to receive services that are considered eligible expenses. This is often referred to as the 2-1/2 month "grace period." If you don't use all the money in your FSAs by August 15, those funds will be forfeited and no longer available to you			
7. If your participation ends during the Benefit Plan Year, you have three months from the termination date to submit claims.			

* Please Note: FSA debit cards are most effectively used at the time of service to pay fixed expenses such as prescription drug copays, dental expenses and vision copayments. If physician, hospital or other providers will bill your insurance first, a discount on the billed fees will likely apply and then you can use the debit card to pay the remaining balance.

Eligible Health Care Expenses

To be eligible for reimbursement from your Health Care FSA, the health care expenses must be:

- Incurred for medical care, defined in Section 213(d) of the Internal Revenue Code, for amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body including prescription drugs.
- Incurred while you are participating in the Health Care FSA. If you decide not to re-enroll in the Program, you are still eligible for reimbursement during the 2½ month period immediately following the end of the Benefit Plan Year as long as you were enrolled in the Health Care FSA on the last day of the Benefit Plan Year.
- Incurred during the Benefit Plan Year or during the 2½ month(s) immediately following the end of the Benefit Plan Year.

Please note
Any reimbursement you receive through your Health Care FSA can not be reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

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Below is a partial list of the types of health care expenses eligible for reimbursement or eligible for a Qualified Reservist Distribution from your Health Care FSA. Generally, eligible health care expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts.

A more comprehensive list of eligible expenses is available at **www.healthhub.com.** Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office, IRS website **www.irs.gov** or by phone at 1-800-TAX-FORM (1-800-829-3676).

Eligible Medical Expenses

- Copayments, coinsurance and deductible amounts;
- Routine physical exams;
- Routine lab and x-rays performed for medical reasons;
- Birth control items prescribed by your doctor;
- Childbirth classes;
- Ambulance services;
- Drug addiction or alcoholism treatment;
- Sterilization unless prohibited by law;
- Other qualified 213(d) medical expenses not covered by the underlying medical plan;

Vision Expenses

- Routine eye examinations;
- Eyeglasses;
- Contact lenses, including all necessary supplies and equipment;

Hearing Expenses

- Routine hearing examinations;
- Hearing aids and repairs;
- Cost and repair of special telephone equipment for the hearing impared;

Dental Expenses

- Copayments, coinsurance and deductible amounts;
- Preventive Care;
- Exams, cleanings, x-rays, root canals and bridges;
- Dentures and fillings;

Prescription Drugs

- Copayments, coinsurance and deductible amounts;
- Cost for allowable prescription drugs.

Over-the-Counter Medications

- All over-the-counter medicines and drugs must be prescribed by an authorized healthcare provider to be eligible for reimbursement from an FSA, except for over-the-counter insulin.

Qualified Reservist Distribution

- In accordance with the "Heroes Earning Assistance and Relief Tax Act of 2008" ("HEART Act") a qualified distribution is permitted of all or part of any unused Health Care FSA contributions if you are a reservist called to active duty when: (1) the reservist is called up for a period of over 179 days or for an indefinite period of time, and (2) the distribution is made during the period of time between when the order or call is made and the last day that a reimbursement could be made from the Health Care FSA for that Benefit Plan Year.
- To receive a qualified distribution of all or part of any unused Health Care FSA contributions, you must give notice to your Employer by calling the Associate Contact Center at **1-800-969-9688**, option **2** as soon as you receive your orders or are called to active duty. For additional details on how to request a qualified distribution, see section entitled, "Requesting a Qualified Distribution from your Flexible Spending Account".

Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements and toothpaste).
- Expenses incurred before the effective date of your account.
- In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, health expenses reimbursed through your Health Care FSA cannot be claimed as deductions on your income tax return.

Planning Your Health Care FSA Election Amount

It is important to use your Health Care FSA only for expenses that are predictable. One way to estimate these expenses is to add up receipts from last year for health care expenses you paid out of your own pocket, including deductibles or copayments that were not covered by your benefit plan last year. Then, adjust for any expected changes in costs and your personal situation for the Benefit Plan Year (June 1 through May 31). You should also consider special situations that may affect your expenses. For example, if you will have expenses for eyeglasses, elective corrective eye surgery, or orthodontia in the coming year, you may want to set aside pre-tax dollars to help pay for them.

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Use this worksheet to help you determine your Health Care FSA election amount. Budget only for those expenses that are eligible for reimbursement through the Health Care FSA. Remember, eligible expenses include those for you, your spouse and your dependents. Consider any other factors that will affect your out-of-pocket health care costs during the current Benefit Plan Year, which ends May 31, and adjust the amount if necessary.

