UFCW Unions & Participating Employers
Health and Welfare Fund

Plan Y30

Summary of Material Modifications

April 2022

This insert is a Summary of Material Modifications (changes) to your Summary Plan Description (SPD) booklet dated October 2017. If there is any discrepancy between the information printed on this insert and the Plan, the Plan will govern. Please keep this insert with your booklet so you will have it when you need to refer to it.

1. 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.

- ***Over-the-Counter COVID-19 Test Coverage***

Effective January 15, 2022 and continuing through the end of the federally-declared public health emergency, certain at-home COVID-19 diagnostic tests purchased without a prescription ("OTC Tests") are now covered under the Plan's Prescription Drug Benefit.

The types of OTC Tests that are covered include diagnostic tests that are approved, cleared, or authorized by the FDA for use without an order or individualized clinical assessment from a health care provider under the applicable FDA

authorization, clearance, or approval. Generally, OTC COVID tests available for purchase in pharmacies will meet this standard. Currently, these OTC Tests are covered with no cost sharing (including deductibles, co-payments, and co-premiums) and no requirement of prior authorization.

- ***You have the following options for coverage of OTC Tests:***

- ***Pay $0 at a participating OptumRx network pharmacy:*** *At participating pharmacies in the OptumRx network, you and your covered dependents will be able to present your OptumRx ID card and obtain up to eight (8) OTC Tests per person, every calendar month, with no out-of-pocket cost. You may be asked to complete an attestation prior to receiving the tests, to confirm that you are purchasing the tests for personal use and not for employment-related COVID-19 testing requirements.* ***Please note: This no-upfront-cost option is currently available only at Rite Aid, Bartell Drugs, Sam's Club Pharmacy, or Walmart Pharmacy. However, OptumRx is working to expand this list of participating pharmacies, so please visit www.optumrx.com/testinfo for an updated list of participating pharmacies before you purchase any OTC Tests.***

To obtain your OTC Tests from a participating OptumRx network pharmacy, first call the pharmacy to see if they have OTC Tests available. When you go to the pharmacy, take your OptumRx ID card with you and bring the COVID-19 OTC Test to the pharmacy counter, not the regular checkout lane. When you check out at the pharmacy counter

with your ID card, your test should automatically ring up at no cost to you. ***Important note:*** *The no up-front-cost option is only available for purchases made at the pharmacy checkout counter using your OptumRx ID card.*

- ***Order OTC Tests online with $0 copay through Optum Store:*** *If you prefer to order your OTC Tests online and have them delivered to your home at $0 copay, register and sign in to www.optumrx.com and click the "Order Now" link under* ***<Get at-home COVID-19 tests with $0 copay>****. Choose the number of boxes (2 tests per box) up to a maximum of 4 boxes (8 tests). You will qualify for free standard shipping if you order at least 2 boxes of OTC Tests (4 total tests).*

- ***Purchase an OTC Test and then submit a form for reimbursement:*** *You or your covered dependents may purchase OTC Tests at non-participating pharmacies, or other retailers, and submit a request for reimbursement to OptumRx for the full cost of up to 8 OTC Tests per covered person per calendar month. A testing kit containing two tests in one box will count as two tests toward this limit.* ***Be sure to obtain a receipt when you purchase the OTC tests****. The Plan will reimburse up to a maximum of $12 per test. You can submit an online claim form for reimbursement, or download and print a paper claim form that you can mail to the address on the form for reimbursement, at www.optumrx.com/testinfo. Please note you will receive reimbursement more quickly if you submit an online claim form. You may also call OptumRx at (866) 290-8147 to request a paper claim form.*

You must include your receipt for the purchase of the OTC Test with your claim form, and you will be required to sign an attestation that the test was purchased for personal use and is not for employment-related COVID-19 testing requirements.

Regardless of whether you obtain the OTC Tests at a participating OptumRx network pharmacy, from the Optum Store online, or out-of-network, coverage is limited to 8 tests per covered participant or dependent per calendar month. Please note, COVID-19 diagnostic tests performed at a provider's office, hospital, or clinic do not count toward this limit.

- ***Important Notes****:*

    - *The Fund is continuing to work with its prescription benefit manager, OptumRx, on the development of this program to provide coverage for OTC COVID tests. As this program develops, the Fund will inform you in the event of any important changes to the scope of coverage of OTC COVID tests. You can also visit www.optumrx.com/testinfo for the latest information on the OTC Test coverage available through OptumRx.*

- *OTC COVID tests are currently in high demand. As an alternative to obtaining these tests at a pharmacy or retailer, you also can visit www.COVIDtests.gov to order 4 free at-home tests that will be mailed to you from the federal government. There also may be additional options in your local area for obtaining OTC COVID tests at no cost.*

If you have any questions, please contact the Fund Office at 1-800-638-2972.

