UFCW LOCAL 1262 AND EMPLOYERS SHOPRITE WELFARE FUND
1389 BROAD STREET
CLIFTON, N.J. 07013-4221
PHONE 973-778-5800 TTY:711 FAX 973-778-1725

Dear Participant/Beneficiary:

The privacy of your personal information is very important to **the UFCW Local 1262 and ShopRite Welfare Fund** (, the "Plan"). We are pleased to make this copy of the Plan's Revised Notice of Privacy Practices ("Notice") available to you. The Notice describes the Plan's policies and procedures for maintaining the privacy of your Protected Health Information ("PHI") and your rights with respect to the Plan's use and disclosure of your PHI.

This Notice is being provided in compliance with the federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Enclosed is a form that you may print and use, if you would like, to authorize the Plan to release your health information to a family member, close personal friend, or another representative of your choosing, without requiring the Plan to contact you first for your authorization. The form is titled **"HIPAA Authorization for Release of Protected Health Information ("PHI")**."

PLEASE READ THE ENCLOSED DOCUMENTS CAREFULLY. If you have any questions, please contact the Fund Office at 973-778-5800**.**

As always, we value the privacy of your personal information, and make it a top priority. Thank you.

Sincerely,
THE BOARD OF TRUSTEES

REVISED NOTICE OF PRIVACY PRACTICES

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

Effective Date of Notice
February 2026

The UFCW Local 1262 and ShopRite Welfare Fund (each a "Fund") are required to take reasonable steps to ensure the privacy of your individually identifiable health information in accordance with the privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations (with HIPAA, "federal health privacy law"). In addition, the Fund must inform you about:

1. The Fund's uses and disclosures of Protected Health Information ("PHI");
2. The Fund's duties with respect to your PHI;
3. Your rights with respect to your PHI;
4. Any instances where there is a breach of your PHI;
5. Your right to file a complaint with the Fund and the Secretary of the U.S. Department of Health and Human Services; and
6. The identity of the person to contact for additional information about the Fund's privacy practices.

PHI includes all individually identifiable health information that is transmitted or maintained by the Fund, or on behalf of the Fund, in connection with the Fund's provision of medical, dental, vision and pharmacy benefits, regardless of whether the information is transmitted or maintained orally, on paper or through electronic medium (such as e-mail).

USES AND DISCLOSURES OF PHI MADE WITHOUT YOUR CONSENT

Except as described in this section, or as provided for by federal privacy law, or as you have otherwise authorized, the Fund uses PHI only to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. The Fund discloses your PHI only for the administration of the Fund and the processing of your health claims. The Fund may also disclose your PHI to other third parties that assist the Fund in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities as permitted by law. Under certain circumstances, the Fund will only use or disclose your health information pursuant to your written authorization. In other cases, your authorization is not needed. The details of the Fund's uses and disclosures of your PHI are described below.

Uses and Disclosures to the Fund Sponsor

The Fund may disclose your PHI to its Board of Trustees as the Fund's sponsor, to enable the Board of Trustees to administer the Fund’s plan of benefits. Such disclosures may be made without your authorization. The Fund's governing documents reflect the Trustees' obligation to protect the privacy of your health information and the Board of Trustees has certified that it will protect any PHI it receives in accordance with federal law.

Uses and Disclosures to Business Associates

The Fund shares PHI with its "business associates," which are third parties that assist the Fund in its operations such as preferred provider networks and prescription benefit program managers. The Fund enters into agreements with its business associates so that the privacy of your health information will be protected by them. A business associate must have any agent or subcontractor to whom the business associate provides your PHI agree to the same restrictions and conditions that apply to the business associate. The Fund is permitted to disclose PHI to its business associates for treatment, payment and health care operations without your authorization as described below.

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

The Fund and its business associates may use and disclose PHI without your authorization for treatment, payment and health care operations as described below.

