2025 Legally Required Disclosures

Each year, there are federal disclosures that Albertsons Companies, Inc. (“Albertsons”) is required to provide to plan members. These disclosures are intended for individuals enrolled in the Albertsons Companies, Inc. Health and Welfare Plan, the New Albertsons Health & Welfare Plan, and the PakN’Save Health and Welfare Plan (the “Albertsons Companies Plans” or “the Plans”). In the event of a conflict between the official Plan Document and these legal notices, the summary plan description, or any other communication related to the Plans, the official Plan Document will govern.

These disclosures are for your information only. There is no action needed. If you have questions after reading these notices, or would like a printed copy of these notices, please contact the Benefit Dept at totalbenefits@unitedtexas.com or 888-791-0220.

Notice or disclosure

Important Note: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 7 for details.

Women's Health and Cancer Rights Act Annual and Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the Albertsons Companies plans. If you would like more information on WHCRA benefits, call the number on your medical ID card and speak with a Member Services Representative.

Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

COMMITMENT TO PRIVACY

Albertsons is committed to protecting the privacy of your Protected Health Information ("PHI"). PHI is information collected, maintained, used and/or disclosed by the Albertsons Companies Plans, including demographic information, that may identify you and that relates to health care services provided to you, the payment of health care services provided to you, or your physical or mental health or condition, in the past, present or future.

The Plans also pledge to provide you with notification regarding certain rights related to your PHI.

By this Notice of Privacy Practices ("Notice"), the Plans inform you that they have the following legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act and the related regulations (collectively "HIPAA"):

- To maintain the privacy of your PHI;
- To provide you with this Notice of its legal duties and privacy practices with respect to your PHI; and
- To follow the terms of this Notice currently in effect.

This Notice also informs you how the Plans use and disclose your PHI and explains the rights that you have with regard to your PHI maintained by the Plans. For purposes of this Notice, "you" and "yours" refers to participants and dependents who are eligible for benefits described under the Plans and related programs.

INFORMATION SUBJECT TO THIS NOTICE

The Plans collect certain PHI about you to help provide health benefits to you, as well as to fulfill legal requirements. The Plans collect this information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plans' administrative staff and health care providers, and from reports and data provided to the Plans by health care service providers or other employee benefit plans. The PHI that the Plans have about you includes, among other things, your name, address, phone number, birth date, social security number, and medical and health claims information. This is the information that is subject to the Plan's privacy practices described in this Notice.

This Notice does not apply to health information collected or maintained by Albertsons on behalf of the non-health employee benefits that it sponsors, including disability benefits, life insurance, accidental death and dismemberment insurance, and workers' compensation insurance. This Notice also does not apply to health information that Albertsons requests, receives, and maintains about you for employment purposes, such as employment testing, or determining your eligibility for medical leave benefits under the Family and Medical Leave Act or disability accommodations under the Americans With Disabilities Act.

THE PLANS' USES AND DISCLOSURES

Except as described in this section, as provided for by federal, state or local law, or as you have otherwise authorized, the Plans only use and disclose your PHI for the administration of the Plans and for processing claims. The uses and disclosures that do not require your written authorization are described below.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

For Treatment. The Plans may use and disclose your PHI to a health care provider, such as a hospital or physician, to assist the provider in treating you. For example, if a Plan maintains information about interactions between your prescription medications, that Plan may disclose this information to your health care provider for your treatment purposes.

For Payment. The Plans may use and disclose your PHI so that your claims for health care services can be paid according to their terms. For example, if a Plan has a question about payment for health care services that you received, that Plan may contact your health care provider for additional information.

For Health Care Operations. The Plans may use or disclose your PHI so they can operate efficiently and in the best interests of their participants. For example, a Plan may disclose PHI to its auditors to conduct an audit involving the accuracy of claim payments.

Uses and Disclosures to Business Associates

The Plans may disclose your PHI to third parties that assist the Plans in their operations. For example, a Plan may share your PHI with its business associate if the business associate is responsible for paying medical claims for that Plan. The Plans' business associates have the same obligation to keep your PHI confidential as the Plans do. The Plans must require their business associates to ensure that your PHI is protected from unauthorized use or disclosure.