- **The second and third sentences under "Hospitalization" in the SPDs' "Schedule of Benefits for Full Time Participants" and the "Schedule of Benefits for Part Time Participants" are deleted and replaced with the following:**

  - **You must use an in-network CareFirst PPO provider**, with the exception of (1) *No Surprises Services* and (2) emergency *Ambulance Service*. Emergency room service is a $75 *Co-payment*, then emergency room and provider charges are covered at 80% for Plan Y, 75% for Plan Y20, and 70% for Plan Y30 of *Allowable Charge*.

- **The last two sentences under "Medical/Surgical" in the SPDs' "Schedule of Benefits for Full Time Participants" and the "Schedule of Benefits for Part Time Participants" are deleted and replaced with the following:**

  - **You must pre-certify all non-emergency *Inpatient Hospital* stays with Conifer** (see section on Conifer Health Solutions for details)**. You must use LabCorp or Quest lab facilities** in order to be covered for laboratory services, except that laboratory services performed by out-of-network providers at in-network facilities also are covered.

- **The following new definitions are added under the "Definitions" section of the SPDs:**

  - **ANCILLARY SERVICES.** With respect to an in-network *Health Care Facility*, (1) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; (2) items and services provided by assistant surgeons, hospitalists, and intensivists; (3) diagnostic services, including radiology and laboratory services; and (4) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

  - **CONTINUING CARE PATIENT.** An individual who is: (1) receiving a course of treatment for a *Serious and Complex Condition*; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility.

  - **EMERGENCY SERVICES**. Any of the following, with respect to an *Emergency Medical Condition*:
    - An appropriate medical screening examination that is within the capability of the emergency department of a *Hospital* or *Independent Freestanding Emergency Department*, including *Ancillary Services* routinely available to the emergency department to evaluate such *Emergency Medical Condition*;
    - Such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and
    - Services provided by an out-of-network provider or facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:
      - The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;
      - The patient is supplied with a written *Notice*, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on such treatment, of the names of any in-network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the in-network providers listed; and

- The patient gives informed *Consent* to continued treatment by the nonparticipating provider, acknowledging that she or he understands that continued treatment by the out-of-network provider may result in greater cost to the patient.

- **HEALTH CARE FACILITY**. For non-*Emergency Services*, a: (1) hospital; (2) hospital outpatient department; (3) critical access hospital; or (4) ambulatory surgical center.

- **INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT**. A facility that is geographically separate and distinct from a *Hospital* under applicable state law and provides, and is licensed under state law to provide, *Emergency Services*.

- **NO SURPRISES ACT.** The No Surprises Act enacted under the federal Consolidated Appropriations Act of 2021, Public Law 116-260.

- **NO SURPRISES SERVICES.** The following services, to the extent covered under the Plan: (1) out-of-network *Emergency Services*; (2) out-of-network air ambulance services; (3) non-emergency *Ancillary Services* (such as anesthesiology, pathology, radiology, neonatology and diagnostic services and other services defined as ancillary under the *No Surprises Act* and its implementing regulations) when performed by out-of-network providers at in-network *Health Care Facilities*; and (4) other out-of-network non-emergency services performed by an out-of-network provider at in-network *Health Care Facilities* with respect to which the provider does not comply with federal *Notice and Consent* requirements.

- **NOTICE AND CONSENT.** With respect to out-of-network services provided at an in-network *Health Care Facility*, *Notice and Consent* means: (1) that at least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed; and (2) you give informed consent to continued treatment by the out-of-network provider, acknowledging that you understand that continued treatment by the out-of-network provider may result in greater cost to you.

- **SERIOUS AND COMPLEX CONDITION.** A condition, (1) in the case of an acute illness, that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic illness or condition, that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

▪ **The definitions of "Co-Insurance or Co-Payment" and "Medical Emergency" under the "Definitions" Section of the SPDs are deleted and replaced with the following:**

- **CO-INSURANCE OR CO-PAYMENT.** The out-of-pocket amount of the *Allowable Charge* that a participant or dependent is responsible for paying when receiving benefits after paying any applicable *Deductible* amount for that year. Effective January 1, 2022, the *Co-insurance* or *Co-payment* applicable to *No Surprises Services* is based on the lesser of the median of the in-network rates payable for the same or similar service in the same geographic region, which may also be referred to as the "Qualifying Payment Amount" ("QPA"), or the amount billed by the provider.