Health Care Expense Planning Worksheet

Deductibles	$ _____
Copayments/Coinsurance (The amount not paid by your medical or dental plan coverage)	$ _____
Amounts paid over Plan limits (Over reasonable and customary allowance)	$ _____
Expenses NOT covered by your insurance plan	
Your share of prescription drug costs	$ _____
Your share of vision care costs	$ _____
Your share of dental/orthodontic care costs	$ _____
Your share of treatments/therapies costs	$ _____
Your share of fees/services costs	$ _____
Your share of medical equipment costs	$ _____
Your share of psychiatric care costs	$ _____
Assistance for the disabled	$ _____
Other eligible expenses (see eligible list)	$ _____
Total Estimated Out-of-Pocket Health Care Expenses (Your election amount for the Benefit Plan Year)	$ _____

Paid and Unpaid Leaves

You may either revoke or continue your coverage during an approved paid or unpaid leave.

To revoke coverage, you must call the Associate Contact Center at **1-800-969-9688**, option **2** and furnish the revocation in writing. If you revoke coverage, you will not be reimbursed for expenses incurred during your leave. If you return from leave within the same Benefit Plan Year, you may file an election to have your contributions resumed with a prorated election amount (e.g., an amount equal to your original Benefit Plan Year election less the amount of contributions missed during the leave) or with a reinstatement of the full annual election (however you will still not be reimbursed for expenses incurred during your leave). Or, you may change your election if you qualify under the rules governing mid-year changes. If you return to work during a new Benefit Plan Year, you will need to have made a new Benefit Plan Year election during the annual enrollment period to participate for the new Benefit Plan Year.

If you continue coverage while on a paid leave, your contributions will continue during the approved leave period and you will be reimbursed for expenses you incur during the leave. If you continue coverage while on an approved unpaid leave or on an approved paid leave where your pay does not fully cover your benefit contributions, you will be reimbursed for expenses incurred during your leave and you must pay for this coverage by making after-tax contributions through the benefits billing process. If the billing process does not keep you completely current, you may be required to make extra catch-up contributions for coverage after you return from your leave. If you do not pay your contributions when due through the benefits billing process, your election will be cancelled. If your election is cancelled and you return from leave within the same Benefit Plan Year, you may file an election to have your contributions resumed with a prorated election amount (e.g., an amount equal to your original Benefit Plan Year election less the amount of contributions missed during the leave) or with a reinstatement of the full annual election (however you will still not be reimbursed for expenses incurred during the period your election was cancelled). At the beginning and end of your unpaid leave, you may file an election change if you qualify under the rules governing mid-year changes.

Regardless of whether you revoke or continue coverage, you will be eligible to participate in annual enrollment, if you meet eligibility requirements in the Eligibility Rules Supplement.

Uniformed Services Leaves

If you begin a leave of absence to serve in the uniformed services, you may have certain rights under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). If you continue your participation in the health care FSA during your USERRA leave, your required payments will be made with after tax dollars.

The election and payment procedures during a USERRA leave are the same as the COBRA procedures described in the COBRA sections of this document except as follows:

1. You must notify PayFlex COBRA department 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 (not only to the end of the Benefit Plan Year as under COBRA).
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).

If you have any questions about eligible health care expenses call the FSA Administrator, PayFlex at 1-800-284-4885.

As with COBRA coverage, you should send all payments for USERRA continuation coverage to PayFlex COBRA department. If you fail to pay your USERRA premium on time, you will lose all continuation rights under the Program, unless failure to pay is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

Effective June 17, 2008, special "qualified reservists distributions" are available from the health care reimbursement account to reservists who are ordered or called to active duty for a period over 179 days or for an indefinite period. In this case, you can take a taxable distribution of all or some of any unused amounts in your health care reimbursement account at any time between the date of your order or call and September 30 of the subsequent Benefit Plan Year. This distribution does not have to be tied to any qualifying medical expenses but, as noted above, it will be reported as taxable income to you.

To request a qualified reservist distribution, call PayFlex FSA department at 1-800-284-4885.

COBRA

Continuing Your Coverage Under COBRA

If you experience a COBRA qualifying event and are unable to continue pre-tax Health Care Flexible Spending Account deposits, you may be eligible to continue participating on an after-tax basis under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

If you are eligible, the FSA coverage can continue through the end of the Benefit Plan Year.

Notification of Continuation Rights

The Program will offer COBRA continuation coverage only after the Plan Administrator receives notice that coverage has ended due to a qualifying event. You must notify the Associate Contact Center at **1-800-969-9688**, option **2** of any address change for your spouse, your former spouse, or other dependents if the address is different from yours. If the Plan Administrator has timely notice that your coverage has ended because of a qualifying event, COBRA coverage for the Health Care FSA will be offered to you and your dependents, if eligible.