For Treatment: If it is necessary for the Fund to make disclosures of PHI related to your health care treatment, such disclosures may be made without your authorization. For example, the Fund may disclose the name of a treating specialist to your treating physician to assist your treating physician in obtaining records from the specialist.

For Payment: The Fund may use and disclose PHI so that your claims for health care treatment, services and supplies can be paid in accordance with the Fund's plan of benefits. For example, the Fund may tell a doctor whether you are eligible for coverage or what portion of your medical bill will be paid by the Fund. In addition, the Fund may disclose your health information to other insurers or benefit plans to coordinate your health care claims with others that may be responsible for some of your health care costs.

For Health Care Operations: The Fund may use and disclose PHI to enable it to operate efficiently. This can include quality assessment and improvement, reviewing competence or qualifications of health care professionals, case management, conducting or arranging for medical review, legal services and auditing functions, business planning and general administrative activities. For example, the Fund may disclose PHI to its actuaries and accountants for benefit planning purposes. However, the Fund will never use or disclose for underwriting purposes PHI that is “genetic information” within the meaning of the Genetic Information Nondiscrimination Act of 2008.

Other Uses and Disclosures That May Be Made Without Your Authorization

In addition to the uses and disclosures of PHI described above for treatment, payment or health care operations, the federal health privacy law provides for specific uses or disclosures that the Fund may make without your authorization, as described below.

Required by Law: PHI may be used or disclosed as required by law. For example, your PHI may be disclosed for judicial and administrative proceedings pursuant to court or administrative order, legal process or authority; to report information related to victims of abuse, neglect, or domestic violence; to assist law enforcement officials in their law enforcement duties; or to notify the appropriate authorities of a breach of unsecured protected health information. Records received from a substance use disorder treatment program, or testimony relaying the content of such records, may not be used or disclosed in a civil, criminal, administrative, or legislative proceeding against you unless based on either your written consent, or a valid court order and subpoena, provided you receive notice of and an opportunity to contest such disclosure.

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

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

Active Members of the Military and Veterans: PHI may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.

Workers' Compensation: PHI may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.

Research: Under certain circumstances, PHI 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.

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

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

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

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

Others Involved In Your Care: Under limited circumstances, your PHI may be used or disclosed to a family member, close personal friend, or others who the Fund has verified are directly involved in your care. For example, this may occur if you are seriously injured and unable to discuss your case with the Fund. Also, upon request, the Fund may advise a family member or close personal friend about (1) your general condition, (2) your location, such as "in the hospital," or (3) your death. 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.

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 people who have Power of Attorney for adults.

Other Uses or Disclosures: The Fund may contact you to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

USES AND DISCLOSURES OF PHI PURSUANT TO YOUR AUTHORIZATION

Uses and disclosures of your PHI ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization at any time, provided you do so in writing. If you revoke a written authorization to use or disclose PHI, the Fund will not use or disclose your PHI in reliance on that authorization, except to the extent that the Fund already relied on your authorization. Once your PHI 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 PHI may be disclosed to your "personal representatives," meaning people who 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.

Although the Fund does not routinely obtain psychotherapy notes, it must generally obtain your written authorization in order to use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you. *Psychotherapy notes* are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Although the Fund does not routinely sell PHI or use it for marketing purposes, it must obtain your written authorization before it may sell your PHI or use it for marketing purposes.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

You have the following rights regarding your PHI that the Fund creates, collects and maintains.

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 eligibility and coverage under the Fund's plan of benefits as well as claims 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 or to obtain a copy of your health record, submit a written request to the Fund's HIPAA Privacy Officer identified below. (See page 8.) The Fund may charge a reasonable fee based on the cost for copying and mailing records associated with your request for paper copies. Records provided in electronic format also may be subject to a small charge. In certain limited circumstances, the Fund may deny your request to inspect and copy your health record. This denial will be provided in writing and will set forth the reasons for the denial and will describe how you may appeal the Fund's decision.

The Fund must provide the requested information within thirty days if the information is maintained on site at the Fund's offices, or within sixty days if the information is maintained offsite. A single thirty day extension is allowed if the Fund is unable to meet the deadline.

