UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 1189 AND ST. PAUL FOOD EMPLOYERS HEALTH CARE PLAN

Plan Document and Summary Plan Description

March 1, 2021

UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 1189 AND ST. PAUL FOOD EMPLOYERS HEALTH CARE PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

AMENDED AND RESTATED MARCH 1, 2021

SCHEDULE OF BENEFITS

Full-Time Employees and Dependents (Plan 1) and Part-Time Employees (Plan 2)

LIFE AND SICKNESS BENEFITS	Plan 1	Plan 2
Life Insurance for Employee	$20,000	$5,000
Dependent Life Insurance	• For Spouse - $2,000 • For Dependent Child 14 days or Older - $1,000	Not Applicable (N/A)
Accidental Death and Dismemberment Benefit for Employee	$12,000	$1,000
Accident and Sickness Benefit	60% of Weekly Earnings up to maximum of $300 per week for up to 26 weeks per disability	N/A

COMPREHENSIVE MAJOR MEDICAL BENEFITS	Plan 1	Plan 2
Comprehensive Major Medical Benefits cover Reasonable Expenses related to Hospital services, Physicians' services, telehealth visits, x-ray and laboratory services, and other covered items and services when Medically Necessary.		
Deductible amount per Calendar Year		
• Per person	$300	$300
• Per family (Plan 1 only)	$900	N/A
• Per group (Plan 2 only, if Dependent Child coverage purchased)	N/A	$900
Plan's **Coinsurance** of Reasonable Expenses (unless otherwise specified)		
• The Plan's Coinsurance will be increased to 90% for maternity-related Covered Expenses if the Participant has enrolled in and completed the UMR Maternity Management program.	80%	80%
Annual **Out-Of-Pocket Maximum** for Covered Expenses per Calendar Year. (Includes Deductible but excludes cost of infertility treatment.)		
• Per person	$2,500	$2,500
• Per family (Plan 1 only)	$5,000	N/A
• Per group (Plan 2 only, if Dependent Child coverage purchased)	N/A	$5,000
Plan pays 100% of **Covered Expenses** in excess of the **Out-Of-Pocket Maximum** for the remainder of that Calendar Year.		
Deductible and **Coinsurance** amounts <u>are waived</u> for Covered Expenses related to the following services: • Pre-admission testing • Hospice Care • Home health care, up to a maximum of 40 visits per person per Calendar Year ○ The Trustees may extend this maximum based on medical necessity. • Doctor on Demand visits, but other telehealth is subject to Deductible and Coinsurance. • Immunizations recommended for routine use in children, adolescents and adults by the Advisory Committee on Immunization Practices (ACIP).		

COMPREHENSIVE MAJOR MEDICAL BENEFITS (continued)	Plan 1	Plan 2
Plans 1 and 2 pay for certain services and supplies covered under the Comprehensive Major Medical Benefits provisions subject to **specific maximum amounts and subject to Copayments,** as follows:		
<u>Hospital room and board expense</u> • For general and acute care • For intensive or coronary care	Up to admitting Hospital's Semi-Private Room rate Up to twice admitting Hospital's Semi-Private Room rate	
<u>Emergency room visits</u> • First 3 emergency room visits per person per Calendar Year covered subject to Deductible, Coinsurance, and Out-Of-Pocket Maximum. • After these 3 visits, separate $250 Copayment per emergency room visit (which applies to Out-Of-Pocket Maximum but not Deductible) and then Deductible and Coinsurance apply. • Copayment is waived if admitted to Hospital from the emergency room.	$250 Copay	$250 Copay
<u>Skilled Nursing Home care</u> • Maximum confinement per person per period of disability	30 days	30 days
<u>Chiropractic fees</u> • Plan's maximum per visit • Plan's maximum per person per Calendar Year	$35 $900	$35 $900
<u>Artificial life support</u> • Limited to first five days after death up to maximum amount	$5,000	$5,000
<u>Infertility treatment</u> (For Plan 1 Employees and Dependent spouses, and for Plan 2 Employees) • Separate Copayment amount per person (once per Lifetime) • Plan's Coinsurance ***(Participant's Coinsurance share will NOT be applied toward Out-Of-Pocket Maximum)*** • Lifetime maximum per person	$100 Copay 80% $10,000	$100 Copay 80% $10,000
<u>Hair prostheses (such as wigs)</u> • Must be prescribed by your physician to remediate hair loss caused by a medical condition, such as chemotherapy, alopecia, trichotillomania, or other medical conditions. • Limited to a Calendar Year maximum per person subject to Deductible and Coinsurance	$300	$300
<u>Genetic testing</u> • Calendar Year maximum per person	$2,000	$2,000

DENTAL CARE BENEFITS	Plan 1	Plan 2
Percentage payable:		
Diagnostic and preventive services • Covered 100% if you use a dental provider in the Delta Preferred Option Network	80%	80%
Basic and special services • Covered 90% if you use a dental provider in the Delta Preferred Option Network	80%	80%
Special restorative services	80%	80%
Prosthetics	80%	50%
Maximum per Calendar Year • Does not apply to following benefits for eligible Dependent children under age 19: routine oral examinations; sealants; dental prophylaxis; and topical fluoride treatments.	$1,250	$1,000
Orthodontics (for Plan 1 Dependent children age 8 through 18 and Plan 2 Employees of any age)		
• Percentage payable • Lifetime maximum	50% $1,000	50% $1,000

VISION CARE BENEFITS (Plan 1 Only)	Plan 1	Plan 2
One eye examination. Lenses, frames, or contact lenses up to the Aggregate Maximum. • Plan's Coinsurance	80%	N/A
Aggregate Maximum per person per Calendar Year. • For eligible Dependent children under age 19: the aggregate maximum does not apply to eye examinations; and after the $300 maximum, glasses for such Dependents are covered at 50%. • In lieu of all other benefits for lenses, frames, and contact lenses, laser eye surgery will be covered up to the aggregate maximum.	$300	N/A

PREFERRED PROVIDER PHARMACY PRESCRIPTION DRUG BENEFITS	Plan 1	Plan 2
Participant's Copayment per prescription: • Up to a 31-day supply at a retail pharmacy, or • Up a 90-day supply for maintenance drugs at a retail pharmacy that participates in the Sav-Rx Walk-In Mail-Order Network. • Specialty drugs limited to a 31-day supply through the Sav-Rx Specialty Program. • If a generic is available, but the pharmacy dispenses the brand name drug (other than a Physician's "dispense as written" or equivalent instructions), the Participant must pay the difference between the cost of the brand name drug and the generic drug in addition to the brand name Copayment.	20% with a $10 minimum Copayment and a $50 maximum Copayment	20% of the discounted cost

For Retirees and Their Dependents Who Are Not Medicare-Eligible (Plan 3 - Available Beginning at Age 55)

COMPREHENSIVE MAJOR MEDICAL BENEFITS	PLAN 3
Comprehensive Major Medical Benefits cover Reasonable Expenses related to Hospital services, Physicians' services, telehealth visits, x-ray and laboratory services, and other covered items and services when Medically Necessary.	
Deductible amount per Calendar Year • Per person • Per family	 $100 $300
Plan's **Coinsurance** of Reasonable Expenses (unless otherwise specified) • The Plan's Coinsurance will be increased to 90% for maternity-related Covered Expenses if the Participant has enrolled in and completed the UMR Maternity Management program.	75%
Annual **Out-Of-Pocket Maximum** for Covered Expenses per person per Calendar Year, including the Deductible amount • Per person • Per family	 $2,500 $7,500
Plan pays 100% of **Covered Expenses** in excess of the **Out-Of-Pocket Maximum** for the remainder of that Calendar Year.	
Deductible and **Coinsurance** requirements <u>waived</u>: • Outpatient surgery • Pre-admission testing • Routine physical examinations (one per Calendar Year per person) • Second surgical opinions • Hospice Care • Home health care ○ The Trustees may extend this maximum based on medical necessity. • Doctor on Demand visits, but other telehealth is subject to Deductible and Coinsurance. • Immunizations recommended for routine use in children, adolescents and adults by the Advisory Committee on Immunization Practices (ACIP).	 100% 100% 100% 100% 100% 100%, up to 40 visits per person per Calendar Year 100% 100%

COMPREHENSIVE MAJOR MEDICAL BENEFITS (continued)	PLAN 3
Plan 3 pays for certain services and supplies covered under the Comprehensive Major Medical Benefits provisions subject to **specific maximum amounts and subject to Copayments,** as follows:	
Hospital room and board expense • For general and acute care • For intensive or coronary care	Up to admitting Hospital's Semi-Private Room rate Up to twice admitting Hospital's Semi-Private Room rate
Emergency room visits • First 3 emergency room visits per person per Calendar Year covered subject to Deductible. o Coinsurance is waived • After these 3 visits, separate Copayment per emergency room visit (which applies to Out-Of-Pocket Maximum but not Deductible) and then covered 100% after Deductible. o Copayment is waived if admitted to Hospital from the emergency room.	100%, after Deductible $250 Copay, then 100% after Deductible
Skilled Nursing Home care • Maximum confinement per person per period of disability	30 days
Chiropractic fees • Plan's maximum per visit • Plan's maximum per person per Calendar Year	$35 $900
Artificial life support • Limited to first five days after death up to maximum amount	$5,000
Hair prostheses (such as wigs) • Must be prescribed by your physician to remediate hair loss caused by a medical condition, such as chemotherapy, alopecia, trichotillomania, or other medical conditions. • Limited to a Calendar Year maximum per person subject to Deductible and Coinsurance	$300
Genetic testing • Calendar Year maximum per person	$2,000

RETIREE DENTAL CARE BENEFITS – if elected from prior participation in Plan 1 or Plan 2	Plan 3 (from Plan 1)	Plan 3 (from Plan 2)
Percentage payable:		
Diagnostic and preventive services	80%	80%
• Covered 100% if you use a dental provider in the Delta Preferred Option Network		
Basic and special services	80%	80%
• Covered 90% if you use a dental provider in the Delta Preferred Option Network		
Special restorative services	80%	80%
Prosthetics	80%	50%
Maximum per Calendar Year	$1,250	$1,000
• Does not apply to the following benefits for eligible Dependent children under age 19: routine oral examinations; sealants; dental prophylaxis; and topical fluoride treatments.		

RETIREE VISION CARE BENEFITS – if elected from prior participation in Plan 1	Plan 3 (Plan 1)
One eye examination. Lenses, frames, or contact lenses up to the Aggregate Maximum. Plan's Coinsurance	80%
Aggregate Maximum per person per Calendar Year. • For eligible Dependent children under age 19: the aggregate maximum does not apply to eye examinations; and after the $300 maximum, glasses for such Dependents are covered at 50%. • In lieu of all other benefits for lenses, frames, and contact lenses, laser eye surgery will be covered up to the aggregate maximum.	$300

PREFERRED PROVIDER PHARMACY PRESCRIPTION DRUG BENEFITS	Plan 3
Participant's Copayment per prescription: • Up to a 31-day supply at a retail pharmacy, or • Up a 90-day supply for maintenance drugs at a retail pharmacy that participates in the Sav-Rx Walk-In Mail-Order Network. • Specialty drugs limited to a 31-day supply from Sav-Rx Specialty Program. • If a generic is available, but the pharmacy dispenses the brand name drug (other than a Physician's "dispense as written" or equivalent instructions), the Participant must pay the difference between the cost of the brand name drug and the generic drug in addition to the brand name Copayment.	25% of the discounted cost

Table of Contents

Page

Page

UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 1189 AND ST. PAUL FOOD EMPLOYERS HEALTH CARE PLAN

To All Active Employees and Retirees:

The Trustees of your Health Care Plan are happy to provide you with this new Summary Plan Description/Plan Document (together called the "Summary" or "SPD") effective March 1, 2021. This SPD tells you how to become and remain eligible for benefits, explains the benefits available, and gives you instructions on how to apply for benefits. This Summary is both the Plan's Summary Plan Description and Plan Document. The Trustees in their sole discretion have the right to change, add, or to delete benefits, self-payment rates, Eligibility Rules, or any other provisions relating to the operation of the Plan.

The benefits described in this Summary are self-funded with the exception of the Life Insurance Benefits for Plans 1 and 2 and Accidental Death and Dismemberment Benefits for Plan 1 insured through United of Omaha Life Insurance Company. Self-funded benefits payable are limited to Fund assets available for such purposes.

The Eligibility Rules and benefits are maintained at levels in line with Trust Fund income and assets and they are reviewed regularly to protect the Fund's financial position. All Plan provisions are updated as necessary to comply with legal requirements, including the Patient Protection and Affordable Care Act and the Mental Health Parity and Addiction Equity Act.

We suggest you familiarize yourself with the information in this Summary and keep it handy for reference. If you have any questions at any time regarding the Plan, please contact the Plan Administrator.

Yours sincerely,

The Board of Trustees

Employer Trustees	**Union Trustees**
Kent Dixon	Jennifer Christensen
Michael Oase	Tami Denn-Bauer
Chris Thienes	James Gleb
Fred Miller, Alternate	Abraham Wangnoo
Jon Born, Alternate	Robert Jordan, Alternate
	James Westin, Alternate

The addresses of the Trustees are found on page 79.

Plan Administrator
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Phone: (952) 854-0795
Toll-Free: 1-800-535-6373
Office Hours: Monday-Friday 8:00 a.m. to 5:00 p.m.
www.ufcw1189benefits.com

GRANDFATHERED STATUS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Trustees believe this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that already was in effect when that law was enacted. Being a grandfathered health plan means that your Plan is not required to include certain consumer protections 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. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of Lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at: United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan, 3001 Metro Drive, Suite 500, Bloomington, MN 55425, (952) 854-0795 or 1-800-535-6373. You also may 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.

ARTICLE I

ELIGIBILITY AND COVERAGE RULES

A. Employee's Eligibility for Plan 1 or Plan 2

You are eligible to receive benefits from the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan under Plan 1 or Plan 2 if you are employed by a Participating Employer and proper Contributions are made to the Plan on your behalf as required by the Collective Bargaining Agreement or other written agreement, such as a Participation Agreement. (Retiree eligibility to participate in Plan 3 is described in Article I, I.)

1. Plan 1 Eligibility and Effective Date of Coverage – Full-Time Employees

To become eligible for coverage in Plan 1 (Full-Time Employees), if you are a Full-Time Employee, and you have eight (8) weeks of full-time Contributions made to the Plan on your behalf during a 12-consecutive week period.

Your coverage in the Plan will start on the first day of the month following satisfaction of the Eligibility criteria.

2. Plan 2 Eligibility and Effective Date of Coverage – Part-Time Employees

When you satisfy these eligibility criteria, your coverage in Plan 2 will start on the first day of the month following satisfaction of the Eligibility criteria.

For any Part-Time Employee hired after March 5, 2005, you will become eligible for coverage under Plan 2 (Part-Time Employees) after working twelve (12) months for a Participating Employer. During that 12-month period, a Participating Employer must make at least one Contribution to the Plan on your behalf in each of the 12 months. (A month is defined by the payment calendar month.)

If the Employer is not required to make Contributions on your behalf for six consecutive months, you must begin the 12-month initial eligibility period again.

If a prime part-time or part-time courtesy Employee hired on or before March 5, 2005, is promoted to a Covered Position (that is, a position that requires Employer Contributions to the Plan), the Employee will become eligible for Plan 2 coverage under the rules in effect prior to March 6, 2005 (26-weeks to be eligible for coverage the first of the following month).

You will become and remain eligible for Plan 2 even if some full-time Contributions are made on your behalf, unless such full-time Contributions are sufficient to establish Plan 1 eligibility.

3. Ancillary Benefits Plan for Employees who are ineligible for Plan 1 or Plan 2 coverage.

Effective on and after January 1, 2020, if you are an Employee who has worked one year with a Participating Employer, but you are not eligible for coverage under Plan 1 or Plan 2, you may obtain certain ancillary benefits under the "United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Ancillary Benefits Plan" or "AB Plan."

You are eligible for coverage in the AB Plan if, in the month following your one-month employment anniversary and every following month, your Employer makes either ancillary-benefit-only Contributions to the Plan under the Collective Bargaining Agreement, or any Contributions to the Plan for you regardless of whether you are eligible for other benefits un Plan 1 or Plan 2. Eligibility will begin on the first day of the month after the Eligible Employee has completed one year of employment with the Participating employer and will terminate on the earlier of the last day of the month in which employment ends or the last day of the month for which an Employer is required to make Contributions on behalf of the Eligible Employee.

The ancillary benefits under the AB Plan are: life insurance, accidental death and dismemberment coverage, and participation in an Employee Assistance Program ("EAP"). There is no dependent coverage for children or spouses in the AB Plan

The terms and conditions of the AB Plan are in a separate Summary Plan Description.

4. Opting Out of Coverage in Plan 1 or Plan 2.

An Eligible Employee may choose to "opt out" of coverage under Plan 1 or Plan 2 as provided in the Employer's Collective Bargaining Agreement and by notifying the Plan Administrator.

Except as provided in Article I, Section C, an Eligible Employee that opts out of Plan coverage for himself or herself and his or her Dependents will not be entitled to re-enroll in the Plan's coverage.

5. Special Reciprocity Rule for Eligibility:

If you transfer between stores of the same Employer from a location covered by the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (and you were covered by such Minneapolis Fund at such location) to a location covered by this Plan, you will become eligible on the first day immediately following satisfaction of these eligibility requirements in Article I, Section A, subparts 1 and 2.

6. Benefits if You Work for More than One Contributing Employer.

If you work for more than one Participating Employer, you will be entitled to benefits no greater than those which would apply if services were performed for only one Participating Employer.

B. Dependents' Eligibility and Coverage

Plan 1: Dependent Spouses and Dependent Children are eligible for coverage following your satisfaction of the initial eligibility criteria in Article I, Section A. If you acquire a new Dependent after your effective date, he or she will be covered on the date he or she became a Dependent.

If your Spouse opts out of other Employer Coverage, your Spouse may then be ineligible to participate in this Plan. If your spouse has other coverage available through his or her own employer and your Spouse chooses to opt out of such coverage, then your Spouse is no longer eligible for coverage as a Dependent under this Plan. To determine if other coverage is available, it must be a group plan whereby individual coverage is offered and the employer contributes at least 50% of the cost for employee-only coverage of the lowest plan offered. If the employer coverage does not meet this requirement, your spouse, under this Plan, does not

meet the requirement of having other coverage available to them, and continues to be eligible. The Spouse may experience a Special Enrollment Event reestablishing eligibility for this Plan.

Plan 2: Part-time Eligible Employees may purchase coverage for their Dependent Children only. If a part-time Eligible Employee purchases coverage for a Dependent Child, the Dependent Child will be covered under the Plan on the first day of the first month following receipt of the part-time Eligible Employee's payment for such coverage.

Spouses are not eligible to participate in Plan 2.

C. Special Enrollment Events

You or your Dependent(s) are entitled to special enrollment rights under the Plan under either of the following circumstances:

1. If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your new Dependent for coverage in the Plan. You must request enrollment for the New Dependent within thirty (30) days of the marriage, birth, adoption or placement for adoption to enroll a New Dependent. If you timely enroll the New Dependent, the effective coverage for the new Dependent will be the date on which he or she became a Dependent: in the case of marriage, the date of the marriage; in the case of a newborn, the date of birth; in the case of adoption, the date of adoption.

2. You or your Dependent's coverage under a Medicaid Plan or under a state children's health insurance program is terminated as a result of loss of eligibility for such coverage and you or your Dependent request coverage under the Plan not later than (60) days after the date of termination of such coverage; or

3. You or your Dependent become eligible for a state premium assistance subsidy from a Medicaid Plan or through a state children's health insurance program with respect to coverage under the Plan not later than 60 days after the date you or your Dependent is determined to be eligible for such assistance.

In addition, if you decline enrollment for your Dependents (including your spouse) in the group health benefits provided in this Plan because of other health insurance or group health plan coverage, you may be able to enroll your Dependents in the applicable group health benefits in this Plan, if such coverage is available to the Dependent, if your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your Dependents' other coverage). (NOTE: An increase in the cost of coverage in the plan that covers your Dependents does not provide a right of special enrollment.) However, you must request enrollment in the applicable health benefits in the Plan within 30 days after your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until the earlier of either (a) sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or (b) one (1) year from the date a Special Enrollment event occurs as a "Tolling Period." During the Tolling Period, the 60-day window (or 30-day window in the case of acquiring a new Dependent) in which you must request special enrollment under the Plan for the circumstances listed above is disregarded and resumes at the end of the Tolling Period.

D. Maintaining Eligibility in this Plan and Using Grace Weeks to Maintain Coverage

Your continued eligibility is determined weekly. Eligibility and coverage continue so long as:

1. Contributions are made to the Plan on your behalf for each subsequent week;

2. If Contributions are insufficient for you to maintain your coverage, you may use "Grace Weeks" to maintain coverage;

3. Once your Grace Weeks have been exhausted, if you experience a Termination of Coverage, you may continue coverage under COBRA.

Grace Weeks. Each Eligible Employee who has qualified for health care benefits, for either full-time or part-time coverage, accumulates a total of eight weeks of grace ("Grace Weeks"). As weekly eligibility must remain consecutive, the Plan Administrator will use one of your Grace Weeks whenever a current weekly Employer Contribution is not required for that week. When all Grace Weeks have been used and there are no current Employer Contributions being paid, then your coverage, whether full-time or part-time (whichever applies), will be terminated. However, you may have an option to continuing coverage by self-payments under COBRA.

The amount of the Employer Contributions is specified by the Collective Bargaining Agreement or Participation Agreement in effect at the time the Contributions are earned. The amount contributed determines the Plan under which you are covered.

If, in any week, your Employer is not required to make either a part-time or full-time Contribution on your behalf, if you are actively employed and scheduled to work, you may buy back the Grace Week(s) used to continue coverage. If you do not buy back the Grace Week(s) used, you risk loss of coverage.

If you are full-time and if in any week your Employer is not required to make a full-time Contribution, but is required to make a part-time Contribution on your behalf because you have not worked the required number of hours and you are actively employed and scheduled to work, you may buy-up the part-time Grace Week used to continue coverage to a full-time Grace Week. If you do not buy-up the part-time Grace Week, you risk loss of Dependent coverage.

Continued eligibility will be given if you are absent from active work due to work-related Injury or Sickness after exhaustion of any FMLA contribution requirement, up to a total of 26 weeks.

In the event you lose eligibility as a Part-Time Employee, the following rules will apply:

1. If you have had less than six months in a row for which at least one Employer Contribution has been made on your behalf, you will regain eligibility by working eight weeks in a 12-week period to be eligible for coverage the first of the following month.

2. If you have had more than six months in a row for which no Employer Contributions are required on your behalf, and you are not on an approved leave of absence from your Employer, you must again satisfy the 12-month eligibility rules in Article I, Section A. 2.

E. Coverage When You Have A Change in Participation Between Plan 1 and Plan 2

The amount and type of benefits payable are determined by the Plan under which you are covered when the claim is incurred.

In the event a change in the number of hours you (as a Full-Time Employee) work causes a change in the Employer Contributions on your behalf, your Plan of benefits will change. In that event, the change in benefits will become effective on the day after you have used all Grace Weeks. If you continue to work part-time under the terms of the Collective Bargaining Agreement or Participation Agreement, if applicable, with part-time Contributions made on your behalf, you will be eligible for Part-Time Employee benefits which provides coverage for the Employee only. Your Dependents no longer will be covered.

In the event that you (as a Part-Time Employee) work the number of hours which requires full-time Contributions to be made on your behalf by the Employer, you and your Dependents will become eligible for full-time benefits if you have eight weeks of full-time Contributions within a 12-consecutive-week period. Full-time coverage will become effective on the first day of the month following the month in which you worked the eighth full-time week.

F. Termination of Coverage

Your coverage and that of your Dependents automatically terminates on the earliest of the following dates, subject to your and your Dependents' rights to continuation coverage under other provisions of the Plan:

1. The date the Plan terminates;

2. the later of the end of the period for which Employer Contributions were made on your behalf, the end of the period of a Disability coverage extension, the exhaustion of Grace Weeks, or the end of a period where Self-Payment Contributions are accepted for coverage;

3. the date you enter the armed forces of any country; or

4. the date you cease to be eligible according to the Plan's Eligibility Rules.

A Dependent's coverage ceases as of the date he no longer meets the Plan's definition of "Dependent."

Coverage may be continued after these termination dates as set forth in this Article for COBRA Continuation Coverage, Military Leave Continuation Coverage, or FMLA Continuation Coverage.

G. Extended Coverage During a Period of Disability

All Employees who become eligible to receive Accident and Sickness Benefits from this Plan or Worker's Compensation Benefits will continue coverage for a period extending for the shorter of: 13 weeks from the date eligibility otherwise would cease; or the date eligibility for Accident and Sickness Benefits or Worker's Compensation Benefits ceases. Employees classified as Meat employees in the St. Paul Retail Meat and Grocery Agreements will be entitled to receive up to an additional 13 weeks of coverage extension for the period that they remain eligible for

Worker's Compensation Benefits. You must notify the Plan Administrator when you are receiving Worker's Compensation Benefits in order to receive the extension of coverage. In no case will benefits be extended beyond 13 weeks for a Grocery Employee or 26 weeks for a Meat Employee.

The extension of eligibility under this provision is provided at Trust Fund expense. After the applicable extension period expires, you may use any accumulated Grace Weeks and then must make Self-Payments as described in the COBRA section, Article I, Section H, which follows, to continue participation.

H. COBRA Continuation of Coverage for Medical, Dental and Vision Plans

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives you and your Dependents the right to be offered an opportunity to make Self-Contributions for continued health care coverage if coverage is lost for certain reasons. This continued coverage is called "Continuation Coverage." If you have questions about COBRA, call the Plan Office.

1. Qualifying Events and Qualifying Beneficiaries

You or your Covered Dependents may continue coverage under the group health benefits in this Plan in which you were covered if current coverage ends or coverage is reduced because of any of the "Qualifying Events" listed in the chart below.

You or your Dependent must be covered by the Plan before the qualifying event in order to continue coverage. For Spouses and Dependent Children who are covered under Plan 1, Qualifying Events occur when coverage is terminated due to a Qualifying Event listed in the chart below occurring while you as an Employee are eligible because of Employer Contributions or the application of Grace Weeks.

