UFCW Unions & Participating Employers
Health and Welfare Fund

Plan T

Summary of Material Modifications

April 2022

This insert is a Summary of Material Modifications (changes) to your Summary Plan Description (SPD) booklet. Please keep this insert with your booklet so you will have it when you need to refer to it.

The following new subsection is added before the "Definitions" section of your SPD:

Prohibition of Assignment of Benefits

No benefit under the Plan or right under ERISA may be assigned or transferred to another party by a participant or beneficiary. The Fund will not recognize any attempted assignment. Nothing in this SPD or the Fund's Trust Agreement shall be construed to make the Fund, the Trustees, UFCW Locals 27 or 400, or any Participating Employer liable to any third-party to whom a participant, dependent, or beneficiary may be liable for medical care, treatment, or services. The Fund may make direct payments to a medical provider. A direct payment by the Fund to a medical provider does not make the provider an assignee, and in no way confers upon the provider any rights that a participant has under the Plan or ERISA.

2. In the first numbered list in the Claims Filing and Review Procedure or Claims Procedures section of the SPDs for Plans Y, Y20, Y30, T, and JSS2, item number 3 (for Plans Y, Y20, and Y30) or number 4 (for Plans JSS2 and T) is revised as follows:

Benefit payments will be sent directly to the provider unless there is no payment direction and evidence of your payment is reflected. In that case, payment will be sent directly to you.

3. In the Claims Filing and Review Procedure section of the SPDs for Plans Y, Y20, Y30, T, and JSS2, under the "When you File a Claim" or "Filing a Claim" subsection, the last sentence of item number 4 (for Plans Y, Y20, and Y30), item number 13 (Plan JSS2), or item number 14 (for Plan T) is revised as follows:

Benefit payments will be sent directly to the provider unless there is no payment direction and there is evidence of your payment on the bill.

Correction to page 1 of your SPD. Change page one, under "Covered Employment," the fifth bullet, to read: "Associated Administrators, LLC's employees who were subject to the collective bargaining agreement beginning on or after May 1997."

- **As of May, 2014, the current Health and Welfare Fund Board of Trustee is shown below.** This replaces Trustees listed on page 6 of your SPD.

UFCW Unions And Participating Employers Health And Welfare Fund
Board of Trustees

Union Trustees	**Employer Trustees**
Mark Federici, Chairman President UFCW Local 400 4301 Garden City Drive Landover, MD 20785	Steven J. Loeffler Senior Director of Labor Relations The Kroger Company 4111 Executive Parkway Westerville, OH 43081-3800
Michelle Eubank Assistant Service Director UFCW Local 27 21 West Road, Second Floor Towson, MD 21204	Michael Mortensen Director of Labor Relations SuperValu, Inc. 7075 Flying Cloud Drive Eden Prairie, MN 55344
Thomas Hipkins UFCW Local 27 21 West Road, Second Floor Towson, MD 21204	Mike Christle The Kroger Company PO Box 14002 Roanoke, VA 24038
Lavoris "Mikki" Harris Secretary, Treasurer UFCW Local 400 4301 Garden City Drive Landover, MD 20785	Donna Gwin Director of Labor Relations Shoppers' Food and Pharmacy 16901 Melford Boulevard Bowie, MD 20715

- **Effective January 1, 2014 – Elimination of Annual Major Medical Benefit Maximum on Essential Health Benefits.** The overall annual dollar limit on essential health benefits under the Plan is eliminated for participants and eligible dependents. This change to the terms of the Plan is required by the Patient Protection and Affordable Care Act (PPACA).

- **September 23, 2013 – Revised Notice of Privacy Practices.** Replaces pages 101 – 195 of your SPD. This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

THE PLAN'S COMMITMENT TO PRIVACY

The United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund (the "Plan") is committed to protecting the privacy of your protected health information ("health information"). Health information is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. In accordance with applicable law, you have certain rights, as described herein, related to your health information.

This Notice is intended to inform you of the Plan's legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice describing its legal duties and privacy practices with respect to your health information; and

- to abide by the terms of this Notice.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" or "your" refers to participants and dependents who are eligible for benefits under the Plan.

