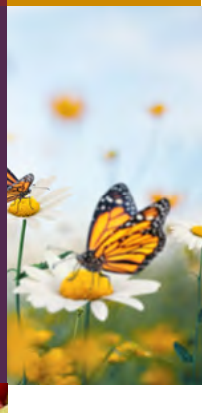
Employee

BENEFITS Guide



20
22

The SAVE MART COMPANIES

NON-UNION TEAM MEMBERS

Employee Benefits Guide 2022

General Information

Core Benefits

Other Benefits

Miscellaneous

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

See the Important Notices included in this guide for additional details.

The information in this brochure is a general outline of the benefits offered under Save Mart's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

Take a Fresh Look

A new year is approaching and now more than ever, access to affordable quality health care is an important part of you and your family's well-being. We are proud that The Save Mart Companies continues to be a leader in our community and our industry in providing a quality benefits package to our team members.

Different from previous years, this year is an "active" enrollment, meaning you must actively enroll for the medical, dental, vision and FSA (if applicable) benefits that you want for the plan year beginning January 1, 2022. Your current 2021 medical, dental, vision and FSA (if applicable) benefit elections WILL NOT roll over to 2022.

This guide is designed to help you navigate through all the offerings available to you as a Save Mart Team Member. Please read it carefully to find out how you can make our benefits work for you and your loved ones.

Open Enrollment for the 2022 Benefits Plan year will take place Monday, October 11 through Sunday, October 24, 2021.

2022 Benefits Overview

Action Required for 2022 Benefits

For 2022, changes have been made to the benefits program. In order to ensure your review and understanding of the new benefit and contribution changes, we will be having an **Active Enrollment**. An Active Enrollment means all Team Members **must log in** (page 5) during the open enrollment period (10/11-10/24) **and elect medical, dental, vision and FSA (if applicable)** benefit coverages for 2022. Team Members will not be re-enrolled in current benefits. **A non-action will result in termination of current medical, dental, vision and FSA (if applicable) benefits effective 1/1/2022.**

Exception: Your current 2021 voluntary benefit elections will roll over to 2022. See page 27 for details.

Team Member Contributions

As healthcare costs rise, we continue to offer comprehensive benefits. Over the past six years, despite continuous and significant increases in health care costs year after year, The Save Mart Companies has not increased employee contributions for benefits. For the benefits plan year beginning January 1, 2022, we are simplifying and making changes to our benefits offerings to be more in line with the national standard for our industry, while staying competitive and comprehensive. These changes include both plan design and employee contributions. We will continue to provide wellness discount opportunities, including the annual biometric screening.

See page 9 for plan comparisons and coverage levels. Remember, you can elect medical, dental or vision separately: they do not have to be bundled together. Team Members married to team members of The Save Mart Companies cannot cover each other as dependents.

REMINDER: You must complete your biometric screening ANNUALLY in order to receive the discounted medical premium rate; biometric screenings from previous years do not qualify you for the 2022 credit. Spouses are no longer required to complete in order to satisfy requirement. See page 18 for more details.

Call Center

The Save Mart call center is available to provide assistance in understanding your benefits, answering claims questions and providing resources for all your benefit needs. You can reach the call center at 1-87SAVEMART (1-877-283-6278). The call center is available to assist you Monday - Friday from 8 a.m. to 5 p.m. PST.

Quick Tip!

After choosing your benefits, you cannot change them during the year unless you have had a qualifying life event (marriage, a new child, etc.). Go to page 4 to learn more.

How do I enroll?

Visit www.mysavemartbenefits.com on a computer, smartphone, or tablet and make your benefit choices. For detailed directions, go page to 5.

2022 Benefits Overview (continued)

Your Open Enrollment Checklist

- Review your benefit options and product brochures.
- **Need to make changes or enroll in Flexible Spending Accounts (FSAs)?** You will need to go through the enrollment process. See FSA section of the Guide to learn more.
- **Enrolling Dependents?** Be prepared with your dependents' dates of birth and Social Security numbers. You will not be able to enroll them without this information. Effective January 1, 2022, a **Working Spouse Rule Applies**. See Eligibility section of the Guide to learn more. Dependent eligibility verification documents (copies of marriage and/or birth certificates) can be uploaded during open enrollment to BenefitSolver by October 24, 2021.
- Confirm your dependents' Social Security numbers and birthdates even if you aren't making changes.
- Review/update your beneficiary designations.

When Do I Get My ID Cards?

For the benefits year beginning January 1, 2022, we are switching from Blue Shield to Anthem.

All Anthem Members: After you enroll, Anthem members will receive a new ID card from the medical plan you selected. When you get your medical benefits ID card, check to make sure the information is accurate. If not, contact our Customer Service call center at 1-87SAVEMART (1-877-283-6278).

Note: Effective January 1, 2022, your current Blue Shield cards will be invalid.

Kaiser Members: New members will receive ID cards. If you are an existing Kaiser member, new ID cards will not be issued. All members will have access to their a digital ID card, which will be available on the Kaiser Permanente mobile app or ordered at kp.org.

You will not receive an ID card for dental or vision coverage.

Please contact the Customer Service Center at 1-87SAVEMART (1-877-283-6278).

Eligibility

Who's Eligible

- Team Members who work full-time with 130 hours or more per month on the clock and have been with the company for at least 60 days of continuous employment.
- Team Members working less than 130 hours per month are subject to a 12-month measurement period before they may enroll in benefits, in accordance with the Affordable Care Act (ACA). The measurement period begins October 3rd and ends October 2nd of the following year.

Eligible employees may enroll dependents as follows:

- Legally married spouse and registered domestic partner
  - **Working Spouse Rule:** Effective January 1, 2022, if your legally married spouse or registered domestic partner works and is eligible for their employer's group health plan, they may not be covered on the Save Mart medical plans. Your working legally married spouse or registered domestic partner will remain eligible for all other Save Mart benefits (dental, vision, life, etc.).
- Children
  - An employee's, married spouse's or domestic partner's natural child, stepchild, legally adopted child or a child for whom the employee, married spouse or domestic partner has legal custody or has been appointed legal guardian by a court of law.
  - The employee, married spouse or domestic partner is legally required to provide group health coverage for the child pursuant to an administrative or court order.
  - A child who is incapable of self-sustaining employment due to a physical or mental condition. If such dependent is age 26 or older, you must provide proof of continuous health coverage for this dependent since the age of 26.
  - Adult children up to the age of 26 (does not include the adult child's spouse or children).
- **Child does not include:** any person who is in active service in the armed forces.

Making Changes

You can only change your benefits elections during Open Enrollment unless you experience a qualifying life event that enables you to make mid-year changes. Make sure to notify the Human Resources Benefits Department within 31 days of the event if you have a qualifying life event and need to make a change (add or drop) to your coverage elections.

Life events include (but are not limited to):

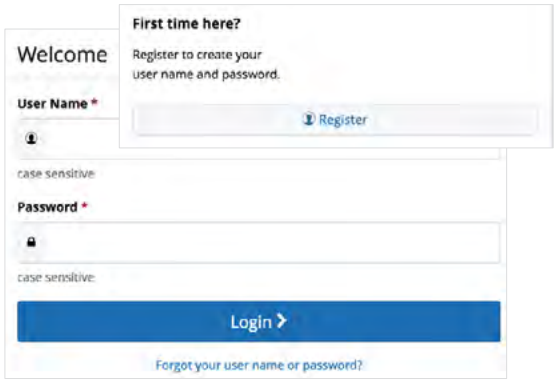
- Birth or adoption of a baby or child
- Loss of other group healthcare coverage
- Eligibility for new group healthcare coverage
- Marriage
- Divorce

Questions?