If you have questions regarding COBRA, please contact the COBRA Administrator at:

PayFlex Systems USA, Inc.
Benefits Billing Department
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.

Electing COBRA Coverage

You, your spouse and your children have a limited time in which you can choose COBRA coverage for the FSA. You must return your completed enrollment form within 60 days of the date of the COBRA notification letter. For your coverage to be effective, the first premium must be received within 45 days of your 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 can be accepted no later than the 30th of the month. Late payments will not be accepted and coverage will be terminated as of the due date if payment is not received by the 30th of the month.

Changing COBRA Coverage

As a COBRA participant, you have the same rights as active employees to change your coverage in the event of a qualified change in status event. You may change the amount of your annual election when electing COBRA coverage or stop your COBRA coverage at any time by calling the COBRA Administrator at **1-800-359-3921**. A written request will be required to complete the termination of your coverage.

Changing Your Health Care FSA Election During the Year

Permitted Mid-Year Changes

The chart below identifies the permitted election change events and the consistency requirements that must be met in order to make a desired change.

Deadline for Making Mid-Year Changes

To make a permitted mid-year change, you must call the Associate Contact Center at **1-800-969-9688**, option **2** prior to or within 31 days after the permitted election change event. You may need to provide proof of your permitted election change event and the date the event occurred. Failure to do so may result in denial of your change request. If you submit the necessary documentation prior to the date of the permitted election change event, your new election will be effective the day of the event (e.g., the date you get married). If you submit the necessary documentation within 31 days after the event, your new election will be effective the day your properly completed election is received by HR Shared Services.

The Consistency Rule

Election changes must be consistent with the change event. If Albertson's LLC decides the requested change does not satisfy this rule, the change will not be permitted.

If you have questions about changing your Health Care FSA election during the year, call the Associate Contact Center at **1-800-969-9688**, option **2**.

Permitted Election Change Event	Permitted Election Change
Marriage	Start or increase contributions Cancel or decrease contributions if you and/or any dependent(s) will become eligible under spouse's employer's health care reimbursement account
Divorce or legal separation	Start or increase contributions if you and/or any dependent(s) lose coverage under spouse's employer's health care reimbursement account Decrease (but not cancel) contributions
Death of spouse	Start or increase contributions if you and/or any dependent(s) lose coverage under spouse's employer's health care reimbursement account Decrease (but not cancel) contributions
Change in number of dependent children because of birth, adoption, death, etc	In the event of birth or adoption, start or increase contributions In the event of death, decrease (but not cancel) contributions
Dependent loses eligibility for health care reimbursement account	Decrease (but not cancel) contributions
Dependent gains eligibility for health care reimbursement account	Start or increase contributions
Spouse's employment status changes so that you or your spouse or dependent(s) gain or lose eligibility under spouse's employer's health care flexible spending account	If eligibility in spouse's account is lost, start or increase contributions If eligibility in spouse's account is gained, cancel or decrease contributions
Your employment status changes so that you gain or lose eligibility under the Health Care FSA (e.g., termination or commencement of employment, strike or lockout, commencement of or return from unpaid leave, change in worksite, change from full time to part time or part time to full time)	If eligibility is gained, start contributions (see rules for initial elections) If eligibility is lost, cancel contributions
Residence change	No change permitted
Medicare or Medicaid eligibility change	Start or increase contributions if Medicare or Medicaid eligibility is lost Cancel or decrease contributions if coverage is lost due to Medicare or Medicaid eligibility
Qualified Medical Child Support Order (QMCSO). A "QMCSO" is any judgment, decree or order issued by a court or appropriate state agency directing one parent to provide a child with health coverage, and which meets certain other requirements. You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.	Start or increase contributions if QMCSO requires you to provide coverage for the child and child's expenses are otherwise reimbursable under the health care reimbursement account Cancel or decrease contributions if another person is required to provide coverage and if as a result of the loss of the dependent your contribution level changes
Change to cost or coverage needs	No change permitted

Dependent Daycare FSA

The Dependent Daycare FSA helps you pay for childcare services that make it possible for you and your spouse (if applicable) to work. Under certain circumstances it may also be used to help pay for the care of elderly parents, or a disabled spouse or dependent. You may deposit an annual minimum of $1,300 and an annual maximum $5,000 of pre-tax pay during the Benefit Plan Year to pay for eligible dependent care expenses ($2,500 annual maximum if you are married and file a separate tax return).