Right to Request That Your Health Information Be Amended

You have the right to request that your PHI be amended if you believe the information is incorrect or incomplete. To request an amendment, submit a detailed written request to the Fund's HIPAA Privacy Officer identified below. This request must provide the reason(s) that support your request. The Fund may deny your request if it is not made in writing, if it does not provide a basis in support of the request, or if you have asked to amend information that (1) was not created by or for the Fund, unless you provide the Fund with information that the person or entity that created the information is no longer available to make the amendment, (2) is not part of the health information maintained by or for the Fund, (3) is not part of the health record information that you are permitted to inspect and copy, or (4) is accurate and complete.

The Fund will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. The Fund has sixty days after receiving your request to act on it. The Fund is allowed a single thirty day extension if it is unable to meet the sixty day deadline. If the Fund denies your request, it will explain the basis for the denial in writing. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of the PHI at issue.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of certain disclosures by the Fund of your PHI. The Fund does not have to provide you with an accounting of disclosures related to treatment, payment for treatment, or health care operations, or disclosures made to you or authorized by you in writing. To request an accounting of certain disclosures, submit a written request to the Fund's HIPAA Privacy Officer identified below. The Fund has sixty days to provide the accounting. The Fund is allowed an additional thirty days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

In response to your request for an accounting of disclosures, the Fund may provide you with a list of business associates who make such disclosures on behalf of the Fund, along with contact information so that you may request the accounting directly from each business associate. If you request more than one accounting within a 12-month period, the Fund will charge a reasonable fee based on the cost for each subsequent accounting. The Fund 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 that the Fund restrict the use and disclosure of your PHI to carry out treatment, payment or health care operations. You also have the right to request restrictions on your health information that the Fund discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. However, the Fund is generally not required to agree to your request for such restrictions, and the Fund may terminate a prior agreement to the restrictions you requested. To request restrictions on the use and disclosure of your PHI, submit a written request to the Fund's HIPAA Privacy Officer identified below. (See page 8).

Your request must explain what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Fund will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates any agreement with respect 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 PHI be communicated to you in confidence by alternative means or to 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 PHI at a specific location. Additionally, you have the right to access your health information in an electronic format.

To request communications by alternative means or at an alternative location, submit a written request to the Fund's HIPAA Privacy Officer identified below. (See page 8). 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 Receive Notice of a Breach of Your Protected Health Information

You are required to be notified if your unsecured PHI has been breached. You will be notified by first class mail, or electronically if you have consented to receive electronic communication, without unreasonable delay. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of PHI. 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.

Right to Complain

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

The Fund will not retaliate or discriminate against you, and no services, payment, or privileges will be withheld from you because you file a complaint with the Fund 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 Fund's HIPAA Privacy Officer identified below.

OTHER IMPORTANT INFORMATION

The Fund's Policy to Disclose Only the Minimum Necessary Protected Health Information

When using or disclosing PHI, or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to you;
- Disclosures made to the Secretary of the United States Department of Health and Human Services, pursuant to its enforcement activities under HIPAA;
- Uses or disclosures required by law; and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

Information that Does Not Identify You

This Notice does not apply to information that has been de-identified. De-identified information is information that does not identify you, and with respect to which there is no reasonable basis to believe that the information can be used to identify you.

Contact Information

If you have any questions or concerns about the Fund's privacy practices, or about this Notice, or if you wish to obtain additional information about the Fund's privacy practices, or if you wish to exercise one of the rights described above with respect to your PHI, please contact:

HIPAA Privacy Officer
Shawn Tyrrell
UFCW Local 1262 and ShopRite Welfare Fund
1389 Broad Street
Clifton, NJ 07013-4221

CHANGES IN THE FUND'S PRIVACY POLICIES

The Fund reserves the right to change its privacy practices and to make the new practices effective for all PHI that it maintains, including PHI that it created or received prior to the effective date of the change, and PHI it may receive in the future. If the Fund materially changes any of its privacy practices, it will revise its Notice and provide you with the revised Notice, 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.