	Qualifying Event	**Who May Continue – Must Have Been Enrolled in Plan Prior to Event**	**Maximum Continuation Period - See H, 5 for more information**
1.	Reduction of Hours in Covered Employment for any reason, including transitioning from full-time to part-time, disability or Sickness	Employees and Dependents	Earlier of: 1. Enrollment date in other group coverage, or 2. 18 consecutive Months from the date hours were reduced
2.	Voluntary or involuntary termination of Covered Employment, certain leaves of absence, or layoff (except gross misconduct on your part), including disability, Sickness or retirement.	Employees and Dependents	Earlier of: 1. Enrollment date in other group coverage, or 2. 18 consecutive Months from the date employment terminated

	Qualifying Event	Who May Continue – Must Have Been Enrolled in Plan Prior to Event	Maximum Continuation Period - See H, 5 for more information
3.	Divorce or legal separation	Former spouse and any Dependent children who lose coverage	Earlier of: 1. 36 Months from the date of divorce, or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end
4.	Death of Employee	Surviving spouse and Dependent children	Earlier of: 1. 36 Months from the date of death, or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end
5.	Dependent ceases to meet the definition of Dependent under the Plan	Dependent child	Earlier of: 1. 36 Months from the date of losing eligibility, or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end
6.	Total Disability	Employee and Dependents	Earliest of: 1. 18 Months, or 2. 29 Months after the qualifying event, or 3. Date Total Disability ends, or 4 Date of enrollment in Medicare, or 5. Date coverage would otherwise end
7.	Employee's Entitlement to Medicare under Part A, Part B or both less than 18 months before Employee reduction in hours or termination of employment	Spouse or Dependent Child	36 months minus the number of months between Medicare entitlement and termination or reduction of employment event

2. Notifications and Due Dates

a. *Qualified Beneficiary Notice Obligations*

When the Qualifying Event relates to your death, divorce, legal separation or a Dependent Child ceasing to meet the definition of Dependent under the Plan, the Qualified Beneficiary must notify the Plan Administrator within 60 days after the Qualifying Event occurs. This notice can be provided to the Plan Administrator by telephone, facsimile, or in writing by mail. This notice allows the Plan Administrator to provide proper notices and explanation to Qualified Beneficiary about continues eligibility. When providing notice to the Plan Administrator, the Qualified Beneficiary must provide documentation to support the occurrence of the Qualifying Event. In the case of divorce or legal separation, a copy of the divorce or legal separation decree or similar documentation evidencing the divorce or legal separation will be required. In the case of a loss of Dependent status, documentation indicating the date Dependent status was lost will be required.

Generally, a Qualified Beneficiary must provide this written notice within 60 days after the date of the Qualifying Event. In some situations, this general 60-day period may be extended. Specifically, you must provide notice within the following time frames, if applicable and if later than the general rule:

(i) within 60 days after the date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

(ii) the date on which the Qualified Beneficiary is informed, through the furnishing of this Summary Plan Description, of the responsibility to provide such notice and the procedures for providing such notice.

This notice may be provided to the Plan Administrator by the Qualified Beneficiary's representative. Notice from one Qualified Beneficiary that informs the Plan of the Event with respect to another Qualified Beneficiary will be considered notification from all Qualified Beneficiaries. This notice and other communications you must make to the Plan (such as the current address of the Qualified Beneficiary) must be provided to the Plan Administrator.

If the Plan is not notified of the Qualifying Event within the specified time frame, the person is no longer a Qualified Beneficiary and loses the opportunity to continue coverage.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until the earlier of either (a) sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or (b) one (1) year from the date a COBRA Qualifying Event as a "Tolling Period." (The Tolling Period may not exceed one (1) year.) During the Tolling Period, the 60-day window in which the Plan Administrator must be notified of a COBRA Qualifying Event is disregarded and resumes at the end of the Tolling Period.

b. *Trustees' Responsibility to Notify a Qualified Beneficiary When the Qualifying Event is Loss of Coverage Due to Your Death, Divorce or Legal Separation, or to a Dependent Child Ceasing to Meet the Plan's Definition of Dependent*

The Plan Administrator, not later than 14 days after receipt of notice, will advise the Qualified Beneficiary of the coverages, options, costs, Self-Payment due dates, and duration of these Self-Payment privileges.

c. *Trustees' Responsibility to Notify a Qualified Beneficiary When Other Qualifying Events Occur*

Based on monthly Employer reports, Trustees are aware of some Qualifying Events, such as loss of eligibility for coverage based on Contributions received from contributing Employers because of a reduction in your hours and your ceasing active work.

The Plan Administrator, not later than 14 days after receipt of notice of your loss of coverage from the Employer or by examining monthly contribution reports, will advise the Qualified Beneficiary of the coverages, options, costs, Self-Payment due dates, and duration of these Self-Payment privileges.

d. *Due Date for Qualified Beneficiary's Response*

A Qualified Beneficiary has 60 days from the date of coverage termination or the receipt of the COBRA Notice, whichever is later, to elect whether to continue coverage. The election should be communicated to the Plan Administrator in writing on the Election Form provided with the notice of a Qualifying Event. Each Employee, spouse, and Dependent child has the right to make their own individual election. However, covered Employees may elect to continue coverage on behalf of their spouses, and parents may elect to continue coverage on behalf of their children.

You have 60 days to elect for COBRA continuation coverage. Failure to properly elect for COBRA continuation coverage by filing the Election Form with the Plan Administrator within 60 days will serve to terminate your right to elect for COBRA continuation coverage.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until the earlier of either (a) sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or (b) one (1) year from the date the COBRA election period starts as a "Tolling Period." (The Tolling Period may not exceed one (1) year.) During the Tolling Period, the 60-day window in which you may elect COBRA continuation coverage is disregarded and resumes at the end of the Tolling Period.

e. *Due Date for Initial Self-Payment for COBRA*

The required initial Self-Payment must be made to the Plan Administrator not later than 45 days following the election to continue coverage (which is the post-mark date, if mailed). Failure to do so will cause eligibility and coverage to terminate retroactively to the date of the Qualifying Event and will cause loss of all continuation coverage rights under the Plan. Your first Self-Payment must cover the cost of continuation coverage from the time your coverage under the Plan terminated up to the time you make your first payment. You are responsible for making

sure that the amount of your first payment is enough to cover this period. You may contact the Plan Administrator to confirm the correct amount of your first payment.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until the earlier of either (a) sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or (b) one (1) year from the date the COBRA election period starts as a "Tolling Period." Your initial Self-Payment is due within the later of 45 days after the end of the Tolling Period or 45 days after the election of COBRA coverage.

f. *Due Dates for Subsequent Self-Payments*

Subsequent monthly Self-Payments must be made by the first day of the month for that month of coverage.

The Plan allows a 30-day grace period for making Self-Payments.

Continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if a periodic payment is made later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. Any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

Failure to make subsequent Self-Payments before the end of the grace period will cause coverage and eligibility to terminate at the end of the month for which a timely Self-Payment was last made and will cause loss of all rights to continuation coverage under the Plan.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until the earlier of either (a) sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or (b) one (1) year from the date the COBRA election period starts as a "Tolling Period." During the Tolling Period, the 30-day grace period to make the subsequent Self Payment is disregarded and resumes after the end of the Tolling Period.

Checks should be made payable to the UFCW 1189 Health Care Plan and sent to the Plan Administrator.

3. Coverages and Options

a. *Employee is the Qualified Beneficiary*

In the event the Employee is the Qualified Beneficiary, the Employee may elect to continue coverage, specifying the following:

(i) Medical Benefits only;

(ii) Medical Benefits plus Dental Care and Vision Care Benefits;

(iii) Medical Benefits, Dental Care, Vision Care, Life and Accidental Death and Dismemberment Benefits;

(iv) Life Benefits only.

Employees continuing coverage are not eligible for Accident and Sickness Benefits; Employees continuing coverage under Plan 2 are not eligible for Vision Care Benefits; Employees receiving only Plan 2's Life, Accidental Death and Dismemberment, and Employee Assistance Program Benefits are not eligible to continue Accidental Death and Dismemberment and Employee Assistance Program Benefits; and Retirees are not eligible to continue Life or Accidental Death and Dismemberment Benefits

b. *Dependent as Qualified Beneficiary*

In the event a Dependent elects to continue coverage, the same choices are available as for an Employee, except Employee Life Benefits are not available and Dependent Life Benefits are available.

c. *Coverage Selection*

After the initial election, the coverage selected may not be changed. However, coverage may be added for a new spouse or to add a new Dependent child as a Qualified Beneficiary, such as upon a child's birth or placement for adoption with you during your period of COBRA continuation coverage.

The Medical, Dental Care, and Vision Care Benefits continued are the same as those in effect the day before coverage terminated and are identical to those benefits provided to similarly situated Employees or family members who have not experienced a Qualifying Event. In the event coverage under the Plan is modified for similarly situated Employees, the Qualified Beneficiary's coverage also will be modified.

A Qualified Beneficiary does not have to show insurability to choose continuation coverage.

4. Cost of Continuation Coverage

The Self-Payment amount depends upon which benefits are continued. The cost is determined annually by the Trustees. There is a separate cost for continued coverage from the 19th through 29th month for those individuals eligible for such disability extension. The Plan Administrator initially will notify Qualified Beneficiaries of the Self-Payment amount and due dates.

Continuation coverage will be purchased on a monthly basis by payment of the predetermined monthly Self-Payment amount. However, Employees and Dependents who lose coverage on any day other than the first of a month will be required only to pay a pro rata share of the monthly Self-Payment to continue coverage until the first day of the next Calendar Month, at which time full monthly Self-Payments will be required for continuing coverage.

5. Duration of Continuation Coverage

When eligibility is lost due to termination of employment or reduction in hours, a Qualified Beneficiary may continue eligibility for up to 18 consecutive months from the date employment terminated or hours were reduced. This 18-month period may be extended to 36 months for the

spouse and Dependent children if a second Qualifying Event [e.g. Employee's death, divorce or legal separation from the Employee, Employee's coverage by Medicare (under Part A, Part B, or both), or a Dependent child ceasing to meet the definition of Dependent under the Plan] occurs during the 18-month period. These Events can be a second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. A Qualified Beneficiary must notify the Plan Administrator within 60 days after a second Qualifying Event occurs if he wants to extend his continuation coverage and must provide any supporting documentation the Plan may request. This provision does not apply in the case of a reduction in work hours followed by a termination of employment.

This 18-month period may be extended up to a total of 29 months for all Qualified Beneficiaries during the disability of the Employee, spouse, or Dependent child, provided:

- the Social Security Administration (SSA) determines that any of the Qualified Beneficiaries are disabled under the Social Security Act either: at the time employment terminated or hours were reduced; or at any time within 60 days of such Qualifying Event, and the disability lasts at least until the end of the 18-month period of continuation coverage; and

- the Qualified Beneficiary notifies the Plan Administrator in writing within 60 days of the SSA determination and before the end of the first 18 months of continuation coverage and provides a copy of the SSA determination to the Plan Administrator.

Each Qualified Beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the Qualified Beneficiary is determined by SSA to no longer be disabled, the Qualified Beneficiary must notify the Plan Administrator within 30 days after the SSA determination.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until the earlier of either (a) sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or (b) one (1) year from the date of the Qualifying Event as a "Tolling Period." (The Tolling Period may not exceed one (1) year.) During the Tolling Period, the sixty (60) day window, and thirty (30) day window, in which the Qualified Beneficiary must notify the Fund Office of a SSA determination are disregarded and resume at the end of the Tolling Period.

Failure to provide notice of a disability or second Qualifying Event as explained previously in this Section H, subsection (5) will affect the right to extend the period of continuation coverage.

When eligibility is lost due to the Employee's death, divorce or legal separation from the Employee, Employee's coverage by Medicare (under Part A, Part B, or both), or a Dependent child ceasing to meet the definition of Dependent under the Plan, the spouse and eligible Dependents may continue coverage for up to 36 months from the date of the Qualifying Event. When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other

than the Employee lasts until 36 months after the date of Medicare entitlement. These general rules are applied to specific circumstances as follows:

a. *Change in Eligibility from Plan 1 to Plan 2*

If, after being covered under Plan 1, you become eligible under Plan 2 because of a reduction in hours, coverage under Plan 1 may be retained for up to 18 months by making Self-Payments as described in these Eligibility Rules.

b. C*easing Active Work*

If you become eligible for leave under the Family and Medical Leave Act of 1993 (FMLA), refer to Article I, Section K at page 22 to determine the effect of the FMLA on the provisions of this section.

(i) If you cease active work due to layoff, maternity leave, or leave of absence, coverage may be continued for up to 18 months from the time coverage ceases.

(ii) If you cease active work due to sick leave, you may continue coverage for up to 18 months or until the end of your period of sick leave, whichever is longer.

(iii) If you cease active work due to a disability which prevents you from performing your regular employment or occupation, you may continue coverage for up to the earlier of two (2) years of disability or entitlement to Medicare.

(iv) If you cease active work due to a disability which prevents you from performing any employment for compensation, profit, or gain:

(A) You may continue coverage for up to 18 months of disability or until the end of your period of disability, whichever is longer, but in no event later than the date of your entitlement to Medicare.

(B) You (or any other Qualified Beneficiary) may continue coverage for yourself and your Dependents for up to 29 months of disability or until the end of your period of disability, whichever is longer, provided the Social Security Administration (SSA) determines that any of the Qualified Beneficiaries are disabled under the Social Security Act either: at the time employment terminated or hours were reduced; or at any time within 60 days of such Qualifying Event, and provided the Qualified Beneficiary notifies Trustees within 60 days of the SSA determination and before the end of the first 18 months of continuation of coverage.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until the earlier of either (a) sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or (b) one (1) year from the date of the

Qualifying Event as a "Tolling Period." During the Tolling Period, the sixty (60) day window in which the Qualified Beneficiary must notify the Fund Office of a SSA determination is disregarded and resumes at the end of the Tolling Period.

(v) If you cease work because of retirement, coverage may be continued as stated in Article I, Section I, page 18, below.

c. *Loss of Dependent Status*

If a Dependent child's coverage ceases because the Dependent child ceases to meet the definition of Dependent under the Plan, the former Dependent's coverage may be continued for up to 36 months.

If family coverage ceases due to your death, divorce or legal separation, coverage may be continued by your Spouse and Dependent children for up to 36 months. However, if a retired Employee who is covered under Plan 3 dies, his surviving Spouse and Dependent children who were covered under the Plan at the time of his death may continue Plan coverage by making Self-Payments. This right terminates if the surviving Spouse becomes covered under another health plan with comparable coverage or, in the case of a Dependent child, such child ceases to meet the definition of Dependent.

6. Multiple Qualifying Events

A spouse or Dependent child, as a Qualified Beneficiary, may experience more than one Qualifying Event. The combined continuation coverage period for all such Events may not exceed 36 consecutive months from the date of the original Qualifying Event. The second or later Qualifying Events, provided they occur within the continuation period provided as a result of the original Qualifying Event, entitle a Qualified Beneficiary to continue coverage for an additional period, but not longer than 36 months from the date of the original Qualifying Event.

7. Termination of Self-Payment Provisions for Qualifying Beneficiaries

Self-Payments no longer are accepted and continued eligibility under this provision will terminate on behalf of all Qualified Beneficiaries (unless otherwise specified) when:

a. the Plan no longer provides health care coverage to any Eligible Employee;

b. the required notice of a Qualifying Event is not provided by the Qualified Beneficiary within 60 days of its occurrence;

c. the election for continuation is not made within 60 days following the date of coverage termination or the receipt of the COBRA Notice, whichever is later;

d. the initial Self-Payment is not paid 45 days from the date the Qualified Beneficiary opts to continue coverage;

e. the subsequent Self-Payments are not paid by the first day of the month for that month of coverage, unless the Self-Payments are made within the 30-day grace period;

f. a Qualified Beneficiary becomes covered, after electing continuation coverage, under another group health care plan that does not impose any pre-existing condition limitations for pre-existing conditions of the Qualified Beneficiary;

g. the maximum continuation coverage period is reached;

h. for a Qualified Beneficiary who was entitled to the additional 11 months continuation coverage based on a disability extension-eligibility for continuing the disability extension will terminate when there has been a final determination that the disability no longer exists; or

i. a Qualified Beneficiary becomes entitled to Medicare (under Part A, Part B, or both) after such person's COBRA election date (although other family members not entitled to Medicare will continue to be eligible for COBRA continuation). However, if a Qualified Beneficiary becomes entitled to Medicare due to End Stage Renal Disease (ESRD), continuation coverage under this provision will not terminate automatically because of eligibility for Medicare. In the case of ESRD, the Plan will be the primary source of coverage for up to 30 months from the date of ESRD-based Medicare entitlement, provided the person is an active Eligible Employee or Dependent or is covered under the Plan with COBRA continuation coverage. In the event the Plan's liability as the primary source of coverage ends before the COBRA continuation period expires, the Plan will become secondary to Medicare for the balance of the continuation coverage for such person.

Continuation coverage also may be terminated for any reason the Plan would terminate coverage of a Participant or Beneficiary not receiving continuation (such as fraud).

8. Coverage Options Other than COBRA

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty (30) day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees. There may also be other coverage options for you and your family through Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight (8) month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of either

(i) the month after your employment ends, or (ii) the month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. For more information, see https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

9. Initial COBRA Notice

The ***Initial COBRA Notice*** attached to this Plan as **Exhibit A** contains further information and details on COBRA in accordance with Department of Labor guidance and forms.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified in the notice. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

I. Retiree Options Under COBRA and Plan 3

If you cease work because of retirement, coverage may be continued under the Plan according to these provisions.

Early Retirement – non-Medicare Eligible. Retirees at retirement will have the option of either choosing COBRA continuation coverage or continuing to pay a nonsubsidized rate for the Plan 3 Retiree benefit level medical and prescription drug coverage immediately upon retirement, provided they are not eligible for Medicare.

The COBRA coverage provides the same level of benefits the Employee had immediately preceding his retirement (Plan 1 or Plan 2).

Coverage for full-time Retirees will continue to be offered on a single or family basis; however, full-time Retirees must pay the "full-time COBRA" rate regardless of Dependent coverage status. A single, full-time Retiree may irrevocably elect to participate in Plan 2 coverage and pay the "part-time COBRA rate," instead of Plan 1 coverage. Retirees will have the option of choosing Medical Benefits only; or Medical, Dental Care and Vision Care Benefits.

Coverage for part-time Retirees will continue to be offered on a single basis. Retirees will have the option of choosing Medical Benefits only; or Medical and Dental Care Benefits.

Medicare Eligible Retirees. As a Retiree, once you become entitled to Medicare, Medical Benefits under the Plan cease. If you retire at or after entitlement to Medicare, no Medical Benefits are available under the Plan. In either case, the Trustees recommend you purchase a Medicare Supplement policy through a provider that the Plan has contracted with. If you do so and you were a Full-Time Employee, you will have a one-time option at attainment of Medicare eligibility or your retirement, whichever is later, to continue Dental Care and Vision Care Benefits under the Plan. If you were a Part-Time Employee, you will have a one-time option at attainment of Medicare eligibility or your retirement, whichever is later, to continue Dental Care Benefits under the Plan. You will not be allowed to add these benefits at a later date. You will not have the option to continue these benefits under the Plan if you do not purchase the recommended Medicare Supplement policy. You also have a one-time option to cancel these benefits if you elect them.

Early Retirees (non-Medicare eligible) Returning to Work After Retirement: If a Retiree who is not Medicare-eligible returns to work on a part-time or temporary basis, Employer Contributions received by the Plan on their behalf will reduce the amount of the full-time or part-time Self-Payment otherwise due for Plan 3 coverage.

Retiree coverage which continues after exhaustion of continuation coverage rights (COBRA) is subject to change based on Trustee review. The Trustees retain the right in their sole discretion to modify Retiree Eligibility Rules, types and amount of benefits, terms and conditions under which benefits are payable, and Self-Payment rates to the extent allowed by COBRA.

J. Military Service – Eligibility, Freezing Coverage or Continuing Coverage

1. Eligibility Status

You, or an appropriate officer, must submit advance notice of Military Service to the Employer (unless circumstances of military necessity as determined by the Defense Department make it impossible or unreasonable to give such advance notice). In order to prevent an interruption in your coverage and receive other important information regarding your USERRA rights, please also provide notification to the Plan Administrator.

If you, or an appropriate officer, do not submit notice, your accumulated Grace Weeks, if any, will be applied until exhausted to further extend your eligibility and the eligibility of your Dependents. Your coverage will terminate on the date all accumulated Grace Weeks have been exhausted. If you subsequently submit notice in a reasonable time period, the application of Grace Weeks will cease.

a. *Military Leaves which are less than 31 Days*

For Military Leaves which are less than 31 days in duration and for which you, an appropriate officer, or an Employer submit the required notice and otherwise satisfy the reemployment requirements described as follows, you and your eligible Dependents' coverage will be continues as though you are actively at work for the duration of such leave.

b. *Military Leaves of 31 Days or More*

For Military Leaves which are 31 or more days in duration and for which you, an appropriate officer, or an Employer submit the required notice, you and your eligible Dependents' coverage will cease and your eligibility status will be frozen as of the date you leave employment for the purposes of performing Military Service with the uniformed services of the United States, unless you elect to continue coverage as described in the following Section J, subsection (2). You do have the option to not elect to continue coverage and not use your Grace Weeks; in such case, you will have your accumulated Grace Weeks available to re-establish eligibility upon your return from Military Leave.

c. *Eligibility Reinstatement upon Return from Service*

Your eligibility will be reinstated on the date you return to work for a Participating Employer (or upon making yourself available for work if no such work is available) within the applicable time limits stated in the following Section J, subsection (3), provided you otherwise satisfy the reemployment requirements necessary to qualify for reemployment rights under USERRA (e.g., provide evidence of honorable discharge, cumulative Military Service of no longer than five years). If all Grace Weeks have been exhausted, you will be allowed to make Self-Payments to be immediately reinstated in the Plan until you have sufficient Grace Weeks to sustain Plan coverage.

2. Military Continuation Coverage

If you fail to provide advance notice of your Military Service, your coverage will terminate on the date all accumulated Grace Weeks have been exhausted and you will not be eligible to continue coverage under this section unless your failure to provide advance notice is excused. Unless otherwise provided by USERRA statute and regulations, the Trustees will, in their sole discretion, determine if your failure to provide advance notice is excusable under the circumstances and may require that you provide documentation to support the excuse. If the Trustees determine that your failure to provide advance notice is excused, you may elect to continue coverage, in accordance with this Section J, subsection (2), retroactive to the date you left employment for the purpose of performing services with the uniformed services of the United States, provided that you elect such coverage and pay all amounts required for the continuation coverage.

When the Employer has been notified that you are entering the Military Service, you will be given the option of continuing your same class of coverage under the Plan. Continuation coverage under this Section J, subsection (2) is the same as that described under the Self-Payment provisions for COBRA continuation coverage. The rules for election of and payment for continuation coverage are the same as the COBRA election and payment rules, provided the COBRA rules do not conflict with USERRA. If you do not elect continuation coverage or do not submit payment for all amounts required to continue coverage within the applicable COBRA timeframe, you will lose your right to continue coverage under this section and such right will not be reinstated.

You will have the option of applying accumulated Grace Weeks, if available, to continue coverage. If Grace Weeks are not available or you choose not to use them, you are required to make timely Self-Payments at the COBRA rate to be determined by the Trustees from time to time to purchase COBRA continuation coverage. If you elect to use Grace Weeks to pay for continuation coverage and you exhaust your Grace Weeks prior to the end of the maximum

coverage period described in this Section J, subsection 2, you may make Self-Payments to continue coverage through the end of your maximum coverage period.

The COBRA continuation coverage rules apply to payment for continuation coverage under this subsection (b) provided that the COBRA payment rules do not conflict with USERRA. You must make all required Self-Payments within the COBRA timeframe described under the Self-Payment provisions in this Summary to continue coverage under this subsection (b) unless the COBRA payment rules conflict with USERRA

You and your eligible Dependents may continue coverage for a period ending the earlier of:

a. the date the Plan no longer provides group health care coverage to any Employees;

b. the day after the date you fail to elect continuation coverage as required by the COBRA continuation coverage election rules;

c. the first day of the month for which a timely Self-Payment has not been received and your Grace Weeks have been exhausted;

d. twenty-four (24) months from the first date of absence due to Military Service; or

e. the day after the date you fail to apply for reemployment with a Participating employer within the applicable time period allowed under Section J, subsection 3 or otherwise cease to have USERRA reemployment rights.

The right to freeze eligibility and make Self-Payments under this provision ceases when you provide notice that you do not intend to return to work for a Participating Employer after uniformed service.

3. Status Upon Return from Military Service

If you are eligible for benefits when you enter the Military Service and you have sufficient Grace Weeks or make timely Self-Payments to maintain coverage upon your return to work, you and your eligible Dependents again will be eligible for benefits on the date of your return to work for a Participating Employer within the following time periods, provided you satisfy the other reemployment requirements of USERRA:

a. For periods of Military Service of less than 31 days, you must report to the Employer not later than the beginning of the first full regularly scheduled work period on the first full calendar day following completion of the period of Military Service plus eight hours, after a period allowing for safe transportation from place of Military Service to place of your residence.

b. For periods of Military Service of more than 30 days but less than 181 days, you must apply for reemployment not later than 14 days after Military Service is completed.

c. For periods of Military Service of more than 180 days, you must apply for reemployment not later than 90 days after Military Service is completed.

Such time periods may be extended up to two years for injuries or Sicknesses, as determined by the Secretary of Veteran Affairs, to have been incurred or aggravated during your service in the uniformed services.

If you exhaust your Grace Weeks prior to your return from Military Service and you do not have USERRA reemployment right, you will be treated as a new Employee. If you exhaust your Grace Weeks prior to your return from Military Service and you satisfy the USERRA reemployment requirements, you will be eligible for benefits on the date of your return to work within the required time periods, provided you make Self-Payments required to continue eligibility under the Self-Payment provisions. If you fail to make Self-Payments as required upon reinstatement in the Plan, your eligibility for coverage will terminate as of the last date of the period for which a timely payment was received and you then will be treated as a new Employee.

These rules are intended to comply with the requirements of USERRA. The USERRA provisions will control in the event there are any inconsistencies between the Act and the Plan.

The Plan will provide continuation coverage and reinstatement rights to the extent required by USERRA. You also may have continuation coverage rights under COBRA. Although the COBRA and USERRA provisions are similar, COBRA continuation coverage and USERRA continuation coverage are not identical. As long as you remain eligible simultaneously for both COBRA and USERRA continuation coverage, you will receive the more generous benefit rights that apply under these statutes. COBRA and USERRA continuation periods will run concurrently.

K. Family and Medical Leave (FMLA)

Not all Employers are covered by Federal Family and Medical Leave Act of 1993 (FMLA), and the benefits of this law do not extend to employees of such Employers. To be subject to the Act, an Employer must have at least 50 Employees within 75 miles. If you are uncertain as to whether FMLA applies to you, ask your Employer or the Plan Office.

If you cease to work due to an Employer-approved family medical leave of absence in accordance with FMLA (or in accordance with any state or local law that is more generous and requires continuation of coverage during the leave) coverage will be continued under the same terms and conditions which would have been provided had you continued to work. The FMLA requires covered Employers to provide up to 12 weeks (or, for care of a service member, up to 26 weeks) of unpaid, job-protected leave to Employees eligible under FMLA.