To be eligible, you must be at work during the time your eligible dependent receives care. You must also meet one of the following eligibility criteria:

- You are a single parent or guardian.
- You have a working spouse or a spouse looking for work.
- Your spouse is a full-time student during the year while you are working.
- Your spouse is physically or mentally unable to provide for his/her own care.
- You are divorced or legally separated and have custody of your child even though your former spouse may claim the child as a dependent for income tax purposes. (Your Dependent Daycare FSA can be used to pay for childcare services provided during the period the child resides with you.)

An eligible dependent is a qualifying individual who spends at least eight hours a day in your home and is one of the following:

- Your dependent under age 13 for whom you can claim an exemption.
- Your child under age 13 for whom you have custody if you are divorced or legally separated.
- Your spouse who is physically or mentally incapable of self-care.
- Your dependent who is physically or mentally incapable of self-care, even if you cannot claim an exemption for the person for income tax purposes.

In addition to the Dependent Daycare FSA, the IRS offers other tax saving programs for working parents with childcare expenses. The most common is the child and dependent care tax credit, which offers taxpayers a reduction in their annual federal tax bill for the same type of expenses as the Dependent Daycare FSA. To determine what works best for you, please consult with your tax advisor.

How the Dependent Daycare FSA Works

1. If you have a qualified dependent, you decide whether to participate and how much to deposit into your Dependent Daycare FSA (a minimum of $1,300 and a maximum of $5,000 for the Benefit Plan Year from June 1st through May 31st).

2. Deposits are deducted from your paycheck and put into your account before taxes are calculated.

3. Once an eligible dependent care expense is incurred, you have the option of submitting a claim online or completing a paper claim form and mailing or faxing it along with your itemized receipt or documentation. Online claims may be submitted after logging in to your account at **www.healthhub.com.** Paper claim forms may be downloaded from the Administrative Forms section at **www.healthhub.com.** Administrative Forms are found by navigating to the "employees" section of the website, then choose "My HealthHub Resources".

4. Any money in your account that is not used for expenses incurred by May 31 will be lost. You have until September 30 to submit claims for the previous Benefit Plan Year's expenses. However, the service must have been received prior to or on May 31 to be eligible for reimbursement.

Reimbursement After Termination

If your employment terminates during the Benefit Plan Year, you may still be able to request reimbursement for qualifying dependent daycare expenses incurred during the 90 days following your termination or the remainder of the Benefit Plan Year, whichever occurs first. Reimbursement would be made from the balance remaining in your Dependent Daycare account at the time of termination of employment. No further salary deductions or contributions will be made on your behalf after you terminate. You must submit claims within 90 days after the termination date.

Eligible Dependent Daycare Expenses

Following is a partial list of the types of dependent daycare expenses eligible for reimbursement or from your Dependent Daycare FSA. Generally, any eligible dependent care expense that is allowed for the dependent care tax credit on your federal income tax return is eligible for reimbursement through the Dependent Daycare FSA. A more comprehensive list of eligible expenses is available through PayFlex's website, **www.healthhub.com** or you may call PayFlex at 1-800-284-4885 to verify whether your dependent care expenses are eligible for reimbursement. Some guidance regarding eligible dependent daycare expenses is also included in IRS Publication 503. To request a copy of this publication, call the IRS at 1-800-829-3676 or access their website at **www.irs.gov.**

Expenses may be reimbursed for the following services:

- Services provided inside or outside your home by anyone other than your spouse, a person you list as your dependent for income tax purposes or one of your children under the age of 19.
- Services provided by a housekeeper whose services include, in part, providing care for a qualifying individual.
- Services provided through child or adult daycare, nursery, preschool, after school, or summer day camp programs. If the child or adult daycare center cares for more than six persons, it must comply with all applicable state and local regulations.

You may choose any dependent care provider, as long as the provider complies with applicable state and local regulations and provides a Social Security number or federal taxpayer ID number. Your provider can be a baby-sitter, neighbor, nanny, or even a housekeeper with dependent care responsibilities. A relative may qualify as long as he or she is at least age 19 and you do not claim that relative as a dependent on your income taxes.

Dependent Daycare Expenses That Are Not Eligible

All submitted expenses are reviewed for eligibility according to the IRS Code Sections 125 and 129. Some examples of dependent daycare expenses that are not eligible include, but are not limited to:

- Dependent care for a child 13 years old or older
- Babysitting that is not work related
- Schooling in kindergarten or higher grades
- Long-term care services
- Transportation expenses
- Overnight camp

Choosing a Dependent Daycare Provider Is Your Responsibility

The Company is not involved in the selection or endorsement of any provider. You have total freedom of choice. Neither the Company nor the Claims Administrator inspects your child/dependent care provider or independently verifies that the provider complies with the applicable laws and regulations.