INFORMATION SUBJECT TO THIS NOTICE

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

SUMMARY OF THE PLAN'S PRIVACY PRACTICES

The Plan's Uses and Disclosures of Your Health Information

The Plan uses your health information to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. The Plan discloses your health information to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Plan may also disclose your health information to third parties that assist the Plan in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Plan will only use or disclose your health information pursuant to your written authorization. In other cases authorization is not needed. The details of the Plan's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- Request to receive your health information through confidential communications;
- Request access to your health information in an electronic format;
- Receive notice of a breach of unsecured protected health information if it affects you;
- File a complaint with the Fund office or the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

Changes in the Plan's Privacy Practices

The Plan reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information

If you have any questions or concerns about the Plan's privacy practices, or about this Notice, or if you wish to obtain additional information about the Plan's privacy practices, please contact:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, Maryland 21152-9451
(410) 683-6500

DETAILED NOTICE OF THE PLAN'S PRIVACY POLICIES
THE PLAN'S USES AND DISCLOSURES

Except as described in this section, as provided for by federal privacy law, or as you have otherwise authorized, the Plan uses and discloses your health information only for the administration of the Plan and the processing of your health claims.

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

1. **For Treatment.** Although the Plan does not anticipate making disclosures "for treatment," if necessary, the Plan may make such disclosures without your authorization. For example, the Plan may disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you.

2. **For Payment.** The Plan may use and disclose your health information so that claims for health care treatment, services and supplies that you receive from health care providers can be paid according to the Plan's terms. For example, the Plan may share your enrollment, eligibility, and claims information with its third party administrator, Associated Administrators LLC ("Associated"), so that it may process your claims. The Plan may use or disclose your health information to health care providers to notify them as to whether certain medical treatment or other health benefits are covered under the Plan. Associated also may disclose your health information to other insurers or benefit plans to coordinate payment of your health care claims with others who may be responsible for certain costs. In addition, Associated may disclose your health information to claims auditors to review billing practices of health care providers, and to verify the appropriateness of claims payment.

3. **For Health Care Operations**. The Plan may use and disclose your health information to enable it to operate efficiently and in the best interest of its participants. For example, the Plan may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Plan.

Uses and Disclosures to Business Associates

The Plan shares health information about you with its "business associates," which are third parties that assist the Plan in its operations. The Plan discloses information, without your authorization, to its business associates for treatment, payment and health care operations. For example, the Plan shares your health information with Associated so that it may process your claims. The Plan may disclose your health information to auditors, actuaries, accountants, and attorneys as described above. In addition, if you are a non-English speaking participant who has questions about a claim, the Plan may disclose your health information to a translator; and Associated may provide names and address information to mailing services.

The Plan enters into agreements with its business associates to ensure that the privacy of your health information is protected. Similarly, Associated contracts with the subcontractors it uses to ensure that the privacy of your health information is protected.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose your health information to the Plan Sponsor, which is the Plan's Board of Trustees, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Plan, without your authorization. The Plan also may disclose your health information to the Plan Sponsor for purposes of hearing and deciding your claims appeals. Before any health information is disclosed to the Plan Sponsor, the Plan Sponsor will certify to the Plan that it will protect your health information and that it has amended the Plan documents to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

As described below, the federal health privacy law provides for specific uses or disclosures that the Plan, may make without your authorization.

1. **Required by Law**. Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for the following purposes:
   - For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority.
   - To report information related to victims of abuse, neglect, or domestic violence.
   - To assist law enforcement officials in their law enforcement duties.
   - To notify the appropriate authorities of a breach of unsecured protected health information.

2. **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.

3. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.

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

5. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.

6. **Emergency Situations**. Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster. If you do not want this information to be shared, you may request that these types of disclosures be restricted as outlined later in this Notice.