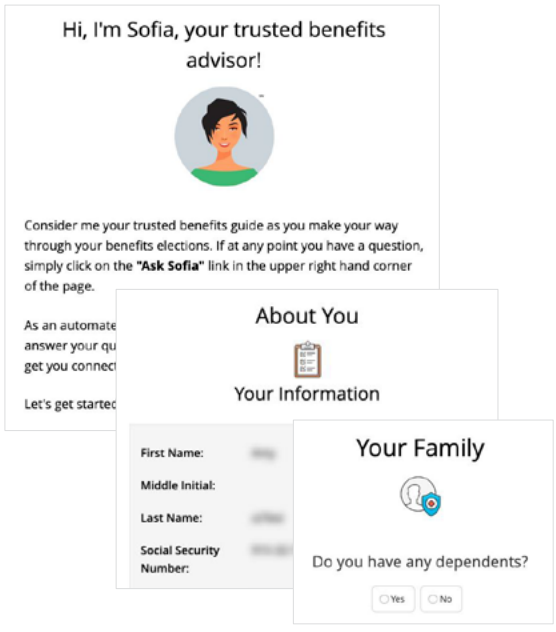
Call 1-87SAVEMART
(1-877-283-6278)

Benefits Enrollment Website

How to enroll in your benefits



RETURNING USERS: Click on the **Forgot your username or password?** link to reset your login details.



REGISTER AND LOGIN

1. Visit **www.MySaveMartBenefits.com** and click the **Register** button to get started. The case-sensitive company key is **savemart**.
2. Create your user name and password, verify your personal information, and answer a few security questions.
3. Log in using your new user name and password.

EXPLORE YOUR OPTIONS

Explore the site to learn about your benefits. You'll find lots of helpful information in the **Reference Center**.

The calendar at the top of the **Home** page lets you know how many days you have to enroll.

START YOUR ENROLLMENT

Click the **Start Here** button to review your personal information and add or edit any dependents you wish to cover.

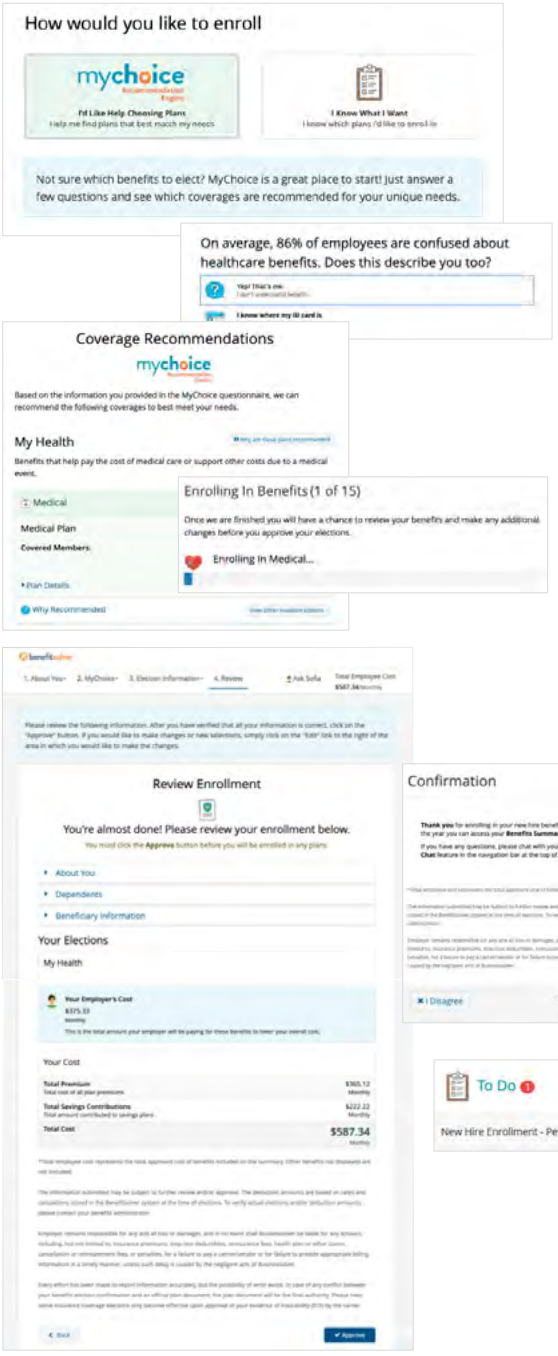
You will need to provide each dependent's legal name, Social Security Number, and birth date to add them to your coverage.*

Sofia, your personal benefits assistant, can answer questions and guide you as you enroll.

*You may be required to provide documentation to prove your relationship to each dependent.

Questions? 877-283-6278
www.MySaveMartBenefits.com
Company Key: savemart

Benefits Enrollment Website (continued)



2 WAYS TO ENROLL IN COVERAGE

- **MyChoice Recommendation Engine**
  Answer a few simple questions to receive a personalized benefits recommendation. Your answers are never shared.
- **Explore on your own**
  Use the **Next** and **Back** buttons to review and elect options available to you. Choose or decline coverage for each option, and select which family members you want to cover.

REVIEW AND FINALIZE YOUR ELECTIONS

Make sure your personal information, elections, dependents, and beneficiaries are accurate, then approve your elections.

To finish, click **I Agree**. When your enrollment is complete, you will receive a confirmation number and can print your **Benefit Summary** for your records.

AFTER YOU ENROLL

Return to the **Home** page to check for any additional tasks needed to complete your enrollment, view or download your **Benefit Summary**, and download the MyChoice™ Mobile App.

Visit this site anytime you want to learn more about your benefits or make a change to your coverage (if you experience a qualifying life event).

Questions? 877-283-6278
www.MySaveMartBenefits.com
Company Key: savemart

Medical – Providers

Choose The Medical Plan That Fits Your Life

Learn about Save Mart's medical plans here to find a plan that best meets your needs. The descriptions below will introduce you to them, then check the medical plan tables beginning on page 9 for specific coverage and cost details.

ACTION REQUIRED: 2022 is an Active Enrollment.

All team members must actively enroll for 2022 medical benefits. Current 2021 medical benefit elections WILL NOT roll over to 2022. **A non-action will result in termination of current medical benefits effective January 1, 2022.**

Anthem

For the benefits year beginning January 1, 2022, we are switching from Blue Shield to Anthem. All Anthem Plans have these features:

- Cost of in-network preventive exams and screenings are 100% covered
- Copays and coinsurance, including pharmacy, count toward the deductible and out-of-pocket maximum
- Coverage through the Anthem network with no requirement to select a primary care physician or get a referral for specialist care

You have two Anthem Plan Options:

1. **Anthem PPO** provides comprehensive coverage for you and your enrolled dependents. You will pay less when using Anthem network providers and facilities.
2. **Anthem Minimum Value PPO** has lesser coverage than the alternative plans at a lower cost, so it may be the best choice for Team Members with very few health problems.

What are the differences between these plans?

- The cost you pay out of your paycheck for the plan you choose
- The costs you pay for healthcare services you receive

It's important to pay special attention to the annual deductible amount.

It's the amount you pay each year for most eligible medical services or medications before your health plan begins to share in the cost of covered services.

You'll also want to consider the annual out-of-pocket maximum.

It's the most you could pay for covered medical expenses in a year. Once you reach your annual out-of-pocket maximum, your health plan will pay all of your covered medical and prescription costs for the rest of the year. **Note:** The out-of-pocket maximum is for in-network coverage only, excluding the Anthem Minimum Value PPO medical plan.

ANTHEM'S CARE & COST FINDER

Log in to www.anthem.com to use the tool to research the difference in the estimated cost of a particular service based on the facility where the service is provided, such as a doctor's office, hospital, imaging center or ambulatory surgery center.

All Anthem members will receive a new ID card. Effective January 1, 2022, current Blue Shield cards will become invalid. Anthem members will receive new ID cards with new member numbers mid-December. Anthem members will need to give the new ID card information to their medical and pharmacy providers. **Team Members currently enrolled in Blue Shield will need to check if their current doctors accept Anthem and are considered in-network.** Otherwise, team members may have to change doctors or pay for out-of-network service costs.

Find an Anthem Provider

https://www.anthem.com/ca/find-care/

Medical – Providers (continued)

Kaiser HMO Plan

Kaiser is a health maintenance organization (HMO). This plan only covers care received at Kaiser health care facilities so it is important to have a Kaiser location nearby. Kaiser is a "one stop shop" for check-ups with physicians, surgery, pharmacy and vision needs, which many people like. If you're unfamiliar with Kaiser, you can learn more by visiting their website at kp.org or by calling Kaiser at 1-800-464-4000.