Leaves of Absence (including Family and Medical Leave Act (FMLA) Leaves)

If you are on an approved paid or unpaid leave of absence, your contributions and coverage will not be continued during your leave. Upon return within the same Benefit Plan Year, you may make a new election subject to the annual dollar limit after taking your prior election into account.

Planning Your Dependent Daycare FSA Election Amount

Dependent daycare expenses are usually predictable. You can probably estimate the number of weeks that a qualified individual will need care. Be sure to adjust for vacation weeks, holidays and other times when you may not need dependent daycare. If you have expenses for only a portion of the year, such as during the summer months, you must spread your payroll deduction over the whole year.

Albertsons

Use this worksheet to help you determine your Dependent Daycare FSA election amount.

Dependent Care Expense Planning Worksheet

Childcare Expenses	**Annual Expense**
Daycare Center	$ _____
In-Home Care	$ _____
Nursery and Preschool	$ _____
After School Care	$ _____
Summer Day Camps	$ _____
Au Pair Services	$ _____
Other Eligible Expenses	$ _____
Elder Care Services	
Daycare Center	$ _____
In-Home Care	$ _____
Other Eligible Expenses	$ _____
Total Estimated Out-of-Pocket Dependent Care Expenses	$ _____

This total gives you an estimated amount that you should elect to place in to your Dependent Daycare FSA.

Changing Your Dependent Daycare FSA Election During the Year

Permitted Mid-Year Changes

The chart below identifies the permitted election change events and the consistency requirements that must be met in order to make a desired change.

Deadline for Making Mid-Year Changes

To make a permitted mid-year change, you must call the Associate Contact Center at **1-800-969-9688**, option **2** prior to or within 31 days after the permitted election change event. You may need to provide proof of your permitted election change event and the date the event occurred. Failure to do so may result in denial of your change request. If you submit the necessary documentation prior to the date of the permitted election change event, your new election will be effective the day of the event (e.g., the date you get married). If you submit the necessary documentation within 31 days after the event, your new election will be effective the day your properly completed election is received by HR Shared Services.

The Consistency Rule

Election changes must be consistent with the change event. If Albertson's LLC decides the requested change does not satisfy this rule, the change will not be permitted.

If you have questions about changing your Dependent Daycare FSA election during the year, please call the Associate Contact Center at **1-800-969-9688,** option **2.**

Permitted Election Change Event	Permitted Election Change
Marriage	Start or increase contributions because of new dependent(s) with eligible expenses Cancel coverage if your spouse does not work outside the home or cancel or decrease contributions if your spouse has dependent care benefits that will reduce your expenses
Divorce or legal separation	Start or increase contributions if as a result of divorce you have new or additional expenses for eligible dependent(s) Cancel or decrease contributions if your dependent(s) with eligible expenses will reside with spouse and your dependent care needs are reduced or eliminated
Death of spouse	Start or increase contributions if as a result of the death you have new or additional expenses for eligible dependent(s) Cancel or decrease contributions if you had eligible dependent care expenses for your spouse
Change in number of dependent children because of birth, adoption, death, etc.	Start or increase contributions Cancel or decrease contributions if the death of a dependent affects your need for dependent care
Dependent loses eligibility for dependent care reimbursement account	Cancel or decrease contributions but only relating to dependent losing eligibility
Dependent gains eligibility for dependent care reimbursement account	Start or increase contributions but only relating to dependent gaining eligibility
Spouse's employment status changes so that you or your spouse or dependent(s) gain or lose eligibility under spouse's employer's dependent care flexible spending account	Start or increase contributions because of loss of other coverage (e.g., if spouse loses coverage in spouse's employer's dependent care reimbursement account) If eligibility is gained, cancel or decrease contributions

Permitted Election Change Event	Permitted Election Change
Your employment status changes so that you gain or lose eligibility under the Dependent Daycare FSA (e.g., termination or commencement of employment, strike or lockout, commencement of or return from unpaid leave, change in worksite, change from full time to part time or part time to full time)	Start contributions if you have gained eligibility for the dependent care reimbursement account and you have eligible dependent care expenses. 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 contributions will be automatically canceled. You will have until September 30 following the end of the Benefit Plan Year to submit any expenses incurred during the Benefit Plan Year (both before and after your contributions were canceled)
Residence change	Start, increase or decrease contributions, as applicable, if your coverage costs or needs change as a result of the residence change
Certain prospective changes are permitted if they are due to and correspond with a permitted change made under your spouse's employer's plan (for example, if your spouse enrolls in coverage under his or her employer's dependent care reimbursement account during the annual enrollment period if it and the plan year are different than Albertson's LLC's annual enrollment and Benefit Plan Year)	Start or increase contributions if you are dropping coverage under spouse's dependent care reimbursement account Cancel or decrease contributions if you and/or any dependent(s) will be covered by spouse's dependent care reimbursement account
Medicare or Medicaid eligibility change	No change permitted
Court order requires you to provide dependent care coverage and, as a result, your coverage needs change	Start or increase contributions, as applicable
Change to cost or coverage needs	Increase or decrease contributions if your dependent care costs (as long as the daycare provider is not your relative) or coverage changes. For example, if your daycare center increases its rates, you can increase your contributions prospectively, as long as you have not already elected to contribute the annual maximum. If your work hours change and you need less or more hours of daycare, you can make a corresponding change to your election