7. **Others Involved In Your Care**. Under limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are directly involved in your care (for example, if you are seriously injured and unable to discuss your case with the Plan). Also, upon request, Associated may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want

this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

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

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

10. **Research**. Under certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

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

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

Uses and Disclosures for Fundraising and Marketing Purposes

The Plan and its business associates, including Associated, do not use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures Require Your Express Authorization

Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose your health information in writing. If you do so, the Plan will not use or disclose your health information as authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Plan creates, collects and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, Maryland 21152-9451
(410) 683-6500

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records. For health records that the Plan keeps in electronic form, you may request to receive the records in an electronic format.

To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. Upon receipt of your request, the Plan will send you a Claims History Report, which is a summary of your claims history that covers the previous two years. If you have been eligible for benefits for less than two years, then the Claims History Report will cover the entire period of your coverage.

If you do not agree to receive a Claims History Report, and instead want to inspect and/or obtain a copy of some or all of your underlying claims record, which includes information such as your actual claims and your eligibility/enrollment card and is not limited to a two year period, state that in your written request, and that request will be accommodated. If you request a paper copy of your underlying health record or a portion of your health record, the

Plan will charge you a fee of $.25 per page for the cost of copying and mailing the response to your request. Records provided in electronic format also may be subject to a small charge.

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

Right to Request That Your Health Information Be Amended

You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your request. The Plan may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

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

The Plan will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Plan denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Plan, including disclosures by Associated to others. The accounting covers up to six years prior to the date of your request, except, in accordance with applicable law, the accounting will not include disclosures made before April 14, 2003. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. In response to your request for an accounting of disclosures, the Plan may provide you with a list of business associates who make such disclosures on behalf of the Plan, along with contact information so that you may request

the accounting directly from each business associate. The first accounting that you request within a twelve-month period will be free. For additional accountings in a twelve-month period, you will be charged for the cost of providing the accounting, but Associated will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment or health care operations. You also have the right to request restrictions on your health information that Associated discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is generally not required to agree to your request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested. The Plan is required to agree to your request for restrictions in the case of a disclosure for payment purposes where you have paid the health care provider in full, out of pocket.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

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

You have the right to request that your health information be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Complain

You have the right to complain to the Plan and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plan, submit a written complaint to the HIPAA Privacy Officer listed above.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Plan or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the HIPAA Privacy Officer listed above. You may also obtain a copy of this Notice at Associated's website, www.Associated-Admin.com.

Right to Receive Notice of a Breach of Your Protected Health Information

You will be notified if your protected health information has been breached. You will be notified by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of protected health information. The notice will provide you with the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what steps are being taken to investigate the breach, mitigate losses, and to protect against further breaches. Please note that not every unauthorized disclosure of health information is a breach that requires notification; you may not be notified if the health information that was disclosed was adequately secured—for example, computer data that is encrypted and inaccessible without a password—or if it is determined that there is a low probability that your health information has been compromised.

CHANGES IN THE PLAN'S PRIVACY POLICIES

The Plan reserves the right to change its privacy practices and make the new practices effective for all protected health information that it maintains, including protected health information that it created or received prior to the effective date of the change and protected health information it may receive in the future. If the Plan materially changes any of its privacy practices, it will revise its Notice and provide you with the revised Notice, either by U.S. Mail or e-mail, within sixty days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request and will be posted for review near the front lobby of Associated's offices in Sparks, Maryland and Landover, Maryland. Any revised notice will also be available at Associated's website, www.Associated-Admin.com.

EFFECTIVE DATE

This Notice was first effective on April 14, 2003, and was revised, effective September 23, 2013, to reflect the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. This Notice will remain in effect unless and until the Plan publishes a revised Notice.

- **Effective July 2, 2013 – Three Year Statute of Limitations To File Suit Against Fund.**
  The following is added at the end of the Claims and Appeals section of your SPD:
  If your claim is denied, in whole or in part, you are not required to appeal the decision. However, before you can file suit under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") on your claim for benefits, you must exhaust your administrative remedies by appealing the denial to the Board of Trustees. Failure to exhaust these administrative remedies will result in the loss of your right to file suit. If you wish to file suit for a denial of a claim for benefits, you must do so within three years of the date the Trustees denied your appeal. For all other actions, you must file suit within three years of the date on which the violation of Plan terms is alleged to have occurred. Additionally, if you wish to file suit against the Plan or the Trustees, you must file suit in the United States District Court for the District of Maryland. These rules apply to you, your spouse, dependent, alternate payee or beneficiary, and any provider who provided services to you or your spouse, dependent or beneficiary. The above paragraph applies to all litigation against the Fund, including litigation in which the Fund is named as a third party defendant.