Upon your return from a FMLA leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms. The use of FMLA cannot result in the loss of any employment benefit that accrued prior to the start of the Employee's leave. If you do not return to work after a FMLA-eligible leave, then for COBRA continuation coverage purposes under Article I, Section H, the date of the Qualifying Event is the last day of your FMLA leave.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under "U.S. Government, Department of

Labor." For information on the Minnesota parental leave law, contact the Minnesota Department of Labor and Industry.

L. Reinstating Coverage

If you are terminated from employment (as that process is defined by the Collective Bargaining Agreement or Participation Agreement), you have exhausted all Grace Weeks of coverage, and you have not continued coverage with COBRA, you will be required to regain eligibility under the terms of Eligibility rules of this Plan before becoming entitled to participate again.

M. Rescission of Coverage

An Eligible Person and persons seeking coverage on behalf of an Eligible Person may not engage in any fraudulent act, practice, or omission in connection with coverage under the Plan or make an intentional misrepresentation of material fact in connection with coverage under the Plan. If an Eligible Person or a person seeking coverage on behalf of an Eligible Person engages in such act, practice, omission, or misrepresentation, the Eligible Person's coverage (including the coverage of any Dependents in the case of an Eligible Employee and the coverage of the Eligible Employee in the case of a Dependent) may be retroactively terminated or cancelled.

Retroactive termination or cancellation includes, but is not necessarily limited to, the following:

1. any loss, expense, or charge incurred as a result of such act, practice, omission, or misrepresentation will not be covered;

2. the Eligible Person (including any Dependents in the case of an Eligible Employee and the Eligible Employee in the case of a Dependent) will be required to reimburse the Plan for any claim erroneously paid by the Plan because of such act, practice, omission, or misrepresentation; and

3. the Trustees of the Plan may treat the Eligible Person's coverage (including the coverage of any Dependents in the case of an Eligible Employee and the coverage of an Eligible Employee in the case of a Dependent) as void from the time the act, practice, omission, or misrepresentation occurred.

The following are examples of fraudulent acts, practices, or omissions or intentional misrepresentations of material fact that may result in the retroactive termination or cancellation of an Eligible Person's coverage. Intentionally or fraudulently failing to:

1. timely update his or her enrollment status;

2. report to the Plan:

    a. his or her divorce;

    b. his or her legal separation;

    c. the death of a Dependent; or

    d. his or her loss of custody of a Dependent child;

3. satisfy his or her notification obligations under this Plan; or

4. honor the Plan's right of subrogation and reimbursement or otherwise failing to cooperate with the Plan.

This is not a complete list of acts, practices, and omissions that are considered fraudulent or a complete list of intentional misrepresentations of fact considered material. The requirements of this provision do not limit the Plan's ability to prospectively terminate your coverage.

N. Notification Obligations

Eligible Persons must notify the Plan Administrator of any event or change in circumstances that affects:

1. any Eligible Person's eligibility for coverage under the Plan; or

2. any Eligible Person's eligibility for payment of any specific claim for benefits.

Notification must be provided to the Plan Administrator in writing within 20 days of any such event or change in circumstances.

O. Coverage for Dependents After You and Your Spouse Divorce

If you are a Full-Time Employee, coverage for your Dependent children who were covered under the Plan on the date of your divorce will remain in force to the same extent as if the divorce had not occurred with no self-payment requirement of or for such Dependent children.

Your former spouse is entitled to continue coverage by making required self-payments under COBRA for up to 36 months of continuation coverage.

P. Coverage for Employees of Newly Participating Employers

The following provisions apply only to an Employee who was covered under their Employer's policy or plan immediately prior to the effective date of his Employer participating under this Plan and who becomes covered under this Plan on that date. Payment of benefits under this Plan will be in lieu of payment under the former policy or plan.

1. If otherwise eligible, your coverage under this Plan will become effective on the date your Employer becomes a Participating Employer. However, you may be required to satisfy the evidence of insurability requirements before becoming eligible for a larger life insurance amount than under the former policy or plan.

2. It is the intent of this provision that you will not lose all coverage solely because your Employer becomes a Participating Employer and you would not be eligible under this Plan due to an effective date provision. Furthermore, it is not the intent of this provision that you will receive greater benefits than you would have under your former plan. Therefore, benefits payable under this Plan under such circumstances will be the lesser of:

a. the amount of any benefits payable by the former plan under any provision of such plan that would not violate the Patient Protection and Affordable Care Act, reduced by the amount paid or payable by that plan; or

b. the amount of benefits provided by this Plan in the absence of any effective date provision or pre-existing condition limitation.

3. If you had applied medical expense toward Deductible amount requirements under the former plan for the Calendar Year during which your Employer becomes a Participating Employer, the Deductible amount requirements under this Plan for that Calendar Year will be reduced by the same amount.

ARTICLE II

YOUR RESPONSIBILITIES UNDER THE PLAN

A. Notify the Plan Administrator Immediately Regarding Any Change in Address.

Most information about your Plan is sent to you by mail. For you to receive this information, we must have a correct address on file at the Plan Administrator at all times.

If you move, it is up to you to let the Plan Administrator know your new address. Failure to do so may jeopardize your eligibility or benefits because we will have no way to contact you about any changes in the Eligibility Rules or benefits.

Remember: The responsibility for advising the Plan Administrator of your new address is yours, and you must do so in writing.

B. Notify the Plan Administrator of a Desired Change in Beneficiary and Any Change in Marital Status.

If your marital status changes or there are other changes in your personal life which might affect the name of the person(s) you wish to designate as your Beneficiary, you must notify the Plan Administrator in writing regarding any change in Beneficiary you wish to make.

Also, notify the Plan Administrator of any change in marital status due to marriage, death, divorce, or legal separation. Notification if your name changes is important, too.

C. Notify the Plan Administrator Immediately Regarding Any Change in Dependent Child Status.

If you acquire a new Dependent child due to birth, adoption, or addition of a stepchild due to marriage, please call the Plan Administrator right away to let them know so they can send you the necessary paperwork. Prompt notification will avoid any potential delays in the processing of claims for your new Dependent.

Also, inform the Plan Administrator immediately if one of your Dependent children becomes ineligible for any reason. Change of Dependent status may trigger COBRA rights.

D. Make Self-Payments on Time and in the Correct Amounts.

Benefits paid by this Plan are financed primarily by Employer Contributions based on the number of hours worked. However, the Plan also provides that if you are not employed or have not worked the required minimum number of hours to maintain eligibility through Employer Contributions, you may make Self-Payments to continue your eligibility under one of the plans for active Employees. The Plan allows Retirees who satisfy certain requirements to continue eligibility after retirement by making Self-Payments.

You are responsible to make the Self-Payments no later than the first of each month. Failure to pay the required amount on time will lead to a loss of eligibility. Remember: The responsibility for making timely Self-Payments is yours.

E. Avoid Unnecessary Delays in Processing Your Claims by Providing All Necessary Information.

A major reason for delays in processing of claims is failure on the part of the providers furnishing services or supplies and the person filing for benefits to provide all the necessary information. You probably would not be aware of the information omitted by your Physician; however, a reminder to the receptionist or nurse in the Physician's office to make sure all information is complete may help to solve the problem. If you are submitting claims yourself, be sure to double-check that you have included all the needed information before you send them in.

F. Notify the Plan Administrator of Other Group Health Care Coverage.

It is your responsibility to inform the Plan Administrator of health care coverage you have under any other group plan so this Plan can coordinate benefits properly. Failure to notify the Plan Administrator could result in a delay in payment of your claims or erroneous payments.

ARTICLE III

LIFE INSURANCE BENEFITS

Plans 1 and 2
For Full-Time and Part-Time Employees Only

The Life Insurance Benefit is fully insured through a policy with United of Omaha Life Insurance Company. The benefit is fully governed by the relevant insurance policy. If there is any conflict between this SPD and the insurance policy, the insurance policy will govern.

A. Beneficiary and Beneficiary Designation

Employee Life Insurance

If you die from any cause, your Beneficiary on record at the Plan Administrator will be paid the amount of the employee life insurance benefit specified in the Schedule of Benefits. The benefit will be paid in full according to the terms of the policy upon receipt of a claim form, death certificate and any other required supporting documentation.

If you do not designate a Beneficiary or if your Beneficiary does not outlive you, the insurance amount will be paid in the following order:

1. to your surviving Spouse; if none, then
2. to your surviving natural and/or adopted children; if none, then
3. to your surviving parent(s); if none, then
4. to your estate.

Benefits will be paid equally among surviving children or surviving parents.

Your Beneficiary designation and any change in Beneficiary must be filed in writing with the Plan Administrator on a properly completed form. It will become effective on the date the request is signed, provided the Life Insurance Benefit had not been paid already before the request is received. If your marital status changes or there are other changes in your personal life which might affect the name of the person(s) you wish to designate as your Beneficiary, please notify the Plan Administrator in writing promptly regarding any change in Beneficiary you wish to make. If you designate a minor child as your Beneficiary, you must provide the Plan Administrator with information regarding the child's guardian or trust. Your Beneficiary designation will be made available to you upon request at the Plan Administrator. You may not assign the Life Insurance Benefit.

If you become disabled and subsequently die, and if anyone has paid expenses incurred because of your disability and death, the Plan may reimburse the amount paid, up to $500. A satisfactory receipt will be proof of expense. Such expenses are reimbursed only if there is no Beneficiary.

Dependent Life Insurance

If one of your covered Dependents dies, the benefits shown in the Schedule of Benefits will be paid in this order to the living:

1. You;

2. Your Spouse;

3. Your children, including legally adopted children; or

4. Your Dependent's estate.

If two or more of your children are entitled to benefits, they will share equally. If both you and your Spouse are eligible as Employees, both may enroll for Life Insurance Benefits. However, if you are insured as an Employee, you will not be eligible to also be insured as a Dependent for Dependent Life Insurance Benefits.

B. Coverage During Total Disability

If your disability begins before your 60th birthday, the Total Disability Benefit continues without premium or Self-Payment until the earliest of the following:

1. the date your disability ends, or you do not submit a required proof of disability; or

2. the date you convert your group insurance.

When you no longer are qualified for the Total Disability Benefit, you will be covered for the amount of your insurance classification if you are eligible and your premium payments are resumed within 31 days. If no longer eligible, you can convert as outlined under "Conversion Privilege."

C. Continuation of Life Insurance

When your coverage for Life Insurance Benefits under the Plan ends because you are laid off, your employment ends, or you no longer satisfy the requirements for hours worked, you may continue life insurance for yourself and your covered Dependents for as long as 18 months by paying the required premium. You may **not** continue life insurance if your employment ends because you are discharged for gross misconduct or the policy is discontinued. The life insurance continued is the amount in force on the day insurance otherwise would have ended.

To continue Life Insurance Benefits, you must send the Plan Administrator written notice that you wish to continue life insurance along with the first monthly premium, payable at the Plan's full cost. You must do so within 60 days after written notification is sent from the Plan Administrator of your right to continue, including the premium amount and due date.

If you or one of your covered Dependents dies within the 60-day election period and before an election whether to continue or not has been made, the insurance company will pay the amount which could have been continued, less any premium owing at the date of death.

Continued Life Insurance Benefits end on the earliest of:

1. the day insurance has been continued for 18 months;

2. the day a conversion policy is obtained;

3. the day you obtain coverage under another group policy, contract, or plan; or

4. the day insurance otherwise would end according to policy provisions.

When continued Life Insurance Benefits end, you and your Dependents can convert as outlined under “Conversion Privilege.”

D. Conversion Privilege of Your (Eligible Employee’s) Life Insurance Policy

When you no longer are eligible for the Life Insurance Benefit, you may convert part or all of your life insurance coverage, without medical examination, to a personal life insurance policy.

If the Life Insurance Benefits end for your group because a policy or class termination occurs, you may convert up to $3,000 of your life insurance coverage to a personal policy, but only if you had been covered under this Plan for at least three years.

The personal policy may be of any type other than term insurance and without disability or accidental death benefits. You must apply for the personal policy and pay the first premium within 31 days after your Life Insurance Benefits end. Premiums for the personal policy will be determined at the time of conversion by your class of risk, the type and amount of insurance, and your age. The personal policy will not become effective prior to the end of the 31-day conversion period.

If you die within 31 days after your Life Insurance Benefits end, your Beneficiary will be paid the amount that could have been converted.

E. Conversion Privilege of Dependent’s Life Policy

If your Dependent’s Life Insurance Benefits end because he no longer qualifies as a Dependent or because of your death or termination of your eligibility for Dependent Life Insurance Benefits (or Dependent’s Life Insurance Benefits end for your group for any reason after your Dependent has been covered for three years), you or your Dependent may convert his life insurance coverage, without medical examination, to a personal life insurance policy.

The personal policy may be of any type other than term insurance and without disability benefits in an amount up to the amount of your Dependent’s life insurance coverage in force at the time of death. You or your Dependent must apply for the personal policy and pay the first premium within 31 days after your Dependent’s Life Insurance Benefits end. Premiums for the personal policy will be determined at the time of conversion by your Dependent’s class of risk, the type and amount of insurance, and his age. The personal policy will not become effective before the end of the 31-day conversion period.

If your Dependent dies within 31 days after his Life Insurance Benefits end, the insurance company will pay the amount for which he was insured.

F. Exclusions or Limitations

The Life Insurance Benefit is an insured benefit. It is subject to the exclusions listed in the Life insurance policy. For further information on exclusions, contact the Plan Administrator to receive a copy of the policy.

G. Claims for Life Insurance Benefits

The Life Insurance Benefit is an insured benefit. The claims process for life insurance is governed by the insurance contract. For information on processing the claim with the insurance company, contact the Plan Administrator.

ARTICLE IV

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Plan 1 (Insured) and Plan 2 (Self-Funded)
For Full-Time and Part-Time Employees Only

A. Determination of the Benefit Amount

If you suffer bodily Injury caused by accidental means while you are a Covered Employee and the Injury causes your death or any of the following specified losses within 90 days of the date of the accident, the following benefits are payable:

AD&D Benefit Event	Amount of Benefit
Loss of: • Life, • Both hands severed at or above the wrist; • Both feet severed at or above the ankle, • One hand severed at or above the wrist and one foot severed at or above the ankle, • Irrecoverable sight of both eyes, • One hand severed at or above the wrist and irrecoverable sight of one eye, or • One foot severed at or above the wrist and irrecoverable sight of one eye	Principal sum specified in the Schedule of Benefits
Loss of: • One hand by severance at or above the wrist; • One foot by severance at or above the ankle; or • Irrecoverable sight of one eye	50% of the principal sum specified in the Schedule of Benefits
Loss of: • Thumb and index finger of either hand	25% of the principal sum specified in the Schedule of Benefits

If you suffer more than one loss in an accident, payment will be made only for the loss for which the larger amount is payable.

B. Limitations and Exclusions

In addition to the Plan's General Limitations, Accidental Death and Dismemberment Benefits do not cover losses from:

1. intentionally self-inflicted Injury or suicide, except if the self-inflicted Injury or suicide is the result of a physical or mental health condition;

2. war or any act of war;

3. military, naval, or air service; or

4. injuries received while operating or riding in any aircraft, except while riding as a passenger in a commercial aircraft which is on a regularly scheduled passenger flight.

C. Claims

Plan 1: The Plan 1 Accidental Death and Dismemberment Benefit is an insured benefit. The claims process for life insurance is governed by the insurance contract.

Plan 2: The Plan 2 Accidental Death and Dismemberment Benefit is a self-insured benefit.

Claims for Accidental Death and Dismemberment Benefits should be submitted to the Plan Administrator in writing on forms provided by the Plan Administrator with all applicable questions and information requested on the form answered and provided by the Eligible Employee or Beneficiary. A certified copy of the death certificate (if applicable) should be provided with the completed claim form.

ARTICLE V

ACCIDENT AND SICKNESS BENEFITS

Plan 1 Only
For Full-Time Employees Only

A. Accident and Sickness Benefit

For each week you are Totally Disabled and under a Physician's care because of Injury, Sickness, or pregnancy, you will be paid a weekly benefit During any Disability equal to the percentage of your Weekly Earnings and up to the maximum per week and number of weeks specified in the Schedule of Benefits.

Benefits begin on the following dates:

1. For an Accident: the first day of Disability.

2. For a Sickness or pregnancy: the first day of inpatient Hospital confinement or eighth consecutive day of Disability, whichever is earlier.

3. For Surgical procedures performed on an outpatient basis: eighth day of Disability (however, if the Disability extends past the seventh day, benefits are paid retroactively to the first day, provided you submit a Physician's written certification of Total Disability)

If Disability benefits are for a fractional period of a week, you will receive one-seventh of the weekly benefit for each day of Disability.

B. Limitations and Exclusions

In addition to the Plan's General Limitations, Accident and Sickness Benefits are not payable:

1. If you are not under the direct and continuous care of a Physician.

2. For an Injury or Sickness sustained while you are engaged in any occupation or employment for wages or profit whether covered by Worker's Compensation or not.

3. For Injury or Sickness for which you may be entitled to receive Worker's Compensation.

4. If you are eligible for and/or collecting unemployment.

5. If you are receiving a pension.

C. Taxation of Weekly Accident and Sickness Benefits

In general, Weekly Accident and Sickness Benefits are subject to Social Security taxes (FICA). You pay half of the tax, and the Plan, standing in place of, and acting as your Employer, pays the other half. According to federal law, the Plan will withhold your share of the FICA tax from

each weekly benefit check paid to you during the first six (6) full months of your Disability and will send it to the government. You must include your Weekly Accident and Sickness Benefits in your gross income and pay federal income tax on the benefits. You should contact a competent tax advisor or attorney if you have any questions regarding taxes on this benefit.

ARTICLE VI

EMPLOYEE ASSISTANCE PROGRAM

Plans 1, 2 and 3

From time to time, we all deal with personal problems, both large and small. Sometimes, we need help to resolve our problems.

Your Employee Assistance Program (EAP) is provided through TEAM. TEAM is a confidential assessment, counseling, and referral service for you and your family to help resolve personal problems which may be affecting your life at work and at home.

Skilled counselors are available 24 hours a day to talk with you in confidence about your problems. Your TEAM counselor can help you with:

- family and marriage problems
- alcohol or substance dependency
- financial concerns
- emotional problems
- legal referrals
- medical concerns
- work-related problems

Sessions are focused on problem resolution and/or appropriate referral to community resources, support groups, or professional counselling services. In addition, TEAM also provides specialty work-life services, such as childcare and elder care referrals, financial counseling and legal resources.

You may access TEAM at:

TEAM
1970 Oakcrest Avenue, Suite 200
Roseville, MN 55113
(800) 634-7710
www.team-mn.com

ARTICLE VII

MAJOR MEDICAL BENEFITS

Plans 1, 2 and 3

A. Preferred Provider Network Benefits

The Board of Trustee has entered into a Preferred Provider arrangement ("PPO") with UnitedHealthcare ("UHC"), using its UnitedHealthcare Choice Plus network of Providers. UHC provides a network of Hospitals, Physicians, and other health care professionals who provide high quality medical care while helping you and the Plan to manage costs. You have the option of choosing a UHC/PPO provider or a non-PPO provider each time you need medical services. Your current Hospital or Physician already may be a member of this network.

To see what Physicians and other Health Care Providers are in your UHC network of Providers, log on to your account at www.umr.com. If you need assistance locating a Physician or other Health Care Provider in your network, please contact the Fund Office.

These Hospitals and Physicians have agreed to offer you and the Plan "preferred" rates. Your out-of-pocket expenses will be less because your Coinsurance will be applied to reduced charges. For charges incurred with PPO providers, the Plan will pay a discounted amount. These providers have agreed to accept payment from the Plan as payment in full, except for applicable Deductibles, Coinsurance, maximum benefit limitations, or other similar limitations under the Plan. PPO providers automatically will file your claim for you if you present your identification card and sign the appropriate form.

For charges incurred with non-PPO providers, the Plan will pay the Reasonable Expense or, if applicable, a separately negotiated amount to the non-PPO provider. The Plan may accept an assignment of these claims to make payment directly to the non-PPO provider. You will be responsible for applicable Deductibles, Coinsurance, maximum benefit limitations, or other similar limitations under the Plan and may be billed for the balance by the non-PPO provider.

An identification card will be issued to you at the time of enrollment. You and your Covered Dependents will be asked to present your identification card whenever you seek services. You may not permit anyone else to use your card to obtain care.

B. Payment Terms

When you or your Dependent require covered services or supplies which are Medically Necessary because of Injury or Sickness, benefits are payable as stated in the Schedule of Benefits, provided you have satisfied any required Deductible. If there are limitations for a particular benefit, they are explained with each benefit. General Limitations for the Plan begin on page 59, Article XI, Section A.

Deductible

The Deductible is the amount of Covered Expenses which you pay before you are entitled to benefits. The Deductible per person per Calendar Year and aggregate maximum per family each Calendar Year for Plan 1 are stated in the Schedule of Benefits. The Deductible applies only once in any Calendar Year.

Normally, the Deductible is applied separately to each Eligible Person in a family. But, if two or more eligible members of a family under Plan 1 are injured in the same accident, only one Deductible will be charged against all resulting Covered Expenses, regardless of the number of family members injured.

Coinsurance

After you satisfy the Deductible amount, the Plan pays Covered Expenses at the Coinsurance percentage stated in the Schedule of Benefits.

When the Out-Of-Pocket Covered Expenses in a Calendar Year, including the Deductible amount, reach the maximum per person or per family for Plan 1 as stated in the Schedule of Benefits, the Plan pays 100% of the balance of Covered Expenses for that person or family for the remainder of that Calendar Year. "Family" means one or more Eligible Persons within a family unit, consisting of you and your Dependents.

Covered Expenses incurred for infertility treatment will not be applied toward your Out-Of-Pocket Maximum.

C. Covered Expenses – Covered Services

Benefits are payable for Reasonable Expenses incurred for the following services and supplies which are Medically Necessary for the treatment of an Injury or Sickness, subject to the Limitations in Article XI, Section A, starting on page 59.

1. Inpatient Hospital Services

Inpatient Hospital Services must be recommended by the attending Physician. The Plan will cover the following Reasonable Expenses:

- Room and Board expense up to Hospital's Semi-Private Room rate
- Confinement in an intensive care or coronary care unit, but room and board expense is not to exceed twice the admitting Hospital's Semi-Private Room rate
- Confinement of 24 or more consecutive hours in a recovery room in the Hospital, if you receive the same care and services as those normally provided in the intensive care unit of the Hospital, but not to exceed twice the admitting Hospital's Semi-Private Room rate.
- Drugs, medicines, diagnostic x-rays and laboratory tests and other Hospital miscellaneous services and supplies not included in the room charges (including the anesthetist's fee when charged by the Hospital), if used while confined in the Hospital as a resident patient.
- The room cost for up to two consecutive days and up to a total of six days during one period of disability for an Eligible Person, undergoing inpatient treatment for a nervous or mental condition, when temporarily released for therapeutic reasons.
- For a Plan 1 Participant, expense of a newborn Dependent child of the Plan 1 Participant are covered during the period his mother is Hospital-confined as the result of giving birth to the child and after the mother's discharge if the newborn has a condition which necessitates further Hospital confinement.

2. Outpatient Services

Outpatient Services must be recommended by the attending Physician. The Plan will cover the following Reasonable Expenses:

- Hospital Services or supplies incurred as an outpatient.
- Outpatient Services in connection with emergency first-aid treatment resulting from Injury or Sickness, provided such services are rendered after the first appearance of the symptoms of a Sickness or within 24 hours after an accident.
- Outpatient services in connection with dental procedures when Medically Necessary due to the patient's age or health.

3. Skilled Nursing Home

The Plan will cover Reasonable Expenses of a licensed Skilled Nursing Home for up to 30 days of confinement per period of disability, provided:

- you are transferred to the Skilled Nursing Home within 24 hours of Hospital discharge;
- you were hospitalized immediately before transfer to the Skilled Nursing Home;
- the attending Physician certifies this care is Medically Necessary and recertification is made every seven days;
- further hospitalization would be necessary if not for Skilled Nursing Home confinement; and
- the daily room rate does not exceed that established by the Minnesota Department of Health and Social Services or by a similar agency if in another state.

4. Physician's and Others' Services

The Plan will pay the Reasonable Expenses for:

- Surgery by a Physician, including charges for outpatient surgery, home deliveries, circumcision of an eligible newborn Dependent child of a Plan 1 Eligible Person, and the surgical removal of impacted wisdom teeth. Sex reassignment surgery is covered only when Medically Necessary according to specified guidelines, and determined to be the most appropriate treatment choice for the Eligible Person's gender dysphoria.
- Anesthetic and its administration by a professional anesthetist when the charge for those services is not included in the Hospital's charges.
- Medical services rendered during in-Hospital, outpatient, office, and home visits; examination of an eligible newborn Dependent child of a Plan 1 Eligible Person when the examination is performed within 48 hours of birth by a Physician; and a simple office visit related to a pap test.

5. Acupuncture

Acupuncture is covered if performed by a Medical Doctor (M.D.) and also when performed by a Licensed Acupuncturist (L.AC) licensed in the state he/she is practicing and under the supervision of a M.D.

6. Chiropractic Services

Chiropractic fees for services of a licensed chiropractor acting within the usual scope of the chiropractic practice will be paid, up to the maximum per visit and per Calendar Year stated in the Schedule of Benefits.

7. Mental Health and Chemical Health Inpatient and Outpatient Services

Reasonable Expenses for Mental Health or Chemical Health Inpatient and Outpatient Services are payable the same as for any other Illness.

- Outpatient treatment must be rendered in a Hospital, approved Outpatient Psychiatric Facility, or a facility licensed by the state of Minnesota to provide these services (or a similar agency if in another state), except that a Physician can render such treatment at any location.
- Outpatient treatment includes collateral interviews with your family, medical evaluations, and psychological testing. Psychological testing over five hours will be reviewed for medical necessity.

8. Diagnostic X-Ray and Laboratory Services

Reasonable Expenses for diagnostic x-ray and laboratory services are covered, including:

- A pap test, regardless of the purpose for which it is performed.
- Amniocentesis.
- Genetic testing, other than amniocentesis, and payable only under the parameters for Genetic Testing.
- Excludes Allergy tests.

9. Physical Therapy, Speech Therapy and Occupational Therapy

Reasonable Expenses for Services of a qualified physiotherapist, occupational therapist, speech therapist, registered nurse (R.N.), or licensed practical nurse (L.P.N.) are covered.

- Benefits are payable for services of a licensed speech therapist under the supervision of a Physician for a condition resulting from an Injury, Sickness, or congenital disorder such as cleft lip or palate.
- However, benefits are not payable for speech therapy for a condition resulting from learning disabilities or a personality disorder.
- Occupational and speech therapy are covered for developmental delays if Medically Necessary as defined by case management and provided school programs have first been utilized to the fullest.