Filing a Claim for Reimbursement

Claim Forms

You can obtain a claim form for both the Health Care and Dependent Daycare FSAs by calling PayFlex at **1-800-284-4885** or by downloading it from the Administrative Forms section at www.healthhub.com. Administrative Forms are found by navigating to the "employees" section of the website then choosing "My Healthhub Resources".

Deadline for Filing Claims

All claims for your FSAs must be filed by September 30 after the Benefit Plan Year ends on May 31st. However, health care expenses must have been incurred prior to or on August 15th to be eligible for reimbursement from the Health Care FSA. Dependent daycare expenses must have been incurred by May 31st to be eligible for reimbursement from the Dependent Daycare FSA. You may file a claim for reimbursement from either of your FSAs at any time during the year. There is no minimum claim amount.

For the Dependent Daycare FSA, you are reimbursed up to the amount you currently have deposited in your account. If your claim exceeds your current deposit, the excess will be held until you have enough money to cover it.

For the Health Care FSA, you can submit a claim at any time for up to the total amount of your annual contribution.

It is your responsibility to ensure that all claims are submitted by the deadline. Claims submitted after the deadline will be denied and you will forfeit any amounts remaining in your account. There will be no exceptions to this deadline.

Whom to Call If You Have FSA Claim Questions

If you have a question about FSA, your account, or a claim you have submitted or wish to submit, contact PayFlex at 1-800-284-4885. You may also review your account online at www.healthhub.com

Automatic Reimbursement

If you have a claim that is eligible for payment under a Blue Cross Medical Program option, a Delta Dental option, or a VSP Vision option you may choose to have the claim automatically submitted by Blue Cross, Delta Dental or VSP to the FSA Administrator, PayFlex. You may be required to sign a written authorization for this service. Other claims require that you complete and submit a claim form with a copy of the expense receipt to the FSA Administrator.

Pay Flex Card®

Another option available for reimbursement of Health Care FSA expenses is the PayFlex Card®. As you incur eligible healthcare expenses, you can use your PayFlex Card® as a form of payment. All you have to do is swipe your card and select "Credit." If you are paying for services or items from a healthcare-related merchant or one that has implemented an inventory information approval system, your transaction will be automatically approved at the point of sale. Documentation of your expenses may be required in order to meet IRS guidelines. Therefore, you should keep copies of all itemized receipts (not just your credit card receipt) and Explanation of Benefits (EOB) for each purchase. You must comply with IRS guidelines by using the card only for qualifying expenses, and providing appropriate documentation upon request.

Filing a Health Care FSA Claim

You may file a claim for reimbursement from your account at any time during the year. If you have not elected automatic reimbursement or the PayFlex Card®, you must file a claim.

By following the steps outlined below, you will provide the information needed to process your claim quickly. You will also have detailed documentation of your claim, which you will need in the event of an IRS audit.

Follow these steps to file a claim:

- After you incur an eligible expense, you have the option of submitting a claim online or completing a paper claim. Online claims may be submitted after logging into your account at PayFlex's website, www.healthhub.com. Paper claim forms are available by calling PayFlex at **1-800-284-4885** or by downloading them from the website, www.healthhub.com.
- When submitting a claim for reimbursement that is partially covered by your health care or dental plan, you must include the explanation of benefits (EOB), which indicates the out-of-pocket expense amount.
- When submitting a claim for reimbursement for which none or only a portion of the expense is covered by your health care or dental plan, you must include a copy of your insurance EOB as well as an itemized bill, receipt or statement from the provider. The form must include all of the following:
  - The provider's name and address
  - The date(s) of service
  - The type of service
  - The dollar amount charged
- When requesting reimbursement for prescription drugs, medical equipment, vision services or specialized therapy, you must include the following:
  - Prescription Drugs - A receipt that provides the patient's name, the prescription name and the dollar amount.
  - Medical Equipment - A letter/note from the physician prescribing the equipment as treatment for a specific condition (for example, glucose monitor for diabetes), as well as an itemized bill or receipt.
  - Vision Services - An itemized receipt for glasses and/or contact lenses. Claims for enzyme solutions and lens solutions must also be accompanied by a receipt identifying the brand name or type of item purchased.
  - Specialized Therapy - A letter/note from your physician prescribing the therapy as treatment for a specific medical condition, as well as an itemized bill or receipt.
- When requesting reimbursement for orthodontia expenses, you are required to submit one of the following:
  - **Coupon Payment Option** – You can submit an itemized statement of your orthodontia expenses as the service is provided. Submit this documentation with a completed claim form for reimbursement.
  - **Monthly Payment Option (Auto Pay)** – To set up orthodontia Auto Pay, download a claim form via My HealthHub Resources, complete all required fields and make sure to check the box for "Automatic Monthly Reimbursement for Orthodontia expenses". You must also include a copy of your orthodontia contract/agreement* with your first claim. Once the claim has been processed, PayFlex will automatically reimburse you each month, according to the agreement.