Uses and Disclosures to the Plan Sponsor

The Plans may disclose your PHI, without your consent, to Albertsons Companies, Inc., its subsidiaries or affiliates, or its designees ("Albertsons") for administration purposes, such as determining the amount of benefits you or your eligible dependent is entitled to from a Plan, determining or investigating facts that are relevant to a benefit claim, determining whether your benefits should be terminated or suspended, performing duties that relate to the establishment, maintenance, administration and/or amendment of a Plan, communicating with you about the status of a claims, recovering any overpayment or mistaken payments made to you, and handling issues related to subrogation and third party claims.

Other Uses and Disclosures That May Be Made Without Your Authorization

HIPAA provides for specific uses or disclosures of your PHI that the Plans may make without your authorization, as follows:

1. **Required by Law.** The Plans may use and disclose PHI about you as required by federal, state or local law. For example, a Plan may disclose your PHI for the following purposes:

- For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority.
- To report information related to victims of abuse, neglect, or domestic violence.
- To assist law enforcement officials in their law enforcement duties.

2. **Health and Safety.** Your PHI may be disclosed to avert a threat to the health or safety of you, any other person, or the public, pursuant to applicable law. Your PHI also may be disclosed for public health activities, such as preventing or controlling disease or disability.

3. **Government Functions.** Your PHI may be disclosed to the government for specialized government functions, such as intelligence, national security activities, and protection of public officials. Your PHI also may be disclosed to health oversight agencies that monitor the health care system for audits, investigation, licensure, and other oversight activities.

4. **Active Members of the Military and Veterans.** Your PHI may be used or disclosed to comply with laws related to military service or veterans' affairs.

5. **Workers Compensation.** Your PHI may be used or disclosed in order to comply with laws related to Workers' Compensation.

6. **Emergency Situations.** Your PHI may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency, or to a disaster relief entity in the event of a disaster.

7. **Others Involved In Your Care.** In limited instances, your PHI may be used or disclosed to a family member, close personal friend, or others who the Plans have verified are involved in your care or payment for your care. For example, if you are seriously injured and unable to discuss your case with a Plan, that Plan may so disclose your PHI. Also, upon request, the Plans may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

8. **Personal Representatives.** Your PHI may be disclosed to people you have authorized or people who have the right to act on your behalf. Examples of personal representatives are parents for minors, and those who have Power of Attorney for adults.

9. **Treatment and Health-Related Benefits Information.** The Plans and their business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services or medication.

10. **Research.** Under certain circumstances, the Plans may use or disclose your PHI for research purposes, as long as the procedures required by law to protect the privacy of the research data are followed.

11. **Organ and Tissue Donation.** If you are an organ donor, your PHI may be used or disclosed to an organ donor, eye, or procurement organization to facilitate an organ or tissue donation or transplantation.

12. **Deceased Individuals.** The PHI of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Prohibition on Use and Disclosures of Genetic Information

The Plans are prohibited from using or disclosing your genetic information for underwriting purposes.

Any Other Uses and Disclosures Require Your Authorization

Most uses or disclosures of psychotherapy notes (where applicable), uses and disclosures of PHI for marketing purposes and disclosures that constitute the sale of PHI require an authorization. Other uses and disclosures of your PHI other than those described above will be made only with your express written authorization. You may revoke your authorization in writing. If you do so, the Plans will not use or disclose your PHI subject to the revoked authorization, except to the extent that the Plans have already relied on your authorization.

Once your PHI has been disclosed pursuant to your authorization, HIPAA protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your or the Plans' knowledge or authorization.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your PHI that the Plans collect and maintain. You are required to submit a written request related to these rights, as described below, and you should address such requests to Albertsons Privacy Office, 250 Parkcenter Blvd, Boise, ID 83706 or **HIPAAHotline@Albertsons.com**.