- **EMERGENCY MEDICAL CONDITION**. A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant

woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

- **All references in the SPDs to the "Usual, Customary, and Reasonable charge" or the "UCR charge" are deleted and replaced with the "Allowable Charge," and the definition of "Usual, Customary, and Reasonable or UCR" under the "Definitions Section of the SPDs is deleted and replaced with the following:**

  - **ALLOWABLE CHARGE.** The fee, as determined by the *Fund*, that is the lowest of: (1) the health care provider's actual charge; (2) the usual charge by the health care provider for the same or similar service or supply; (3) the maximum amount that the Fund has determined it will pay for the service or supply; or (4) the amount that is reasonable and customary for the locality in which incurred. Notwithstanding the above, for CareFirst in-network claims, the *Allowable Charge* is the CareFirst allowed amount.

- **The "Use Participating Doctors" Subsection of the "Consumer Tips" Section of the Plan Y30 SPD is deleted and replaced with the following:**

  Use Participating Doctors
  When you need to see a doctor or go to a *Hospital* or other facility, you must use a CareFirst provider to have coverage, with the exception of (1) *No Surprises Services* and emergency *Ambulance Service*. To locate a CareFirst provider, contact CareFirst at the number listed on your ID card.

- **The first two paragraphs of the SPDs' "CareFirst PPO" Section are deleted and replaced with the following:**

  CareFirst PPO is a network of *Hospitals*, *Physicians*, and other health care providers which offers medical and *Hospital* services at discounted rates that are generally lower than usual provider fees. **You must use a CareFirst provider to have coverage for *Hospital*, medical, or surgical benefits under the *Fund*** (with the exception of: (1) *No Surprises Services* and (2) emergency *Ambulance Service*)**.**

  Exceptions
  You are covered for non-PPO emergency *Ambulance Service,* as well as for *No Surprises Services*. *No Surprises Services* include the following, to the extent they are covered under the Plan in-network: (1) out-of-network *Emergency Services*; (2) out-of-network air ambulance services; (3) non-emergency *Ancillary Services* (such as anesthesiology, pathology, radiology and diagnostic services and other services defined as ancillary under the *No Surprises Act* and its implementing regulations) when performed by out-of-network providers at in-network facilities; and (4) other out-of-network non-*Emergency Services* performed by an out-of-network provider at in-network facilities with respect to which the provider does not comply with certain federal *Notice and Consent* requirements.

- **The following paragraph is added to the SPDs' "CareFirst PPO" Section:**

  <u>Provider Directory</u>
  The provider directory listing those providers that are in-network because they participate in CareFirst's network will be updated at least every ninety (90) days and will be available through the Fund's website. If you receive services from a provider that you thought was in-network, based on inaccurate information in a current provider directory, then the services provided by that out-of-network provider will be covered as if the provider was in-network.

- **The last paragraph of the SPDs' "CareFirst PPO" Section is deleted and replaced with the following:**

  <u>Important:</u> For laboratory services to be covered, you must use either LabCorp or Quest Diagnostic Laboratories for all laboratory services (except those performed when you are an *Inpatient* in the *Hospital* or by out-of-network providers at in-network facilities). Lab services performed in your doctor's office or other locations generally will

not be covered. To find the nearest LabCorp location, call (888) 522-2677 or log onto their website at www.labcorp.com/psc/index.html. To find the nearest Quest location, call (800) 377-7220 or go to their website at www.questdiagnostics.com/appointment.

- **The following is added to the beginning of the "Comprehensive Medical Benefits" Section of the SPDs:**

  Notwithstanding anything in this Section to the contrary, no prior authorization requirement will apply to *Emergency Services*.

- **The following new sections are added under the "Comprehensive Medical Benefits" Section of the SPDs:**

  Air Ambulance Services
  Under applicable law, the cost-sharing requirement applicable to out-of-network air ambulance services must be no greater than the cost-sharing requirement that would apply if the services had been furnished by an in-network provider. In general, you cannot be balance billed for these air ambulance services.

  Continuing Care Patients
  If an in-network provider leaves the CareFirst network, a *Continuing Care Patient* who is receiving care with that provider will be notified, and may elect to continue to receive such care at the same in-network *Co-Payment* and *Co-Insurance* rate for up to 90 days after the provider leaves the network.

- **The "You Must Use a CareFirst Provider" Subsection of the SPDs' "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

  You Must Use a CareFirst Provider
  Medical benefits will be covered ***only if services are performed by an in-network provider,*** with the exception of: (1) *No Surprises Services* and (2) emergency *Ambulance Service*. When you need to use a provider (whether a *Hospital*, *Physician*, or other health care provider), be sure they are in the CareFirst network. Otherwise, your claim will be denied unless it fits into one of the specific exceptions mentioned above.