    * Your orthodontia contract/agreement needs to include patient name, date the service begins, length of service, charge for initial banding work and dollar amount charged each month.
  - **Total Payment Option** – If you paid the full amount when the orthodontia treatment began, you can get reimbursed for the amount you paid for the treatment, minus the amount covered by your dental insurance.
- Keep a copy of all bills and completed FSA claim forms for your records.
- For online submission, claim information is entered online and proof of the expense may be uploaded directly to PayFlex for processing. For paper claims, send or fax the completed claim form along with proof of the expense to the address or fax number on the Reimbursement Accounts Claim Form.
- When the claim is processed, the FSA Administrator will send you an explanation of payment and a check for reimbursement of your eligible health care expenses. You have the option to receive payment through direct deposit. Enrollment for direct deposit can be completed after registering and logging into your account at www.healthhub.com.

Filing a Dependent Daycare FSA Claim

You must send completed Reimbursement Accounts Claim Forms to PayFlex by the filing deadline to receive reimbursement for eligible dependent daycare expenses. Follow these steps to file a claim:

- Each time you request reimbursement of eligible expenses, fill in a Reimbursement Accounts Claim Form with the dollar amount of the expense and the dates that dependent daycare services were provided. Be sure to sign the FSA claim form. Claim forms are available by calling PayFlex at **1-800-284-4885** or by downloading them from PayFlex's website www.healthhub.com. Online claims may also be submitted after logging into your account at www.healthhub.com.
- Have your dependent daycare provider sign the FSA Claim Form or provide a valid receipt to support your request for reimbursement.
- For online submission, claim information is entered online and proof of the expense may be uploaded directly to PayFlex for processing. For paper claims, send or fax the completed claim form along with proof of the expense to the address or fax number on the Reimbursement Accounts Claim Form.
- When the claim is processed, the FSA Administrator will send you an explanation of payment and a check for reimbursement of your eligible health care expenses. You have the option to receive payment through direct deposit. Enrollment for direct deposit can be completed after registering and logging into your account at www.healthhub.com.

You can submit claims at any time, but reimbursement will only be up to the amount of funds available in your account. If your Dependent Daycare FSA balance is less than the amount of reimbursement requested, you will receive reimbursement for the amount remaining in your account. The balance of your request will automatically be paid after additional funds are deposited into your account.

If a Claim Is Denied

If you disagree with a benefit determination or if your claim for benefits is denied, in whole or in part, you will be sent a written notice explaining the reason(s) for the denial, usually within 30 days of the claim.

Claims Review and Appeal Procedures

If your claim under the Program is denied in whole or part, you will receive, by mail, a written explanation of the specific reason for the denial. You may elect to receive notifications by email through PayFlex's ENotify electronic notification service. This written notice will include specific references to the Program provisions on which the denial is based and will explain the Program's review procedures.

You have the right to appeal the denial of the claim to the Claims Administrator. You can request by appealing, in writing, to the Claims Administrator within 180 days after you receive the written notice of the reduction or denial. Upon request, Albertson's LLC will provide documents, records and other information that is relevant to your claim for benefits. This information will be provided free of charge.

The Claims Administrator will review and make decisions on all claim denials. A decision will be made within 60 days of when the Claims Administrator receives the appeal. The decision will be sent to you in writing and will include specific reasons for the decision and specific references to the Program provisions on which the decision is based.

If you have followed these procedures and you still do not agree with the Claim Administrator's decision about your claim, you can file suit in federal court.

Claims Procedures for Eligibility, Contributions and Plan Administrative Claims Determinations

For a dispute concerning your eligibility to participate in the FSA 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 E. 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 FSA Program and to determine all factual and legal questions under the FSA 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 FSA 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 Filing a Claim for Reimbursement section), 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 FSA Program (including those in the Filing a Claim for Reimbursement section). In addition, in any legal action brought after you have exhausted administrative remedies, all determinations made by the Benefits Administrative Committee and the Benefit Plans Committee, shall be afforded the maximum deference permitted by law.