Right to Inspect and Copy PHI

You have the right to inspect and obtain a copy of your health record. This includes, among other things, PHI about your plan coverages, claim records, and billing records. To inspect and copy your health record maintained by the Plans, submit your request in writing to the Albertsons Privacy Office at the address above. The Plans may charge a reasonable fee per page for the hardcopy copies, which includes the cost of mailing your health record to you. If your health record is maintained electronically, you have the right to receive such electronic PHI in the electronic form and format you request if it is readily producible or, if not, in a readable electronic form and format agreed to by you and the Plans. The Plans may charge you for the cost of any electronic media (other than email) used to provide your electronic PHI. In certain limited circumstances, the Plans may deny your request to

inspect and copy your health record. If a Plan does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that the Plans communicate your PHI to you in confidence by alternative means or in an alternative location. For example, you can ask that a Plan only contact you at work or by mail, or that a Plan provide you with access to your PHI at a specific location. To request confidential communications by alternative means or at an alternative location, submit your request in writing to the Albertsons Privacy Office at the address above. Your written request should state the reason(s) for your request and the alternative means by or location at which you would like to receive your PHI. If appropriate, your request should state that the disclosure of all or part of your PHI by non-confidential communications could endanger you. The Plans will accommodate reasonable requests and will notify you appropriately.

Right to Request That Your PHI Be Amended

You have the right to request that the Plans amend your PHI if you believe the information is incorrect or incomplete. To request an amendment, submit a detailed request in writing to the Albertsons Privacy Office at the address above and provide the reason(s) that support your request. A Plan may deny your request if you have asked to amend information that:

- Was not created by the Plan, unless you provide the Plan with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of your PHI maintained by or for the Plan;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Albertsons Privacy Office will notify you in writing as to whether it accepts or denies your request for an amendment to your PHI. If Albertsons Privacy Office denies your request, it will explain the reason(s) for the denial and describe how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your PHI by a Plan to others, except that disclosures for treatment, payment or health care operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The accounting covers up to six years prior to the date of your request.

To request an accounting of disclosures, submit your request in writing to the Albertsons Privacy Office at the address above. If you want an accounting that covers a time period of less than six years, please state that in your request. The first accounting that you request within a twelve-month period will be free. For additional accountings in a twelve-month period, the Plans will charge you for the cost of providing the accounting, but the Plans will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your PHI that the Plans use or disclose about you to carry out treatment, payment or health care operations. Also, you have the right to request restrictions on your PHI that the Plans discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plans are not required to agree to your request for such restrictions, and the Plans may terminate their agreement to the restrictions you requested. To request restrictions, submit your request in writing to the Albertsons Privacy Office at the address above, and advise the applicable Plan as to what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions. The Plan will also notify you in writing if it terminates an agreement to the restrictions that you requested.

Right to Receive Breach Notification.

You have the right to, and will receive, notification if a breach of your unsecured PHI requiring notification occurs.

Right to Complain

You have the right to complain to the Plans and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with a Plan, submit your complaint in writing to the Albertsons Privacy Office as detailed above. You will not be retaliated or discriminated against, and no services, payment, or privileges will be withheld from you because you file a complaint with a Plan or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the Albertsons Privacy Office at the address above.

You may also obtain a copy of this Notice on the enrollment website.

CHANGES IN THE PLAN'S PRIVACY PRACTICES

The Plans reserve the right to change their privacy practices and make the new practices effective for all PHI that they maintain, including your PHI that they created or received prior to the effective date of the change and your PHI they may receive in the future.

If the Plans materially change any of their privacy practices covered by this Notice, they will revise this Notice, and: (1) prominently post the material change or the revised Notice on the enrollment website by the effective date of the material change to the Notice; and
(2) provide the revised Notice, or information about the material change and how to obtain the revised Notice during the next annual enrollment or at the beginning of the plan year if there is no annual enrollment process. In addition, copies of the revised Notice will be made available to you upon your written request.

CONTACT INFORMATION

If you have any questions, concerns or would like more information about the Plans' privacy practices or this Notice, please contact the Albertsons Privacy Office.

HIPAA Privacy Officer
Albertsons Privacy Office
877-251-6559 (toll free)
HIPAAHotline@albertsons.com
250 Parkcenter Blvd
Boise, ID 83706

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Important Note: This brief summary of the right you and your dependents have to continue insurance is not intended as the official notice of your rights required by federal and state law. We've included this brief summary to inform you that you have these rights.
You'll receive a separate, detailed explanation of your right to continue health insurance coverage when applicable. Specific information is also available from the United Benefit Department.