10. Ambulance and Medical Transportation

The following Reasonable Expenses for Ambulance and Medical Transportation are covered:

- Local professional ground ambulance service to the nearest Hospital that is equipped to provide the Medically Necessary treatment.
- The Plan also will cover Medically Necessary professional ambulance service by air or helicopter only for life-threatening emergencies when a Participant could not be safely transported by ground ambulance, and only to the nearest facility where proper medical care is available.
- Charges for ambulance service by railroad, ship, bus, or other common carrier are not Covered Expenses.
- Benefits are not payable for transportation or transfer based solely on your or your Physician's convenience, personal preference, or any reason other than medical necessity.

11. Dental Services for Fractured Jaw or Injury

Dental services (including dental x-rays, but excluding dental implants) rendered by a Physician, Dentist, or dental Surgeon for treatment of a fractured jaw or Injury to natural teeth, including replacement of such teeth within six months after the date of the accident.

12. Equipment, Services and Supplies

The following equipment, services or supplies are covered by the Plan (excluding sales tax, shipping and handling):

- Surgical dressings, casts, trusses, and crutches;
- Rental of Hospital-type bed, wheelchair, or iron lung (or the purchase of such device if the rental would exceed the purchase price);
- Initial artificial limbs and eyes replacing natural limbs and eyes, provided such replacement occurs promptly following the loss and in no event later than six months from the date of the loss
- Oxygen and the rental of equipment for its administration; x-ray, radium, or cobalt treatment, including the services of a radiologist and the rental (but not purchase) of such radioactive materials, provided that treatment is rendered in the radiologist's office or in the outpatient department of the Hospital making the charge;
- Blood and blood plasma (if not replaced) and its administration;
- The first set of lenses following cataract surgery;
- Contraceptive devices which require the written prescription of a Physician and contraceptive injections and surgical procedures when administered or performed by a Physician (voluntary sterilizations are covered for Employees and Dependent spouses);
- Initial pair of podiatric orthotic appliances when prescribed by a Physician and Medically Necessary replacement;
- Custom-made stockings, such as Jobst stockings, up to two pair per Participant per Calendar Year;
- Over-the-counter splints, braces (except dental braces), and stockings when prescribed by a Physician for a medical condition and an itemized bill that includes the patient's name is obtained from the supplier;
- Blood glucose meters; and
- Any other Medically Necessary durable medical equipment.

13. Mastectomy Benefits

The Plan covers:

- Reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce symmetrical appearance, prostheses and treatment for physical complications during all stages of mastectomy, including lymphedemas.
- Two mastectomy bras per Participant per Calendar Year.
- A prophylactic mastectomy if the Participant has tested positive for the BRCA1 or BRCA2 gene mutation or has a history of cancer in the contralateral breast or has a strong family history of breast cancer.
- A prophylactic oophorectomy will be covered when a Participant has tested positive for the BRCA1 or BRCA2 gene mutation or has a strong family history of ovarian cancer.
- A "strong family history" means that at least two of your first degree relatives or three second degree relatives have been diagnosed with such cancer. The term "first degree relatives" means your mother or sisters. The term "second degree relatives" means your aunts or grandmothers.

14. Major Medical Covered Prescriptions

Reasonable Expenses for drugs and medicines requiring the written prescription of a Physician and dispensed by a licensed pharmacist which are obtained at a pharmacy that does not participate in the Preferred Provider Network are covered.

Benefits for prescription drugs paid using the Preferred Provider Network are described in the Schedule of Benefits and at Article VIII, page 50.

15. Artificial Life Support

Artificial life support systems for the first five days after a medical determination that death has occurred, up to a maximum of $5,000, when a Participant is determined to be legally or clinically dead.

16. Infertility Treatment

Coverage is for Employees and Dependent Spouses in Plan 1, Employees in Plan 2.

- Covered Expenses for infertility treatment include diagnostic testing, Physicians' office visits, related prescription drugs, artificial insemination, and invitro-fertilization.
- There is a separate Copay amount per person charged once per lifetime. The Participant's Coinsurance for this benefit is not applied to the Participant's Out-of-Pocket Maximum in the Plan.
- The aggregate maximum amount payable for infertility treatment will not exceed the Lifetime Maximum per person amount stated in the Schedule of Benefits.

17. Genetic Testing

Reasonable Expenses for Genetic Testing and Counseling is covered if the services are provided for one or more of the following reasons:

- You and/or your Dependents suffer from a hereditary disease;
- A strong family history of hereditary disease is present even though neither you or your Dependent spouse has the disease (a strong family history means at least one first-degree relative or at least two second-degree relatives of you or your Dependent spouse has been diagnosed with a hereditary disease);
- You and/or your Dependent spouse has produced a child with intellectual disability, a hereditary disease, or a birth defect; or
- You and/or your Dependent spouse has had two or more miscarriages or babies who died in infancy.

Genetic testing, other than amniocentesis, is subject to the Calendar Year maximum per Participant as stated in the Schedule of Benefits.

18. Organ and Tissue Transplant Surgery

Organ and Tissue Transplant Surgery and related covered costs including human organ or tissue transplants during the transplant benefit period to a recipient who is an Eligible Person are covered. A transplant benefit period consists of five (5) days before and eighteen (18) months after the date of the transplant. If the transplant decision has been approved as specified in this section, but the eligible transplant procedure has to be delayed for reasons such as the recipient's medical condition or the unavailability of an organ, the transplant benefit period may be extended to include more than five (5) days prior to the transplant. Organ transplant benefits are payable provided each of the following conditions is satisfied:

- You or your Dependent mush have been eligible under the Plan for at least twenty-four (24) consecutive months immediately prior to incurring Covered Expenses. Newborn Dependent children covered under Plan 1 will be eligible for organ transplant benefits provided the parent who is an Employee has been a Full-Time Employee for at least twenty-four (24) months immediately prior to the newborn organ transplant.
- You receive two (2) written opinions by board-certified specialists in the involved field of surgery on the necessity for transplant surgery.
- The specialists certify in writing that alternative procedures, services, or courses of treatment would not be effective in the treatment of your condition.
- All decisions related to the transplant surgery satisfy applicable state requirements.
- You must contact the Plan Administrator for prior approval for all organ transplants.

Transplants of the following human organs or tissues are covered when transplanted to an Eligible Person:

- cornea;
- kidney;
- bone marrow;
- liver;
- heart;
- heart/lung;
- lung; and/or
- pancreas

Postoperative follow-up expenses, including immunosuppressant drug therapy, are covered the same as for any other disability. All other Covered Expenses for the recipient will be payable under the Plan the same as for any other Injury or Sickness.

Multiple transplants during one operative session are payable in the same manner as are other multiple procedures during the same anesthesia period. Benefits for replacement transplant(s) if the first organ fails or is rejected are payable in the same manner as for the initial transplant, unless failure or rejection is due to Physician or Hospital error in which case no benefits are payable.

Benefits are payable for the temporary use of mechanical equipment which is not Experimental pending the acquisition of "matched" human organ(s).

No organ transplant benefits are payable for:

- services not ordered by a Physician;
- any expenses for a transplant when approved alternative courses of treatment are available or when other specified conditions are not satisfied;
- animal or mechanical organs for transplantation;
- investigational drugs;
- any items specified in the Plan's General Limitations, which are in Article XI, Section A at page 59;
- purchase of the organ or tissue;
- the use of Experimental mechanical equipment;
- donor-related services for: testing; life support; transportation; organ and tissue procurement; and expenses related to the treatment of a condition resulting from the donation of an organ or tissue; or
- transportation, lodging and meals for the recipient or other person to and from the transplant site.

The Plan uses the Optum Transplant Centers of Excellence network. Contact the Plan Administrator for more information.

19. Routine Physical Examinations

The Reasonable Expenses of a Plan 1 Employee or Dependent Spouse or Plan 2 Employee for an examination, x-rays, and laboratory tests for a routine physical examination performed by a Physician in a Hospital, clinic, or Physician's office are covered. Routine mammography and PSA screening are covered under this subsection.

20. Well Baby/Well Child Care

Covered Reasonable Expenses for an Eligible Dependent Child include routine examinations and related x-ray and laboratory charges.

21. Routine Immunizations

Reasonable Expenses for services and supplies for immunizations recommended for routine use in children, adolescents and adults by the Advisory Committee on Immunization Practices (ACIP) are covered 100%. Other medically necessary immunizations are covered subject to the Plan's Coinsurance and Copay requirements.

Benefits are not provided under this subsection for:

- Services rendered or supplies dispensed before the Employee or Dependent is a Participant, whether or not a series of treatments for immunization continues after such person is a Participant;
- Treatment related to allergy;
- Medications not normally prescribed or administered by a Physician or paramedical personnel, such as vitamins; or
- Any charges in connection with the administration of the immunization.

22. Hospice Care

When it is medically determined that a Participant is Terminally Ill, the Participant (or his authorized representative, such as a family member) and the Physician may prefer Hospice Care as opposed to Hospital confinement. Benefits are payable for 100% of Reasonable Expenses incurred for covered hospice services during the period in which the Participant otherwise, upon recommendation of his Physician, would have to be Hospital-confined. Such benefits are payable for home care administered under an approved Hospice Program or Home Health Care Agency at the patient's home, or for care in a hospice unit of a Hospital or a separate Hospice Facility. Covered hospice services include:

- Physicians' visits;
- care provided by registered nurses (R.N.), licensed practical nurses (L.P.N.), and home health care aides;
- assessment visit by a Hospice Program staff member;
- physical, occupational, speech, and respiratory therapy; and
- drugs and supplies prescribed by a Physician.

In the event the medical determination is made that the terminal condition is reversed, benefits are payable as provided under other sections of the Plan.

23. Home Health Care

Home health care benefits are payable for 100% of Reasonable Expenses incurred by you or your Dependent for home health care services provided in the patient's place of residence, subject to your attending Physician certifying that:

- hospitalization or confinement in a Skilled Nursing Home would be required in the absence of home health care;
- the patient's family or persons residing with the patient cannot provide necessary care and treatment without causing an undue hardship; and

- home health care services are coordinated by a state-licensed or Medicare-certified Home Health Care Agency or certified rehabilitation agency.

Up to each four consecutive hours of home health aide service, evaluation, or planning in 24 hours is considered one home health care visit.

Reasonable Expenses are payable for up to 40 visits per person each Calendar Year. Benefits are payable for additional visits exceeding the 40-visit maximum, provided the Trustees determine such visits to be Medically Necessary, cost-effective, and the most appropriate course of treatment based upon recommendations of the case manager.

Covered home health care services include:

- part-time or intermittent nursing care under the supervision of a registered nurse (R.N.), including services of a licensed practical nurse (L.P.N.) when prescribed by a Physician;
- Medically Necessary home health aide services (part-time or intermittently) solely for the care of the patient and under the supervision of a R.N. or a medical social worker;
- physical, respiratory, occupational, or speech therapy;
- medical supplies, drugs, and medications prescribed by a Physician and necessary laboratory services to the extent they would have been covered during a Hospital confinement;
- nutritional counseling by a registered dietitian when Medically Necessary; and
- evaluation of the need for development of a plan for home health care by a R.N., Physician extender, or medical social worker when requested or approved by the attending Physician.

Limitations on Home Health: Home health care benefits are not provided for:

- food, housing, homemaker services, or home-delivered meals;
- Custodial Care;
- services or supplies not included in the Home Health Care Plan established for the patient;
- services provided by the patient's family or anyone residing with the patient; or
- any services not specifically listed in this section.

24. Virtual Telehealth

Doctor on Demand visits are payable at 100% for you and your Dependents. Deductible and Coinsurance is waived for Doctor on Demand visits. Other telehealth visits are subject to the Plan's Deductible and Coinsurance listed on the Schedule of benefits.

Doctor On Demand is a convenient way for you to interact with a Physician via live, two-way video on your smartphone, tablet, or computer with a front-facing camera 24/7, 365 days a year. Common issues treated include:

- Urgent care: cough, cold, flu, rash, pink eye, sports Injury, bug bite, urinary tract infection, vomiting, and sore throat.
- Mental health: depression, anxiety, work-related stress, relationship issues, smoking cessation, ADHD, mood changes, trauma, and eating disorders.
- Lactation consulting: latch issues, milk supply, mastitis, thrush, plugged ducts, transitioning back to work, and pumping questions.

You can download the app from the App Store or Google Pay or access Doctor On Demand via the website (DoctorOnDemand.com). Within just a few minutes, you are able to sign up and connect to a US-licensed provider for a live video online care visit. The average wait time to connect to an urgent care Physician is 90 seconds.

Please Note: In the case of a medical emergency, call 911 or seek treatment at an emergency room. The services provided by Doctor on Demand or other telehealth are in no way meant to replace the emergency room or an office visit when Medically Necessary.

25. TMJ

The Plan covers diagnostic, dental x-rays, non-surgical and surgical treatment of Temporomandibular Disorder (TMD), when such care is Medically Necessary.

26. Implantable Hearing Devices

Implantable hearing devices are covered if Medically Necessary.

27. Wigs and Toupees or other Cranial Prosthesis

Wigs and toupees or other cranial prosthesis prescribed by your physician to remediate hair loss caused by a medical condition such as chemotherapy, alopecia, trichotillomania or other medical conditions will be covered up to the maximum of $300 per year. Your annual Deductible and Coinsurance will apply.

28. COVID-19

Effective March 18, 2020 and for the duration of the public health emergency concerning COVID-19, the Plan will cover at 100% (no member cost share) the cost of diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized by an applicable government agency, as well as the administration of such diagnostic products. The Plan will also cover at 100% (no member cost share) items and services furnished to you during health care provider visits (including both in-person and telehealth visits), urgent care center visits, and emergency room visits as described above, to the extent such items and services relate to the furnishing or administration of such product.

D. Pre-Admission Testing

Laboratory tests and x-rays sometimes are needed by your Physician before treatment begins or surgery takes place. Sometimes these tests and x-rays may be performed without being Hospital-confined. Whether they are performed before or after hospitalization begins is a decision for you and your Physician to make.

When you or your Dependent incur expenses for pre-admission testing, the Plan will pay 100% of the Reasonable Expenses incurred (waiving the Plan's Deductible and Coinsurance) for diagnostic laboratory tests and x-rays performed in a Hospital outpatient department, Physician's office, or clinic which are required for Medically Necessary treatment you are scheduled to receive upon Hospital admission, provided:

1. you are scheduled for Hospital admission and the scheduled admission occurs;

2. the treatment is initiated or the surgery is performed within seven days of the testing; and

3. Hospital benefits are payable for the treatment or surgery.

If you are not admitted to the Hospital following the testing, such benefits still are available provided:

1. the tests showed a medical condition which required treatment prior to Hospital admission;

2. a Hospital bed is not available; or

3. the tests showed that admission is not Medically Necessary or that treatment or surgery is required to be deferred beyond seven days of the testing.

E. UMR Maternity Management Program

You and your eligible Dependents have access to the UMR Maternity Management Program. The UMR Maternity Management Program provides information and coaching to women considering having a child, prenatal education and guidance to those expecting, and high-risk pregnancy identification to help expectant mothers carry their babies to term. The result is an increase number of healthy, full-term deliveries and a decrease in costly, extended hospital stays.

To participate in the program, you self-enroll online at www.umr.com. Once enrolled, expectant mothers are contacted by nurse case managers who have extensive clinical backgrounds in obstetrics/gynecology. The nurses complete an assessment to determine the mother's risk level, if any, and provide her with timely education, follow-up calls and support. After delivery, mothers are contacted one more time to make sure there are no postpartum issues.

Enrollment and completion of the program will reduce Out-Of-Pocket maternity-related Covered Expenses under Comprehensive Major Medical Benefits to 10% instead of 20%.

In addition, if you enroll in the first or second trimester you are eligible to select a high-quality book or other materials from UMR containing helpful information about pregnancy, pre-term labor, childbirth, breastfeeding and infant care. If you successfully complete the program after enrolling in your first or second trimmest, you are eligible to receive a UMR-funded $25 gift card. If you wait until your third trimester, you will receive some educational offerings, but are not eligible for the program gift card. UMR may change these incentives from time to time.

If you need more information, please contact the Plan Administrator.

F. Tobacco Cessation Program

You and your eligible Dependents also have access to the Tobacco Cessation Program offered by UMR. For information, please contact the Plan Administrator.

G. Comprehensive Major Medical Benefits Limitations

In addition to the Plan's General Limitations which begin at Article XI, Section A on page 59 and other limits that apply to specific benefit provisions as described in those sections, Comprehensive Major Medical Benefits do not cover:

1. dental treatment, dental implants, or dental x-rays, except as specifically provided;
2. purchase of radioactive materials for x-ray, radium, or cobalt treatment;
3. examination for correction of vision or fitting of glasses or contact lenses, except as specifically provided;
4. care in a rest home other than in a Hospital;
5. any loss caused by or resulting from mental deficiency, intellectual disability, develop-mental deficiencies, or any treatment for learning disabilities;
6. counseling or treatment for conditions not supported by a bona fide medical diagnosis, such as aptitude testing and marriage counseling;
7. hospitalizations starting on weekends for treatment or surgery scheduled to begin the following Monday or later, unless scheduled to begin before 6:00 a.m. Monday morning;
8. services provided by a person who ordinarily resides in your home or is a member of your immediate family (comprised of your spouse and your and your spouse's children, brothers, sisters, and parents); or
9. routine care for Dependent children (except well baby/well child care is covered for eligible Dependent children who are covered under Plan 1).

ARTICLE VIII

PREFERRED PROVIDER PHARMACY PRESCRIPTION DRUG BENEFITS

Plans 1, 2, and 3
For Full-Time Employees and Their Dependents, Part-Time Employees, and Retirees and Their Dependents

A. Prescription Drugs

Your personal identification card is used for obtaining prescriptions at participating pharmacies. Following is the procedure for obtaining Prescription Drug Benefits from a participating Retail Network Pharmacy:

1. Present the identification card to the pharmacist with the prescription.
2. Verify and sign the pharmacy prescription signature log prepared by the pharmacist.
3. Pay the pharmacy your Copayment stated in the Schedule of Benefits.

Prior authorization is required for certain medications.

You can find a participating network pharmacy by calling: Sav-Rx 800-228-3108 or www.savrx.com.

When you incur expense for prescription drugs at a Preferred Provider Pharmacy, benefits will be payable for the following:

1. federal legend drugs;
2. insulin;
3. OTC and legend inhaler-assisting devices;
4. Buproprion and Zyban (smoking deterrents);
5. antihemophilia agents;
6. OTC and legend diabetic supplies/insulin needles, syringes;
7. androgenic agents;
8. drugs to treat impotency;
9. contraceptives requiring a written prescription executed by a Physician and dispensed by a licensed pharmacist;
10. daily low dose erectile dysfunction drugs (other erectile dysfunction medications limited to 10 pills per month);
11. multivitamins with fluoride and prenatal vitamins;
12. injectables;
13. growth hormones;
14. migraine therapy medications;

15. hormone replacement therapy; and

16. acne-related products such as Retin-A, Accutane, and Azelex.

If your prescription is being obtained from an out-of-network retail pharmacy (including for maintenance drugs in a 90-day supply), then you must pay the pharmacist for the entire discounted cost of the prescription at the time of purchase and submit a claim for reimbursement to the Plan. You will be reimbursed for 100% of the discounted prescription price, less your Copayment, provided the prescription is for a Participant. Out-of-network pharmacies include Walmart, Sam's Club, CVS/Target, and Econo Foods.

B. Dispensing Limitations

At a retail pharmacy, you are entitled to the amount of prescription legend drugs or insulin usually prescribed by the attending Physician or Dentist, but not to exceed a 31-day supply.

Maintenance drugs may be purchased in a 90-day supply at a retail pharmacy that participates in the Sav-Rx Walk-in Mail-Order Network.

All participating pharmacists are instructed to fill prescriptions with generic drugs unless the Physician specifically prescribes otherwise.

Certain medications are included in the Drug Quantity Management program and have a dispensing limit so you receive the right amount of medication that is considered safe and effective according to FDA guidelines.

The Step Therapy program is for people who take prescription drugs regularly to treat an ongoing medical condition, such as arthritis, asthma, or high blood pressure. In step therapy, prescription drugs are grouped in categories (front-line and back-up drugs) based on several factors. Front-line drugs are the first step and are lower cost drugs that are proven safe, effective, and affordable. These medications should be tried first because they can provide the same health benefit as more expensive medications. Back-up drugs (step 2 and step 3 drugs) are brand name drugs such as those you may see advertised on TV, and likely cost more than front-line drugs. If you receive a prescription for a new medication that requires step therapy, as with prior authorizations, your pharmacist will work with your Physician to ensure you receive the right medication.

C. Compound Management

Compounding is a practice in which a licensed pharmacist or Physician combines, mixes, or alters ingredients of a drug (or multiple drugs) to create a medication tailored to the needs of an individual patient. The Compound Management Program helps prevent inappropriate use of compounded ingredients due to commercially available products and/or lack of clinical data for inclusion of these products. The Compound Management Program evaluates every ingredient within the compound and excludes bulk chemicals, pain patches, and compound kits that are not FDA approved.

D. Specialty Drugs

The Plan covers specialty drugs through Sav-Rx Specialty Pharmacy up to a 31-day supply. Specialty drugs are drugs prescribed for people with complex and ongoing medical conditions, such as multiple sclerosis or rheumatoid arthritis.

The Step Therapy Program for certain specialty medications requires that you first try a clinically appropriate, cost-effective drug before other more costly drugs are approved for payment.

E. Vaccinations

You are able to obtain your vaccinations at a retail network pharmacy at the brand name Copayment. Vaccinations available include flu, pneumonia, zoster (shingles), hepatitis, childhood diseases (measles, mumps, etc.), HPV, meningitis, rabies, tetanus/diphtheria/pertussis, and travel/bioterrorism. Vaccines available through retail network pharmacies are more convenient for you because you don't need to schedule a Physician's appointment or miss work time.

F. Limitations

In addition to the Plan's General Limitations which begin on page 59, Article XI, Section A, Preferred Provider Pharmacy Prescription Drug Benefits are not payable under this section for:

1. drugs which are lawfully obtainable without a prescription, except insulin and insulin syringes;
2. administration of prescription legend drugs or injectable insulin or implantable/injectable contraceptives;
3. drugs labeled: "Caution - limited by federal law for investigational use," or Experimental drugs, even though a charge is made to the individual;
4. refilling of a prescription in excess of the number specified by a Physician or Dentist;
5. medication dispensed during Hospital confinement including confinement in a rest home, sanitarium, extended care facility, Skilled Nursing Home, convalescent Hospital, or similar institution which operates on its premises a facility for dispensing pharmaceuticals;
6. drugs prescribed for treatment of infertility (see page 42 for coverage of such prescription drugs);
7. cosmetic drugs, except where classified as "prescription legend drugs;"
8. emergency contraceptive kits;
9. drugs whose sole purpose is to promote or stimulate hair growth (such as Rogaine);
10. Renova;
11. alcohol wipes and insulin pump supplies for diabetics;
12. smoking cessation gums, inhalers, sprays, and patches;

13. abortifacients (Mifeprex);

14. nutritional supplements and combo nutritional products;

15. ostomy supplies;

16. dental fluoride products;

17. Synagis/Respigam;

18. hyperglycemics, oral (OTC);

19. HSDD agents – mixed Seratonin agonist/Antagonist (i.e. Addyi);

20. allergy sera;

21. blood or blood plasma products; or

22. anorexic drugs. Anorexic drugs (meaning weight loss drugs and appetite suppressants) are excluded, unless the Eligible Person has been diagnosed as morbidly obese and such prescriptions are preauthorized by the Plan Administrator.

23. Propecia (to stimulate hair growth), unless the Eligible Person obtains preauthorization from the Plan Administrator.

ARTICLE IX

DENTAL CARE BENEFITS

Plans 1 and 2
Plan 3, if elected

Delta Dental has been selected to provide your dental coverage. You can find a participating network Dentist by calling: 1-800-448-3815 or visiting: www.deltadentalmn.org.

The Plan stresses the concept of "preventive care," encouraging you and your Dependents to receive regular dental care to avoid the acute and expensive problems that many times arise from neglected dental care.

You are free to go to the Dentist of your choice. When your Dentist is a Delta Dental of Minnesota Participating Dentist, benefits are payable at the applicable percentage of negotiated charges as stated in the Schedule of Benefits. You will not be billed for charges that exceed the negotiated amount.

If you utilize a dental provider who participates in the Delta Preferred Option network, benefits for regular diagnostic and preventive services, and basic and special services are payable at a higher percentage as stated in the Schedule of Benefits.

When you are treated by a non-participating Dentist, benefits are payable at the applicable percentage of Reasonable Expenses as stated in the Schedule of Benefits. You may be billed for charges that exceed Reasonable Expenses.

Description of Covered Procedures

Benefits are payable for the following dental procedures performed, up to the maximum and at the applicable percentages stated in the Schedule of Benefits. For eligible Dependent children under age 19, the maximum does not apply to routine oral examinations, sealants, dental prophylaxis and topical fluoride treatments.

A. Regular Diagnostic and Preventive Services

Regular diagnostic and preventive services include:

1. oral examinations, but not more than two in 12 months, including bitewing x-rays once each six months;
2. full mouth x-rays once each three years, unless special need is shown;
3. dental prophylaxis as prescribed by the Dentist, but not more than two in 12 months;
4. topical fluoride applications as prescribed by the Dentist, but not more than once each 12 months;

5. oral hygiene instruction as prescribed by the Dentist, but not more than once per Lifetime of an Eligible Person; and

6. space maintainers for missing posterior primary teeth of eligible Dependent children up to their 16th birthday.

B. Basic and Special Restorative Services

If you incur expenses as the result of a dental disease, defect, or Injury while your coverage is in force, benefits are payable under this section for the basic and special restorative services listed.

Basic services include:

1. emergency treatment for relief of pain;
2. amalgam, preformed crowns, and synthetic porcelain restorations; plastic or composite restorations for anterior teeth only;
3. routine oral surgery: provides for tooth removal (including alveolectomy, where indicated), including pre- and post-operative care;
4. endodontics: includes pulpal therapy and root canal filling; and
5. sealants: coverage limited to once per Lifetime of permanent molars of eligible Dependent children under age 19.

Special services include:

1. Non-surgical periodontics: procedures necessary for the treatment of the diseases of the gingiva (gums).

   Limitation: Benefits for the repeat of any non-surgical periodontal treatment will be provided once each two years.

2. Surgical periodontics: surgical procedures necessary for the treatment of diseases of the gingiva (gums) and bone supporting the teeth.

   Limitation: Benefits for the repeat of any surgical periodontal treatment will be provided once each three years.

3. All other oral surgery not herein mentioned, subject to coordination of benefits provisions.
4. Non-surgical dental treatment of temporo-mandibular joint disorder (TMJ) and craniomandibular disorder, subject to coordination of benefits provisions.