Key Features:

- Available to all Team Members residing in California
- Fixed copays and low deductible
- Requires a referral for specialist care but does not require designation of a Primary Care Physician (PCP)
- Kaiser network only. No out-of-network benefits (other than medical emergencies)

Manage Health Care on the Go

Download the Kaiser Permanente app today at no cost from the Apple App Store or Google Play store.

This app allows you to:

- Email your doctor's office
- Refill most prescriptions
- View most lab test results
- Schedule or cancel routine appointments
- Access your ID card

Kaiser Resources

Video Visits

Kaiser Members can video chat with a doctor from the comfort of their own homes, without an appointment. For more information, visit: mydoctor.kp.org/ncal/videovisit

Kaiser Pharmacy

Kaiser Permanente has many medical offices that provide pharmacy services. They also offer a low-cost mail order service with free shipping. Register or login on kp.org to find a location closest to you.

Find a Doctor

healthy.kaiserpermanente.org/doctors-locations

Save Mart/Express Scripts Pharmacy Benefit

Pharmacy benefits for Anthem Members

As a reminder, The Save Mart Companies Team Members must fill prescriptions at a Save Mart Companies Pharmacy.

Express Scripts manages your pharmacy benefit and will help you with your prescriptions.

Save Mart Mail-Order: If you take ongoing maintenance medications, you can obtain a 90-day supply through the mail-order program. Please refer to the mail order form for full instructions located on **Cornerstone > Connections > Benefits Connection > Pharmacy** or call 1-209-863-1483.

For Specialty Medications please see your Save Mart Pharmacist. If the Save Mart Pharmacy is unable to provide your medication, contact Express Scripts for assistance. For more information about this service, please contact Express Scripts at 1-877-849-5523.

FAQs

What if I have an emergency or don't live near a Save Mart Pharmacy?

Your first fill is allowed at any retail pharmacy (CVS, Walgreens, etc.), second fills and maintenance drugs will have to be filled at a Save Mart Pharmacy or through the Save Mart mail-order program.

What if I want to continue to use a non-Save Mart Pharmacy after the first fill?

You can have your prescription filled at a retail pharmacy, but you will be subject to the full price of the drug.

Can prescriptions be filled at Save Mart and Lucky Pharmacies?

Yes! You can utilize any Save Mart or Lucky pharmacy.

What if Save Mart does not carry the drug that I need?

If Save Mart is unable to fill your prescription, Express Scripts will ensure that you receive your medications in a timely manner.

Medical Plans

ACTION REQUIRED: 2022 is an Active Enrollment.

All team members must actively enroll for 2022 medical benefits. Current 2021 medical benefit elections WILL NOT roll over to 2022. **A non-action will result in termination of current medical benefits effective January 1, 2022.**

Plan Highlights[1]	Anthem PPO Medical Plan		Kaiser HMO Medical Plan	Anthem Minimum Value PPO Medical Plan	
	Employee Cost Share		Employee Cost Share	Employee Cost Share	
	In-Network[2]	Out-of-Network[3]	Kaiser Network	In-Network[2]	Out-of-Network[3]
Deductible *(applies to all services unless otherwise indicated)*	$1,000/person; $2,000 family max	$3,000/person; $6,000/family max	$1,000/person; $2,000 family max	$2,500/person $5,000/family max	
Calendar Year Out-of- Pocket Maximum	$3,000/person; $6,000/family max	None	$3,000/person; $6,000/family max	$5,500/person $11,000/family max	
Doctor's Office Visits	$30[4]	50%	$30[4]	30%	50%
Specialist Office Visits	$60[4]	50%	$30[4]	30%	50%
Preventive Care	No charge[4]	50%	No charge[4]	No charge[4]	50%
Diagnostic X-Ray and Lab Tests	30%	50%	$10	30%	50%[4]
Chiropractic Care	$30[4,5]	50%[5]	$15[4,5]	30%[5]	50%[5]
Inpatient Hospital Services/Surgeon's Fees	30%	50%	30%	30%	50%
Emergency Room	30%		30%[6]	30%	
Mental Health/ Substance Abuse Outpatient Services	$25[4]	50%	Individual therapy: $30[4]; Group therapy: $15[4]/Mental Health; $5[4]/Substance Abuse	30%	50%
Prescription Drug Benefits[2,7,8]				Minimum Value PPO: All prescriptions subject to deductible	
Save Mart Pharmacies *(Up to 30 Day Supply)*	Generic: $15 Brand Formulary: $25 Non-Formulary: $35	Generic: $30 Brand: $55 Non-Formulary: $90	Generic: $10 Brand Formulary: $30 (Kaiser pharmacies only)	Generic: $15 Brand Formulary: $25 Non-Formulary: $35	Generic: $30 Brand Formulary: $55 Non-formulary: $90
Save Mart Retail/Mail Order Pharmacies *(Up to 90 Day Supply)*	Generic: $30 Brand Formulary: $50 Non-Formulary: $70	Not covered	Generic: $20 Brand Formulary: $60 (Kaiser pharmacies only)	Generic: $30 Brand Formulary: $50 Non-Formulary: $70	Not covered

1. This is a summary only; for more detailed information, please refer to the Summary Plan Description or Plan Summary for each plan.
2. Subject to the deductible and paid at in-network, negotiated rates.
3. Members pays applicable coinsurance and any amount above Anthem's negotiated rates.
4. Deductible waived.
5. See Summary Plan Description for number of visits covered per year and out-of-network plan payment maximums.
6. If you are admitted directly to the hospital as an inpatient for Services, you will pay the per admission inpatient cost share instead of the Emergency Room Cost Share.
7. **Anthem members:** Out-of-network prescription drug coverage under the Anthem plans is limited to a 30-day supply for first-time fills only.
8. **Kaiser members:** Prescriptions obtained from non-Kaiser pharmacies are not covered.

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Anthem

Are you looking for a doctor?

It's easy to find one online

The right doctor can have a positive impact on your health and well-being. Choosing one in your plan can save you money as well. The **Find Care** tool helps you locate doctors, dentists, eye care professionals, hospitals, labs, and other health care providers in your plan. If you decide to see a doctor outside your plan, your costs will be higher and your care may not be covered. Therefore, it is a good idea to learn how this convenient tool can help you find care.

How to find a doctor near you:

1. Go to **anthem.com/ca/find-care**
2. You can look for a doctor by using either:
   - **Search as a member:** Log in with a username and password or with the member number on your ID card.
   - **Search as guest:** Select a plan or network,* or search by all plans and networks
3. Once you log in, select the **Find Care** option on the welcome menu.
4. Next, choose who you would like to see. You can search for a doctor nearby or use the doctor's name.
5. Select a provider to see more details, such as:
   - Specialties
   - Gender
   - Languages spoken
   - Training
   - A map of their office location
   - Phone number

Health information that goes where you go

The **Sydney Health app** makes it easy to find information about your plan benefits wherever you are. The app keeps everything you need to know about your plan personalized and in one place. Download the app today.

* If you don't know the name of the plan or network, check with your human resources department or benefits administrator.

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Medical Plans: Supplement

Telehealth Services through Anthem's Live Health Online

Available to Anthem members only. Whether you're sick or don't have time to wait for a doctor's appointment, you can still access care for non-life-threatening conditions through our integrated virtual care service program. This program gives you 24/7/365 access to clinical support and expertise through the convenience of phone or video consults. Take control of your health when, where and how it best works for you, and get the care you need at your convenience.

Telehealth can treat many general medical conditions, including:

- Cold and flu symptoms
- Allergies
- Asthma
- Bronchitis
- Fever
- Nausea
- Respiratory infection
- Rashes/Skin infections
- Sore throat
- Sinus problems
- Urinary tract infections
- And more!