Time Limits for Commencing Legal Action

If you file a claim within the required time, complete the entire claims procedure (including those in the Filing a Claim for Reimbursement section), 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 FSA Program, see the Claims Procedures in the "Filing a Claim for Reimbursement" section.

Other Important Information

Your ERISA Rights

As a participant in the Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all 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 Program and a copy of the latest annual report (Form 5500 Series) that the 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 Program, including insurance contracts and collective bargaining agreements, 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 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 Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the 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 Program on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Program participants, ERISA imposes duties upon the people who are responsible for the operation of the FSA Program. The people who operate your Program, called fiduciaries of the Program, have a duty to do so prudently and in the interest of you and other 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 was 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 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 Program's Claims Procedures. In addition, if you disagree with the 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 Program fiduciaries misuse the 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 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), 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, including the "Claims Review and Appeal Procedures" section. If you have questions about your benefits under the FSA Program that are not answered in this booklet, you are encouraged to contact the FSA 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 FSA 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 Plan 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 FSA 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 FSA 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 FSA Program and decide all questions of eligibility.
2. prescribe forms, procedures, policies and rules to be followed by you and other persons claiming benefits under the FSA Program;
3. prepare and distribute information to you explaining the FSA Program;
4. receive from you and any other parties the necessary information for the proper administration of eligibility requirements under the FSA Program;
5. receive, review and maintain reports of the financial condition and receipts and disbursements of the FSA 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 FSA 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 FSA Program, except with respect to claim 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 FSA Program and/or to provide advice and assistance in the general administration of the FSA Program. Such service agent(s) may also be given the authority to make payments of benefits under the FSA 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 procedures, policies, interpretations, rules, or practices made, adopted, or approved by the Plan Administrator.

Termination or Changes to the FSA Program

The FSA 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 FSA Program is funded by contributions from the Employees.

Controlling Law

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

Collective Bargaining Agreements

The FSA 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.

General Plan Information

PLAN NAME	Albertson's LLC Health & Welfare Plan The FSA 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	Flexible Spending Account
CONTRIBUTION SOURCE	Employee contributions
FUNDING	The Health Care Flexible Spending Accounts and Dependent Daycare Flexible Spending Accounts are only bookkeeping entries. There are no assets in the accounts and there is no fund or trust for the benefits. All claims for benefits are paid from the general assets of the Employer. With respect to the amounts withheld from your pay, you are only a general, unsecured creditor of the Employer. Forfeitures from accounts are used to pay some of the administrative expenses of the Program. 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.
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	Albertson's LLC P.O. Box 20 Boise, ID 83726 Telephone: 1-800-969-9688
FSA CLAIMS ADMINISTRATOR	PayFlex Systems USA, Inc. P.O. Box 3039 Omaha, NE 68103-3039 Telephone: 1-800-284-4885 www.healthhub.com
TYPE OF ADMINISTRATION	Contract Administration
ALBERTSON'S LLC BENEFITS ADMINISTRATIVE COMMITTEE AND/OR ALBERTSON'S LLC BENEFIT PLANS COMMITTEE	Albertson's LLC Attn: Director of Employee Benefits P.O. Box 20 Boise, ID 83726
PLAN YEAR (Benefit Plan Year)	June 1 through May 31
COBRA Administrator	PayFlex Systems USA, Inc. P.O. Box 2239 Omaha, NE 68103-2239 Telephone: 1-800-359-3921

Appendix A

ALBERTSON'S LLC

HEALTH & WELFARE PLAN

HIPAA PRIVACY AND SECURITY PROVISIONS

SECTION 1

INTRODUCTION

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

SECTION 2

DEFINITIONS AND HYBRID ENTITY

DESIGNATION

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

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

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

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

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

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

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

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

(g) as Required By Law;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3

USE AND DISCLOSURE OF PHI

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

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

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

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

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

3.4. Pursuant to an Authorization. Pursuant to an authorization that satisfies the requirements of the Privacy Rule and the HITECH Act, if and when applicable, Covered Entity may disclose PHI to Plan Sponsor, to an Identified Person, or to any other person identified in the authorization ("recipient") and such recipient may further use or disclose such PHI for any purpose specified in the authorization. The terms of these HIPAA provisions (including but not limited to Sections 3 and 4) shall not apply to disclosures of PHI made pursuant to an authorization.

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

SECTION 4

CERTIFIED OBLIGATIONS OF PLAN SPONSOR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 5

ADEQUATE SEPARATION

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

5.2. Compliance Requirements.

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

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

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

SCHEDULE A

IDENTIFIED PERSONS

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