- **Effective 2013 Plan Year – Notice of Waiver of Annual Limit Requirement.**
  Below is a Notice that we are required by federal law to send to you. Under the Patient Protection and Affordable Care Act, group health plans generally cannot have annual limits of less than $2 million for the Plan Year beginning in 2013. Plans can seek a waiver of that annual limit from the Department of Health and Human Services ("HHS") if complying with the new annual limit would result in a significant decrease in employee access to benefits or a significant increase in employee payments.

  Because your plan currently has annual limits on comprehensive medical benefits and rehabilitation benefits that are below $2 million, and the Fund's benefit consultant projected that the Fund's cost of benefits would increase if it were required to increase these annual limits to $1.25 million, the Board of Trustees obtained a waiver of the annual limits until December 31, 2013. If the Fund did not obtain the waiver, the Trustees would have been required to consider decreasing benefits or increasing participant cost sharing, such as increases in deductibles, co-payments and co-insurance. To avoid having to consider decreasing benefits or increasing the out of pocket costs you pay for your health coverage, the Trustees decided that the best approach was to apply to HHS for the waiver.

  <u>You should be aware that as a result of obtaining the waiver, there will be no reductions in the current package of health benefits you are receiving</u>. The Board of Trustees is proud of the affordable health benefits that they have been able to provide over many years.

JANUARY 2013 NOTICE OF WAIVER OF ANNUAL LIMIT REQUIREMENT

This notice applies to participants with traditional Fund coverage, not HMO coverage.
The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least $2 million.
Your health coverage, offered by the United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund, does not meet the minimum standards required by the Affordable Care Act described above.

This means that your health coverage might not pay for all the health care expenses you incur.
Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least $2 million this year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until December 31, 2013.

If you are concerned about your plan's lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact the Administrative Manager at 301-459-3020 or toll-free at 800-638-2972. In addition, if you live in Maryland, you can contact the Maryland Office of the Attorney General, Health Education and Advocacy Unit, at (877) 261-8807. If you live in Virginia, you can contact the Virginia Consumer Assistance Program, at (877) 310-6560.

- **Effective 2012 - Dental Benefits for Dependents.** For participants in Plans T, Z, Y, Y20, K2 and K20, dental benefits for dependents terminate at the end of the year in which the dependent turns age 19. Student coverage does not include dental benefits.

- **Effective October 1, 2011 – CareFirst Is Your New PPO Provider**
On October 1, 2011, CareFirst replaced OneNet PPO as your new Preferred Provider Organization ("PPO"). When you use a provider (whether a hospital, physician, or other health care provider) who is in the CareFirst network, you will receive discounted rates that are generally lower than usual provider fees.

  New ID Card
  A new medical ID card was sent to you. ***Be sure to show the new ID card to all providers of service so that your claims are filed and processed correctly!***

  Locating A CareFirst Provider
  - You may call the CareFirst telephone number located on the back of your medical ID card.
    - If you received a white ID card with blue writing, call: (800) 235-5160.
    - If you received a white ID card with black writing, call (800) 810-2583.
  - You may go online to the CareFirst website, www.carefirst.com.

    White ID Card Holders with Blue Writing
    Click on "Members and Visitors," then on "Find a doctor or other provider in your Plan." On the next screen, click on the "Find a Doctor" link. Blue ID card holders should click on the button that reads, "Within MD/DC/Northern VA" under "PPO.' Click on "Continue." You may refine your search by clicking on "Type of Doctor" or "Type of Facility" and then clicking "Continue."

    White ID Card Holders with Black Writing
    Click on "Members and Visitors," then on "Find a doctor or other provider in your Plan." On the next screen, click on the "Find a Doctor" link. White ID card holders should click on the button that reads, "Outside MD/DC/Northern VA" under "PPO." Click on "Continue." You may refine your search by clicking on "Type of Doctor" or "Type of Facility" and then clicking "Continue."