If you're an associate with medical, dental, vision, CompPsych (EAP), or Health Care FSA coverage under the Albertsons Companies Plans, you have the right to choose continuation coverage if you lose your group health coverage due to reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct. Your eligible dependents may also have the right to elect and pay for continuation of coverage for a temporary period in certain circumstances where their coverage under the Plan would otherwise end, for example, due to a divorce, or no longer meeting eligibility requirements.

Notice of Nondiscrimination

To the extent required by Section 1557 of the Patient Protection and Affordable Care Act (the "ACA"), Albertsons and the respective Plans comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Albertsons and the Plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

To the extent required by Section 1557 of the ACA, Albertsons and the Plans:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - — Qualified sign language interpreters
  - — Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - — Qualified interpreters
  - — Information written in other languages

If you need these services, please contact the Ethics and Compliance Department as indicated below.

If you believe that Albertsons or the Plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Albertsons Companies, Attn: Chief Compliance Officer, 250 Parkcenter Blvd., Boise, ID 83706, or call 855-673- 1084 (toll free), or send a fax to 208-395-4656 (fax), or email **ethics.compliance@albertsons.com**. You can file a grievance by mail, fax, or email. If you need assistance in filing a grievance, you may contact a member of our compliance department.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

If you speak Arabic, Armenian, Chinese, French, Haitian Creole, Italian, Japanese, Korean, Persian (Farsi), Polish, Portuguese, Russian, Spanish,Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 855-673-1084 (TTY: 855-673-1084).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة
اللغوية تتوافر لك بالمجان. اتصل برقم
855-673-1084 (855-673-1084). :

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 855-673-1084 (TTY հեռատիպ) (855-673-1084).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-673-1084 (TTY: 855-673-1084)。

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855-673-1084 (ATS: 855-673-1084).

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 855-673-1084 (TTY: 855-673-1084).

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 855-673-1084 (TTY: 855-673-1084).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。855-673-1084 (TTY: 855-673-1084）まで、お電話にてご連絡ください。

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-673-1084 (TTY: 855-673-1084)번으로 전화해 주십시오.

Persian-Farsi

هجوت :ناگیار نابز کمک ، دینک یم تبحص یسراف هب رگا
سامت (TTY: 855-673-1084) 855-673-1084 تسا. اب
.دیریگب

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 855-673-1084 (TTY: 855-673-1084).

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 855-673-1084 (TTY: 855-673-1084).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855-673-1084 (телетайп: 855-673-1084).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-673-1084 (TTY: 855-673-1084).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855-673-1084 (TTY: 855-673-1084).

Vietnamese

CHÚ Y: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855-673-1084 (TTY: 855-673-1084).

Medicare Part D Creditable Coverage Notice From Albertsons

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Medical Programs in the Plans:

This notice also has information about your options under Medicare's prescription drug coverage. It is your responsibility to provide a copy of this notice to your Medicare-eligible spouse or dependent if enrolled in one of these Plans, as applicable. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

If you are covered under any Medical Program Option other than the Bronze PPO Option, there are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Albertsons has determined that the prescription drug coverage offered by these Medical Program Options is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

- Because your existing coverage is Creditable Coverage, you can keep coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you are covered under the Bronze PPO Option under the Plans, there are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Albertsons has determined that the prescription drug coverage offered by the Bronze PPO Option under the Plans is NOT, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Non-Creditable Coverage**. This is important because, most likely, you will get more help on your drug costs if you join a Medicare drug plan than if you only participate in the Bronze PPO Option. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible for Medicare.

- You can keep your current coverage from the Bronze PPO Option. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully — it explains your options.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. If you are enrolled in any Medical Program Options other than the Bronze PPO Option Medical Program and you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you are covered under the Bronze PPO Option (Non-Creditable Coverage) and you lose or decide to drop your current coverage under your Plan, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Bronze PPO Option.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

If you are enrolled in any Medical Program Options other than the Bronze PPO Option, if you drop or lose coverage with the Plan and you don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you are covered under the Bronze PPO Option (Non-Creditable Coverage), depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens to Your Current Coverage If You Participate in the Bronze PPO Option and You Decide to Join A Medicare Drug Plan?