Special restorative services include:

1. Procedures to restore lost tooth structure as a result of tooth decay or fracture.
2. Gold or cast restorations when the teeth cannot be restored with another filling material.

3. Crowns when the teeth cannot be restored with a filling material.

   Limitation: Benefits for the replacement of a crown will be provided once each five years.

4. Filled composite resin restorations for posterior teeth.

   Limitations:

   a. Posterior teeth will have a composite restoration maximum of three surfaces; and

   b. Coverage for replacement of a filled composite restoration, or further restoration by any other procedure, will be provided once each two years.

C. Prosthetics (Removable and Fixed)

Prosthetics includes coverage for:

1. repairs and adjustments to prosthetic appliances; and
2. bridges, partial dentures, and complete dentures for the replacement of fully extracted or missing permanent teeth.

Replacement Benefits

A given prosthetic appliance for the purpose of replacing an existing appliance will be provided once each five years, and then only in the event that the existing appliance is not, and cannot be made, satisfactory. Services which are necessary to make an appliance satisfactory will be provided.

Limitation: Coverage is not provided for replacement of misplaced, lost, or stolen dental prosthetic appliances.

D. Orthodontics (For Dependents of Full-Time Employees and Part-Time Employees)

Benefits are payable under this section for a Full-Time Employee's eligible Dependent children ages 8 through 18 and for Part-Time Employees of any age.

Covered Expenses include treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

Limitation: Coverage is not provided for the repair or replacement of any orthodontic appliance.

E. Dental Care Benefits Limitations

In addition to the Plan's General Limitations which begin on Article XI, Section A, page 59, Dental Care Benefits are not payable for:

1. services performed for purely cosmetic purposes, or to correct congenital conditions other than by orthodontic care;
2. charges for dental services which were completed prior to the date the person became covered under this Plan;
3. services of anesthesia, except by a Dentist or by an employee of the Dentist when the service is performed in his office, all in conjunction with covered services;
4. charges for any services not specifically covered under this Plan, including any Hospital charges or prescription drug charges (new or Experimental dental techniques or procedures may be denied until there is, to the satisfaction of the Trustees, an established scientific basis for recommendation);
5. services performed other than by a licensed Dentist, his employees, or agents;
6. procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and Gnathologic recordings (if these services are performed, cost responsibility would be that of the patient, unless provided under orthodontic provisions of the Plan);
7. direct diagnostic or treatment procedures applied to body joints or muscles, except as provided under orthodontic provisions of the Plan;
8. implants (artificial materials implanted or grafted into or onto bone or soft tissue) or surgical removal of implants;
9. veneers (bonding of coverings to the teeth); or
10. orthodontic treatment procedures, unless specified as a covered dental benefit.

Alternative Treatment Plans

In all cases in which there are alternative plans of treatment carrying different treatment costs, the decision as to which course of treatment to be followed will be solely that of the patient and the Dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the responsibility of the patient.

Reconstructive Surgery

Benefits will be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from Injury, Sickness, or other diseases of the involved part, or when such dental procedure is performed on an eligible Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending Physician provided, however, that such procedures are dental reconstructive surgical procedures and otherwise would be a covered service under the Plan.

ARTICLE X

VISION CARE BENEFITS

Plan 1
Plan 3, if elected

If you or your Dependent incur Physicians' charges for any of the following Covered Expenses (eye examinations, lenses, frames, contact lenses, and/or laser eye surgery), benefits are payable at the Coinsurance and up to the aggregate maximum amount per Eligible Person per Calendar Year stated in the Schedule of Benefits. The aggregate maximum amount per Eligible Person per Calendar Year does not apply to eye examinations for eligible Dependent children under age 19.

Eye Examinations

Each Eligible Person is entitled to one exam each Calendar Year.

Lenses and Frames

Each Eligible Person is provided an annual maximum dollar amount which may be used to purchase lenses, frames, or contact lenses each Calendar Year. Fees for professional services for fitting and adjusting also are covered.

Benefits are payable for contact lenses when necessary after cataract surgery or if visual acuity is not correctable to 20/70 in the better eye without their use.

Laser Eye Surgery

In lieu of all other benefits for lenses, frames, and contact lenses, laser eye surgery will be covered up to the aggregate maximum each Calendar Year as stated in the Schedule of Benefits.

Limitations

In addition to the Plan's General Limitations which begin on Article XI, Section A, page 59, Vision Care Benefits are not payable for:

1. sunglasses;
2. safety lenses and goggles;
3. orthoptics, vision training, or aniseikonia; or
4. any refraction made or material furnished as the result of a refraction which began before eligible under this Plan.

ARTICLE XI

GENERAL PROVISIONS

A. General Limitations

The General Limitations apply to all benefits provided under the Plan. In addition, specific limitations may apply to certain benefits and are stated within the applicable benefit section.

General Limitations for all Plan benefits include the following. No Plan benefits are provided for:

1. Any Injury or Sickness for which the Eligible Person is not under the care of a Physician.

2. Any loss, expense, or charge incurred as the result of any accidental bodily Injury, Sickness, disease, mental or nervous disorder sustained while the Eligible Person was performing any act of employment or doing anything pertaining to any occupation or employment for remuneration or profit.

3. Any loss, expense, or charge incurred as the result of any accidental bodily Injury, Sickness, disease, mental or nervous disorder which arises out of and in the course of any occupation or employment for wage or profit or which may be payable in whole or in part under any Worker's Compensation Law, Employer's Liability Law, Occupational Diseases Law or similar law. However, the Plan will consider advancing medical expenses payable in whole or in part under Worker's Compensation Law provided that the Eligible Person signs a subrogation agreement with the Plan.

4. Services or supplies:

    a. for which no charge is made;

    b. for which you are not required to pay;

    c. which are furnished by or payable under any plan or law of any government (federal or state, dominion or provincial) or its political subdivision;

    d. which are furnished by or payable by a county, parish, or municipal Hospital where there is no legal requirement to pay for such services or supplies;

    e. for marriage counseling, except as provided by TEAM;

    f. for artificial life support after legal or clinical death, except as provided on page 42; or

    g. which are not Medically Necessary, as defined starting on page 98.

5. Hearing aids, hearing aid batteries, and repairs.

6. Cosmetic surgery unless:

   a. necessary for repair or alleviation of damage resulting from an Injury; or

   b. to correct a scar or disfigurement to the area above the shoulders which is the result of a Sickness, disease, surgery, or previous therapeutic process that is a Covered Expense under this Plan; but excluding conditions related to developmental disabilities or congenital deformities, such as by way of example but not limited to, port wine stain, unless such condition has resulted in a functional defect.

   Such surgery must be performed promptly following the Injury, Sickness, disease, surgery, or therapeutic process that caused the scar or disfigurement, but in no event later than six months from the date of the Injury or surgery that caused the scar or disfigurement; or the date the treatment or therapeutic process that caused the disfigurement ended.

   Benefits are payable for: reconstructive surgery following a covered mastectomy, including reconstruction of the contralateral breast to produce symmetrical appearance; and for a prophylactic mastectomy or prophylactic oophorectomy as provided on page 42.

7. Any loss or services to treat Injuries or Sicknesses determined by the Secretary of Veterans' Affairs to have been incurred in, or aggravated during performance of service in the uniformed services.

8. Services or supplies to treat any Injury or Sickness incurred in, or aggravated during, an Eligible Person's past or present participation in an act of war. For purposes of this exclusion, "act of war" includes any act or conduct during war, declared or undeclared, act of terrorism, or war-like activity by any individual, government, military, sovereign group, terrorist, or other organization.

9. Experimental or Investigative surgical procedures or treatments, except as specifically provided or authorized by the Board of Trustees pursuant to competent medical consultation.

10. Dental services and supplies (except as provided under Dental Care Benefits), unless for necessary expense incurred after an accident to repair or alleviate damage to natural teeth resulting from an accident, provided such services are performed promptly following the accident and in no event later than six months from the date of such accident.

11. Application of podiatric orthotic appliances.

12. Artificial insemination, including related services and supplies, and invitro-fertilization, except as provided on page 42.

13. Reversal or attempted reversal of a previous sterilization procedure.

14. Charges incurred for education, training, or room and board while an Eligible Person is confined in an institution which is primarily a school or other institution for learning or training.

15. Charges incurred while an Eligible Person is confined for purposes of Custodial Care in an institution which is primarily a place of rest, a place for the aged, or a Skilled Nursing Home.

16. Charges incurred for any type of Custodial Care (care that is designed primarily to assist an Eligible Person in meeting the activities of daily living), regardless of what the care is called.

17. Charges incurred for any services or treatment not prescribed by a Physician. This exclusion applies to items such as vitamins, cough medicine, aspirin, cosmetics, soap, toothpaste, etc.

18. Charges incurred for all enteral feedings and other nutritional and electrolyte supplements or formula whether or not prescribed by a Physician.

19. Charges incurred for services, treatment, or surgical procedures rendered in connection with an overweight condition or condition of obesity including diet plans and related visits to a Physician, except Medically Necessary surgical procedures for the treatment of morbid obesity.

20. Charges incurred for any services or supplies which are not recommended or approved by the attending Physician.

21. Charges incurred for services or supplies received from a Physician who does not meet this Plan's definition of a Physician or from a Hospital which does not meet this Plan's definition of a Hospital.

22. Charges incurred for services, treatment, supplies, or procedures which are not rendered for the treatment or correction of, or in connection with, a specified non-occupational Injury or Sickness unless such charges are specifically identified as being Covered Expenses under the Plan.

23. Charges incurred for physical therapy or any other type of therapy if either the prognosis or history of the Eligible Person receiving the treatment or therapy does not indicate to the Trustees that there is a reasonable chance of improvement.

24. Charges incurred for speech therapy, except when it is Medically Necessary because of physical impairment caused by Injury or Sickness or developmental delays if Medically Necessary as defined by case management.

25. Charges incurred for any special education rendered to any Eligible Person, regardless of the type of education, the purpose of the education, except for nutritional consultation sessions as specifically provided.

26. Charges incurred for the completing of claim forms (or forms required by the Plan for the processing of claims) by a Physician or other provider of medical services or supplies.

27. Charges incurred for travel, whether or not recommended by a Physician, except if specified as a Covered Expense under the Plan.

28. Charges incurred for physical, occupational, and speech therapy for treatment of an Eligible Person diagnosed as developmentally delayed except if such occupational or speech therapy is Medically Necessary as defined by case management.

29. Any amount of an incurred charge that is determined to be in excess of Reasonable Expenses.

30. Charges incurred for the rental or purchase of any durable medical equipment or other equipment that is not used solely for the therapeutic treatment of an Eligible Person's Injury or Sickness.

31. Charges incurred for any of the following list of items, regardless of intended use, including but not limited to: air conditioners; air purifiers; whirlpools; swimming pools; humidifiers; de-humidifiers; allergy-free pillows, blankets, or mattress covers; electric heating units; orthopedic mattresses; exercise equipment; gravity lumbar reduction chairs; vibratory equipment; elevators or stair lifts; stethoscopes; clinical thermometers; scales; blood pressure monitors; and magnetic devices.

32. Charges incurred for any items such as telephones, televisions, cosmetics, barber or beauty service, magazines, newspapers, laundry, guest trays, beds or cots for guests or other family members, or any other personal comfort or convenience items (in- or out-of-Hospital) that are not Medically Necessary.

33. Charges incurred for confinement and services at a halfway house or group home.

34. Drugs or medicines prescribed by a Physician which are available as over-the-counter purchases, e.g., aspirin, cough medicine, or vitamin supplements.

35. Charges for injections prescribed or administered by a chiropractor.

36. Charges for or related to membership in a health or fitness club/facility, work-hardening program, therapeutic exercise programs, and all materials and products related to these programs, except as specifically provided.

37. Charges for special home construction to accommodate a disabled Eligible Person.

38. Charges for telephone conversations/ telephone consultations, unless such charges are specifically identified as being Covered Expenses under the Plan.

39. Charges incurred for hypnosis.

40. Elective abortion, except therapeutic abortions when continuation of the pregnancy seriously endangers the life or health of the prospective mother if the fetus were to be carried to term.

41. Charges incurred by Dependent children for vasectomies or other sterilization procedures unless recommended by a Physician for therapeutic purposes of the patient.

42. Court-ordered treatment/confinement unless there is substantiation of medical necessity.

43. Shipping and handling for charges incurred on Covered Expenses.

44. Radial Keratotomy or laser eye surgery, except as otherwise specified under Vision Care Benefits on page 58.

45. Services of a massage therapist.

46. All expenses associated with personal blood storage.

47. Homeopathic providers, services, and supplies.

48. Breast pumps.

49. Any loss, expense, or charge for which a Third Party may be liable for which the individual on whose behalf the claim was filed did not submit the required subrogation agreement to the Plan. The term "Third Party," as used in these General Limitations, includes any individual, insurer, entity, or federal, state or local government agency, who is or may be in any way legally obligated to reimburse, compensate, or pay for an Eligible Person's loss, damages, Injuries or claims relating in any way to the Injury, occurrence, condition, or circumstance giving rise to the Plan's provision of medical, dental, or disability benefits, including but not limited to, insurers providing liability, medical expense, wage loss, uninsured motorist or underinsured motorist coverages.

50. Any loss, expense, or charge for which a Third Party may be liable and for which either:

    a. a recovery subject to the Plan's subrogation and reimbursement rights has been received (whether before or after the submission of or payment of claims by the Plan);

    b. the Plan determines it likely that recovery will be received. At the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement.

51. Any losses, expenses, or charges incurred by an Eligible Person at a time that an Eligible Person owes a payment to the Plan, or to any losses, expenses, or charges incurred by an individual who performs an act, practice, or omission that

constitutes fraud or makes an intentional misrepresentation of material fact in connection with coverage under the Plan, including failure to honor the Plan's right of subrogation or reimbursement or otherwise cooperate with the Plan as specified.

52. Any loss, expense, or charge incurred as the result of any Injury, occurrence, condition, or circumstance for which an Eligible Person:

    a. has the right to recover payment from a Third Party (at the discretion of the Trustees, losses, expenses, and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement);

    b. has recovered from a Third Party; or

    c. has not submitted a claim for such loss, expense, or charge prior to resolution of the Third Party claim.

53. Attorney's fees or costs that an Eligible Person may incur in pursuing a claim for benefits or recovery from a Third Party.

54. Any loss, expense, or charges for Sickness or Injury resulting from engaging in an illegal act. "Illegal act" will mean any illegal occupation or conduct that constitutes a gross misdemeanor or felony offense under federal law or the laws in the State of Minnesota, or equivalent laws of the state in which the occupation or conduct occurred, and for which the Eligible Person is charged or may be charged regardless of whether the Eligible Person subsequently pleads guilty to a lesser charge. Subject to the other limitations and exclusions provided in this Summary booklet, the Plan may cover any loss, expense, or charge related to an act of domestic violence committed against the Eligible Person, or if the illegal act is related to a physical or mental health condition of the Eligible Person.

55. Any loss, expense, or charge arising from the maintenance or use of an automobile, motorcycle, watercraft, or other recreational vehicle or motor vehicle (collectively "vehicle"):

    a. Where the statutory minimum level of no-fault medical insurance protection is not maintained, provided the individual is required by the applicable state statute to maintain this coverage (this exclusion will apply only to the amount of no-fault insurance required to be maintained under state law).

    b. Where there is applicable no-fault coverage but the Eligible Person has failed to apply for that coverage.

    c. Where the no-fault carrier determined the charges are not reasonable and customary or are not Medically Necessary.

    d. Where a no-fault carrier discontinues benefits prior to the exhaustion of no-fault coverage and the Eligible Person fails to arbitrate the notice of discontinuance. No further benefits will be paid for Injuries of conditions

sustained as a result of the accident until such time as the arbitration proceedings are complete and an award issued.

e. In states without a no-fault statute, where the Eligible Person does not first exhaust medical payment coverage on the vehicle(s) involved in the accident.

f. Where the Eligible Person, whether or not a minor, has a right to recover or claim a right to recover or has already recovered from a Third Party, in which event the provisions of exclusion 49. 50 and 52 will apply.

In cases where the no-fault carrier disputes coverage of the Eligible Person, the Plan may subrogate its interest in the payment of charges.

56. Any loss, expense, or charge incurred at any time as the result of an Injury or Sickness that is subject to the Plan's right of subrogation and reimbursement and either:

a. as to which the Plan has agreed to a settlement of that right;

b. the Eligible Person has recovered payment from a Third Party; or

c. otherwise would be considered a future related medical expense, even if incurred but not paid before the settlement, unless the Trustees have explicitly agreed in writing that the Plan will pay for such a loss, expense, or charge.

57. Habilitation services.

58. Long-term care.

59. Non-emergency care when traveling outside the United States.

60. Private-duty nursing.

61. Routine foot care.

62. Sales tax, mailing, delivery charges, shipping and handling or service call charges related to the purchase or rental of durable medical equipment.

63. Costs for services, products or devices related to Never Events.

B. Coordination of Benefits

If you or your Dependents are entitled to benefits under any other group health care plan, the amount of benefits payable by this Plan will be coordinated so that the total amount paid will not exceed 100% of the incurred medical expenses which are Medically Necessary, Reasonable Expenses for treatment of an Injury or Sickness. In no event will this Plan's payment exceed the amount which would have been paid if there were no other plan involved. Benefits payable under another plan include the benefits that would have been payable even if no claim actually

was filed. Benefits of this Plan will be reduced to the extent necessary to prevent the other group plan from refusing to pay benefits available under its policy.

If the other group plan does not contain a coordination of benefits or similar provision, then that plan always will calculate and pay its benefits first. When duplicate coverage arises and both plans contain a coordination of benefits or similar provision, this Plan has established the following rules to decide which group plan will calculate and pay its benefits first:

1. If a patient is eligible as an employee in one plan and as a dependent in another, the plan covering the patient as an employee will determine its benefits first.

2. If a patient is eligible as a dependent child in two plans, the plan covering the patient as a dependent of the parent whose date of birth, excluding year of birth, occurs earlier in a Calendar Year will determine its benefits first.

3. When parents are divorced or separated, the order of benefit determination for a dependent child's claims is:

   a. The plan of the parent having custody pays first.

   b. If the parent having custody has remarried, the order is:

      - the plan of the parent having custody;
      - the plan of the spouse of the parent having custody;
      - the plan of the parent not having custody; then
      - the plan of the spouse of the parent not having custody

   However, if there is a court decree or Qualified Medical Child Support Order (QMCSO) which directs that one of the parents is responsible for the child's health care expenses, the plan of that parent will pay first and will supersede any order given here.

4. If rules (1), (2), and (3) do not determine which plan will calculate and pay its benefits first, then the plan that has covered the patient for the longer period of time will determine its benefits before a plan has covered the patient for a shorter time. There is one exception to this rule: A plan that covers a person other than as a laid-off or retired employee, or a dependent of such person, will determine its benefits before a plan which covers that person as a laid-off or retired employee, or a dependent of such person.

5. Coordination of Benefits with Automobile Insurance

   Benefits payable under this Plan are not in lieu of those that would be payable under no-fault automobile insurance and do not affect any legal requirement that you or your Dependent maintain the minimum no-fault automobile insurance coverage within the jurisdiction in which you or your Dependent reside. For any expenses arising from the maintenance or use of a motor vehicle, no-fault

automobile insurance will calculate and pay its benefits first and this Plan will calculate and pay benefits second.

Benefits that would be payable under no-fault automobile insurance will not be paid by this Plan merely because no claim for no-fault benefits was filed. If you or your Dependent fail to maintain the legally required no-fault automobile insurance within the jurisdiction in which you or your Dependent reside, Plan benefits will not be payable for amounts which the legally required minimum amount of no-fault automobile insurance otherwise would have paid.

If you or your Dependent are injured in an automobile accident which is or should be covered by no-fault automobile insurance, you must arbitrate any notice of discontinuance of no-fault automobile insurance or no further benefits for said injuries will be payable under this Plan.

6. Coordination of Benefits With Other Types of Insurance

Coverage under this Plan is secondary coverage to any plan or policy of insurance that may pay medical expenses for a specific risk, including but not limited to, any automobile policy, motor vehicle policy, homeowner's policy, or premises insurance policy. The Plan may require that an Eligible Person show that a reasonable effort was made to find out if there is an applicable other insurance policy. Benefits that otherwise might be payable under another insurance policy will not be paid by this Plan merely because the Eligible Person has not made a claim under the other insurance policy.

7. Coordination of Benefits with Medicare

The provisions in this section apply to some, but not all, Covered Persons who are eligible for Medicare. They apply in situations where the federal Medicare Secondary Payer Program allows Medicare to be the primary payer of a Covered Person's medical care claims.

In general, Medicare is secondary payer for Medicare enrollees who: (1) are active employees and (2) are covered by Medicare because they have reached age 65. The Medicare secondary payer rules change from time to time and the most recent rule will be applied.

Medicare is the primary payer:

- For Covered Persons with end stage renal disease, after the 30 month period following the earlier of (1) the month in which the Covered Person begins a regular course of renal dialysis, or (2) the first of the month in which the Covered Person became entitled to Medicare, if the Covered Person received a kidney transplant without first beginning dialysis. This is regardless of the size of the employer;
- For retirees who are age 65 or over.

If Medicare is the primary payer, this Plan also reserves the right to reduce benefits for any medical expenses covered under this Plan by the amount of any benefits available for such expenses under Medicare. This will be done before

the benefits under this Plan are calculated. Charges for services used to satisfy a Covered Person's Medicare Part B deductible will be applied under this Plan in the order received by this Plan. Two or more charges for services received at the same time will be applied starting with the largest first.

If Medicare is the primary payer, the benefits under this Plan will only be reduced to the extent that the Covered Person has actually enrolled in Medicare.

The provisions of this section will apply to the maximum extent permitted by federal or state law. This Plan will not reduce the benefits due any Covered Person due to that Covered Person's eligibility for Medicare where federal law requires that this Plan determine the benefits for that Covered Person without regard to the benefits available under Medicare.

8. Right to Receive and Release Necessary Information

In order to properly administer the coordination of benefits and other applicable Plan provisions, the Trustees may, without consent or notice to any person, release to or obtain from any insurance company or other organization or person providing benefits or services any information they deem necessary, unless federal law prevents such disclosure without your consent. You will be required to furnish the Trustees with any information they feel necessary. Also, the Trustees in their sole discretion may furnish information to applicable professional licensing authorities and other governmental authorities when provider fraud is suspected.

Regardless of any other rule stating otherwise, all benefits payable under this Plan will be limited to being in excess of the benefits which are payable by any other plan or group insurance policy which is or purports to be an “excess policy” or an “excess plan” paying benefits only in excess of benefits provided by any other plan or policy.

If an entity or insurer of such other group “excess plan” or group “excess policy” agrees to pay benefits as if it were not an excess plan or policy, this Plan’s benefits will be payable without regard to the provisions of the previous paragraph, subject to the coordination of benefits provisions.

Coverage will not be changed at any time when your Employer’s compliance with federal law requires this Plan’s benefits for an individual to be determined before benefits are payable under Medicare.

C. Right of Subrogation and Reimbursement

The Plan has a first priority subrogation and reimbursement right if it provides benefits resulting from or related to an Injury, occurrence, or condition for which the Eligible Person has a right of redress against any Third Party.

First priority right of subrogation and reimbursement means that if the Plan pays benefits which are, in any way, compensated by a Third Party, such as an insurance company, you agree that when a recovery is made from that Third Party, the Plan is fully reimbursed out of that recovery

for the benefits the Plan previously paid. If you do not agree to the Plan's subrogation and reimbursement rules, benefits will not be paid.

For example, the subrogation and reimbursement right may apply if you are injured at work, in an automobile accident, at a home or business, in an assault, or in any other way for which a Third Party has or may have responsibility. If a recovery is obtained from a Third Party, such as an insurance company, the Plan will be paid first and to the full extent of the benefits it paid. You receive payment only after the Plan is fully reimbursed.

The rights of subrogation and reimbursement are incorporated into this Plan for the benefit of each Eligible Person in recognition of the fact that the value of benefits provided to each Eligible Person will be maintained and enhanced by enforcement of these rights.

The following rules apply to the Plan's right of subrogation and reimbursement:

1. **Subrogation and Reimbursement Rights in Return for Benefits:** In return for the receipt of benefits from the Plan, the Eligible Person agrees that the Plan has the subrogation and reimbursement rights as described in this Right of Subrogation and Reimbursement section. Further, the Eligible Person, and anyone else the Plan deems necessary, such as the Eligible Person's attorney, must sign a form acknowledging the Plan's subrogation and reimbursement rights prior to payment, or further payment, of benefits. Benefits may not be paid if an acknowledgment form is not on file for the Eligible Person. Benefits may not be paid if the Eligible Person refuses to sign the acknowledgment. The Plan's subrogation and reimbursement rights to benefits paid prior to Plan notice of a subrogation and reimbursement right are not impacted if the Eligible Person refuses to sign the acknowledgment. The Plan has the sole discretion to determine, calculate, and/or itemize which benefits paid by the Plan are subject to the Plan's subrogation and reimbursement rights.

2. **Constructive Trust or Equitable Lien:** The Plan's subrogation and reimbursement rights grant the Plan an equitable lien on the proceeds of any recovery obtained by the Eligible Person from a Third Party, whether by settlement, judgment, or otherwise. The Plan's recovery operates on every dollar received by the Eligible Person from a Third Party. When a recovery is obtained, the recovery proceeds are held in trust for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovery proceeds and is paid to the full extent of its equitable subrogation and reimbursement rights. If the Eligible Person fails to hold the recovery proceeds in trust or in any other way prejudices or adversely impacts the Plan's subrogation and reimbursement rights, the Plan reserves the right to, among other things, pursue all available equitable action and offset any future benefits payable to the Eligible Person under the Plan. If the Plan initiates an equitable action for reimbursement, the Plan is seeking to enforce an equitable lien by agreement.

3. **Plan Paid First:** Amounts recovered or recoverable by or on the Eligible Person's behalf are paid to the Plan first, to the full extent of its subrogation and reimbursement rights, and the remaining balance, if any, to the Eligible Person. The Plan's subrogation and reimbursement right comes first even if the Eligible Person is not paid for all of their claims for damages. If the Plan's subrogation and reimbursement rights are not fully satisfied directly by a Third Party, the

Plan's right to reimbursement may be enforced to the full extent of any recovery that the Eligible Person may have received or may be entitled to receive from the Third Party.

4. **Right to Take Action:** The Plan's right of subrogation and reimbursement is an equitable one and applies to all categories of benefits paid by the Plan. The Plan and any other Eligible Person can bring an action (including in the Eligible Person's name) for specific performance, injunction, to enforce an equitable lien by agreement, or any other equitable action necessary to protect the Plan's rights in the cause of action, right of recovery, or recovery by an Eligible Person. The Plan will commence any action it deems appropriate against an Eligible Person, an attorney, or any Third Party to protect the Plan's subrogation and reimbursement rights. The subrogation and reimbursement right applies to claims of eligible Dependents covered by the Plan regardless of whether such Dependent is legally obligated for expenses of treatment.