Virtual Behavioral Health Care through Anthem's Live Health Online

Available to Anthem members only. Team Members have access to the quality care they need without the obstacles of conventional in-office options. Members speak with board certified psychiatrists, licensed psychologist, or therapists conveniently by video and phone from wherever they feel most comfortable. Members can book appointments with ease seven days a week and build ongoing relationships with mental health professionals of their choice - all without having to travel to or wait at the doctor's office.

Telehealth and Virtual Behavioral Health Care through Anthem's Live Health Online is available to eligible Team Members enrolled in Anthem plans. A $5 copay per virtual visit applies. To access your telehealth and virtual behavioral health care or have any questions, please contact 1.844.784.8409 or visit www.livehealthonline.com.

Non-Union Team Member Cost Sharing

2022 Cost Sharing for Team Members

The Save Mart Companies pays the majority of the cost for health plan coverage. Team Members pay a portion of the cost of coverage as outlined below. All employee contributions are deducted on a pre-tax basis.

Effective January 1, 2022, Team Members who indicate they are tobacco users during benefit enrollment will pay an additional $15 per week for medical coverage for the 2022 benefit year. Tobacco users can earn the tobacco-free discount by completing six sessions of a tobacco cessation program or other alternative by March 31, 2022. For more information, please see the Well-Being section of the Guide.

Effective January 1, 2022, Team Members who do not complete their biometric screenings will pay an additional $20 per week for medical coverage for the 2022 benefit year. Biometric screenings from previous years do not qualify you for the 2022 discount. Screening requirement applies to Save Mart team members only; spouse screening is not required. For more information, please see the Well-Being section of the Guide.

Medical Plans

	Employees Participating in Screening*	Employees Not Participating in Screening*	Additional Premium for Tobacco Users** (Pre- Tax)
	2022 Weekly	2022 Weekly	2022 Weekly
Anthem PPO Medical Plans			
PPO Plan			
• Employee Only	$29.00	$49.00	+ $15.00
• Employee + Spouse/Domestic Partner	$60.00	$80.00	+ $15.00
• Employee + Child(ren)	$53.00	$73.00	+ $15.00
• Employee + Family	$82.00	$102.00	+ $15.00
Minimum Value PPO Plan			
• Employee Only	$22.00	$42.00	+ $15.00
• Employee + Spouse/Domestic Partner	$43.00	$63.00	+ $15.00
• Employee + Child(ren)	$39.00	$59.00	+ $15.00
• Employee + Family	$59.00	$79.00	+ $15.00
Kaiser HMO Plan			
• Employee Only	$29.00	$49.00	+ $15.00
• Employee + Spouse/Domestic Partner	$60.00	$80.00	+ $15.00
• Employee + Child(ren)	$53.00	$73.00	+ $15.00
• Employee + Family	$82.00	$102.00	+ $15.00

* You must complete your biometric screening annually in order to receive a $20 per week discount on your medical premium. For more information, please see the Well-Being section of the Guide.

** If you use tobacco products you will pay an additional $15 per week.

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Non-Union Team Member Cost Sharing (continued)

Dental and Vision Plans

Effective January 1, 2022, screening discounts no longer apply to dental and vision.

	Employees
	2022 Weekly
MetLife Dental Plan (Select Dental)	
• Employee Only	$6.00
• Employee + Spouse/Domestic Partner	$10.00
• Employee + Child(ren)	$9.00
• Employee + Family	$12.00
Vision Service Plan (Select Vision)	
• Employee Only	$3.00
• Employee + Spouse/Domestic Partner	$5.00
• Employee + Child(ren)	$4.00
• Employee + Family	$6.00

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Dental

MetLife Dental

You can choose your own dentist with the Dental PPO plan from MetLife. However, you can save money if you pick a dentist from the MetLife PDP Plus network because they have agreed to charge discounted fees. The table below explains what portion of the fees the plan will cover.

ACTION REQUIRED: 2022 is an Active Enrollment.

All team members must actively enroll for 2022 dental benefits. Current 2021 dental benefit elections WILL NOT roll over to 2022. **A non-action will result in termination of current medical benefits effective January 1, 2022.**

Please see Contact Information section in the Guide for group number and contact information.

Plan Benefits	MetLife Dental PPO Plan In-Network[1] Employee Cost Share
Deductible[2]	$50/person $150/family maximum
Benefit Maximum	$1,500/person
Preventive Care Benefits	
• X-Rays, Routine Exams and Two Semi-Annual Teeth Cleanings	No Charge
Basic Care Benefits	
• Fillings, Extractions, Endodontics, Periodontics, and Oral Surgery	20%
Major Care Benefits	
• Crowns, Inlays, Onlays, Bridges, Dentures, and Restorations	50%
Orthodontia Benefits	
• Adults and Children	50% $1,500 Lifetime Maximum Benefit

1. Paid at negotiated rates.
2. All services are subject to the deductible except in-network preventive care.

ID cards are not required to obtain dental care

Find a dentist

metlife.com/insurance/dental-insurance/

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Vision

Kaiser Vision

When you enroll in the Kaiser HMO medical plan option, Kaiser Vision coverage is included. You must be enrolled in the Kaiser medical plan to be eligible for Kaiser Vision coverage. You may only use your optical benefit when you visit a Kaiser Optical Center for service; there is no out-of-network coverage.

ACTION REQUIRED: 2022 is an Active Enrollment.

All team members must actively enroll for 2022 Kaiser medical and vision benefits. Current 2021 medical benefit elections WILL NOT roll over to 2022. A non-action will result in termination of current medical benefits effective **January 1, 2022**.

Plan Benefits	Kaiser Vision	
	Benefit Amount	Frequency
Eye Exam	Covered by your Kaiser Permanente Health Plan benefit	No limit
Prescription Eyeglasses	Covered up to a maximum of $120[1]	12 months
Lenses	One pair of regular eyeglass lenses will be covered at no charge when prescribed by a physician or optometrist and a Plan Provider puts the lenses into an eyeglass frame[2]	12 months
Contact Lenses in Lieu of Glasses	$300 allowance toward the purchase price of contact lenses, fitting, and dispensing	12 months

1. To apply your optical benefits, frames must be purchased with at least one lens that has a prescription.
2. Clear plastic lenses, single-vision, flat-top multi-focal, or lenticular.

Additional Savings, Discounts & Services

Special Events

- Throughout the year, Kaiser optical stores host eyewear shows featuring the latest frames from brand-name designers with a 20% discount the day of the show. Upcoming show listings are available at kp2020.org

Online contact lens refill orders

- Place your order online 24/7 at kp2020.org. Shipping is always free. **Note:** Contact lens online refills are for soft lenses only.

Laser Vision Correction

Trust your eyes to Kaiser professionals. Kaiser offers a range of laser vision correction procedures including LASIK, Wavefront, Intralase and Intraocular Lens Implantation. Services are on a fee-for-service basis and are not covered under your Health Plan benefit. For more information, go to kplaservisioncorrection.com.

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Vision (continued)

Vision Service Plan (VSP)

Anthem members are eligible for vision coverage through Vision Service Plan (VSP). VSP has the most extensive network of optometrists and vision care specialists in the country. Under this plan, you can use a VSP provider or another provider of your choice. However, when you obtain vision care through a non-VSP provider, you will have to pay the full cost up-front, and you will receive a reduced level of benefits. Vision care access that is out-of-network is reimbursed to the patient up to the allowed maximums.

ACTION REQUIRED: 2022 is an Active Enrollment.

All team members must actively enroll for 2022 vision benefits. Current 2021 vision benefit elections WILL NOT roll over to 2022. **A non-action will result in termination of current medical benefits effective January 1, 2022.**

Remember! No ID cards will be issued for the vision plan. When using an in-network provider simply tell them at your appointment you have VSP. You can also print a vision card when you login to vsp.com.

Please see Contact Information section of the Guide for group number and contact information.

