UFCW LOCAL 1262 AND
SHOPRITE WELFARE FUND
1389 BROAD STREET, CLIFTON, N.J. 07013

ADMINISTRATOR
FRANK M. VACCARO

SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees of the UFCW Local 1262 and ShopRite Welfare Fund ("Fund") has adopted the following changes to the UFCW Local 1262 and ShopRite Welfare Plan for full-time employees ("Plan"). The changes described below are effective as specified below. Please keep this document with your Summary Plan Description ("SPD").

1. Effective October 1, 2022 the following new definitions are added to the Glossary of key terms at the end of your SPD:

Ancillary Services means, with respect to services provided at a participating Provider facility and except to the extent excluded by applicable law, Covered Services that are (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; (4) items and services provided by an out-of-network Provider if there is no participating Provider who can furnish such item or service at such facility; (5) other services defined as ancillary under the No Surprises Act and its implementing regulations.

Emergency Medical Condition means 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.

Emergency Services means the 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, including Ancillary Services routinely available in the emergency department to evaluate the Emergency Medical Condition;
- 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);
- 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 that the patient is able to travel using nonmedical transportation or nonemergency medical transportation; and

The patient is supplied with a written Notice and Consent, 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 out-of-network 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, means a: (1) Hospital; (2) Hospital outpatient department; (3) critical access hospital; or (4) ambulatory surgical center.

Independent Freestanding Emergency Department means a facility that is geographically separate and distinct from a Hospital that is licensed under applicable State law to provide Emergency Services.

Notice and Consent with respect Covered Services rendered by an out-of-network Provider at a participating Provider Health Care Facility, Notice and Consent means: (1) that you are provided with a written notice consistent with the requirements of federal law (generally stating that the provider is an out-of-network Provider, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any participating Providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating 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 means: (1) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent disability; or (2) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

Surprise Services means the following services, to the extent required by applicable law and to extent they are Covered Services under the Plan: (1) out-of-network Emergency Services; (2) out-of-network air ambulance services; (3) non-emergency Ancillary Services when performed by out-of-network Providers at participating Provider facilities; and (4) other out-of-network non-Emergency Services performed by an out-of-network Provider at a participating Provider facility with respect to which the Notice and Consent requirements have not been met.

Qualified Payment Amount ("QPA") generally means the median of the in-network rates payable for a particular service as of a particular date, based on Horizon BCBSNJ's book of

business. In all cases, QPA shall be determined consistent with the No Surprises Act and any regulations issued thereunder.

2. Effective October 1, 2022, the second sentence in the definition of Allowed Amount is deleted and replaced with the following.

For out-of-network charges for Surprise Services, the Allowed Amount is the Qualified Payment Amount (QPA). For any other out-of-network charges that are covered by the Plan, the Allowed Amount will be up to the maximum Advantage EPO Network reimbursement level within the same geographic area in which the service was performed.

3. Effective October 1, 2022, the second column in the chart on page 53 regarding "What are my out-of pocket costs?" is deleted and replaced with the following language:

In general, for services provided by Advantage EPO in-network Providers and for Surprise Services, you pay part of the Allowed Amount through a deductible, copay and/or coinsurance. However, you will not be subject to any balance billing for the cost of Covered Services that exceed the Allowed Amount. If you use out-of-network Providers for non-Surprise Services, the Fund will not pay any benefits, unless an exception has been provided because there is no in-network Provider to provide a Covered Service within 50 miles of the Participant's primary residence, in which case the Plan will not pay more than it would have paid to an in-network Provider for that same service and you are responsible for any additional amounts charged by the Provider.

4. Effective October 1, 2022, the second column in the chart on page 54 regarding "What if I need to go into the Hospital?" is revised to add the following language to the end.

Notwithstanding anything in this Section to the contrary, no prior authorization is required for Emergency Services and for surgical services for which pre-authorization requirements are not permitted by applicable law.

5. Effective October 1, 2022, the second column in the chart on page 54 regarding "What if I have an emergency?" is revised to delete the last sentence and replace it with the following:

Notwithstanding anything in this Section to the contrary, no prior authorization is required for Emergency Services and for surgical services for which pre-authorization requirements are not permitted by applicable law.