5. **Applies to All Rights of Recovery or Causes of Action:** The Plan's subrogation and reimbursement rights apply to any and all rights of recovery or causes of action the Eligible Person has or may have against any Third Party.

6. **No Assignment:** The Eligible Person cannot assign any rights or causes of action they may have against a Third Party to recover medical expenses without the express written consent of the Plan.

7. **Full Cooperation:** The Eligible Person must cooperate fully with the Plan and do nothing to prejudice or adversely affect the Plan's subrogation and reimbursement rights. The Eligible Person, whether personally or through an attorney, must periodically update the Plan on the status of any action against a Third Party. The time period between updates must not exceed 45 days. The Eligible Person must notify the Plan before executing any settlement agreement with a Third Party, regardless of whether the settlement agreement purports to include or exclude the Plan's subrogation or reimbursement interest. Benefits may be denied if the Eligible Person does not cooperate with the Plan.

8. **Notification to the Plan:** The Eligible Person must promptly advise the Plan Administrator, in writing, of any claim being made against any person or entity to pay the Eligible Person for their Injuries, Sickness, or death. Further, the Eligible Person must periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of the Eligible Person's claims.

9. **Third Party:** Third Party includes, but is not limited to, all individuals, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, Worker's Compensation, premises liability, no-fault, uninsured or underinsured motorist insurers), who reimburse, compensate or pay for an Eligible Person's losses, damages, Injuries, or claims relating in any way to the Injury, occurrence, conditions, or circumstances leading to the Plan's payment of benefits. This right of subrogation and reimbursement exists regardless of whether the policy of insurance is owned by the Eligible Person.

10. **Apportionment, Comparative Fault, Contributory Negligence, and Equitable Defenses Do Not Apply:** The Plan's subrogation and reimbursement rights include all portions of the Eligible Person's claims or recovery regardless of any allocation or apportionment that purports to dispose of any portion of the claims not otherwise subject to subrogation, including, but not limited to, any apportionment for pain and suffering, wage loss, partial or Total Disability, or to a spouse for loss of consortium. The Plan's subrogation and reimbursement rights are not affected, reduced, or eliminated by comparative fault, contributory negligence, the double-recovery rule, the make-whole or common-fund doctrines, or any other equitable defenses.

11. **Attorney's Fees:** The Plan will not be responsible for any attorney's fees or costs incurred by the Eligible Person in any legal proceeding or claim for recovery, under the common-fund doctrine or any other legal theory, unless prior to incurring such fees or costs, the Trustees agree in writing to pay all or some portion of attorney's fees or costs. In the event any attorney's fees are awarded to an Eligible Person's attorney from the Plan's recovery, an Eligible Person will reimburse or indemnify the Plan for any such amounts.

12. **Course and Scope of Employment:** If the Plan has paid benefits for any Injury which arises out of and in the course and scope of employment, the Plan's right of subrogation and reimbursement will apply to all awards or settlements received by the Eligible Person regardless of how the award or settlement is characterized and regardless of whether the Plan has intervened in the action. If attorney's fees are awarded to the Eligible Person's attorney from the Plan's recovery, the Eligible Person must reimburse the Plan for the attorney's fees.

D. Right of Recovery

Whenever the Plan has made payments in excess of the maximum amount applicable at that time, the Trustees have the right to recover such overpayments from one or more of the following sources:

1. any persons to or for whom such payments were made, including by making deductions from benefits which may be payable to or on behalf of an Eligible Person in the future;

2. any insurance companies; or

3. any other organizations.

E. Termination of Plan

This Plan may be terminated:

1. as to Participants (and their Dependents) in a particular collective bargaining unit, by agreement of the Union and Employer Association (or individual Employers, where applicable) which negotiate the labor agreements covering such collective bargaining units;

2. for a particular Employer and his Non-Bargaining Unit Employees, the Trustees determine that an Employer, signatory to a Participation Agreement to cover Non-Bargaining Unit Employees, no longer meets the requirements of such Participation Agreement and related policies; or

3. when the Trustees determine that the Trust Fund is inadequate to carry out the intent and purpose of the Trust Agreement or is inadequate to meet the payments due or to become due Participants and/or Dependents under the Trust Agreement or under the Summary.

In the event of termination, the Trustees will:

1. make provision out of the Trust Fund for the payment of expenses incurred up to the date of termination of the Trust and the expenses incidental to such termination;

2. arrange for a final audit and report of their transactions and accounts, for the purpose of termination of their Trusteeship;

3. apply the Trust Fund to pay any and all obligations of the Trust and distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Trust and the requirements of law; and

4. give any notices and prepare and file any reports which may be required by law.

F. Trustee Interpretation, Authority, and Right

The Trustees have the authority to interpret the Plan, all Plan documents, rules, and procedures. Their interpretation will be final and binding on all individuals dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the Trustees that such decisions are to be upheld unless it is determined by the court to be arbitrary or capricious.

The Trustees have the authority to change the Eligibility Rules and other provisions of the Plan, to amend, increase, decrease, or eliminate benefits, and to terminate the Plan, in whole or in part, at any time. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them.

The right to change or eliminate any and all aspects of benefits provided for Retirees is a right specifically reserved to the Trustees, since the Retiree coverage is not an "accrued" benefit. The Trustees may reduce Retiree benefits, increase Self-Payments for the benefits, or completely terminate the benefits at any time. Such a change will be effective even though an Employee has already become a Retiree. The Trustees may adopt rules as they feel are necessary, desirable, or appropriate in the exercise of their fiduciary duty, and they may change these rules and procedures at any time.

G. Prohibition Against Assignment to Providers

You, as an Eligible Person, Participant, or Beneficiary, may not assign any right under the Plan or statutory right under applicable law to a provider of services or supplies. The prohibition against assignment of such rights includes, but is not limited to, the right to:

1. receive benefits;

2. claim benefits in accordance with Plan procedures and/or federal law;

3. commence legal action against the Plan, Trustees, Trust Fund, its agents, or Employees;

4. request Plan documents or other instruments under which the Plan is established or operated;

5. request any other information that a Participant or Beneficiary as defined in Section 102 of ERISA may be entitled to receive upon written request to a Plan Administrator; and

6. any and all other rights afforded an Eligible Person, Participant, or Beneficiary under the Plan, Restated Trust Agreement, federal law, and state law.

Assignment is prohibited unless agreed to in writing by the Trustees. This provision does not have the effect of prohibiting the claims administrator or the Trustees from mailing payment of benefits under the Plan directly to a provider of services or supplies.

H. Release of Information, Access to Records and Confidentiality

The Plan, its Board of Trustees, the Plan Office and the Medical Plan Administrator comply with applicable state and federal laws governing the confidentiality and use of protected health information and medical records. As part of this Summary Plan Description, the Board of Trustees, the Plan Office and the Medical Plan Administrator is authorized to have access to and use protected health information held by any health care provider who delivers health care services to you under this Summary Plan Description. The Board of Trustees, the Plan Office and the Medical Plan Administrator are also allowed to use your protected health information when necessary, for: certain health care operations including, but not limited to, claims processing, including claims made for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management; care coordination and utilization management, disease management, underwriting, premium rating, claims experience reporting, the evaluation of potential or actual claims against the Plan, auditing and legal services, and other access and use without further authorization if permitted or required by another law.

In the event that protected health information is disclosed to the Board of Trustees, the Plan Office or the Medical Plan Administrator, they may only use or disclose such information as permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated thereunder and as amended including, certain Plan administrative functions such as: claims review, subrogation, quality assurance, auditing, monitoring and management of carve out plans. A HIPAA Notice of Privacy Practices of this Plan is attached as Exhibit B.

I. Genetic Information Nondiscrimination Act

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

J. Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, (the "Affordable Care Act") imposes a number of requirements on group health plans, such as this Plan. The federal Departments of Health and Human Services, Treasury, and Labor have jointly issued regulations implementing some provisions of the Affordable Care Act. While the Trustees have taken care to ensure that the terms of the Plan comply with the requirements of the Affordable Care Act, a significant amount of ambiguity remains as to the requirements of the Affordable Care Act. The terms and provisions of the Plan will be construed, to the extent possible, to comply with the Affordable Care Act, or any amended version of the Affordable Care Act. If it is determined that any term or provision of the Plan cannot reasonably be construed to comply with the Affordable Care Act, or any amended version of the Affordable Care Act, that term or provision will not be enforced to the extent that it does not comply with the Affordable Care Act. A determination that a term or provision of the Plan cannot reasonably be construed to comply with the Affordable Care Act will not affect any other term or provision of the Plan.

ARTICLE XII

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

In 1974, Congress passed and the President signed the Employee Retirement Income Security Act, commonly referred to as ERISA.

ERISA sets forth certain minimum standards for the design and operation of privately-sponsored health care plans. The law also spells out certain rights and protections to which you are entitled as a Participant.

The Trustees of the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan want you to be fully aware of your rights, and for this reason a statement of your rights follows.

As a Participant in the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan:

1. You automatically will receive a Summary (this booklet). The purpose of this booklet is to describe all pertinent information about the Plan.

2. If any substantial changes are made in the Plan, you will be notified within the time limits required by ERISA.

   Federal regulations under HIPAA require that Participants and Beneficiaries receive a summary of material modifications of any modification or change that is a material reduction in covered services or benefits under a group health plan within 60 days after the adoption of the modification or change, unless the Plan sponsor regularly sends out summaries of the modifications or changes at regular intervals of 90 or fewer days.

3. Each year you automatically will receive a summary of the Plan's latest annual financial report. A copy of the full report also is available upon written request.

4. You may examine, without charge, all documents relating to the operation of this Plan. These documents include: the legal Summary, insurance contracts, Collective Bargaining Agreements, Participation Agreements, and copies of all documents filed by the Plan with the Department of Labor or the Internal Revenue Service, such as annual reports (Form 5500 Series) and Plan descriptions.

   Such documents may be examined by request at the Plan Administrator (or at other required locations such as worksites or Union halls) during normal business hours.

   In order to ensure that your request is handled promptly and that you are given the information you want, the Trustees have adopted certain procedures which you should follow:

   a. Your request should be in writing.

b. It should specify what materials you wish to look at.

c. It should be received at the Plan Administrator at least three days before you want to review the materials at the Plan Administrator.

Although all pertinent Plan documents are on file at the Plan Administrator, arrangements can be made upon written request to make the documents you want available at any worksite or Union location at which 50 or more Participants report to work. Allow 10 days for delivery.

5. You may obtain copies of any Plan document governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary upon written request to the Trustees, addressed to the Plan Administrator. ERISA provides that the Trustees may make a reasonable charge for the actual cost of reproducing any document you request. However, you are entitled to know what the charge will be in advance. Just ask the Plan Administrator.

6. You have the right to continue health care coverage for yourself, your spouse, or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

7. No one including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way or take any action which would prevent you from obtaining a benefit to which you may be entitled or from exercising any of your rights under ERISA.

8. In accordance with Section 503 of ERISA and related regulations, the Trustees have adopted certain procedures to protect your rights if you are not satisfied with the action taken on your claim. These procedures start on page 83 of this booklet. These procedures are designed to give you a full and fair review and to provide maximum opportunity for all the pertinent facts to be presented in your behalf.

   a. If your claim for a health care benefit is denied, in whole or in part, you have a right to know why this was done, you will receive a written explanation of the reason(s) for the denial, and you have a right to obtain copies of documents relating to the decision without charge.

   b. Then, if you still are not satisfied with the action on your claim, you have the right to have the Plan review and reconsider your claim in accordance with the Plan's claims review and appeal procedures.

9. In addition to creating rights for Plan Participants, ERISA also defines the obligations of people involved in operating employee benefit plans. These persons are known as “fiduciaries.” They have the duty to operate your Plan with reasonable care and look out for your best interests as a Participant under the Plan and the best interests of other Plan Participants and Beneficiaries under the Plan. The duties of a fiduciary are complex and are constantly changing as new

laws and regulations are adopted applicable to employee benefit plans. Be assured that the Trustees of this Plan will do their best to know what is required of them as "fiduciaries" and to take whatever actions are necessary to ensure full compliance with all state and federal laws.

10. Under ERISA, you may take certain actions to enforce the rights previously listed.

    a. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court.

       Of course, before taking such action, you will no doubt want to check again with the Plan Administrator to make sure that:

       i. the request actually was received;

       ii. the material was mailed to the right address; or

       iii. the failure to send the material was not due to circumstances beyond the Trustees' control.

       If you still are not able to get the information you want, you may wish to take legal action. The court may require the Trustees to provide the materials promptly or pay you a fine of up to $110 for each day's delay until you actually receive the materials (unless the delay was caused by reasons beyond the Trustees' control).

    b. Although the Trustees will make every effort to settle any disputed claims with Participants fairly and promptly, there always is the possibility that differences cannot be resolved satisfactorily. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court if you feel that you have been improperly denied a benefit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

       However, before exercising this right, you must take advantage of all the claims review and appeal procedures provided under the Plan at no cost. If you still are not satisfied, then you may wish to seek legal advice.

    c. If it should happen that Plan fiduciaries misuse the Plan's money or discriminate against you for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you are not successful, the court may order you to pay these costs and fees. For example, if the court finds your claim is frivolous, you may be expected to pay legal costs and fees.

If you have any questions about your Plan, you should contact the Trustees by writing to:

The Board of Trustees
c/o Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Or phone: (952) 854-0795
Call toll-free: 1-800-535-6373

Or, if you have questions about this statement or your rights under ERISA or if you need assistance in obtaining documents from the Trustees, you may contact the nearest office of the Employee Benefits Security Administration (EBSA) at U.S. Department of Labor listed in your telephone directory or at: Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You also may find answers to your Plan questions, your rights and responsibilities under ERISA, and a list of EBSA field offices by contacting the EBSA by: calling 1-866-444-3272; sending electronic inquiries to www.askebsa.dol.gov; or visiting the website of the EBSA at www.dol.gov/ebsa/.

ARTICLE XIII

INFORMATION ABOUT THE PLAN

A. Names and Addresses of the Trustees

Employer Trustees

Kent Dixon
Jerry's Foods
5101 Vernon Avenue South
Edina, MN 55436

Michael Oase
Kowalski's Companies
8505 Valley Creek Road
Woodbury, MN 55125

Chris Thienes
Knowlan's Super Markets, Inc.
d/b/a/ Festival Foods
111 East County Road F
Vadnais Heights, MN 55127

Jon Born, Alternate
UNFI
11840 Valley View Road
Eden Prairie, MN 55344

Fred Miller, Alternate
Lund Food Holdings, Inc.
4100 West 50th Street, Suite 2100
Edina, MN 55424

Union Trustees

Jennifer Christensen
UFCW Union Local 1189
266 Hardman Avenue North
South St. Paul, MN 55075

Tami Denn-Bauer
UFCW Union Local 1189
266 Hardman Avenue North
South St. Paul, MN 55075

James Gleb
UFCW Union Local 1189
266 Hardman Avenue North
South St. Paul, MN 55075

Abraham Wangnoo
UFCW Union Local 1189
266 Hardman Avenue North
South St. Paul, MN 55075

Robert Jordan, Alternate
UFCW Union Local 1189
266 Hardman Avenue North
South St. Paul, MN 55075

James Westin, Alternate
UFCW Union Local 1189
266 Harmon Avenue North
South St. Paul, MN 55075

B. Names and Address of Plan Administrator

The Plan is administered and maintained by the Board of Trustees. The Plan Administrator is located at:

United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Phone: (952) 854-0795
Toll-Free: 1-800-535-6373

C. Type of Plan

This Plan is a group health plan. It is maintained for the exclusive benefit of the Employees and provides death, accidental death and dismemberment, and Accident and Sickness Benefits for Employees and health care, vision, and dental benefits for Employees and Dependents. This Plan is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

D. Plan Sponsor

The Plan Sponsor is the Board of Trustees of United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan. This Plan is maintained by several Employers and one or more Employee organizations, and is administered by a Joint Board of Trustees. A complete list of the Employers and Employee organizations sponsoring the Plan may be obtained by Participants and Beneficiaries upon written request to the Plan Administrator, and is available for examination by Participants and Beneficiaries at the Plan Administrator.

E. Type of Plan Administration

The Trustees have selected a professional employee benefits administration firm, Wilson-McShane Corporation, as the Administrative Manager of the Plan. The Administrative Manager is responsible for carrying out Trustees' policy decisions, recordkeeping, accounting, and paying benefits subject to the Summary.

Plan benefits are provided under the terms of the Summary. Additionally, life insurance is a fully-insured benefit provided via a master insurance policy with United of Omaha Life Insurance Company. For life insurance, should any conflict arise between the provisions of this document and the Master Insurance Policy, the Master Insurance Policy will govern.

F. Parties to the Collective Bargaining Agreement

United Food and Commercial Workers Union Local 1189
266 Hardman Avenue North
South St. Paul, MN 55075

And those Employers which execute an individual Collective Bargaining Agreement or Participation Agreement with the participating Local Union. Participants and Beneficiaries may obtain, upon written request to the Administrative Manager, information as to the address of a particular Employer and whether that Employer is required to pay Contributions to the Plan.

G. Internal Revenue Service Employer and Plan Identification Numbers

The Employer Identification Number (EIN) issued to the Board of Trustees is 41-6051513 and the Plan Number (PN) is 501.

H. Name and Address of the Person Designated as Agent for Service of Legal Process:

Dana Hanson
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Service of legal process also may be made upon any Plan Trustee.

I. Eligibility Requirements

The Plan's requirements with respect to eligibility for benefits are shown in the Eligibility Rules. Circumstances which may cause the Participant to lose eligibility also are explained in the Eligibility Rules.

J. Sources of Trust Fund Income

Sources of Trust Fund income include Employer Contributions, Self-Payments, and investment earnings.

All Employer Contributions are paid to the Trust Fund subject to provisions in the Collective Bargaining Agreements between the Union and Employers and Participation Agreements between Employers and Trustees. The labor agreements specify the amount of Contribution, due date of Employer Contributions, type of work for which Contributions are payable, and the geographic area covered by the labor contract.

Employee Self-Payments are permitted by the Trustees under certain conditions.

Contributions to the Plan are held in trust and invested by the Trustees in a way that sets a reasonable balance between safety and return while providing enough liquidity to pay benefits when due.

The Trustees maintain a reserve which, in their sole judgment, is adequate to maintain the Plan. The Trustees' determination regarding the level of reserves considers the length of the Collective Bargaining Agreements, total Plan costs including claims paid and payable, extended eligibility as provided in the Eligibility Rules, and any other data as the Trustees may consider necessary.

The Trustees maintain an Excess Risk Indemnification Agreement which limits Trust Fund liability for claims to an annual aggregate maximum. The aggregate maximum and other provisions are determined in accordance with the agreement which is part of and attached to the administration services contract in effect between Trustees and the contracting claims administrator.

K. Method of Funding Benefits

All Plan benefits except Life Insurance Benefits for Plans 1 and 2 and Accidental Death and Dismemberment Benefits for Plan 1 are self-funded from accumulated assets and are provided directly from the Trust Fund. A portion of Plan assets is allocated for reserves to carry out the objectives of the Plan. Self-Funded benefits payable are limited to Plan assets available for such purposes. All assets of the Plan are held by a custodian (bank) selected by the Trustees.

Assets not needed for the immediate payment of benefits and other Plan expenses are invested by an investment consultant hired by the Trustees in accordance with guidelines established and monitored by the Trustees.

Benefits for Life Insurance for Plans 1 and 2 as described on pages 28 through 31 and Accidental Death and Dismemberment Benefits for Plan 1 as described on page 32, are provided subject to Master Insurance Policy No. GLUG-PJ60 through United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175. Benefits eligible under the Life Insurance and Accidental Death and Dismemberment policy are submitted to the Plan Administrator and paid by United of Omaha directly to you, if living, otherwise to your Beneficiary.

L. Fiscal Year of the Plan

The Plan's fiscal year begins March 1 and ends the last day of February in the following year.

ARTICLE XIV

CLAIM FILING AND PROCESSING PROCEDURES

A. Initial Claim Filing and Processing Procedures

1. General Timing and Completeness Rules

Except as otherwise provided, the deadline for filing a claim for benefits is 12 months after the date the Eligible Person incurred the claim. A claim submitted after that deadline will be denied for failure to file timely.

Effective May 4, 2020, the Department of Labor declared Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until the earlier of either (a) sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or (b) one (1) year from the date the Eligible Person incurred a claim as a "Tolling Period." (The Tolling Period may not exceed one (1) year.) During the Tolling Period, the 12-month deadline for filing a claim is disregarded and resumes at the end of the Tolling Period.

Incomplete Claims. If an Eligible Person sends a claim to the Plan Administrator and the claim cannot be processed because information is missing, the Eligible Person will receive a notice stating why the claim cannot be completed and what additional information is needed. It is the Eligible Person's responsibility to send this information to the Plan Administrator.

2. Types of Claims

a. **Urgent Care Claims.** An urgent care claim is a claim for medical care or treatment where the application of non-urgent care time frames could seriously jeopardize an individual's life or health or the individual's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the individual's medical condition, would subject him to severe pain that cannot be managed without the care or treatment that is the subject of the claim.

The Plan will waive its prior authorization requirements for urgent care claims. Even so, the Eligible Person or his medical provider must notify the Plan as soon as reasonably possible after the emergency medical care or treatment is provided.

b. **Pre-Service Claims.** A pre-service claim is a claim for which the terms of the Plan condition receipt of Plan benefits on the Eligible Person receiving prior authorization from the Plan for the treatment or services before the medical care is provided. If this Summary booklet says that an Eligible Person must obtain prior authorization from the Plan for a procedure or course of treatment before it will be treated as a Covered Expense, the claim for the procedure or course of treatment is a pre-service claim.

An Eligible Person must contact the Plan Administrator for prior authorization for all organ transplants, in-patient hospitalization, injectable specialty drugs and certain prescription drugs. In addition the Trustees must approve home health care visits extensions beyond 40 visits per Eligible Person per Calendar Year for Plans 1, 2, and 3.

c. **Concurrent Care Claims.** The Plan is making a concurrent care decision when the Plan has approved an ongoing course of treatment to be provided over a period of time and there is a reduction or termination of the treatment before the scheduled end of the treatment.

d. **Disability Claims.** A disability claim is a claim for Accident and Sickness Benefits under the Plan.

e. **Post-Service Claims.** A claim that is not a pre-service claim is a post-service claim. An Eligible Person must submit all post-service claims within 90 days after the Eligible Person receives the bill for such treatment, or as soon as reasonably possible.

3. Claim Procedure

Once you become eligible, you will receive an identification card from the Plan. Preferred Providers automatically will file your claim for you upon presentation of your I.D. card and signing of the appropriate form. For non-participating providers, you must submit post-service claims in writing to the Plan Administrator (c/o Wilson-McShane Corporation, 3001 Metro Drive, Suite 500, Bloomington, MN 55425) on forms provided by the Plan Administrator (unless otherwise authorized by administrative rule) with all applicable questions and information requested on the form answered and provided by you, the Hospital, attending Physician, or other provider of service.

Claims should be complete. They should contain, at a minimum:

a. Plan name (United Food and Commercial Workers Local Union No. 1189 and St. Paul Food Employers Health Plan);

b. Employee's name and identification number;

c. Full name (including "Jr.," if applicable) and date of birth of the Eligible Person who incurred the Covered Expense;

d. Name and address of the service provider;

e. Federal tax identification number of provider;

f. Diagnosis of the condition (this must be indicated on each medical claim submitted);

g. Procedure or nature of the treatment;

h. Date of and place where the procedure or treatment has been provided;

i. Amount billed and the amount of the Covered Expense not paid through coverage other than this Plan, as appropriate; and

j. Evidence that substantiates the nature, amount, and timeliness of each Covered Expense that is in a reasonably understandable format and is in compliance with all applicable law.

Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address. A general request for an interpretation of Plan provisions will not be considered a claim for benefits. Predetermined amounts you must pay, such as a prescription drug Copayment or amount required because of use of a network or non-network provider, will not be considered a claim for benefits subject to the claims procedures.

You or an authorized representative can pursue a claim. You may authorize a representative by submitting a written authorization to the Plan Administrator.

Benefits are paid directly to you, or to the provider if you assign benefits to the provider on a form provided by the Plan Administrator.

B. Time Frames for Initial Claims Decisions.

1. Urgent Care Claims.

The Plan will notify an Eligible Person of an urgent care claim decision as soon as possible but not later than 72 hours after receiving a claim, unless the Eligible Person fails to provide sufficient information to determine whether benefits are payable. In that case, the Plan will ask the Eligible Person for the missing information within 24 hours after receiving the claim; the Eligible Person then will have 48 hours to provide that information; and the Plan will notify him of the claim decision within 48 hours after the earlier of: (1) receiving the missing information from the Eligible Person; or (2) the deadline given to the Eligible Person for providing the specified information. In any event, if the Eligible Person fails to follow the Plan's rules for filing an urgent care claim, the Plan will notify the Eligible Person of the failure (and the proper filing procedure) within 24 hours after the failure.

2. Pre-Service Claims.

The Plan will notify an Eligible Person of a pre-service claim decision within 15 days of receiving a claim. The Plan may extend this deadline up to 15 days if the extension is due to matters beyond the Plan's control as long as the Plan notifies the Eligible Person of the reason for the extension (and the expected decision date) within 15 days after receiving the claim. If an extension is needed because the Eligible Person failed to submit necessary information, the Plan will tell the Eligible Person what the information it needs and give the Eligible Person 45 days to provide the information. In any event, if the Eligible Person fails to follow the Plan's rules for filing a pre-service claim, the Plan will notify the Eligible Person of the failure (and of the proper filing procedure) within 5 days (or within 24 hours, in the case of a claim involving urgent care) following the failure.

3. Concurrent Care Claims.

If the Plan reduces or terminates coverage of a treatment before the end of the course of treatment, the Plan will notify the Eligible Person far enough in advance of the termination or reduction to allow the Eligible Person to appeal and to receive an appeal decision before the termination or reduction. If the Eligible Person requests to extend the treatment, the Plan will notify him within 24 hours if the claim involves urgent care.

4. Disability Claims.

The Plan will notify the Employee of a disability claim denial within 45 days of receiving a claim. The Plan may extend this deadline up to 30 days if the extension is due to matters beyond the Plan's control as long as the Plan notifies the Employee of the reason for the extension (and the expected decision date) within 45 days after receiving the claim. The Plan may extend this extended deadline up to an additional 30 days if the additional extension is due to matters beyond the Plan's control as long as the Plan notifies the Employee of the reason for the extension (and the expected decision date) within 75 days after receiving the claim. In either case, the notice of extension will explain the standards for receiving the benefit, the unresolved issues preventing a claim decision, and the additional information needed to resolve those issues. The Employee will have 45 days to provide the specified information.