Plan Benefits	Vision Service Plan (VSP) Select Vision Plan	
	In-Network Employee Cost Share	Out-of-Network Plan Reimburses
Exams *(once every 12 months)*	$15	After copay, reimbursement up to $50
Contact Lenses Fitting and Evaluation	15% discount if performed in addition to the routine eye exam. Maximum copay of $60	
Lenses *(once every 12 months)*	$15[1] (Included in exam copay)	After copay, reimbursement up to: Single Vision: $50 Lined Bifocal: $75 Lined Trifocal: $100 Lenticular: $125
Frames *(once every 12 months)*	After exam copay, covered to a maximum of $120[2]	After copay, reimbursement up to $70
Contact Lenses *(in lieu of lenses and frames)*	$300 allowance for contacts; copay does not apply. Contact lens exam (fitting and evaluation)	Up to $300
Medically Necessary	$15	After copay, reimbursement up to $210
Elective *(once every 12 months)*	After copay[3], covered up to a maximum of $300	Reimbursed up to $300
Laser Vision Care	VSP offers discounts for PRK and LASIK surgeries through contracted laser centers. Details regarding this program are available on vsp.com.	

1. Tints and photochromatic lenses are covered. Extra lens options such as scratch resistant coatings are available at VSP member preferred pricing.
2. 20% discount for additional sunglasses and frames that exceed the plan allowance.
3. Applies to the cost of contact lenses and contact lenses exam.

ID cards are not required to obtain vision care

Find an eye doctor

www.vsp.com/eye-doctor

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Well-Being

Complete a Biometric Screening to Receive a $20 Per Week Medical Premium Discount in 2022

To increase the awareness of your risk for chronic health conditions, The Save Mart Companies offers Team Members enrolled in the Anthem or Kaiser Permanente health plans the opportunity to receive a biometric screening – including tests for blood pressure, blood glucose, cholesterol, triglycerides, and body mass index (BMI) – and receive a $20 per week discount on your 2022 medical premium contributions. Your personal test results are completely confidential and are never shared with The Save Mart Companies.

PLEASE NOTE: You must complete your biometric screening ANNUALLY in order to receive the $20 per week medical premium discount; biometric screenings from previous years (prior to October 1, 2021) do not qualify you for the 2022 medical premium discount. Only Team Members need to satisfy the biometric screening requirement; spouses/domestic partners are no longer required to complete the screening to qualify.

You can complete your biometric screening at any time (by September 30, 2022), but the sooner you complete it, the sooner you earn the 2022 medical premium discount of $20 per week.

To Complete Your Biometric Screening:

Log into the LabCorp website: https://www.wellconnectplus.com/?company=FYVJJP

Option 1: LabCorp Facility Screening

- Download the voucher and verify the information on the voucher is correct.
- Schedule an appointment at the nearest facility: www.labcorp.com/findalab
- You must select "Employee wellness with body measurement" when searching.
- On the next page, choose your preferred clinic and select "Make Appointment."
- Enter your appointment details and on the billing page, select "I have already paid or someone else is responsible."
- Bring a paper copy of your voucher with you to your scheduled appointment.
- There are no fees associated with the Lab option.

Option 2: Physician Screening

- Download the form.
- If you have test results taken October 1, 2021, and after, you may use them and have your physician sign the form.
- If you do not have recent test results, make an appointment with your physician, and have your physician complete the form with your new test results.
- Return the form by uploading to the LabCorp site, or fax to 888-972-1871.
- There may be fees associated with completing the Physician Form with your physician, applied to copays, deductibles, or form completion. You are responsible for the fees related to the Physician Form visit.

Team Members who complete their screening between October 1 and December 31, 2021, will have satisfied the requirement for the 2022 medical premium discount, effective January 2022. For screenings completed between January 1 and February 28, 2022, the 2022 medical premium discount will be applied retroactively back to January 2022. For screenings completed March 1, 2022 and after, the 2022 medical premium discount will not be prorated back to the beginning of your health plan coverage date.

If you need any assistance accessing the LabCorp screening options, please contact support@lescustomercare.zendesk.com or 844-251-6524. Or call 1-87SAVEMART (1-877-283-6278).

If you have any questions about the biometric screening, please call 1-87SAVEMART (1-877-283-6278) or send an email to keenanwell@keenan.com.

Well-Being (continued)

It Pays to Be Tobacco-Free

As part of our commitment to support you in your wellbeing, we are providing an incentive to live tobacco-free. Team Members who are tobacco-free will need to indicate their tobacco-free status during the online open enrollment to avoid the $15 per week tobacco-user medical premium during the 2022 plan year.

If you indicate during benefit enrollment that you are tobacco-free, you are verifying that you have not used tobacco products during the past 30 days, are currently tobacco-free, and will not use tobacco products during the 2022 benefits year. Tobacco products include cigarettes, cigars, chewing or pipe tobacco, any other tobacco products (including electronic cigarettes or "vapes"), regardless of the frequency or method of use. Misrepresentation of your tobacco status may result in the imposition of the tobacco-user premium for the entire year, as well as disciplinary action.

Team Members who are current tobacco users can become eligible for removal of the tobacco-user medical premium during the 2022 plan year by completing 6 sessions of a tobacco cessation program or other alternative by March 31, 2022.

Team Members can access no-cost tobacco cessation programs and coaching by visiting nobutts.org. The California Smokers' Helpline is a free tobacco cessation program service that provides the individualized quit support you need to be successful. A trained telephone counselor will help assess your situation and develop a customized plan to quit that fits your needs. Free cessation information, multi-session telephone counseling, and self-help materials are provided. Some Helpline callers are eligible for free nicotine patches, sent directly to their home. Participants must request a certificate of completion from their California Smokers' Helpline tobacco cessation counselor for proof of completion of the tobacco cessation program. Call 1-800-NO BUTTS (1-800-662-8887) to get started.

Once you have completed the tobacco cessation program, submit written confirmation to Benefits Department at Benefits@SaveMart.com. The $15 per week tobacco-user medical premium will be removed the first pay period following verification of the completed tobacco cessation program, and any higher premium collected during the preceding pay periods for the 2022 plan year will be rebated back to the employee.

A reasonable alternative option for meeting the requirement for waiver of the tobacco-user medical premium is available to any employee for whom it is unreasonably difficult to satisfy the requirement, or for whom it is medically inadvisable to attempt to satisfy the requirement.

Diabetes and Hypertension Management through Omada

To assist individuals living with diabetes (Type 1 or 2) and/or high blood pressure (hypertension), Team Members enrolled in Save Mart medical benefits have the opportunity to participate in the Omada Health diabetes/hypertension management program. If you are eligible and enroll in the Omada program, you will be provided with the following resources, at no cost to you:

- A dedicated specialized health coach to keep you on track
- Connected wireless device(s) for glucose and/or blood pressure monitoring
- Medication adherence support
- Health metrics tracking
- Interactive online lessons for making healthier choices
- Online peer support community

If you have been diagnosed with diabetes or hypertension, you may self-enroll through the Omada website at omadahealth.com/savemart. You may also receive outreach communications from Omada.

Team Members who are eligible and enroll in the Omada program will be rewarded with a $50 gift card, and those enrolled who maintain consistent engagement in the program throughout the plan year will be rewarded with a $100 gift card. If you participated in the Omada program in 2021, you do not need to re-enroll and you could earn another $100 gift card for consistent engagement through 2022. Omada is available to both Anthem and Kaiser enrollees. If you have questions about the program, please call 1-87SAVEMART (1-877-283-6278) for assistance.

Well-Being (continued)

Be Well at Save Mart

Anthem and Kaiser also have healthy resources that can help you get healthy and stay healthy so you feel your best over a lifetime. The resources are free for their members.

Here are some highlights:

Wellness Resources from Anthem

Anthem has a variety of resources and expert guidance to help keep you healthy and safe – day or night, and save you money.

- 24/7 NurseLine gives you access to a registered nurse anytime, whether you need to decide what to do about a fever, get allergy relief tips, or need advice on where to go for care. For help, call the 24/7 NurseLine at 800-700-0197.
- The Find Care tool can help you choose the right doctor that can have a positive impact on your health and well-being, and save you money as well. To find care near you, go to anthem.com/ca/find-care.
- The Estimate Your Cost tool can help you estimate your health care costs ahead of time and compare costs to find quality care for less. To estimate your costs call 877-309-4886, or go to anthem.com/ca and choose 'Estimate Your Cost'.