Your Bronze PPO Option medical coverage pays for other medical expenses in addition to prescription drugs. You or your covered family members that choose to enroll in a Medicare prescription drug plan will be eligible to continue receiving these other medical benefits. In general, for those who are Medicare eligible and active Albertsons employees, the Bronze PPO Option prescription drug coverage will continue to pay primary for you or your covered family members that enroll in a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current coverage under the Bronze PPO Option, be aware that you and your dependents may not be able to get this coverage back.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the Benefits Department at 888-791-0220 or .

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if your coverage through the Plans changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 800-772-1213 (TTY 800-325-0778).

Keep this notice. If you decide to join a Medicare drug plan, you may be required to show a copy of this notice.

If you require proof of creditable coverage when applying for Medicare Part D coverage, please contact the Benefits Service Center.

Date:
October 15, 2024

Name of Entity/Sender:
United Supermarket

Mailing Address:
United Supermarket
Attn: Benefits Department
7830 Orlando Ave

Notice Regarding Wellness Program

(Only applies to certain current employees in eligible workgroups as communicated in enrollment materials)

As part of the medical programs for Albertsons Companies, WellConnected is a voluntary wellness program that may be available to employees who are eligible for the employer-sponsored plans. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health assessment that asks a series of questions about your health- related activities and behaviors and whether you have or had certain medical conditions (e.g. cancer, diabetes, or heart disease). You will also be required to complete a preventive care visit with your doctor. The medical claim may automatically submit, or you may need to have your healthcare provider fill out a form with your biometric data, including cholesterol and blood sugar levels. You are not required to complete the health assessment or to participate in the blood test or other medical examinations.

However, employees and/or their eligible spouse who choose to participate in the wellness program and complete the requirements by the deadline communicated in Open Enrollment materials will receive a weekly incentive in the form of reduced required contributions for participation in the Medical Program. Note, some work groups are not eligible for this incentive. The information you receive about your required contributions to participate in the Medical Program will provide information about the incentive if it is available for your work group.
Although you are not required to complete the personal health assessment or to participate in the biometric screening, only employees who do so will receive the wellness incentive.

If your network provider requires you to participate in certain health-related activities or achieve certain health outcomes, you may be entitled to a reasonable accommodation or, if it is unreasonably difficult for you to meet the program requirements or medically inadvisable to do so, you may request a waiver form from your medical plan provider. For employees enrolled in medical coverage through Blue Cross of Idaho or SelectHealth call Blue Cross of Idaho at 855-854- 1412.

The information from your health assessment and biometric screenings will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as health and wellness coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Albertsons Companies may use aggregate information it collects to design a program based on identified health risks in the workplace, WellConnected will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) your healthcare provider and your medical plan provider health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decisions. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participation in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact:

HIPAA Privacy Officer
Albertsons Privacy Office
877-251-6559 (toll free)
HIPAAHotline@albertsons.com
250 E. Parkcenter Blvd.
Boise, Idaho 83726

Your Right to Appeal

Eligibility and Administrative Claims

If you disagree with an initial determination regarding your eligibility to participate in the Plan or a particular Plan 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, you must appeal in writing. Send your written appeal to the Albertsons Companies Health and Welfare Benefits Administrative Claims Committee ("Administrative Claims Committee"), at the following address:

United Supermarket
Attn: Benefits Department
7830 Orlando Ave
Lubbock, TX 79424

Eligibility and Administrative Appeals

If you feel benefits have been denied due to an eligibility or administrative issue, you have the right to appeal the decision with the Albertsons Companies Health and Welfare Benefits Administrative Claims Committee ("Administrative Claims Committee").

To file an appeal be sure to send all supporting information along with a letter of explanation to:

United Supermarket
Attn: Benefits Department
7830 Orlando Ave
Lubbock, TX 79424

You must file your appeal within the timeframe and in accordance with the rules set forth in the official Plan document, SPD, or insurance contract. Please carefully review those documents because there is a specific deadline for filing an appeal. You will receive a written decision within 60 days of the date your appeal was received.