- **Effective March 2011 – Send Appeals To Sparks Address**
Change the address of where you should send your written appeal to:

UFCW and Participating Employers
Health and Welfare Fund
Board of Trustees
911 Ridgebrook Road
Sparks, MD 21152-9451

Please make this change on page 96 of your SPD, under the heading "Review of a Denied Claim."

- **Effective January 1, 2011.** Pursuant to the Patient Protection and Affordable Health Care Act (PPACA), effective January 1, 2011, the Board of Trustees of the UFCW Unions and Participating Employers Health and Welfare Fund ("Fund") has made several changes to the Fund's Plan of benefits.

1. Extension of Coverage for Dependent Children.
Effective January 1, 2011, your eligible dependents include your spouse and your children, as defined below.

Generally, your biological children, adopted children and children placed with you for adoption are eligible for medical and prescription coverage as your dependent if they are:

- Under age 26
- Not eligible for coverage under another employer-provided group health plan (other than this Plan or a plan covering their parent(s)).

Stepchildren and children over whom you have legal custody, as well as biological children, adopted children, and children placed for adoption, who do not meet the above criteria, are eligible for coverage as your dependent if they are:

- Under age 19 (unless eligible for student coverage)
- Not married
- Not employed on a regular full time basis, and
- Dependent on you for financial support

In order to ensure continued coverage under the Plan, Dependents and/or Participants (as applicable) must complete any request for information issued by the Fund for the purpose of confirming continued eligibility for benefits. Failure to respond to any such requests may result in the suspension or termination of coverage.

If you are actively working, you had the opportunity to enroll your dependent child for medical coverage under these new rules during the special enrollment period that ran from November 19, 2010 to December 20, 2010.

2. Elimination of Pre-existing Condition Exclusions Applicable to Children.
Effective January 1, 2011, the pre-existing condition exclusions under the Plan no longer apply to participants and dependents under the age of 19. Specifically, this means that the general pre-existing condition exclusion applicable to dependent children over whom a participant has legal custody is eliminated. Further, the pre-existing condition exclusions on specific benefits under the Plan do not apply to participants and dependents under age 19.

3. Elimination of Certain Lifetime Limits.
The following lifetime benefit maximums under the Fund are eliminated, effective January 1, 2011. If you previously lost coverage under the Fund because you reached or exceeded one of

these lifetime maximums, you are again eligible to receive such benefits, subject to the terms of the Plan.

Comprehensive Medical /Major Medical	Plans JSS2, K2, Y	$400,000
	Plans T, Z	$350,000
	Plan JS	$250,000
	Plan K20	$150,000
	Plan Y20	$100,000
Rehabilitation Benefits	All Plans	$ 25,000

4. Changes to Annual Limits.

Effective January 1, 2011, the following annual limits are added to the Plan:

Comprehensive Medical /Major Medical	Plans JSS2, K2, Y	$400,000
	Plans T, Z	$350,000
	Plan JS	$250,000
	Plan K20	$150,000
	Plan Y20	$100,000
Rehabilitation Benefits	All Plans	$ 25,000

Notice of "Grandfathered" Status under the PPACA

This is to notify you that Plans JS, JSS2, K, K20, T, Y, Y20 and Z under the UFCW Unions and Participating Employers Health and Welfare Fund ("Fund") qualify as "grandfathered health plans" under the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act).

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Because the above-referenced Plans qualify as grandfathered health plans, certain provisions of the Affordable Care Act that apply to other plans—for example, the requirement for the provision of preventive health services without any cost sharing—do not currently apply to these Plans. However, the Plans offer other consumer protections under the Affordable Care Act, including the elimination of all lifetime limits on essential benefits.