6. Effective October 1, 2022, the paragraph in bold under the Section titled "Medical and Hospital Benefits" on page 60 is deleted and replaced with the following language:

For Hospital and medical Covered Services with an out-of-network Provider that are not Surprise Services, the Fund will not provide any coverage and you will be responsible to pay the out-of-network Provider directly. For Hospital and medical Covered Services with an out-of-network Provider that are Surprise Services, the Fund will provide coverage to the same extent as

if the Covered Service was provided by a participating Provider and you cannot be balance billed for the difference. In most cases, this will result in the Fund paying the lesser of 100% of the QPA or the actual billed charges.

7. Effective October 1, 2022, the following language is added after the paragraph in bold on page 61:

Continuing Care Patients

If a participating Provider leaves the network, you may continue to receive treatment from that provider for a limited period of time as if the provider remained in the in-network, provided you are considered a "Continuing Care Patient" and you timely make an election to be so treated. A Continuing Care Patient means 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. To be treated as a Continuing Care Patient, you must properly complete an election form and return it to Horizon BCBSNJ within 30 days of the date on which it is provided to you. Once Horizon BCBSNJ receives a properly completed election form, it will determine whether you meet the requirements for Continuation of Care. If you are considered a Continuing Care Patient and timely make an election, services rendered by that provider will be treated as "in-network" until the earlier of: (i) the 90th day after the provider left the network or you were provided with a Continuation of Care notice and election form, whichever is later; or (ii) the date on which you no longer need treatment for the condition that made you a Continuing of Care Patient.

8. Effective October 1, 2022, the first full paragraph on page 62 is deleted and replaced with the following language:

Not all expenses are included in the out-of-pocket maximum. For example, certain amounts you pay to an out-of-network Provider will not be included, but only to the extent permitted by law. Nor are any expenses you pay for non-Covered Services, vision and dental charges, penalties for failure to pre-certify a claim, or other services excluded from coverage under the Plan. Even if you meet the out-of-pocket maximum in any Calendar Year, you are still responsible for non-covered charges billed by an out-of-network Provider.

9. Effective October 1, 2022, the following language is added to end of the section titled "Pre-authorization" on that begins on page 62:

Notwithstanding anything in this Section to the contrary, no prior authorization is required for Emergency Medical Services and for surgical services for which pre-authorization requirements are not permitted by applicable law.

10. Effective October 1, 2022, for the charts appearing on pages 66-84, the columns titled "Out-of-Area Benefits" are revised for Surprise Services only, to the extent

necessary to reflect the same coverage terms as the Advantage EPO Benefits. Out of Area Benefits for non-Surprise Services are NOT changing.

11. Effective October 1, 2022, the first paragraph under the bullet points in the Section titled "Mental Health and Substance Use Disorder Treatment" on page 79 is deleted and replaced with the following language:

All mental health and substance use disorder services must be coordinated through Carelon Behavioral Health, formerly Beacon Health Options, by calling (800) 843-5503. **If you use a Provider who is not in the Carelon Behavioral Health network, coverage (except for emergency treatment and Surprise Services) will be denied and you will be responsible for all amounts billed. For emergency treatment, the Plan will pay up to the maximum amount required by law.** The Plan will cover Surprise Services from a Provider who is not in the Carelon Behavioral Health network under the same coverage terms as if provided by an in-network Provider, to the extent required by federal law and you cannot be balanced billed for the difference. In most cases, this will result in the Fund paying the lesser of 100% of the QPA or the actual billed charges.

12. Effective October 1, 2022, the first paragraph in the "Expenses the Medical Plan Does Not Cover" Section on page 88 is deleted in its entirety and replaced with the following paragraph:

Each particular benefit section of this Plan will contain limitations and exclusions applicable to that particular benefit. In addition, listed below are limitations, exclusions, and circumstances applicable to all benefits provided under this Plan. To the extent a service listed below is otherwise required to be covered under applicable federal law, it is covered to the extent necessary to comply with such law.

13. Effective October 1, 2022, the following new paragraph is added at the end of the Post-Service Claims subsection on page 17:

For Surprise Services, a decision on a post-service claim will be made within 30 days of the Fund's receipt of all information necessary to adjudicate the claim.

14. Effective October 1, 2022, the subsection heading on page 22 "External Review of Denied Medical, Mental Health, or Prescription Drug Claims" is modified to include "claims for Surprise Services."