BENEFIT HIGHLIGHTS

Effective January 1, 2012

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Health Care Account *(paid by United Supermarkets)*	*$1,000 Individual / $1,250 Family*	*NA*
Team Member Deductible	*$1,300 Individual / $3,350 Family*	*NA*
Total Calendar Year Deductible (HCA + Team Member Deductible Combined)		
****4th quarter carryover applies***		
Applies to all Eligible Expenses, unless otherwise indicated	*$2,300 Individual / $4,600 Family*	*$4,600 Individual / $9,200 Family*
Per-admission Deductible	*None*	*$300*
Out-of-Pocket Maximum **Deductibles are not applied to the Out-of-Pocket Maximum. Your benefit booklet will provide more details.**	*$3,500 Individual / $7,000 Family* *In-Network Out-of-Pocket Maximum **will only** apply toward In-Network Out-of-Pocket Maximum*	*$7,000 Individual / $14,000 Family* *Out-of-Network Out-of-Pocket Maximum **will also** apply toward In-Network Out-of-Pocket Maximum*
Maximum Lifetime Benefits		
Per Participant	*Unlimited*	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All services must be preauthorized		
Inpatient Hospital Expenses *Each admission must be preauthorized*	*80% of Allowable Amount after Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
All usual hospital services and supplies, including semiprivate room, intensive care, and coronary care units		
Penalty for failure to preauthorize services	*None*	*$250*
Medical/Surgical Expenses		
Medical / Surgical Expenses		
-Services performed during the Physician's office visit/consultation, including lab & x-ray -Lab & x-ray in other outpatient facilities -Physician surgical services in any setting -Physician inpatient hospital visits -Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan -Home Infusion Therapy *(Services must be preauthorized)* -All other outpatient services and supplies	*80% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Extended Care Expenses	**In-Network Benefits**	**Out-of-Network Benefits**
Extended Care Expenses		
All services must be preauthorized -Skilled Nursing Facility -Home Health Care -Hospice Care	*80% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*

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Special Provisions Expenses	In-Network Benefits	Out-of-Network Benefits
Serious Mental Illness / Mental Health Care Treatment of Chemical Dependency		
Inpatient Services (All services must be preauthorized)		
-Hospital services (facility) *(Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency Treatment Center)*	*80% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
-Physician services	*80% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Outpatient Services (All services must be preauthorized)		
-Services performed during Physician office visit/consultation (does not include psychological testing)	*80% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
-All outpatient services and psychological testing		
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care (within 48 hours) -Facility charges - Physician charges	*80% of Allowable Amount after Calendar Year Deductible*	
Non-Emergency Care (after 48 hours) -Facility charges -Physician charges	*80% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Urgent Care Services Urgent Care center visit, including lab & x-ray services Certain Diagnostic Procedures include: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan, surgical procedures and all other services and supplies	*80% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Ground and Air Ambulance Services	*80% of Allowable Amount after Calendar Year Deductible*	
Preventive Care Including (Age Limitations May Apply): Annual Physical, Lab and X-Ray, Well-Baby Care, Immunizations, Hearing Exams, Chiropractic Care, Screening Mammograms, Prostate Screening, Bone Mass Measurement **Your provider must bill these services as "preventive care" in order for them to be covered at 100%.	*100% of Allowable Amount*	*60% of allowable Amount after Calendar Year Deductible*
Speech and Hearing Services Services to restore loss of or correct an impaired speech or hearing function	*Covered same as any other sickness*	*Covered same as any other sickness*
Hearing Aids	*80% of allowable Amount after Calendar Year Deductible*	*50% of allowable Amount after Calendar Year Deductible*
Hearing Aid Maximum	*Hearing aids are subject to a $1,000 maximum amount each 36-month period**	
Physical Medicine Services Chiropractic Care* *If not billed as preventive	*80% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Calendar Year Maximum *includes Chiropractic Services paid under Preventive Benefit	*20 visit maximum each Calendar Year**	

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Prescription Drug Benefits (Administered by Express Scripts)

United Supermarkets Pharmacy

*Prescription Drug Benefits**

(Benefit payments are based on a 30-day supply - With appropriate Prescription Order)	
Generic Drug	*$5*
Preferred Brand Name Drug	*$30*
Non-Preferred Brand Name Drug	*$55*
Specialty Drug	*$80*

*** Preferred Brand Name Drugs – Team Member will pay 100% of the cost of the brand name drug when a generic equivalent is available.*
****Out-of-Network pharmacy – Team Member will pay 100% of the cost when purchasing a prescription at a non-United Supermarkets pharmacy in a city where a United pharmacy is available. The Team Member may be reimbursed for 50% of the prescription payment after the medical deductible has been met by filing a paper claim to the medical plan.*

Diabetes Supplies are available under Prescription Drug Benefits. Diabetic Supplies include insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, all required test strips and tablets which test for glucose, ketones, and protein, lancets and lancet devices, biohazard disposable containers, glucagon emergency kits, and other injection aids. All Prescription Drug provisions of the plan will apply including copayment amounts and any pricing differences that may apply to the items dispensed.

Important Note: Covered charges incurred under medical benefits for pre-existing conditions are not payable unless incurred 12 months after enrollment date. This time may be offset if the insured has creditable coverage from his/her previous plan. Pre-existing condition exclusion does not apply to dependent children under the age of 19.