Wellness Resources from Kaiser

Take advantage of the extra perks offered for Kaiser Permanente members – from personal health coaching to reduced rates on alternative medical therapies. Please visit https://healthy.kaiserpermanente.org/northern-california/health-wellness for more information or click the links below.

- Healthy lifestyle programs to lose weight, eat healthier, quit smoking, reduce stress, and manage ongoing conditions like diabetes or depression: kp.org/healthylifestyles
- Get a wellness coach to work with you one-on-one to reach your health goals: kp.org/wellnesscoach
- Join health classes and support groups offered at Kaiser facilities: kp.org/classes
- Enjoy reduced rates on a variety of health-related products and services, including Active&Fit fitness centers, acupuncture, chiropractic care, and massage therapy: kp.org/choosehealthy
- Take time for self-care to manage stress, improve your mood, sleep better with the help of no-cost wellness apps: kp.org/selfcareapps

Employee Assistance Program

Claremont Employee Assistance Program (EAP)

The Claremont Employee Assistance Program (EAP) is here for Team Members and covered dependents of The Save Mart Companies to help with personal issues.

How does it work?

When you and your family face difficult challenges at different stages of your life and need assistance in balancing work and family, you can reach out to Claremont EAP for support.

Is it private?

The EAP is a confidential service and Claremont understands the importance of privacy. Your communication with Claremont is afforded the maximum confidentiality permitted under the law.

How much does it cost?

There is no cost to you or your covered dependents for EAP services.

What's the first step?

Call the number below to discuss your question or issue with an experienced counselor who will refer you to the resources most appropriate for your needs. You can also fill out an online help request.

- **Call 24-7:** 1-800-834-3773
- **Visit us at:** claremonteap.com

For more info

Cornerstone > Connections > Benefit Connection > Wellbeing

Resources to help with any personal issue - mental health counseling, legal & financial resources, and more.

Free EAP Services

Mental Health & Counseling

Confidential, in-person counseling services are available to you and your family. There is no paperwork or claim forms and the cost is completely covered by Save Mart.

Counselors can help with:

- Marital/Relationship Issues
- Substance Use and Abuse
- Stress and Trauma
- Work Stress
- Anxiety
- Depression
- Parent/Child Conflicts
- Domestic Violence
- Any Other Personal Issue

When you call

You or your family member will speak with an experienced counselor who will ask for some identifying information and a general description of the situation or problem so that the counselor can refer you to a provider with the experience to best meet your needs.

This is an easy, no cost service to help address a range of personal and professional issues.

Legal Services

Attorneys are available to answer your legal questions, either in-person or over the phone. They provide up to 30 minutes of free consultation per incident. If you need further assistance, services are offered at a 25% discount.

The EAP can assist with legal issues such as:

- Divorce
- Child custody
- Real estate
- Personal injury
- Criminal law
- Free simple will kits

Employee Assistance Program (continued)

Financial Consultation & Assistance

The EAP offers one free 30-60 minute phone consultation per issue for many important financial concerns, including:

- Budgeting
- Debt management
- Financial planning
- First time home buyer program
- Tax questions
- Identity theft service
- Free credit report/ review

You can call with all kinds of financial questions. Some examples:

- How can I get out of debt?
- How can I find a low-interest credit card?
- How much life insurance do I need for my family's security?
- How can I get a copy of my credit report?
- How can I design a realistic budget?
- My daughter is ten -- how should I invest my savings to prepare for her college education?
- What do I need to apply for a mortgage or home loan?
- I am getting a divorce. Who is responsible for the bills and how will this affect my credit?

Work/Life Services*

Claremont's Work/Life Consultants can help refer you with specialists and information on a wide range of services such as those listed below. You have access to unlimited referrals, so if your needs change you can always call them back for an updated search.

- Child care
- Senior/Elder care
- Pet care
- Parenting skills
- Adoption assistance
- School/College assistance such as tutors
- Health and wellness, like support groups and fitness centers
- Convenience referrals, like housekeepers or apartment locators

* The EAP cannot offer recommendations for Work/Life Referrals. Individuals have the responsibility to evaluate and choose the most appropriate services to meet their needs.

- **Call 24-7:** 1-800-834-3773
- **Visit us at:** claremonteap.com

Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSA)

FSAs let you take money from your paycheck, before it's taxed, to pay for eligible healthcare and dependent daycare expenses. Funds put into the plan avoid Federal Income Tax, FICA and most state taxes. There are different types of FSAs.

Healthcare FSA

The Health Care FSA is used to pay for eligible medical, dental and vision expenses, such as deductibles and copays. Money deposited into the FSA will not count as taxable income, so you will not pay taxes on those dollars.

What you can pay for with your Health Care FSA:

- Deductibles and copays for medical, dental, and vision plans
- Vision services, contact lenses and solution, eye examinations, and glasses
- Dental services and orthodontia
- Chiropractic care and acupuncture

You'll receive a pre-paid benefits debit card to make it easy to pay for eligible expenses.

What can I contribute in 2022?

For 2022, you may contribute up to $2,750 pre-tax dollars into your account.

The table below shows how the Health Care FSA works if 25% of your pay is taken out in taxes and you choose to put $2,400 per year in your FSA account.

	Without an FSA	With an FSA
Gross Monthly Salary	$3,000	$3,000
Monthly Pre-Tax Health Care FSA Deductions	$0	-$200
Taxable Salary	$3,000	$2,800
Less: Federal & State Taxes	-$750	-$700
Take Home Pay	$2,250	$2,100
Post-Tax Health Care Expenses	-$200	$0
Total Net Take Home Pay	$2,050	$2,100
Monthly Tax Savings	$0	$50
ANNUAL TAX SAVINGS	**$0**	**$600**

For a complete list of eligible expenses
www.mysavemartbenefits.com

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Flexible Spending Accounts (FSA) (continued)

Dependent Care FSA

The Dependent Care FSA allows you to pay for child or adult dependent care for your tax dependents with money from your paycheck that is not taxed. Services must be provided while the employee and their spouse are at work, looking for work or attending classes as a full-time student.

Services that are eligible:

- In-home babysitter
- After school activities
- Daycare center
- Outside babysitter
- Nursery school
- Senior/Elder custodial care & daycare
- Latchkey program
- Summer day camp

Services that are not eligible:

- Services provided by a dependent or spouse
- Services provided by a child's sibling under age 19
- Services provided while an employee and/or spouse are not at work, such as overnight summer camps

How much can I contribute in 2022?

The IRS limits the total amount of money you can contribute to a dependent care to $5,000 each year for married couples filing jointly, unmarried couples, and single individuals, and $2,750 if you are married and filing separately.

Commuter/Transportation FSA

Commuter benefits allow you to set aside up to $270 a month on a pre-tax basis to pay for certain expenses incurred while traveling to and from work, including bus, subway and ferry passes, vanpooling and parking.

Eligible services include:

- Bus transportation
- Mass transit vehicles and passes (bus, subway, and ferry transportation)
- Passes, vouchers, or other similar means for commuting on mass transit
- Vanpooling: the transportation between an employee's home and work in a vehicle that seats at least six adults in addition to the driver and a minimum of 80% of the vehicle's mileage is for commuting
- Parking expenses incurred at work
- Parking expenses incurred at a location where you park to commute to work by mass transit
- Carpooling in a commuter highway vehicle
- Vendor parking lots
- Vendor parking garages

For a complete list of eligible expenses
www.mysavemartbenefits.com

Retirement Benefits – 401(k)

Save Mart's 401(k) plan allows you to work toward your future dreams through easy and convenient payroll deductions. Team Members may participate immediately upon hire and will receive a match (up to 4%) after six months of employment.

You can contribute up to a total of $19,500 between both pre-tax and Roth accounts ($6,500 if you're age 50 or over) and can choose from a variety of investment fund options. Contribution limits are set by IRS and subject to change.