If you have questions about which protections apply and which protections do not apply to a grandfathered health plan, or about what might cause these Plans to stop being treated as a grandfathered health plan, please contact the Participant Services at 1-800-638-2972. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Retroactive Termination of Coverage

Effective January 1, 2011, the Fund reserves the right to retroactively terminate your and your dependents' coverage under the Plan if you or any of your dependents engage in fraud and/or intentionally misrepresent or omit a material fact relevant to your Plan coverage, or if you or your participating employer fail to timely pay any applicable premium or contribution to the Fund relating to your benefits. Failure to follow the terms of the Plan, including but not limited to failing to notify the Fund of a change in dependent status, accepting benefits in excess of what is covered under the Plan, and accepting benefits after you or your dependent are no longer eligible for coverage, will be considered fraud and/or intentional misrepresentation. You are treated as having full knowledge of all the eligibility terms of this Plan.

Notice of Early Retiree Reinsurance Program Participation

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses the Fund for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, the Fund may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the Fund chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this Fund chooses to use the reimbursements for this purpose. The Fund may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in the Fund's costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

- **Effective January 1, 2011 – K2, K20, Y, Y20, JS, JSS2, T, and Z Participants: Changes As A Result of Health Care Reform (PPACA)**

Dependent Children Eligibility

Under "Dependent Eligibility," the section entitled "Who is an Eligible Dependent?" and the paragraph entitled "Legal Custody" are deleted and replaced with the following:

Who Is an Eligible Dependent?

Eligible dependents include your spouse and children, as defined in this Section.

Biological Children, Adopted Children and Children Placed for Adoption – For Plans K2, K20, T, Z, Y and Y20

Medical and Prescription Drug Benefit Eligibility

Generally, your biological children, adopted children and children placed with you for adoption are eligible for medical and prescription drug benefit coverage as your dependents if they are:

- Under age 26; and

- Not eligible for coverage under another employer-sponsored group health plan (other than this Plan or a plan covering their parent(s)).

Optical Benefit Eligibility
Generally, your biological children, adopted children and children placed with you for adoption are eligible for optical benefit coverage as your dependents:
- Through the end of the calendar year in which the dependent turns age 23; and
- Provided they are not eligible for coverage under another employer-sponsored group health plan (other than this Plan or a plan covering their parent(s)).

Dental Benefit Eligibility
For active participants, subject to the requirements described in the dental benefit sections of your SPD, your biological children, adopted children, and children placed for adoption, are eligible for dental benefit coverage as your dependents if they are:
- Under age 19;
- Not Married;
- Not employed on a regular full time basis; and
- Dependent on you for financial support.

Note: Children of retirees are not eligible for dental, optical or prescription benefits. For active participants, children under age four are not eligible for dental benefits.

Coverage for Full Time Students – Legal Custody and Stepchildren – Plans K2, K20, T, Z, Y and Y20
Generally, stepchildren and children over whom you have legal custody are eligible until the end of the calendar **year** in which they turn age 19. However, if your son or daughter is a full-time student at an accredited college or university, **medical and optical** coverage may be continued until the earliest of the last day of the calendar month in which he/she marries, ceases to be financially dependent on you for support, ceases to be a full-time student, or the end of the calendar year in which he/she turns age 23.

- **Effective July 1, 2010 – GVS Is New Vision Care Provider**
  The Board of Trustees announced improved optical coverage which began on July 1, 2010 and is provided through Group Vision Services ("GVS"). This coverage replaces coverage that was provided through United Optical (Spectera).

  Improved Network – One-Stop Shopping
  GVS has an extended network of providers located in major malls and convenient city locations, making it easy to find a provider. You have a choice of independent optometrists and ophthalmologists, as well as retail locations such as LensCrafters, Sears Optical, JCPenney Optical and participating Pearle Vision locations.

  Locating a Provider
  To locate the most current providers in the GVS network, log on to the GVS website at www.gvsmd.com. The names of providers are updated regularly. You can also call GVS' customer service toll-free at 1-866-265-4626.

- **Effective January 1, 2010 – Michelle's Law Extends Student Coverage During Illness**
  The Board of Trustees has adopted the following change to the UFCW Unions and Participating Employers Health and Welfare Fund.