Appealing Claims for Benefits: Medical, Dental, Vision, and Flexible Spending Accounts

Each plan maintains its own appeals process for benefit claims that have been denied in whole or in part. Here are some steps to take for filing an appeal:

- Call the plan's Member Services number on your ID card.
- Make sure they have all the information needed to make their decision.
- Request a review and follow their instructions on how to file a timely request.

Arbitration

Some of the health plans, including those provided through Kaiser, require resolution of medical malpractice and other disputes through binding arbitration. If you select one of these plans, you agree to give up your right to a jury or court trial for resolution of these disputes. For additional information about each plan's arbitration provision, contact the plan you select.

HIPAA Special Enrollment Events

If you are declining enrollment in medical, dental or vision benefits for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in such benefits under the Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Program (CHIP) coverage, and you request enrollment within 60 days after that coverage ends: or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two circumstances relating to Medicaid and state CHIP. As described above, a 31-day period applies to most special enrollments. If you request a change due to a special enrollment event within 31- or 60-day timeframe, as applicable, coverage will generally be effective the first of the month following your request for enrollment. For birth, adoption, or placement for adoption, coverage will be effective retroactive to the date of birth, adoption or placement for adoption if timely notice is provided. Specific restrictions with respect to Medicaid/ CHIP eligibility special enrollment may apply, depending on federal and state law. See below.

To request special enrollment or to learn more, contact the Benefit Department at 888-791-0220 or totalbenefits@unitedtexas.com.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery to less than 48 hours, and (2) following a cesarean section, to less than 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards, an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

State	Website	Telephone
Alabama – Medicaid	http://myalhipp.com/	1-855-692-5447
Alaska – Medicaid	The AK Health Insurance Premium Payment Program: http://myakhipp.com/ Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	1-866-251-4861
Arkansas – Medicaid	http://myarhipp.com/	1-855-MyARHIPP (855-692-7447)
California – Medicaid	Health Insurance Premium Payment (HIPP) Program: http://dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 FAX: 916-440-5676
Colorado – Health First Colorado & Child Health Plan Plus (CHP+)	Health First Colorado Website: https://www.healthfirstcolorado.com/ CHP+: https://hcpf.colorado.gov/child-health-plan-plus HIBI: https://www.mycohibi.com/	HFC: 1-800-221-3943 / State Relay 711 CHP+: 1-800-359-1991 / State Relay 711 HIBI: 1-855-692-6442
Florida – Medicaid	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
Georgia – Medicaid	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, Press 1 678-564-1162, Press 2
Indiana – Medicaid	Health Insurance Premium Payment Program: http://www.in.gov/fssa/hip/ All other Medicaid: https://www.in.gov/medicaid/	1-800-403-0864 Family and SS Admin 1-800-457-4584 Membeer Services
Iowa – Medicaid & CHIP (Hawki)	Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	Medicaid: 1-800-338-8366 Hawki: 1-800-257-8563 HIPP: 1-888-346-9562
Kansas – Medicaid	https://www.kancare.ks.gov/	1-800-792-4884 HIPP Phone 1-800-967-4660
Kentucky – Medicaid	KI-HIPP Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	1-855-459-6328 1-877-524-4718

Louisiana – Medicaid	www.medicaid.la.gov or www.ldh.la.gov/lahipp	Medicaid hotline 1-888-342-6207 LaHIPP 1-855-618-5488