Learn more at Cornerstone > Connections > Benefit Connection > Retirement

Company Paid Benefits

For the 2022 "Active" Open Enrollment, your current 2021 Company Paid Benefits **will roll over** to 2022 and do not require you to re-elect for plan year beginning January 1, 2022.

Long-Term Disability

Long-Term Disability (LTD) coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like Workers' Compensation and Social Security.

If you qualify, long-term disability benefits begin after short-term disability benefits end. Coverage is provided by Prudential.

Coverage for Long-Term Disability	
Monthly Benefit Amount	66.67% of salary
Maximum Monthly Amount	Grades 15 and below: $4,800 Grades 16+ and pharmacists: $10,000
Maximum Payment Period*	SSNRA with ADEA I

* The age at which the disability begins may affect the duration of the benefits.

Life and AD&D

The Save Mart Companies provides a Basic Life and Accidental Death & Dismemberment (AD&D) benefit for all eligible employees and your dependents. This benefit is paid for by The Save Mart Companies and the benefits are insured by Prudential.

Eligible Employees	Continuous Employment	Maximum Life Amount	Effective Date*
Grade 15 and below	60 days	$10,000	60 days*
Grade 15 and below	1 year	$20,000	1 year*
Grade 15 and below	5 or more years	$250,000	5 years*
Grade 16-19	60 days	$150,000	60 days*
Grade 20-22	60 days	$400,000	60 days*
Grade 23-31	60 days	$1,000,000	60 days*
Pharmacists	60 days	$250,000	60 days*

* 1st of the month following continuous employment

Life Insurance for Your Dependents

Basic Dependent Life

- **For Your Spouse:** $5,000
- **Dependent Children:** $5,000

Optional Dependent Life

Team members must enroll in optional life in order for dependents to enroll in optional life.

- **For Your Spouse:** $5,000 Increments up to $250,000. Spouse Guarantee Issue Amount: $25,000. Note: Spouse Maximum cannot exceed 50% of employee's Optional Life Benefit
- **Dependent Children:** $10,000

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Company Paid Benefits (continued)

For the 2022 "Active" Open Enrollment, your current 2021 Company Paid Benefits **will roll over** to 2022 and do not require you to re-elect for plan year beginning January 1, 2022.

Perks and Discounts

All information on Perks and Discounts can be found by going to **Cornerstone > Connections > Benefit Connection > Employee Discount**s

Discounts:

- All Team Members receive a 10% discount at Save Mart, 10% at Lucky and 5% at FoodMaxx (restrictions apply, find out more on Cornerstone under Team Member Connection)
- Save Mart Employee Association (SMEA)
- AT&T Wireless - Discounts available
- Verizon Wireless - Show a current paystub in store for discount
- Health club memberships available (For more details go to: **Cornerstone > Connections > Benefit Connection > Wellness**)

Perks:

- TruGrocer Credit Union
- SAFE Credit Union
- California Community Credit Union

Save Mart Employee Association (SMEA)

SMEA was started when a number of Team Members expressed the desire to band together (outside of company and union) to create a way to do things together and help each other out when needed. The association offers the following:

- Catastrophic Assistance to members in need due to a catastrophic event resulting in hardship (catastrophic injury, catastrophic personal loss, and loss of dependent household family).
- Discounts to sporting events, picnics, movies, theme parks, legal and identity theft protection, AT&T, Apple, travel, shopping, and more.
- Other assistance such as opportunities for scholarships, holiday meal sponsorship, and more.

To learn more visit:
mysmea.com

Voluntary Benefits

You have the opportunity to apply for insurance plans at discounted group rates. Premiums are deducted from your paycheck on a post-tax basis. Don't miss your opportunity to enroll in these benefits.

For the 2022 "Active" Open Enrollment, your current 2021 voluntary benefits summarized on page 27-28 will roll over to 2022 and do not require you to re-elect for plan year beginning January 1, 2022.

Supplemental Term Life Insurance

This plan pays a lump sum benefit to your designated beneficiary if you die. It also covers funeral planning services. Coverage can be purchased for you, your spouse and your unmarried child(ren) from birth to age 26.

If you did not enroll within your initial eligibility period or wish to increase your amount of coverage, you will be required to complete Evidence of Insurability.

You must elect employee coverage if you wish to elect coverage for your eligible spouse or child(ren).

Coverage for Supplemental Term Life Insurance	
Employee	$10,000 – $500,000 (or 5 times pay) in $10,000 increments
Spouse	$5,000 – $250,000 in $5,000 increments (not to exceed 50% of Employee coverage)
Child(ren)	6 months and older: $10,000 per child Children under 6 months have a reduced benefit

Accident Insurance

Accident insurance is a supplement to medical insurance or disability insurance.

Accident insurance pays a benefit (per treatment) that you can use for any purpose including to help pay for out-of-pocket medical expenses such as copays, deductibles, and medicine - in addition to out-of-pocket non-medical expenses such as transportation or help at home.

Voluntary Short-Term Disability (STD)

Team Members have the option to purchase Voluntary STD coverage through Prudential. If you did not enroll within your initial eligibility period or wish to increase your amount of coverage, you will be required to complete Evidence of Insurability.

Level of Coverage	Voluntary STD
Benefit Amount	60% of weekly salary
Maximum Bi-Weekly Benefit	$3,000
Elimination Period	First 7 days of disability
Benefit Begins	On the 8th day
Maximum Payment Period	25 weeks

Important Consideration - benefits available under this plan will be reduced by amounts received from California State Disability Insurance (SDI).

We do not recommend California Team Members making less than $23,000 annually enroll in Voluntary STD.

Below is an example of how STD and California SDI coordinate for those who would be eligible for a benefit from State Disability*:

Employee earning $50,000 STD benefit is 60% or $1,153 bi-weekly.

- **Estimated bi-weekly benefit from California SDI = $1,154**
- **The coordination of benefits provision reduces the benefit received from the STD policy by the amount received from California SDI as follows:**

$1,153 - $1,154 = ($1.00)

The result is a negative amount. In this case the STD policy would pay a minimum bi-weekly benefit of $50.

**Sample calculation based on estimates. Actual amounts dependent on eligibility.*

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Voluntary Benefits (continued)

Critical Illness Insurance

This coverage through Prudential pays a lump sum if you or an eligible family member is diagnosed with a covered critical illness including heart attack, major organ failure, benign brain tumor, blindness, end- stage renal disease, coronary artery bypass surgery, stroke, or permanent paralysis. The benefit can be used any way you choose, and you don't have to be disabled or terminally ill to receive benefits.

Speak with a benefits counselor for more information about coverage options and associated premiums at 844-455-1002 (M-F 8am – 8pm EST), via email at VBservices@prudential.com or online www.prudential.com.

Allstate Identity Protection

You can elect Identity Theft Protection through Allstate Identity Protection Plan.

Services in this plan include:

- Personal, medical, and financial data protection
- Privacy protection, detection, and removal
- Online account monitoring
- Fraud and privacy alerts
- Credit monitoring
- Lost wallet protection
- Cyber predator protection
- Cyberbullying detection
- Child ID theft scanning and protection

Level of Coverage	Monthly Cost
Employee Only	$8.45
Employee plus Family	$13.25

Note: These benefits are included in the online enrollment process.

MetLaw Legal Plan

You have the option of electing coverage for legal services through MetLaw. By enrolling in MetLaw, you have access to unlimited telephone and office consultations for eligible legal services.

The cost of the legal plan is $16.50 per month, deducted from your paycheck on an after-tax basis. The plan covers you, your spouse, and your dependents.

To use the legal plan or for more information about this benefit, call MetLaw's confidential toll-free number at 1-800-821-6400 or visit legalplans.com. Visitors may access the website using the password "MetLaw."

Note: If you elect this benefit for 2022, you must stay enrolled for the whole year. You may not cancel mid-year.

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Contact Information

Below is a listing of the telephone numbers you can call with questions about the plans available to you. You can also use the web site (if available) to access information from providers for the various plans.