- **The "Payment of Benefits" Subsection of the SPDs' "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

  Payment of Benefits
  When the professional services described below are rendered by a *Physician*, physician's assistant, nurse practitioner or certified surgical assistant, the Plan will provide benefit payment at the percentage shown in your Schedule of Benefits, up to the *Allowable Charge*. The annual *Deductible* applies, except as may otherwise be provided here or under applicable law. Payment by the *Fund* will constitute full and final payment, except as may otherwise be provided or limited here or under applicable law. Charges made in excess of these amounts are the responsibility of the patient, **except** in the case of *No Surprises Services*. Your only financial responsibility for any *No Surprises Service* is any applicable *Deductible*, *Co-Insurance* or *Co-Payment* amount, up to the lesser of the median of the in-network rates payable for the same or similar service in the same geographic region, which may also be referred to as the "Qualifying Payment Amount" ("QPA"), or the amount billed by the provider. You will not be responsible for any other amount relating to *No Surprises Services*, even if the provider does not accept the *Allowable Charge*.

- **The "Hospital Services" Subsection of the SPDs' "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

  Hospital Services

You must contact *Conifer for pre-authorization for all Hospital admissions*, except that there is no prior authorization requirement for *Emergency Services*. Contact Conifer toll free at (833) 778-9806. Fax number is (410) 972-2044.

- **The third paragraph under the "Diagnostic X-Ray and Laboratory Services" Subsection of the SPDs' "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

  Important: For laboratory services to be covered, you must use either LabCorp or Quest Diagnostic Laboratories for all laboratory services (except those performed when you are an *Inpatient* in the Hospital or by out-of-network providers at in-network facilities). Lab services performed in your doctor's office or other locations will not be covered. To find the nearest LabCorp location, call (888) 522-2677 or log onto their website at www.labcorp.com/psc/index.html. To find the nearest Quest location, call (800) 377-7220 or go to their website at www.questdiagnostics.com/appointment.

- **The second, third, and fourth paragraphs under the "Inpatient Medical Services" Subsection of the SPDs' "Comprehensive Medical Benefits" Section are deleted.**

- **The "Outpatient Emergency Care" Subsection of the SPDs' "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

  Outpatient Emergency Care
  Benefits are available to you or your eligible dependents for care received within 72 hours of an *Accidental Injury*, by a *Physician*, wherever it is performed, and for *Outpatient Emergency Services*.

- **The "Outpatient Treatment" Subsection of the SPDs' "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

  Outpatient Treatment
  Outpatient Hospital treatment will be covered when the treatment is for:
  1. The performance by a *Physician* of minor surgical procedures required for treatment and not solely for diagnosis,
  2. care rendered within 72 hours after a non-occupational *Accidental Injury*, or
  3. *Emergency Services*.

  Benefits for coverage of *Outpatient* radiation and radioactive isotope therapy will be provided when performed in the *Outpatient* department of a *Hospital* and billed as a *Hospital* service.

- **In the "Conifer Health Solutions" Section of the SPDs, the last bullet point under "2. Emergency Admission (Requires Certification within 48 Hours of Admission)" is deleted and replaced with the following:**

  - Emergency room visits do not require certification and *Emergency Services* do not require prior authorization.

- **In the first numbered list under the SPDs' "Claims Filing and Review Procedure" Section, the first sentence of number 6. is deleted and replaced with the following:**

  - **You must use a CareFirst PPO participating provider** (with the exception of (1) *No Surprises Services* and (2) emergency *Ambulance Service*).

- **COVID-19 Vaccination Coverage**

  The following services will be covered under Comprehensive Medical Benefits and the Prescription Drug Benefit on an in-network and out-of-network basis with no cost sharing (including deductibles, co-payments and co-premiums) and no requirement of prior authorization:

- A COVID-19 immunization that has a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (regardless of whether the immunization is recommended for routine use), after such recommendation has been in effect for 15 business days; and

- items and services that are an integral part of furnishing the covered immunization, including vaccine administration.

Office Visit Coverage

There are limited situations in which an office visit is payable under this COVID-19 Vaccination Coverage. The following conditions apply to payment for office visits under the COVID-19 Vaccination Coverage.

- If the covered immunization, item or service is billed separately from an office visit, then the Fund will impose cost-sharing with respect to the office visit.

- If the covered immunization, item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of the immunization, then the Fund will pay for the office visit without cost-sharing.

- If the covered immunization, item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of the immunization, then the Fund will impose cost-sharing with respect to the office visit.