State	Website	Telephone
Maine – Medicaid	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms	1-800-442-6003 TTY: Maine relay 711 1-800-977-6740 TTY: Maine relay 711
Massachusetts – Medicaid & CHIP	https://www.mass.gov/masshealth/pa E-mail: masspremassistance@accenture.com Email: masspremassistance@accenture.com	1-800-862-4840: TTY:711
Minnesota – Medicaid	https://mn.gov/dhs/health-care-coverage/	1-800-657-3672
Missouri – Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana – Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Email: HHSHIPPProgram@mt.gov	1-800-694-3084
Nebraska – Medicaid	http://www.ACCESSNebraska.ne.gov	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada – Medicaid	http://dhcfp.nv.gov	1-800-992-0900
New Hampshire – Medicaid	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
New Jersey – Medicaid & CHIP	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 1-800-356-1561 CHIP Premium Assist 609-631-2392 CHIP: 1-800-701-0710: TTY: 711
New York – Medicaid	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina – Medicaid	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota – Medicaid	https://www.hhs.nd.gov/healthcare	1-844-854-4825
Oklahoma – Medicaid & CHIP	http://www.insureoklahoma.org	1-888-365-3742
Oregon – Medicaid	http://healthcare.oregon.gov/Pages/index.aspx	1-800-699-9075
Pennsylvania – Medicaid & CHIP	https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 1-800-692-7462 CHIP: 1-800-986-KIDS (5437)
Rhode Island – Medicaid & CHIP	http://www.eohhs.ri.gov/	1-855-697-4347, or Direct RIte Share Line 401-462-0311
South Carolina – Medicaid	https://www.scdhhs.gov	1-888-549-0820
South Dakota – Medicaid	http://dss.sd.gov	1-888-828-0059
Texas – Medicaid	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment- hipp-program	1-800-440-0493
Utah – Medicaid & CHIP	UPP Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	1-888-222-2542
Vermont – Medicaid	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia – Medicaid & CHIP	https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	1-800-432-5924
Washington – Medicaid	https://www.hca.wa.gov/	1-800-562-3022
West Virginia – Medicaid & CHIP	https://dhhr.wv.gov/bms/ https://mywvhipp.com/	Medicaid: 304-558-1700 CHIP Toll-free: 1-855-699-8447
Wisconsin – Medicaid & CHIP	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming – Medicaid	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in- network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - — Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - — Cover emergency services by out-of-network providers.
  - — Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - — Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the federal telephone number for information and complaints is 1-800-985-3059.

Visit **<u>cms.gov/nosurprises/consumers</u>** for more information about your rights under federal law.

Patient Protection Disclosure

Certain options available to you under the Medical Program generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your available network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier at the number on the back of your Medical Program ID Card, or contact the Benefit Department at 888-791-0220 or totalbenefits@unitedtexas.com.

You do not need prior authorization from Albertsons Companies Benefit Plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your plan's provider network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your insurance carrier at the number on the back of your Medical Program ID Card or contact the Benefit Department at 888-791-0220 or totalbenefits@unitedtexas.com.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage

that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment- based coverage. Also, this employer contribution -as well as your employee contribution to employment- based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

1 Indexed annually; see **https://www.irs.gov/pub/irs-drop/rp-22-34.pdf** for 2023.

2 An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage**.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit **https://www.healthcare.gov/Medicaid-chip/getting-Medicaid-chip/** for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact the Benefit Department at 888-791-0220 or totalbenefits@unitedtexas.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: **Albertsons Companies, Inc.**	4. Employer Identification Number (EIN): **82-0184434**	
5. Employer address: **7830 Orlando Ave**	6. Employer phone number: **888-791-0220**	
7. City: **Lubbock**	8. State: **TX**	9. ZIP code: **79423**
10. Who can we contact about employee health coverage at this job? Albertsons Associate Experience Center		
11. Phone number (if different from above): **888-255-2269, press 2, then press 2 again**	12. Email address: totalbenefits@unitedtexas.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  All employees. Eligible employees

  ☐ are:

  ☐ Some employees. Eligible employees are:
  In general, employees working 30 or more hours per week. Some variations exist for employees in Hawaii and for some associates covered under a collective bargaining agreement.

- With respect to dependents:

  ☐ We do offer coverage. Eligible dependents are:
  Your spouse, same-sex or opposite-sex domestic partner, your children up to age 26 including your biological children, adopted children, stepchildren and legal wards. Disabled children age 26 and older who became disabled prior to turning age 26 and is primarily dependent on you for support and enrolled in a medical program on the day prior to attaining age 26.

  ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ Yes (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15)

☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

- An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)


The United Family
United supermarkets
Amigos
Albertsons market
Market STREET
United EXPRESS
R.C. Taylor
Prater's
LIANO