Effective January 1, 2010, the following language is added at the end of the subsection entitled "Student Coverage" in your SPD:

If a dependent child enrolled in Student Coverage ceases to be a full-time student at an accredited school because of a medically necessary leave of absence resulting from a serious injury or illness, coverage under this Plan will be extended to the dependent during his or her leave of absence until the earlier of:

1. the one-year anniversary of the date on which the dependent child's leave of absence began, or
2. the date on which the dependent child's coverage under the Plan would otherwise terminate in accordance with this section.

To be eligible for this extended coverage, you must provide the Plan with written certification from the dependent child's treating physician that his or her leave of absence from school is medically necessary and is as a result of a serious illness or injury. The extended coverage will not be provided until the date such certification is received by the Fund, but will be retroactive to the date on which his/her leave of absence began.

- **April 1, 2009. Special Enrollment for Dependents – Medicaid and "CHIP."**
  The following is added to the Section of your SPD entitled "Eligibility for Dependents."

  If you turned down coverage for either yourself or your dependents when you were first eligible and, later, you or your dependents lose eligibility for financial assistance under Medicaid or the State Children's Health Insurance Program ("CHIP"), you may be able to enroll yourself or your dependents for coverage under the Fund. However, you must request enrollment under the Fund within 60 days of the date that CHIP or Medicaid assistance terminates for you or your dependent.

  In addition, you may be able to enroll yourself and your dependents in this Plan if you or your dependents become eligible to participate in a health insurance premium assistance program under Medicaid or CHIP. Again, you must request enrollment within 60 days of the date you or your dependent becomes eligible for premium assistance through Medicaid or CHIP, in order to be covered under the Fund.

- **Effective January 16, 2009 – "FMLA" Changes for Military Service**
  The following sentence is added to the end of the section entitled "Continuation of Coverage under the Family and Medical Leave Act":

  Eligible employees are entitled to up to 12 weeks per year of unpaid leave for a qualifying exigency that arises in connection with the active military service of a child, spouse, or parent.

- **Effective January 28, 2008,** the following is added to the end of the first paragraph under the section entitled "Continuation of Coverage under the Family and Medical Leave Act":

  You may be entitled to up to 26 weeks of FMLA leave if you are injured in military service, or to care for a family member who is injured in military service. Contact the Fund office for more information.

- **August 1, 2008. InforMed (pronounced IN-for-med) replaced Optum/CARE as your new Utilization Management ("UM") provider.** Wherever Optum/CARE appears in your SPD, change to InforMed.

Contact InforMed at (866) 290-8147 to pre-certify all non-emergency hospital stays, and within 24 hours after an emergency admission. Remember, you must certify all hospital stays in order to receive coverage under your Plan. This is very important!

Did my benefits change?
No. You have the same coverage, payment structures, exclusions, etc.

When must I pre-certify care?
Call InforMed to certify the following procedures:

- All elective (non-emergency) hospital admissions
- Surgical procedures performed at the outpatient center of a hospital or at an ambulatory surgical center
- All inpatient and outpatient rehabilitation care
- Home Care
- Hospice Care
- Within 24 hours of emergency admission to a hospital.

ID card sent
In July 2008, you were mailed a new Fund ID card with the InforMed name on the back of the card. It is very important that you show your new ID card to all providers of care!

Disease Management Program provided through InforMed
InforMed provides a "disease management" service to all active participants and dependents except those who are Medicare eligible or who are in an HMO.

What is disease management?
It is a program designed to assist participants and dependants with chronic, ongoing health conditions such as diabetes, lung/breathing problems, heart conditions and more. A personal nurse can answer questions and help you make lifestyle changes which may help your condition. InforMed also provides "Ask A Nurse" services to participants and dependants. Call InforMed toll-free at 1-866-290-8147 if you are interested in this program.

- **September 2007. Clarification of COBRA Second Qualifying Event.**
  The following is intended to clarify the description of a second Qualifying Event, found in the COBRA Section of your Summary Plan Description ("SPD") in the fourth paragraph under the heading "Notification Requirements".