5. Post-Service Claims.

The Plan will notify the Eligible Person of the denial of a post-service claim within 30 days after receiving the claim. The Plan may extend this deadline up to 15 days if the extension is due to matters beyond the Plan's control as long as the Plan notifies the Eligible Person of the reason for the extension (and the expected decision date) within 30 days after receiving the claim. If the extension is needed because the Eligible Person failed to submit necessary information, the Plan will notify the Eligible Person of information it needs and will allow the Eligible Person 45 days to provide the information.

C. Claim Denials

1. Information Contained in the Adverse Determination Letter. If your claim is denied or your coverage is rescinded, the Plan will notify you within the time frames stated above. The notice will be culturally and linguistically appropriate and will:

   a. Tell you the date of service, the health care provider and the claim amount (if applicable);

   b. Tell you the specific reasons your claim was denied, including (if applicable) the denial code and its corresponding meaning;

   c. Reference the specific Plan provisions) on which the determination was based;

   d. Describe any additional material or information for you to complete the claim and an explanation of why the material or information is necessary;

   e. Describe the Plan's review procedures and the time limits for those procedures and indicate that the Eligible Person has the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") if any claim appeal that he might file is ultimately denied ;

   f. A statement that you have the right to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim;

g. If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, provide a description of such rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse benefit determination and a statement that a copy of such criterion will be provided free of charge to you upon request;

h. If the claim decision was based on a Medical Necessity or Experimental treatment exclusion, explain the scientific or clinical judgment for the determination or a statement that the explanation will be provided to you upon your request;

i. If the claim involves urgent care, describe the Plan's expedited review process for urgent care claims;

j. If the adverse benefit determination for a disability claim differs from a disability determination made by the Social Security Administration that is presented with your claim, provide a discussion of the basis for disagreeing with the Social Security Administration's disability determination.

While considering or reconsidering your claim, the Plan will provide you with any new or additional evidence considered, relied upon, or generated by (or for) the Plan in connection with the claim. The Plan will provide you with new or additional evidence free of charge, as soon as possible, and sufficiently in advance of the time limit for deciding claims to give you a reasonable opportunity to respond. If the Plan denies your claim on the basis of a new or additional rationale, the Plan will provide you the rationale free of charge, as soon as possible, and sufficiently in advance of the time limit for deciding claims to give you a reasonable opportunity to respond.

D. Appointing an Authorized Representative to Act on Your Behalf

Another person may act on behalf of an Eligible Person behalf in pursuing a benefit claim or claim appeal, but only after the Eligible Person delivers a signed letter to the Plan Administrator specifically naming the person as the authorized representative of the Eligible Person. In any event, such a duly authorized representative will not have the right to make a personal appearance before the Board of Trustees or before any committee created by the Board of Trustees.

E. Claim Appeal Procedure

If all or part of your claim is denied or your coverage is rescinded after the Plan has received all information the Plan determines is necessary, you have the right to appeal the decision and request a review of the claim.

1. Deadline for Filing Claim Appeals

An Eligible Person has the right to appeal an adverse benefit determination, including a charge that the Eligible Person believes is an improper dollar or percentage Copayment. The claim appeal must be in writing and must be delivered to the Plan Administrator within 180 days after the Eligible Person receives the adverse benefit determination. A claim appeal filed after that deadline will be denied for failure to file timely.

Effective May 4, 2020, the Department of Labor declared Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until the earlier of either (a) sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or (b) one (1) year from the date the Eligible Person received an adverse benefit determination as a "Tolling Period." (The Tolling Period may not exceed one (1) year.) During the Tolling Period, the 180-day window in which an Eligible Person may file an appeal of a denial of benefits is disregarded and resumes at the end of the Tolling Period.

2. Claim Appeal Rights Under Federal Law

When appealing an adverse benefit determination, an Eligible Person's rights under federal law include the following:

a. The Eligible Person will have the opportunity to submit written comments, documents, records, and other information relating to the claim which the Eligible Person believes will support the claim but will not have the right to make a personal appearance before the Board of Trustees or before any committee created by the Board of Trustees.

b. The Eligible Person will be provided, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the Eligible Person's claims for benefits.

c. The review by the Plan will take into account all comments, documents, records, and other information the Eligible Person submitted relating to the adverse benefit determination, whether or not they were submitted before the initial adverse benefit determination.

d. The review will be conducted by an Appeals Committee (or, if none has been appointed, by the Board of Trustees acting as an Appeals Committee). The review will not be conducted by the person who made the initial adverse benefit determination or by a subordinate of that person, and the review will not afford deference to the initial adverse benefit determination. If the appeal relates to an adverse benefit determination that was based at least in part on a medical judgment (including a judgment about whether a particular treatment, drug, or other item is Experimental or Investigative, or not Medically Necessary), the Appeals Committee will consult with a healthcare professional who is trained and experienced in the field of medicine involved in that medical judgment and who was not consulted in connection with the initial adverse benefit determination and who is not the subordinate of anyone so consulted. Upon request, the Plan will identify any healthcare professional that the Appeals Committee consulted in relation to the claim.

e. If the appeal involves a claim for urgent care, the request for an expedited appeal can be submitted orally or in writing, and all information will be transmitted between the Eligible Person and the Plan by telephone, fax, or similar method, including the appeal decision.

3. Time Frames for Appeal Decisions

a. **Urgent Care Claims.** If an Eligible Person has appealed the denial of an urgent care claim, the Plan will notify the Eligible Person of the appeal decision as soon as possible, but not later than 72 hours after the Plan Administrator receives the appeal.

b. **Pre-Service Claims.** If an Eligible Person has appealed the denial of a pre-service claim, the Plan will notify the Eligible Person of the appeal decision within 30 days after the Plan Administrator receives the appeal.

c. **Post-Service Claims and Disability Claims.** If an Eligible Person has appealed the denial of a claim other than an urgent care claim or a pre-service claim, the Appeals Committee will review the appeal at their next regularly scheduled meeting after the Plan Administrator receives the appeal, unless the Plan Administrator receives the appeal within 30 days of their regularly scheduled meeting. In that case, the Appeals Committee will review the appeal at their second regularly scheduled meeting after the Plan Administrator receives the appeal. If special circumstances require a further extension of time for processing, the Plan Administrator will notify the Eligible Person of the extension in writing (describing the special circumstances and the expected decision date) before the extension begins, and the Appeals Committee will review the appeal no later than their third regularly scheduled meeting after the Plan Administrator receives the appeal. Once the Appeals Committee reviews the appeal, the Plan Administrator will notify the Eligible Person of the appeal decision within five business days.

4. Contents of Appeal Denial Notice

If an Eligible Person's appeal is partly or completely denied, the Plan's appeal denial notice will be in writing and will:

a. Provide the specific reason or reasons for the denial of the appeal.

b. Refer to the specific Plan provisions on which the denial is based.

c. State that the Eligible Person has the right to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim.

d. State that the Eligible Person has the right to bring a civil action under Section 502(a) of ERISA.

e. If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, provide a description of such rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination.

f. If the adverse benefit determination for a disability claim differs from a disability determination made by the Social Security Administration that is

presented with your appeal, provide a discussion of the basis for disagreeing with the Social Security Administration's disability determination.

g. If the appeal was denied based on a medical necessity or Experimental treatment or similar exclusion or limit, either provide an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the medical circumstances at issue) or state that he can obtain that explanation, upon request and free of charge, from the Plan.

The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner. You will be given an opportunity consistent with applicable law to present your viewpoint on any denied claim. You may not begin any legal action, including proceedings before administrative agencies, until you have followed the procedures and exhausted the appeal opportunities described here. You may, at your own expense, have legal representation at any stage of these appeal procedures. Benefits under this Plan will be paid only if the Board of Trustees (or its Plan Administrator) decides in its discretion that you are entitled to them. The Plan will be interpreted and applied in the sole discretion of the Board of Trustees (or its delegate including, but not limited to, its Plan Administrator). Such decision will be final and binding on all persons covered by the Plan who are claiming any benefits under the Plan.

If you have any questions about the claims review and appeal procedures described here, please contact the Plan Administrator.

ARTICLE XV

GENERAL DEFINITIONS

Wherever used in this Summary, the following definitions apply.

Bargaining Unit Employee means any Employee represented by the Union and working for an Employer (as defined in the Trust Agreement) who is required to make Contributions to the Trust Fund.

Beneficiary means a person designated by a Participant or by the terms of the Plan established pursuant to the Trust Agreement who is or may become entitled to a benefit hereunder.

Calendar Month means any one of the 12 named months of the Calendar Year, beginning with the first day of that month.

Calendar Year means the period of 12 consecutive months commencing on January 1.

Coinsurance/Copayment is the portion of a Covered Expense in excess of the Deductible that an Eligible Person or Retiree must pay.

Collective Bargaining Agreement means the negotiated labor agreement between the Union and an Employer or Employer Association requiring the Employer or Employer Association to make Contributions to the Plan's Trust Fund on behalf of its Bargaining Unit Employees.

Contribution(s) are: payments made to the Trust Fund by Participating Employers pursuant to a Collective Bargaining Agreement or Participation Agreement on behalf of their Employees; and Self-Payments.

Convalescent Facility means an institution (or distinct part of an institution) which has proper accreditation and fully meets every one of the following tests:

1. is licensed to provide, and is engaged in providing, on an inpatient basis, for persons convalescing from Injury or disease, professional nursing services rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse; also physical restoration services to assist patients in reaching a degree of bodily functioning to permit self care in essential daily living activities;

2. provides for patient services under the full-time supervision of a Physician or registered nurse;

3. provides 24 hour-per-day nursing services by licensed nurses, under the direction of a full-time registered nurse;

4. maintains complete medical records on each patient;

5. has an effective utilization review plan; and

6. is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, custodial or educational care, or care of mental disorders.

Covered Expense(s) are the Reasonable Expenses or allowed charges that are incurred for the Medically Necessary treatment of conditions that are covered under this Plan. This does not mean that all Covered Expenses will be paid by the Plan. Payment also will be based on: (a) the provisions of each benefit; (b) the limitations listed in the Schedule of Benefits and the General Limitation Sections of this Summary booklet; (c) any Deductibles, Copayments, and Coinsurance an Eligible Person or Retiree may be required to pay; and (d) other provisions of the Plan, including, but not limited to, the coordination of benefits and subrogation sections.

Covered Position or **Covered Employment** means a position or work performed within the jurisdiction of the Union by an Employee for an Employer for which the Employer is required to make Contributions to the Plan on the Employee's behalf or work performed within the jurisdiction of another local Union for which Contributions may be transferred under reciprocal agreement.

Custodial Care is care comprised of services and supplies, including room and board and other institutional services, which are provided to an Eligible Person, whether disabled or not, primarily to assist him or her in the activities of daily living. Such services and supplies are Custodial Care without regard to the practitioner or provider by whom or by which they are prescribed, recommended, or performed.

Deductible means the amount that an Eligible Person must pay each Calendar Year for Covered Expenses before the Plan will begin to pay for Covered Expenses (subject to all other Plan terms and conditions).

Dentist means a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the license and practice of dentistry.

Dependent means an Eligible Employee's:

1. Spouse (or former spouses as provided for under Article I, Section H). Spouse means an individual who is the legally recognized spouse of an Employee under the laws of the state in which the marriage or civil union was established. For this purpose, a legal civil union will be considered a legal marriage. A certified copy of the marriage certificate or other documentation substantiating status as a spouse may be required to be on file at the Plan Administrator before claims for such spouse will be processed.

   However, if your spouse has other coverage available through his or her own employer and choose to opt out of such coverage, then your spouse no longer will be eligible for coverage as a Dependent under this Plan. To determine if other coverage is available, it must be a group plan whereby individual coverage is offered and the employer contributes at least 50% of the cost for employee-only coverage of the lowest plan offered. If the employer coverage does not meet this requirement, your spouse, under this Plan, does not meet the requirement of having other coverage available to them.

2. Child (or children) who is under 26 years of age. Age 26 is the "termination age." Attainment of age 26 will cause loss of eligibility except as described in subparagraph (f) below.

   For purposes of the definition of a Dependent, the term "child" or "children" includes:

   a. Any biological child of an Eligible Employee.

   b. Any child legally adopted by or placed for adoption with an Eligible Employee. Placement for adoption means the assumption and retention by an Eligible Employee of a legal obligation for support of a child in anticipation of the legal adoption of such child by the Eligible Employee. Placement for adoption will terminate upon the termination of such legal obligation.

   c. Any stepchild of an Eligible Employee, meaning any child of an Eligible Employee's current spouse from whom the Eligible Employee is not divorced or legally separated:

      i. who was born to such spouse;

      ii. who was legally adopted by such spouse;

      iii. who has been placed for adoption with such spouse; or

      iv. who is a foster child placed with such spouse by an authorized placement agency or a court.

      The Plan's obligation to provide benefits will be secondary to any obligation of either or both of the natural parents created by court order or judgment of divorce or legal separation. The stepparent must promptly provide a copy of any such court order or judgment and, if one or more of the parents is under such an obligation, the stepchildren first must seek payment or provision of benefits pursuant to the obligation of the parent(s). If collection under, or enforcement of, that obligation is impossible or impracticable in the judgment of the Trustees, this Plan will provide benefits the same as for legally adopted children in accordance with the terms and conditions of the Summary, provided that, as a condition precedent to such provision of benefits, the Participant will assign to the Plan in writing the right to enforce such obligation so as to entitle the Plan to obtain reimbursement from the responsible parent or parents, or from their insurer, for benefits provided.

   d. Any foster child placed with an Eligible Employee by an authorized placement agency or a court.

   e. An unmarried child who is named in a Qualified Medical Child Support Order with which an Eligible Person and the Plan are obligated to comply.

f. Any child incapable of self-sustaining employment by reason of developmental cognitive disability or physical handicap, and who became so incapable prior to attainment of the termination age stated previously and who is primarily financially dependent upon the Eligible Employee, provided the Eligible Employee furnishes due proof of such incapacity to the Trustees within 31 days of the date such child's coverage otherwise would terminate due to attainment of the termination age. Proof of the continued existence of such incapability and dependency must be furnished to the Trustees from time to time at their request.

During any Disability means, as it applies to an Eligible Employee, all periods of disability arising from the same cause including any and all complications, except that if you completely recover or return to active full-time employment for two weeks, any subsequent period of disability from the same cause will be considered a new disability.

As it applies to your Dependents, the term means all periods of disability arising from the same cause including complications, except that if the Dependent recovers and resumes normal activities of a person of like age and sex for a period of six months, any subsequent period of disability from the same cause will be considered a new disability.

Eligible Employee means any Employee or former Employee of an Employer who is eligible for benefits in accordance with the Eligibility Rules of the Plan as adopted by the Trustees from time to time.

The term "Employee" will include Bargaining Unit Employees and, provided the Employer is party to an approved Participation Agreement, the term also will include certain Non-Bargaining Unit Employees.

Eligible Person means either the Eligible Employee or an eligible Dependent.

Employee means an individual who is performing work for an Employer as an Employee and on whose behalf Contributions are being made to the Plan pursuant to a Collective Bargaining Agreement or a Participation Agreement, unless the context in which the term is used indicates a different meaning.

Employer means any Employer who is required to make payments to the Plan for the purpose of providing employee benefits pursuant to a Collective Bargaining Agreement or Participation Agreement.

Employer Association means an entity with Employer members that is a party to a Collective Bargaining Agreement requiring Contributions to the Trust Fund and which is entitled to appoint Employer Trustees pursuant to the Trust Agreement.

Experimental or **Investigative** means the use of any diagnostic procedure or treatment (which includes use of any treatment, procedure, facility, drug, equipment, device, or supply) which is not yet generally recognized as accepted medical practice, or its use requires federal or other governmental agency approval and the approval has not been granted at the time the service or supply is provided, or its use is not supported by the reliable evidence which shows that, as applied to a particular condition, it:

1. is generally recognized as a safe and effective diagnostic procedure or treatment of the condition by those practicing the appropriate medical specialty;

2. has a definite positive effect on health outcomes;

3. over time leads to improvement in health outcomes under standard conditions of medical practice outside clinical investigatory settings (i.e., the beneficial effects outweigh the harmful effects); and

4. is at least as effective as standard means of treatment in improving health outcomes, or is usable in appropriate clinical contexts in which standard treatment is not employable.

"Reliable evidence" includes only:

1. published reports and articles in authoritative medical and scientific literature;

2. written investigational or research protocols and/or written informed consent used by the treating facility or of another facility which is studying the same service, supply, or procedure; and

3. compilations, conclusions, and other information which is available and may be drawn or inferred from the immediately preceding (a) or (b).

Consideration may be given to whether:

1. the diagnostic procedure or treatment cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the treatment is furnished; or

2. "reliable evidence" shows that the diagnostic procedure or treatment is the subject of ongoing Phase I, II, or III clinical trials are under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis;

3. "reliable evidence" shows that consensus among experts regarding the diagnostic procedure or treatment is that further studies or clinical trials are necessary to determine tolerated doses, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis; or

4. the mortality rate of the treatment, the cure rate and the survival rate for patients using the treatment for the particular Injury, Sickness, or condition as compared with rates for similarly situated patients using no treatment or using existing treatments which are generally accepted by the Food and Drug Administration; and the number of patients who have received the treatment for the same Injury, Sickness, or condition.

The Trustees will have the final determination as to whether the use of a treatment is Experimental or Investigative.

Full-Time Employee means a Bargaining Unit Employee who works for a Participating Employer an average of 32 or more hours per week (excluding Sunday and holiday hours). If an Employee is on a four-days-per-week, ten-hours-per-day regular schedule, he will be considered a Full-Time Employee if he works 30 or more hours per week. If an Employee is covered by the St. Paul Retail Meat and Grocery Agreement and was hired prior to March 1, 1992, he will be considered a Full-Time Employee if he works 24 or more hours per week (excluding Sunday and holiday hours).

Home Health Care Agency means an agency or organization which fully meets all of the following requirements:

1. Is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services (but not Custodial Care);

2. Has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one registered nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a Physician or registered nurse;

3. Maintains a complete medical record on each individual; and

4. Has a full-time administrator.

Home Health Care Plan means a program for care and treatment of the individual established and approved in writing by the individual's attending Physician. The attending Physician must certify that the proper treatment of the Sickness or Injury would require confinement as a resident inpatient in a Hospital or Convalescent Facility in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospice Care is care given to a Terminally Ill individual by or under arrangements with a Hospice Care Agency. The care must be a part of a Hospice Program.

Hospice Care Agency is an agency or organization which:

1. Has Hospice Care available 24 hours a day;

2. Meets any licensing or certification standards set forth by the jurisdiction where it is located;

3. Provides skilled nursing services, medical social services, psychological and dietary counseling, and bereavement counseling for the immediate family;

4. Provides or arranges for other services which will include services of a Physician, physical or occupational therapy, part-time home health aide services which mainly consist of caring for Terminally Ill individuals, and inpatient care in a facility when needed for pain control and acute and chronic symptom management;

5. has personnel which includes at least one Physician, one registered nurse (R.N.), one licensed or certified social worker employed by the agency, and one pastoral or other counselor;

6. Has established policies governing the provision of Hospice Care;

7. Assesses the patient's medical and social needs;

8. Develops a Hospice Program to meet the patient's medical and social needs;

9. Provides an ongoing quality assurance program, including reviews by Physicians other than those who own or direct the agency;

10. Permits all area medical personnel to utilize its services for their patients;

11. Keeps medical records on each patient;

12. Utilizes volunteers trained in providing services for non-medical needs; and

13. Has a full-time administrator.

Hospice Facility is a facility, or distinct part of one, which:

1. Mainly provides inpatient Hospice Care to Terminally Ill individuals;

2. Charges its patients for expenses incurred;

3. Meets any licensing or certification standards set forth by the jurisdiction where it is located;

4. Keeps medical records on each patient;

5. Provides an ongoing quality assurance program, including reviews by Physicians other than those who own or direct the facility;

6. Is run by a staff of Physicians and at least one such Physician must be on call at all times;

7. Provides 24 hour a day nursing services under the direction of a registered nurse (R.N.); and

8. Has a full-time administrator.

Hospice Program means a program which has received a certificate of need from the state or locality in which it operates to initiate Hospice Care in a given area; is eligible to satisfy accreditation requirements as developed by Medicare and/or the Joint Commission on the Accreditation of Health Care Organizations; and meets all of the following criteria:

1. The patient and family are seen as the unit of care.

2. An integrated, centralized administrative structure ensures continuity for home care and inpatient care.

3. There is direct provision of care by an interdisciplinary team consisting of Physicians, nurses, social workers, chaplains, and volunteers.

4. Volunteers are used to assist paid staff members.

Hospital means an establishment which meets each of the following requirements:

1. is operating lawfully in the jurisdiction where it is located;

2. operates primarily for the reception, care, and treatment of injured or sick persons as inpatients;

3. provides 24-hour-per-day nursing service by registered nurses;

4. has a staff of one or more licensed Physicians available at all times; and

5. provides organized facilities for diagnostic, therapeutic, and surgical services.

"Hospital" also will include:

1. a residential primary treatment program licensed by the Minnesota Department of Health for the treatment of alcoholics or substance addicts;

2. a residential treatment facility licensed by the Minnesota Commissioner of Public Welfare for the treatment of emotionally handicapped children;

3. a community health center or mental health clinic approved or licensed by the Commissioner of Public Welfare or other authorized state agency; and

4. a free-standing ambulatory surgical center or other facility offering ambulatory medical services 24 hours per day, seven days per week, which is not part of a Hospital but has been reviewed and approved by the State Board of Health to provide specified health care treatments or services.

"Hospital" will not include an institution operated primarily as a clinic, nursing, rest, or convalescent home or similar establishment.

Injury means bodily harm caused by external means due to an accident which requires treatment by a Physician and which results in loss independently of Sickness and other causes.

Lifetime, with reference to benefit maximums and limitations, means aggregate Covered Expenses incurred while an Eligible Person is both alive and covered under the Plan.

Medically Necessary means those services, treatment, or supplies provided by a Hospital, Physician, or other qualified provider of medical services or supplies that are required to identify or treat an Eligible Person's Injury or Sickness and which:

1. are consistent with the symptoms or diagnosis and treatment of the Eligible Person's condition, disease, ailment, or Injury;

2. are appropriate according to professional standards of medical practice;

3. are not solely for the convenience of the Eligible Person (including his family or caregiver), Physician, or Hospital;

4. are the most appropriate which can be provided safely to the Eligible Person;

5. are not deemed to be Experimental or Investigative; and

6. are not furnished in connection with medical or other research.

The Trustees will make the final determination regarding questions of medical necessity.

Military Service or **Military Leave** means service or leave to serve in the United States Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps, or the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Never Event or Never Events means an adverse health care event identified under the Minnesota Adverse Health Care Reporting Act, Minn. Stat. §§ 144.706-144.7069 or as Serious Reportable Events by the National Quality Forum, as amended from time to time, including but not limited to adverse surgical or invasive procedure events, adverse product or device events, adverse patient protection events, adverse care management events, adverse environmental events, adverse radiological events or adverse potential criminal events.

Non-Bargaining Unit Employee means an Employer's Employees who perform work which is not covered by a labor contract requiring Contributions to this Plan and who are, therefore, not represented by a labor organization.

Outpatient Psychiatric Facility means a Hospital, community mental health center, day care center, or night care center associated with a Hospital and licensed as required by applicable law. It does not include institutions or facilities primarily engaged in providing services which are custodial, recreational, social, or educational in nature. An approved Outpatient Psychiatric Facility will be recognized only if there is either a psychiatric Physician or a licensed psychologist present in the facility on a regularly scheduled basis who assumes the overall responsibility for coordinating the care of all patients. Services must be available through the professional staff of the facility, as needed, from a psychiatric Physician, licensed psychologist, registered nurse, and psychiatric social worker. Emergency medical care must be accessible through formal agreement with a Hospital.

Part-Time Employee means a Bargaining Unit Employee (other than bagger/carryout/part-time maintenance Employees) who works less than 32 hours per week (excluding Sunday and holiday hours) for a Participating Employer.

Participant means any Employee or former Employee of an Employer or a Dependent who is eligible to receive any benefit from this Plan in accordance with the Eligibility Rules or other regulations that the Trustees may establish from time to time.

Participating Employer means any Employer which:

1. is bound by the Trust Agreement establishing the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan; and

2. is required by the terms of a Collective Bargaining Agreement or other written agreement to make Contributions to the Plan.

Participation Agreement means a written agreement between the Trustees and an Employer in which the Trustees approve the Employer's participation in the Plan and the Employer agrees to make and the Trustees agree to accept Contributions to the Trust Fund on behalf of its Employees who are not members of the bargaining group. The Trustees will by appropriate action determine the Employer's contribution rate.

Permanent and Total Disability means the statutory definition used by the Social Security Administration to determine eligibility for Social Security Disability Benefits and, subject to that definition, will mean an Employee who has a physical or mental impairment of such severity that he or she is not only unable to do his or her previous work but cannot, considering his or her age, education, and work experience, engage in any other kind of substantial gainful work.

Personal Pronoun Usage. Words used in this Summary in the masculine or feminine gender will be considered as the feminine gender or masculine gender respectively, where appropriate. Words used in the singular or plural will be considered as the plural or singular, respectively, where appropriate.

Physician and **Surgeon** means any individual, other than you or your Dependent, licensed to practice medicine by the governmental authority having jurisdiction over such licensure in his state and who is acting within the usual scope of such practice. Physician will include, but will not be limited to, Medical Doctor, M.D.; Osteopath, D.O.; Podiatrist, D.P.M.; Doctor of Dental Surgery, D.D.S.; Chiropractor, D.C.; Optometrist, O.D.; and licensed midwives to the extent they perform the same services as a Physician.

Plan means the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan and document which has been adopted by the Trustees, as amended from time to time, which incorporates the provisions, terms, and conditions under which benefits are paid and the schedule of benefits which is in effect.

Plan Administrator means the individual or entity designated by the Board of Trustees to provide administrative services to the Plan

Plan Year means the 12 months beginning March 1st and ending the last day of February of the following calendar year.

Preferred Provider means a:

1. Physician, Dentist, registered nurse, physical therapist, or other licensed health care provider;

2. Hospital;

3. alcohol and substance abuse treatment facility;

4. hospice;

5. laboratory;

6. outpatient surgical facility;

7. pharmacy;

8. business establishment selling or renting durable medical equipment; or

9. any other source for services or supplies covered under this Plan;

who/which alone, or as part of a group, enter into a contract with the Trustees and who/which agree to be compensated for their services and supplies as are covered under this Plan according to the terms of the contract. Such parties are Preferred Providers while such contract is in effect.

Current types of Preferred Providers include the following:

1. "Preferred Provider Hospital" or "Contract Hospital" or "Preferred Provider Physician" means any of the Hospitals or Physicians which contract with the Trustees through their agent from time to time. This Preferred Provider arrangement is provided through UnitedHealthcare. The network of Hospitals and Physicians are named in a directory given to Eligible Persons.