Plan Type/Provider	Policy/Group	Phone Number	Website/Email
Benefits Call Center			
• Keenan Call Center	N/A	1-87SAVEMART (1-877-283-6278)	www.keenan.com/benefits
Benefits Administration			
• Benefitsolver Enrollment	N/A	*Refer to Keenan Call Center*	www.mysavemartbenefits.com
Medical			
• Kaiser Permanente	**Northern CA:** 600526 **Southern CA:** 227440	1-800-464-4000	kp.org
Telehealth and Virtual Behavioral Health Care			
• LiveHealth Online *(through Anthem)*	N/A	1-844-784-8409	www.livehealthonline.com
Pharmacy			
• Express Scripts Prescription Drugs	N/A	1-877-849-5523	www.express-scripts.com
• Save Mart Mail Order	N/A	1-209-863-1483	www.express-scripts.com
Dental			
• MetLife	312030	1-800-942-0854	metlife.com/dental
Vision			
• VSP	00103825	1-800-877-7195	vsp.com
• Kaiser Vision *(must be enrolled in Kaiser Medical Plan)*	**Northern CA:** 600526 **Southern CA:** 227440	1-800-464-4000	**Northern CA:** kp2020.org/noca **Southern CA:** kp2020.org/soca
Term Life and AD&D, Child & Spouse Life, Supplemental Child & Spouse Life, Disability			
• Prudential	70398	1-888-598-5671	prudential.com
Accident Health and Critical Illness			
• Prudential	70398	1-844-455-1002	prudential.com Vbservices@prudential .com
Flexible Spending Accounts			
• Benefitsolver	N/A	1-87SAVEMART (1-877-283-6278)	www.mysavemartbenefits.com
EAP			
• Claremont EAP	GHP1160-14672	1-800-834-3773	claremonteap.com
Legal			
• MetLife Legal	N/A	1-800-821-6400	info.legalplans.com **Access Code:** GetLaw
Identity Theft			
• Allstate	1638	1-800-789-2720	myaip.com clientservices@infoarmor.com

Important Notices

Discrimination Is Against the Law

Save Mart Select Health Benefit Plan complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Save Mart Select Health Benefit Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Save Mart Select Health Benefit Plan :

- Provides free aids and services to people with disabilities to communicate effectively with it, such as:
  - Qualified sign language interpreters
  - Written information in other formats (e.g., large print, audio, accessible electronic formats, etc.)
- Provides 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, contact the Benefits Department at 209.577.1600.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn generally may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 209.577.1600.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser at 800.464.4000 or Anthem at 855.817.5785.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Keenan EBTPA/Anthem and Kaiser. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims, and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The employer must notify the Plan Administrator of the following Qualifying Events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number and Social Security Number; the full name, address, phone number and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

Important Notices (continued)

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. (See Notice and Election Procedures.)

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the spouse and any dependent children receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying Event would have caused the spouse or the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (See Notice and Election Procedures.)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Important Notices (continued)

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans subject to ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For more information about the Marketplace, visit www.healthcare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment 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 and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or Qualified Medical Child Support Order, you may be able to enroll yourself and / or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Jennifer Susnara
Director Benefits and Leaves
209.404.6504

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Save Mart Select Health Benefit Plan and about your options under Medicare's prescription drug coverage. 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.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- **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.**

Important Notices (continued)

- **Save Mart Select Health Benefit Plan has determined that the prescription drug coverage offered by Express Scripts 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 this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

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.

However, if 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.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Save Mart Select Health Benefit Plan coverage will not be affected. If you keep this coverage and elect Medicare, the Save Mart Select Health Benefit Plan coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Save Mart Select Health Benefit Plan coverage, be aware that you and your dependents will be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Save Mart Select Health Benefit Plan and 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 go 63 continuous days or longer without creditable prescription drug coverage, 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 (i.e., a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information. **Note:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Save Mart Select Health Benefit Plan 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 will 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 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).

REMEMBER

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 2021
Name of Entity / Sender:	The Save Mart Companies
Contact:	The Benefits Department
Address:	1600 Yosemite Blvd. Modesto, CA 95354
Phone:	209.577.1600

Important Notices (continued)

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

Save Mart Select Health Benefit Plan Group maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the Benefits Department at 209.577.1600.

Wellness – Alternative Standards

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all participating employees. If you think you might be unable to meet a standard for a reward under the wellness program, you might qualify for an opportunity to earn the same reward by different means. Please contact the Benefits Department at 209.577.1600 or email benefits@savemart.com and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you with regard to your health status.

Important Notice Regarding Wellness Information

The Save Mart Well-Being Program is a voluntary wellness program available to employees who participate in Save Mart Select Health Benefit Plan, and is subject to federal law including the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.

If you choose to participate in the biometric screening program provided to Save Mart Team Members through LabCorp, you may be asked to complete a voluntary biometric screening which includes height, weight, body mass index (BMI), glucose, blood pressure, HDL/LDL/total cholesterol, and triglycerides.

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

If you choose to participate in the diabetes and hypertension management program provided to Save Mart Team Members through Omada Health, you may be asked to complete a voluntary health assessment that asks questions about your health-related activities and behaviors and whether you have or had certain medical conditions. The information gathered from your health assessment will be used to provide you with information to help you understand your current health condition and potential risks, and to offer you the Omada diabetes and hypertension management program services. You are also encouraged to share your results or concerns with your own doctor.

The law requires us to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Save Mart Select Health Benefit Plan may use aggregate, non-employee specific information to design a program to address health risks in the workplace, your personal identifiable information will never be disclosed publicly or to your employer. Medical information that personally identifies you in connection with the wellness program will not be disclosed to your supervisors or managers and will never be used to make decisions regarding your employment. Anyone (e.g., a registered nurse, a doctor, health coach, etc.) who receives information about you for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

All medical information obtained through the wellness program will be protected as mandated by applicable federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). Save Mart Select Health Benefit Plan will only receive aggregate reporting which will be used by Save Mart Select Health Benefit Plan to design wellness initiatives that focus on the greatest needs of the employee population. No individual results will be shared with Save Mart Select Health Benefit Plan.

If you have any questions or concerns, please contact the Benefits Department at 209.577.1600 or email benefits@savemart.com.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Save Mart Select Health Benefit Plan in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from the Benefits Department is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California will begin November 1, 2021, and is anticipated to end on January 31, 2022. Open Enrollment for other states will begin on November 1 and close on December 15 of each year. Some states have expanded the open enrollment period beyond December 15, 2021 for coverage to begin in 2022. Notably, Covered California continues its special enrollment period for coverage beginning in 2021 to December 31, 2021.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.61% (for 2022) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered medical coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange, all the information you need from the Benefits Department is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com.

3. Employer name The Save Mart Companies	**4. Employer Identification Number (EIN)** 94-1245496	
5. Employer address 1800 Standiford Avenue	**6. Employer phone number** 209.577.1600	
7. City Modesto	**8. State** CA	**9. ZIP code** 95350
10. Who can we contact about employee health coverage at this job? Jennifer Susnara, Director Benefits and Leaves		
11. Phone number (if different from above) 209.404.6504	**12. Email address** Jennifer.Susnara@savemart.com	

Important Notices (continued)

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 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 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, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866.251.4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916.445.8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado
Colorado's Medicaid Program & Child Health Plan Plus (CHIP+)
Healthy First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 800.221.3943
TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 800.359.1991
TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877.357.3268

GEORGIA – Medicaid
Website: http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678.564.1162, ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877.438.4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800.338.8366
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888.346.9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800.792.4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855.459.6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877.524.4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888.342.6207 (Medicaid hotline) or
855.618.5488 (LaHIPP)

Important Notices (continued)

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 800.862.4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800.657.3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800.694.3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov/
Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603.271.5218
Toll-Free for the HIPP program: 800.852.3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800.701.0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800.541.2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888.365.3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800.699.9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 800.692.7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347, or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888.549.0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888.828.0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800.440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877.543.7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800.250.8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp/
Medicaid Phone: 800.432.5924
CHIP Phone: 800.432.5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800.562.3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800.362.3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565