- **Effective March 1, 2019 – Cost to Add Dependent Children for Plans Y20 and Y30 Part Time Participants**
  The cost for dependent coverage for children of part time participants in Plans Y20 and Y30 has changed.

Plan	Per Child Rate	3 or More Children Rate
Plan Y20 Part Time	$147.85 per month	$443.55 per month
Plan Y30 Part Time	$145.21 per month	$435.63 per month

The 2019 amount will automatically be deducted from your paycheck beginning in March ***unless you contact the Fund Office*** within 30 days of the date you first receive notice of the new rates to advise that you want to drop the coverage. If you don't contact the Fund Office, you will remain enrolled for Dependent Child coverage at the same level you have currently, and the new rate will apply to you starting in March.

- **Effective April 1, 2018 – Disability Benefit Claims and Appeals**
  The Board of Trustees of the UFCW Unions and Participating Employers Health & Welfare Fund ("Fund") has adopted the following changes to the UFCW Unions and Participating Employers Active Health and Welfare Plan ("Active Plan") and UFCW Unions and Participating Employers Retiree Health and Welfare Plan ("Retiree Plan") effective April 1, 2018. These changes provide you with more information on how the Fund reviews certain disability benefit claims and appeals.

1. **Effective for claims for disability benefits filed on or after April 1, 2018, the following language is added after the "If Your Weekly Disability Claim is Denied" Subsection of the Section entitled "Claims Filing and Review Procedure" in your SPD:**

   Initial Disability Claim Denial Involving Discretionary Determination of Disability by the Fund
   In the case of a denial of your claim for disability benefits that is based on a determination by the *Fund* (and not by a third party acting independent of the *Fund* such as the Social Security Administration ("SSA")) that you are not disabled under the Plan rules, the written notice of the denial also will include the following:

1. A discussion of the decision, including, if applicable, an explanation of the *Fund's* basis for disagreeing with or not following:

   (a) The views you presented to the *Fund* of health care professionals treating you and vocational professionals who evaluated you (if any);
   (b) The views of any medical or vocational experts whose advice was obtained on behalf of the *Fund* in connection with the denial of your claim, even if the advice was not relied upon in making the determination; and
   (c) A disability determination made by the SSA, if you provided it to the *Fund*.

2. A copy of the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; and

3. A statement that you are entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

2. Effective for claims for disability benefits filed on or after April 1, 2018, the following language is added after the "Appeals Procedures – Weekly Disability Claims" Subsection of the Section entitled "Claims Filing and Review Procedure" in the SPD:

Disability Decision on Appeal Involving Discretionary Determination of Disability by the Fund
In the case of a denial of your appeal involving a claim for a disability benefit that is based on a determination by the *Fund* (and not by a third party acting independent of the *Fund* such as the SSA) that you are not disabled under the Plan rules, the written notice of denial also will include all of the information in the "Initial Disability Claim Denial Involving Discretionary Determination of Disability by the *Fund*" section above, as well as the calendar date on which the contractual limitations period expires for the claim.

3. Effective April 1, 2018, the following is added at the end of: (a) the first paragraph of the "Denial of a Claim" Subsection of the Section entitled "Claims Filing and Review Procedure;" and (b) the second paragraph of the "If Your Weekly Disability Claim is Denied" Subsection of the Section entitled "Claims Filing and Review Procedure":

The written notice of denial also will include a description of any contractual limitations period that applies to your right to bring an action under ERISA if your appeal is denied.

- **Effective March 1, 2018 – Cost to Add Dependent Children for Part Time Participants in Plans Y20 and Y30**
  The cost for dependent coverage for children of Part Time participants in Shoppers Plan Y20 and Plan Y30 will change.

  The chart below shows the cost for the coverage will be effective March 1, 2018.

Plan	2018 Rates Per Child	2018 Rates for Three or More Children
Plan Y20 Part Time	$137.57 per month	$412.71 per month
Plan Y30 Part Time	$135.12 per month	$405.36 per month

The 2018 amount will automatically be deducted from your paycheck beginning in March ***unless you contact the Fund Office*** to advise that you want to drop the coverage. If you don't contact the Fund Office, you will remain enrolled for Dependent Child coverage at the same level you have currently, and the new rate will apply to you starting in March.

- **Effective January 1, 2018 – Revised ACA Preventive Services.** The Patient Protection and Affordable Care Act of 2010 ("ACA") requires 100% coverage for certain medical services **as long as the patient is seen by an in-network provider.** This means you will have no deductible, co-payment or co-insurance for preventive services as long as you see a participating provider.

  Complete List on the Fund's Website
  A complete list of the 2018 ACA Preventive Services can be found on the Fund's website at www.associated-admin.com.