2. "Employee Assistance Program (EAP) Manager" means the organization which contracts with the Trustees to provide specified family assistance services. The current EAP manager is TEAM.

3. "Preferred Provider Pharmacy (PPRx)" means the pharmacy which is party to contract with the Trustees. Currently, Sav-Rx is the PPRx.

Qualified Medical Child Support Order (QMCSO) means any court judgment, decree, or order, including a court's approval of a domestic relations settlement agreement, or any judgment, decree, or order issued through an administrative process established under state law which has the force and effect of law under applicable state law, that:

1. provides for child support payments related to health benefits with respect to a child or requires health benefit coverage of such child by the Plan, and is ordered under state domestic relations law; or

2. enforces a state law relating to medical child support payments with respect to the Plan; and

3. creates or recognizes the right of a child as an alternative recipient who is recognized under the order as having a right to be enrolled under the Plan to receive benefits derived from such child's relationship to an Eligible Employee who is a Participant in the Plan; and

4. includes the name and last known address of the Participant from whom such child's status as an alternate recipient under this Plan is derived and of each alternate recipient, a reasonable description of the type of coverage to be provided by the Plan, and the period for which coverage must be provided; and

5. does not require or purport to require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act; and

6. has been determined to be a Qualified Medical Child Support Order under reason-able procedures adopted and uniformly applied by the Plan. A copy of the written procedures for determining whether or not an order is "qualified" is available from the Plan Administrator upon request at no charge.

Reasonable Expense(s) means the fees and prices regularly and customarily charged for the medical services and supplies generally furnished for cases of comparable nature and severity in the particular geographic area concerned. Reasonableness is determined by comparisons with fees and charges by other providers for similar services and supplies as authorized by the Trustees and may include data obtained from Context (a division of ADP) for relevant zip codes at the percentile Trustees adopt (currently the 90th percentile) or from guidelines obtain from other sources as well. Eligible expenses are limited to those incurred by you or your Dependents while covered under the Plan as a result of Injury or Sickness; expense is considered to be incurred on the date the service or supply is rendered or obtained.

Retiree means an individual who was an Eligible Employee under this Plan on the day preceding the date of his or her retirement and who is now retired either under the retirement provisions of a pension plan negotiated or sponsored by the Union or under the provisions of the Social Security Program.

Self-Funded Plan means a group health care plan in which the Plan assumes the financial risk for providing health care benefits to its Employees. Instead of paying a fixed premium to an insurance company to pay the claims, a Self-Funded Plan directs Employer Contributions, Self-Payments, and investment earnings into a Trust Fund that is overseen by strict federal government regulation. The Plan pays claims directly from accumulated Trust Fund assets.

Self-Payment(s) are payments made to the Trust Fund by Eligible Persons and Retirees on their own behalf for the purpose of maintaining coverage under the Plan. Payments made to the Trust Fund for continuation coverage under COBRA are an example of Self-Payments.

Semi-Private Room means the daily room and board charge which an institution applies to the greatest number of beds in its Semi-Private Rooms containing two or more beds. If the institution has no Semi-Private Rooms, the semi-private rate will be the daily room and board rate most commonly charged for Semi-Private Rooms with two or more beds by similar institutions in the area. The term "area" means a city, county, or any greater area necessary to obtain a representative cross section of similar institutions.

Sickness means a disease, disorder, or condition (including pregnancy and childbirth and any related conditions) which requires treatment by a Physician.

Effective March 18, 2020, for purposes of Accident and Sickness Benefits, and for the duration of the public health emergency related to COVID-19, Sickness will also include the inability of an Eligible Employee to work due to the advice of a health care provider to self-quarantine due to concerns related to COVID-19 or experiencing symptoms of COVID-19 and seeking a medical diagnosis.

Skilled Nursing Home means an institution which fully meets each of the following requirements:

1. is regularly engaged in providing skilled nursing care for injured and sick persons at the patient's expense;

2. requires that patients regularly be attended by a Physician and that medications be given only on the order of the Physician;

3. maintains a daily medical record of each patient;

4. continuously provides nursing care under 24-hour-per-day supervision by a registered nurse;

5. is not, except incidentally, a place for the aged, a rest home, or the like;

6. is not, except incidentally, a place for treatment of substance addiction, alcoholism, or mental illness;

7. is currently licensed as a Skilled Nursing Home, if licensing is required in the area where it is located, and is classified as a Skilled Nursing Home under Medicare;

8. has permanent facilities for the care of six or more resident patients; and

9. requires a Physician's certification that confinement is Medically Necessary.

Terminally Ill means an individual's medical prognosis indicates a life expectancy of six months or less.

Third Party includes, but is not limited to, all individuals, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, Worker's Compensation, premises liability, no-fault, uninsured or underinsured motorist insurers), who is or may be in any way legally obligated to reimburse, compensate, or pay for a Eligible Person's losses, damages, injuries, or claims relating in any way to the Injury, occurrence, conditions, or circumstances leading to the Plan's provision of medical, dental, or disability benefits.

Totally Disabled or **Total Disability** means:

1. An Eligible Employee is Totally Disabled if he or she is completely unable to perform substantially all of the essential functions of his or her occupation or employment, with or without a reasonable accommodation, because of an accidental bodily Injury or Sickness; and

2. A Dependent is Totally Disabled if he or she is completely unable to perform the normal activities of a person of like age and sex in good health because of a non-occupational accidental bodily Injury or Sickness.

Trust Agreement means the "Agreement and Declaration of Trust" including all restatements, amendments, and modifications as may from time to time be made.

Trust Fund or **Fund** means the entire trust estate of the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan as it may from time to time be constituted, including but not limited to policies of insurance, investments, and the income from any and all investments, Employers' Contributions, and any and all other assets, property, or money received by or held by the Trustees for the uses and purpose of this Trust.

Trustee(s) or **Board of Trustees** means the Board of Trustees of the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan equally representing the Union and the Employer.

Weekly Earnings means an average of the five weeks in which the highest wages or salary were received from a Participating Employer during the eight-week period immediately prior to the date the disability began, exclusive of commissions, bonuses, overtime, or any other additional remunerations.

Union refers to the United Food and Commercial Workers Local No. 1189 and such other local Unions as may from time to time become a party to the Trust Agreement.

You and **your** generally have the same meaning as Employee or Retiree, as applicable.

EXHIBIT A

INITIAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

For the UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 1189 AND ST. PAUL FOOD EMPLOYERS HEALTH CARE PLAN

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under one or more of the following health benefits programs in the Unite Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan ("Plan"):

Medical Plan

Dental Plan

Vision Plan

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

The Plan may afford continuation terms in addition to that required in COBRA. Review the Summary Plan Description at Article I, Section H for continuation details.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent

children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you're a Participant, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of a Participant, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- You become divorced or legally separated from your spouse.
- The parent-Participant dies;
- The parent-Participant's hours of employment are reduced;
- The parent-Participant's employment ends for any reason other than his or her gross misconduct;
- The parent-Participant becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to an employer of the Plan, and that bankruptcy results in the loss of coverage of any retired Participant covered under the Plan, the retired Participant will become a qualified beneficiary. The retired Participant's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan Administrative Manager for each Plan is:

Plan Administrative Manager
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
952-854-0795

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the Participant;
- Commencement of a proceeding in bankruptcy with respect to an employer; or
- The Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the Participant and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Plan Administrative Manager
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
952-854-0795

How is COBRA coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. The Plan requires a copy of the Social Security Determination letter in processing this request.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the Participant or former Participant dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Extended Timeframes in Response to COVID-19 from March 1, 2020

In response to COVID-19, the Plan adopted temporary rules in response to federal legislation providing extended timeframes related to COBRA.

Starting on March 1, 2020, certain deadlines are suspended during a "Tolling Period" which ends on the earlier of:

- Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

- One (1) year from the date the Participant is first eligible for relief from a deadline related to Special Enrollment, COBRA or Claims/Appeals. The earliest date that a Participant is first eligible for relief from a deadline is either:

    - March 1, 2020 for triggering events occurring on or before March 1, 2020, including periods during which an action is required or permitted to be complete that began before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
    - Upon the occurrence of a triggering event occurring after March 1, 2020.

The calculation of an individual's Tolling Period and relief from deadlines and suspension of certain requirements is fact specific and is analyzed as to each individual Participant. The Tolling Period may not exceed one (1) year. If the triggering event occurred prior to March 1, 2020, the number of days that a Participant is required to take action after the Tolling Period is

shortened by the number of days between the trigger event date and March 1, 2020 (the "Proration Rule").

- **COBRA Continuation Coverage under Extended Time Period Rules**.
    - Election of COBRA Coverage. Eligible beneficiaries may elect COBRA continuation coverage up until sixty (60) days after the end of the Tolling Period, subject to the Proration Rule. The Plan must still provide you with COBRA election notices within the normal timeframe.
    - Initial COBRA Premium Payment. A COBRA qualified beneficiary may now make the first COBRA premium payment within the later of 45 days after the end of the Tolling Period or 45 days after the election of COBRA coverage.
    - COBRA Premium Payments after the Initial COBRA Premium Payment. COBRA premium payments (other than an initial COBRA premium payment) may be tolled during the months of the Tolling Period, subject to the Proration Rule. Payments for any COBRA coverage during the months of the Tolling Period may be due within thirty (30) days after the end of the Tolling Period. For example, if a person was receiving COBRA coverage on March 1, 2020 and the Tolling Period ends on February 28, 2021, then payments for COBRA premiums for the months of March 2020 through February 2021 will be due on March 30, 2021. COBRA premiums are paid for consecutive months of coverage, with no gap from the time of the Initial COBRA Premium Payment. Failing to pay COBRA premiums will result in the loss of coverage for the months for which premiums were not paid.
    - Notice of Loss of Dependent Status. Your or your Dependent's obligation to notify the Plan of an event causing a loss of dependent status (e.g., notice of divorce or child reaching age 26) is extended to sixty (60) days after the end of the Tolling Period, subject to the Proration Rule.
    - Notice of Disability. You or your Dependent's obligation to notify the Plan of a disability qualifying for a disability extension coverage is extended to sixty (60) days after the end of the Tolling Period, subject to the Proration Rule.
        - Remember that under the Proration Rule, if a COBRA action period was triggered prior to March 1, 2020, the extension periods are shortened by the number of days between the event and March 1, 2020.
    - For more information regarding COBRA continuation coverage, please see Article I, Section H.

Plan contact information

Plan Administrative Manager
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
952-854-0795

EXHIBIT B

HIPAA PRIVACY PRACTICES
UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 1189 AND
ST. PAUL FOOD EMPLOYERS HEALTH CARE PLAN

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.

The United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan (the "Plan") is required by federal law to provide you this notice of the Plan's privacy practices and related legal duties and of your rights in connection with the use and disclosure of your protected health information ("PHI"). PHI is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its regulations (the "Privacy Rule"). PHI generally means individually identifiable health information that is created or received by a covered entity, including the Plan, in any form or media, including electronic, paper and oral. Individually identifiable health information includes demographic data that relates to an individual's past, present or future physical or mental health or condition, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. For purposes of the Plan and this notice, PHI includes information related to the medical claims that are submitted to the Plan about you, and information about the payment of those claims.

While this notice is in effect, the Plan must follow the privacy practice described. You may have additional rights under state law. State laws that provide greater privacy protection or broader privacy rights will continue to apply. This notice applies to all PHI the Plan maintains. This notice does not apply to PHI that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. Your health care provider may have different policies or notices regarding its use and disclosure of your medical information it creates.

A. The Plan's Rights and Obligations.

1. The Plan is required by law to maintain the privacy and security of your PHI.

2. The Plan is required by law to notify affected individuals of a breach of unsecured PHI.

3. The Plan is required to follow the terms and privacy practices described in this notice, which will remain in effect until the Plan replaces or modifies them. The Plan is required by law to provide individuals notice of the Plan's legal duties and privacy practices with respect to PHI.

4. The Plan reserves the right to change its privacy practices and the terms of this notice at any time, provided that the change is permitted by law. The Plan reserves the right to have such a change affect all PHI it maintains, including PHI it received or created before the change was made. When the Plan makes a material change in its privacy practices, it will revise this notice and post it on its website by the effective date of the material change and the Plan will provide the revised notice, or information about the material change and how to obtain the revised notice, in the next annual mailing to participants.

B. The Plan's Uses and Disclosures of PHI.

The Plan may use or disclose your PHI in certain permissible ways, including the uses and disclosures described below. To the extent required by HIPAA, only the minimum amount of your PHI necessary to perform these tasks will be used or disclosed. The following categories describe the different ways the Plan uses and discloses your PHI. Not every use or disclosure within a category is listed, but all uses and disclosures fall into one of the following categories:

1. Payment. The Plan may use and disclose your PHI for all activities that are included within the definition of "payment" under the Privacy Rule, such as determining your eligibility for Plan benefits, the eligibility of your dependents, facilitating payment for your treatment and health care services, determining benefit responsibility under the Plan, coordinating benefits with other plans, or determining medical necessity. The definition of "payment" includes more items, so please refer to the Privacy Rule for a complete list.

2. Treatment. The Plan does not provide treatment. The Plan may use or disclose your PHI for "treatment" purposes, as defined in the Privacy Rule. This includes helping providers coordinate your health care. For example, a doctor may contact the Plan to ensure you have coverage.

3. Health Care Operations. The Plan may use and disclose your PHI for "health care operations," as defined in the Privacy Rule. These uses and disclosures are necessary to operate the Plan. Health care operations may include developing quality improvement programs, conducting pilot projects, and developing new programs, as well as cost management purposes. The definition of "health care operations" includes more items, so please refer to the Privacy Rule for a complete list.

4. Underwriting. The Plan may disclose summary health information for underwriting. The Plan is prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

5. Authorizations. Except as otherwise provided in this notice, the Plan will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You may give the Plan written authorization to use your PHI or to disclose it to anyone for any purpose. You have the right to revoke that authorization in writing and the Plan will stop using or disclosing your PHI in accordance with that authorization except to the extent that the Plan has taken action in reliance upon the authorization. In addition, the Plan is required to obtain your authorization under the following circumstances:

a. Psychotherapy Notes. Most uses and disclosures of psychotherapy notes will require your authorization.

b. Marketing. Uses and disclosures of PHI which result in the Plan receiving financial payment from a third party whose product or services are being marketed will require your authorization.

c. Sale of PHI. The Plan will not sell your PHI. Disclosures that constitute a sale of PHI will require your authorization.

6. Disclosures to the Plan Sponsor (the Board of Trustees). The Plan may disclose your PHI and enrollment information to the Board of Trustees, which is considered the Plan Sponsor, to the extent necessary to administer the Plan. These disclosures may be made only to designated personnel and will be limited to the disclosures necessary for Plan administration functions. These individuals will protect the privacy of your PHI and will ensure that it is used only as described in this notice and as permitted by law. The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending, or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants, and excludes identifying information in accordance with HIPAA. Your PHI will not be used by the Plan Sponsor for any employment-related actions or decisions or in connection with any other benefit plan offered by the Plan Sponsor.

7. Other Programs. The Plan may disclose your PHI to a health care provider for treatment activities, to another covered entity or a health care provider for payment activities of the receiving entity, and to another covered entity for its health care operation activities under certain circumstances.

8. Communications About Product, Service, and Benefits. The Plan may use and disclose your PHI to tell you about possible medical treatment options, programs, or alternatives, or to tell you about health-related products or services, including payment or coverage for such products or services, that may be of interest to you, provided the Plan does not receive financial remuneration for making such communications. The Plan may also use your PHI to contact you with information about benefits under the Plan, including certain communications about Plan networks, health plan changes, and services or products specifically related to a health condition you may have. The Plan may use and disclose your PHI to contact you to provide reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

9. Communications With Individuals Involved in Your Treatment and/or Plan Payment. Although the Plan will generally communicate directly with you about your claims and other Plan-related matters that involve your PHI, there may be instances when it is more appropriate to communicate with other individuals about your health care or payment. This may include family, relatives, or close personal friends (or anyone else you may choose to designate).

With your authorization, the Plan may use or disclose your PHI to a relative or other individual whom you have identified as being involved in your health care and which PHI is directly relevant to that individual's involvement in these matters. If you are not present, the Plan's disclosure will be limited to the PHI that directly relates to the individual's involvement in your health care. The Plan may also make such disclosures to these persons if: (i) you are given the opportunity to object to the disclosures and do not do so. This verbal permission will cover only a single encounter, and is not a substitute for a written authorization; or (ii) if the Plan reasonably infers from the circumstances that you do not object to disclose to these persons, such as if you are not present or are unable to give your permission and the Plan determines (based on its professional judgment) that the use or disclosure is in your best interest. The Plan will not need your written authorization to disclose your PHI when, for example, you are attempting to resolve a claims dispute with the Plan and you orally inform the Plan that your spouse will call the Plan for additional discussion relevant to these matters. The Plan may also provide limited PHI to your former spouse to the extent reasonably required to continue your former spouse on your Plan, including information related to cost, payment, benefits, and the coverage of any joint children.

The Plan may also use or disclose your name, location, and general condition (or death) to notify, or help to notify, persons involved in your care about your situation. If you are incapacitated or in an emergency, the Plan may disclose your PHI to persons it reasonably believes to be involved in your care (or payment) if it determines that the disclosure is in your best interest.

10. Research. The Plan may use or disclose your PHI for research purposes, provided that the researcher follows certain procedures to protect your privacy.

11. Business Associates. The Plan may disclose your PHI to a "business associate." The Plan's business associates are the individuals and entities the Plan engages to perform various duties on behalf of the Plan, or to provide services to the Plan. For example, the Plan's business associates might provide claims management services or utilization reviews. Business associates are permitted to receive, create, maintain, use, or disclose PHI, but only as provided in the Privacy Rule, and only after agreeing in writing to appropriately safeguard your PHI pursuant to a business associate agreement.

12. Other Uses and Disclosures. The Plan may make certain other uses and disclosures of your PHI without your authorization:

    a. The Plan may use or disclose your PHI for any purpose required by federal, state, or local law.

    b. The Plan may disclose your PHI in the course of a judicial or administrative proceeding in response to an order of a court or an administrative tribunal or to a subpoena, discovery request, or other lawful process if certain conditions are satisfied.

    c. The Plan may use or disclose your PHI for public health activities that are permitted or required by law, including reporting of disease, injury, birth, and death, and for public health investigations.

d. The Plan may disclose your PHI to a public or private organization authorized to assist in disaster relief efforts. The Plan may use or disclose your PHI to help notify a relative or other individual who is responsible for your health care of your location, general condition, or death. In such situations, if you are present and able to give your verbal permission, the Plan will use or disclose your PHI only with your permission. This verbal permission will cover only a single encounter, and is not a substitute for a written authorization. If you are not present or are unable to give your permission, the Plan will use or disclose your PHI only if it determines (based on its professional judgment) that the use or disclosure is in your best interest.

e. The Plan may disclose your PHI to a health oversight agency for activities authorized by law. Relevant agencies include governmental units that oversee or monitor the health care system, government benefit and regulatory programs, and compliance with civil rights laws. Relevant activities include conducting audits, investigations, or civil or criminal proceedings.

f. Under limited circumstances (such as required reporting laws or in response to a grand jury subpoena), the Plan may disclose your PHI to the appropriate law enforcement officials for law enforcement purposes.

g. The Plan may disclose your PHI to coroners, medical examiners, and funeral directors as necessary for them to carry out their duties. If you are an organ donor, the Plan may disclose your PHI to organ procurement or organ, eye, or tissue transplantation organizations, as necessary to facilitate organ or tissue donation and transplantation.

h. The Plan may use or disclose your PHI to avert a serious threat to your health or safety or to the health and safety of others. Any such disclosure will be made to someone who would be able to help prevent the threat.

i. The Plan may disclose your PHI, if you are in the Armed Forces, for activities deemed necessary by appropriate military command authorities, for determination of benefit eligibility by the Department of Veterans Affairs, or to foreign military authorities if you are a member of that foreign military service. The Plan may disclose your PHI to authorized federal officials for conducting national security and intelligence activities (including for the provision of protective services to the President of the United States) or to the Department of State to make medical suitability determinations. If you are an inmate at a correctional institution, then under certain circumstances the Plan may disclose your PHI to the correctional institution.

j. The Plan may disclose your PHI to the extent necessary to comply with laws concerning workers' compensation or to comply with similar programs that are established by law and provide benefits for work-related injuries or illness.

k. The Plan may disclose your PHI, consistent with applicable federal and state laws, if the Plan believes that you have been a victim of abuse, neglect, or domestic violence. Such disclosure will be made to the governmental entity or agency authorized to receive such information.

l. The Plan will disclose your PHI to the Secretary of the Department of Health and Human Services, when required to do so, to enable the Secretary to investigate or determine the Plan's compliance with HIPAA and the Privacy Rule.

C. Your Rights Regarding Your PHI.

1. Right To Access, Inspect, and Copy Your PHI. You have the right to look at or obtain copies of your PHI maintained by the Plan that may be used to make decisions about your Plan eligibility and benefits, with limited exceptions. The Plan requires you to make this request in writing to the Privacy Official listed at the end of this notice. The Plan will generally respond to your request within 30 days after the Plan receives it; if more time is needed, the Plan will notify you within the original 30-day period. The Plan may deny your request to inspect and copy in certain limited circumstances. The Privacy Rule contains a few exceptions to your right to inspect and copy your PHI maintained by the Plan. You do not have the right to inspect or copy, among other things, psychotherapy notes or materials that are compiled in anticipation of litigation or similar proceedings. If your written request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If the information you request is maintained electronically, and you request an electronic copy, the Plan will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, the Plan will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, the Plan will provide you with a paper copy. You have a right to choose to receive a copy of all or of only portions of your PHI. The Plan may charge a fee for copying or mailing your PHI for you but may waive that charge depending on your circumstances. If you make a request in advance, the Plan will provide you with an estimate of the cost of copying or mailing the requested information.

2. Right To Request an Amendment of Your PHI. If you believe there is a mistake or missing information in a record of your PHI held by the Plan or one of its business associates, you may request, in writing, that the record be corrected or supplemented. You have the right to request an amendment for as long as the PHI is kept by or for the Plan. Your request must be in writing and must include a reason or explanation that supports your request. The Plan will usually respond within 60 days of receiving your request; if more time is needed, the Plan will notify you within the original 60-day period. The Plan may deny the request if it is not in writing, it is determined that the PHI is correct and complete, the information is not part of the PHI kept by or for the Plan, not created by the Plan or its business associates, and/or not part of the Plan's or business associate's records (unless the person or entity that created the information is no longer available to make the amendment), or it is not part of the information which you would be permitted to inspect and copy. All denials will be made in writing. Any

denial will include the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the Plan denies your request for an amendment, you may file a written statement of disagreement, which the Plan may rebut in writing. The denial, statement of disagreement, and rebuttal will be included in any future disclosures of the relevant PHI. If your request for amendment is approved, the Plan or the business associate will change the PHI and inform you of the change and inform others that need to know about the change. If the Plan approves your request, the Plan will include the amendment in any future disclosures of the relevant PHI.

3. Right To Request and Receive an Accounting of Disclosures. You have a right to receive a list of routine and non-routine disclosures that the Plan has made of your PHI. This does not include a list of disclosures for treatment, payment, health care operations, and certain other purposes (such as disclosures made for national security purposes, to law enforcement officials, or correctional facilities). If the PHI disclosed is not an "electronic health record," the accounting will include disclosures for the six years prior to the date of your request. In this case, as noted above, the accounting is not required to include all disclosures. If the PHI disclosed is an "electronic health record," the accounting will include disclosures up to three years before the date of your request. Your request for the accounting must be made in writing. Your request must include the time frame that you would like the Plan to cover. You will normally receive a response to your written disclosure for this accounting within 60 days after your request is received; if more time is needed, the Plan will notify you within the original 60-day period. There will be no charge for up to one such list in each 12-month period but there may be a charge for more frequent requests. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

4. Right To Request Restrictions. You have the right to request that the Plan restrict how it uses or discloses your PHI for treatment, payment, or health care operations. You also have the right to request a limit on the PHI about you that the Plan discloses to someone who is involved in your care or the payment of your care. The Plan will consider your request but generally is not legally bound to agree to the request for restriction. However, the Plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which you, or another person on your behalf, has paid the health care provider involved in full. Your request must be in writing. In your request, you must tell the Plan (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosure to your spouse. If the Plan does agree to your restriction it must comply with the agreed-to restriction, except for purposes of treating you in a medical emergency.

5. Right To Alternate Communications. You have the right to request that the Plan communicate with you about your PHI by alternative means or at an alternative location. For example, you may request that the Plan contact you only at a designated address or phone number. Your request must be in writing. In your

request, you must tell us how or where you wish to be contacted. The Plan will make a reasonable accommodation of an individual's request for confidential communication if the request is reasonable and if the individual clearly states that releasing the information could endanger the individual. The Plan will notify the individual if the request is granted or denied.

6. Right To Request a Copy of This Notice in an Alternative Format. You are entitled to receive a printed copy of this notice at any time as well as a non-English translation. You may ask the Plan to give you a paper or electronic copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Contact the Plan using the information listed in Section E to obtain an alternative copy of this notice.

D. Complaints.

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, send a written complaint to the Privacy Official listed in Section E. The Plan will not retaliate against you for filing a complaint, and you will not be penalized in any other way for filing a complaint.

E. Contact Information.

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official through the Plan Administrative Manager, who will forward your questions to the Plan's Privacy Official. The Plan's Administrative Manager is:

Plan Administrative Manager
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
952-854-0795

F. Personal Representatives.

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms: (i) a notarized power of attorney for health care purposes; (ii) a court order of appointment of the person as an individual's conservator or guardian; or (iii) an individual who is the parent of an unemancipated minor child (subject to state law). The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

G. Changes to the Terms of this Notice.

The Plan may change the terms of this notice. This notice is effective June 1, 2020.

PLAN PROVIDER CONTACT INFORMATION

Plan Administrative Manager
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Plan Legal Counsel
Attorney Cindy L Davis
Kutak Rock LLP
60 South Sixth Street, Suite 3400
Minneapolis, MN 55402-4400

Plan Consultant
Lee Jost and Associates
One Park Plaza
11270 West Park Place, Suite 950
Milwaukee, WI 53224

Life and Accidental Death and Dismemberment
Underwritten and Insured by
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175

Plan Preferred Provider Network
UnitedHealthcare
www.umr.com

Plan Preferred Provider Pharmacy Network Manager
Sav-Rx
www.savrx.com

Employee Assistance Program Provider
TEAM
1970 Oakcrest Avenue, Suite 200
Roseville, MN 55113

Plan Dental Provider Network
Delta Dental of Minnesota
P.O. Box 9304
Minneapolis, MN 55440-9304