  If you become eligible for COBRA Continuation Coverage under the Plan as a result of your termination of employment or a reduction in your hours, and you elect to receive COBRA Continuation Coverage for yourself and your dependents, generally you and your dependents will be entitled to continue your COBRA Continuation Coverage for up to 18 months, subject to the limitations described in your SPD. If, during that 18-month Coverage period, a second qualifying event (described below) occurs, your dependents may be eligible to receive an additional 18 months of COBRA Continuation Coverage, for a total of 36 months of Coverage. Under no circumstances will COBRA Continuation Coverage extend beyond 36 months.

  Second qualifying events include the death of the Participant, divorce or separation from the Participant or a dependent child's ceasing to be eligible for coverage as a dependent under the Fund. The events described in this paragraph are second qualifying events only if they would have caused the qualified beneficiary to lose coverage under the Fund if the first qualifying event had not occurred. Consequently, since the Plan's eligibility rules permit active Participants and their dependents to

remain covered after the Participant becomes eligible for Medicare, eligibility for Medicare is not a second qualifying event (so it does not extend COBRA coverage).

Here are some examples of how these rules work:

1. You and your dependents are currently receiving COBRA Continuation Coverage under the Plan for an 18-month period as a result of your termination of employment. If you and your spouse are divorced during that 18-month period, your dependents would be entitled to extend their COBRA Continuation Period for an additional 18 months.

2. You and your dependents are receiving COBRA Continuation Coverage under the Plan for an 18-month period as a result of your termination of employment and, during that 18-month period, you become eligible for Medicare because you have attained age 65. Your dependents will not be entitled to extend their period of COBRA Continuation Coverage under the Plan because your eligibility for Medicare would not have caused you to lose coverage under the Plan if you were still an active Participant under the Plan on your 65th birthday.

Please remember that your spouse and dependents must notify the Fund office in writing and in accordance with the notification procedures described in your SPD in order to extend their period of COBRA Continuation Coverage upon the occurrence of a second Qualifying Event.

- **March 2007. The following language regarding overpaid benefits is added to your SPD:**
  If the Fund pays benefits in error, such as where the Fund pays you or your dependent more benefits than you are entitled to, or if the Fund advances benefits that you or your dependent are required to reimburse either because you have received a compensable workers' compensation claim or have received a third party recovery (see "Subrogation" and Advance Benefits for Workers' Compensation Claims"), the Fund shall be entitled to recover such benefits. The Fund may recover these benefits by offsetting all future benefits otherwise payable by the Fund on your behalf or on behalf of your dependents. For example, if the overpayment or advancement was made to you as the Fund participant, the Fund may offset the future benefits payable by the Fund to you and your dependents. If the overpayment or advancement was made to your dependent, the Fund may offset the future benefits payable by the Fund to you and your dependents. The Fund also may recover any overpaid or advanced benefits by pursuing legal action against the party on whose behalf the benefits were paid. By accepting benefits under the terms of this Plan, you and your dependents agree to waive any applicable statute of limitations defense available to you and your dependents regarding the enforcement of any of the Fund's rights to reimbursement.

  The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid or advanced benefits received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this Section, and any such amount shall be deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, you and your dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

  In the event you, or if applicable, your dependent or beneficiary, fail to reimburse the Fund and the Fund is required to pursue legal action against you or your dependent or beneficiary to obtain repayment of the benefits advanced by the Fund, you or your dependent or beneficiary shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the

collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. You or your dependent or beneficiary shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed.

- **October 2006. Spectera/United Optical is now called UnitedHealthCare Vision.** If you live outside the UnitedHealthcare Vision area and request reimbursement, send your paid itemized receipts to: UnitedHealthCare Vision Claims Dept., P.O. Box 30978, Salt Lake City, UT 84130. Make these changes on pages 66, 67 and 68 of your SPD.

- Change the telephone number on page 86 for the Employee Assistance Program to (800) 353-3572.

- **September 2006. Alliance PPO, LLC changed its name to OneNet PPO, LLC ("OneNet").** Medical claims should be sent to: OneNet PPO, LLC, P.O. Box 936, Frederick, MD 21705-0936.

  You can select a provider at their new website www.onenetppo.com or call the OneNet Member Service Department at (800) 342-3289.