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, and is further revised effective February 16, 2026. This Notice will remain in effect unless and until the Fund publishes a revised Notice.

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ("PHI")
FOR
UFCW LOCAL 1262 AND EMPLOYERS HEALTH AND WELFARE FUND
UFCW LOCAL 1262 AND SHOPRITE WELFARE FUND

This HIPAA Authorization ("Authorization") allows the Fund to use and disclose your protected health information to another individual who assists with your medical care and/or the payment related to your medical care. If you want to authorize the Fund to speak about your claims, your medical care and/or the payment related to your benefits under the Fund, please complete and return this Authorization to the Fund Office as soon as possible.

Without this Authorization, the Fund will not be able to speak about your claims, your medical care and/or the payment related to your benefits under the Fund with any other third party unless required to do so under applicable law or, for example, in emergency situations (as permitted under HIPAA). By completing this Authorization, you are asking that the Fund use and disclose your protected health information to the designated third party listed below. The Fund will be able to speak and communicate (whether orally or in writing) on all matters related to your medical claims, medical care and/or payment for such claims with the authorized individual(s) below. Please note that the information used and disclosed pursuant to this Authorization may no longer be protected by the federal health privacy rule (HIPAA) and may be subject to re-disclosure by the recipient.

YOU HAVE THE RIGHT TO REVOKE YOUR AUTHORIZATION FOR THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION AT ANY TIME BY NOTIFYING THE FUND OFFICE IN WRITING AT THE FOLLOWING ADDRESS:

HIPAA Privacy Officer
Shawn Tyrrell
UFCW Local 1262 and ShopRite Welfare Fund
1389 Broad Street
Clifton, NJ 07013-4221

NOTE THAT THIS AUTHORIZATION WILL REMAIN IN FULL EFFECT UNTIL YOU REVOKE IT WITH THE FUND OFFICE IN WRITING.

The effective date of your revocation will be the date the Privacy Officer receives your written revocation. Any revocation will be effective only to the extent that the Fund has not already taken action in reliance on this Authorization.

The Fund is not conditioning your treatment, payment, enrollment, or eligibility for benefits on whether you complete and sign this Authorization.

Participant Signature _____ **Date** _____

More than one adult eligible family member may provide responses on the form on the reverse side.

ENTER INFORMATION ON THE REVERSE SIDE

PLEASE NAME BELOW THOSE AUTHORIZED TO RECEIVE PHI:

Name: _____ ☐ Participant ☐ Spouse
(Please print) ☐ Child over the age of 18 ☐ Other

Signature: _____
DOB (mm/dd/yyyy): _____ SSN: _____/_____/_____

Individuals to whom your health information may be disclosed (please check all that apply):

☐ Spouse
Name: _____
DOB (mm/dd/yyyy): _____
SSN: _____/_____/_____

☐ Child(ren)
Name: _____
DOB (mm/dd/yyyy): _____
SSN: _____/_____/_____

☐ Child(ren)
Name: _____
DOB (mm/dd/yyyy): _____
SSN: _____/_____/_____

☐ Child(ren)
Name: _____
DOB (mm/dd/yyyy): _____
SSN: _____/_____/_____

☐ Child(ren)
Name: _____
DOB (mm/dd/yyyy): _____
SSN: _____/_____/_____

☐ Child(ren)
Name: _____
DOB (mm/dd/yyyy): _____
SSN: _____/_____/_____

☐ Parent(s)
Name: _____
DOB (mm/dd/yyyy): _____
SSN: _____/_____/_____

☐ Parent(s)
Name: _____
DOB (mm/dd/yyyy): _____
SSN: _____/_____/_____

☐ Other
Name: _____
DOB (mm/dd/yyyy): _____
SSN: _____/_____/_____

☐ Other
Name: _____
DOB (mm/dd/yyyy): _____
SSN: _____/_____/_____