United Food & Commercial Workers Local Union #1189 and St. Paul Food Employers Health Care Plan

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IMPORTANT NOTICE

Summary of Material Modifications

TO: Participants and Beneficiaries of the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan

FROM: The Board of Trustees

DATE: April 2022

This is a Summary of Material Modifications ("SMM") regarding the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan (the "Plan"). The Board of Trustees of the Plan has amended the Summary Plan Description and Plan Document (Amended and Restated March 1, 2021) as described below.

Amendment No. 3: Surprise Billing Protections

Effective March 1, 2022 (the first day of the plan year), the Plan was amended to comply with the requirements of the federal No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021. Under the No Surprises Act, the Plan will cover claims for certain "surprise" out-of-network health care costs as if they were in-network expenses. For claims subject to the No Surprises Act, this means that you will not be "balance billed" by the out-of-network provider or health care facility for additional expenses beyond the recognized amount that is covered subject to the Plan's standard cost-sharing rules (copayments, coinsurance, and deductibles).

The No Surprises Act protections will apply to the following three categories of claims:

- Emergency Services provided by an out-of-network provider and/or at an out-of-network health care facility;
- Certain Non-Emergency Services provided by an out-of-network provider at an in-network health care facility; and
- Out-of-network Medically Necessary Air Ambulance Services.

"Emergency Services" are defined as appropriate medical screening examinations and treatment for an Emergency medical condition. Emergency Services also may include services after the patient stabilizes, such as observation and inpatient or outpatient stays in connection with the Emergency.

Non-Emergency Services provided by an out-of-network provider at an in-network health care facility include, but are not limited to, services such as anesthesiology, pathology, radiology, and neonatal care as well as services provided by assistant surgeons, hospitalists, intensivists, and,

generally, any out-of-network provider at the facility if there is no in-network provider at the facility who can provide the items or services that provider provides.

In certain cases, however, Emergency Services provided by an out-of-network provider and/or at an out-of-network health care facility and non-Emergency Services provided by an out-of-network provider at an in-network health care facility will not be treated as in-network claims under the No Surprises Act if the provider or facility provides the patient with a notice regarding the out-of-network status of the services or facility and the patient consents to receive those out-of-network services (except for specific circumstances described below).

This notice and consent exception never applies to the following:

- Unforeseen urgent medical needs;
- Pre-stabilization Emergency Services;
- Post-stabilization Emergency Services, unless:
    - The attending provider determines that the patient is able to travel without Emergency medical transportation; and
    - The patient is provided a list of any in-network providers at the facility who are able to furnish the Medically Necessary items or services and is offered a referral to those providers;
- Certain "ancillary" services provided by an out-of-network provider at an in-network facility, specifically:
    - Anesthesiology, pathology, radiology, and neonatal care;
    - Services provided by an assistant surgeon, hospitalist, or intensivist; and
    - Diagnostic services such as radiology and laboratory services; and
- Items and services provided by an out-of-network provider if there is no in-network provider at the facility who can provide those items and services at the in-network facility.

In other cases where the notice and consent exception is available, the notice must contain specific information required by the No Surprises Act, including a statement of out-of-network status, a good faith estimate of the charges and notice that the estimate is not a binding contract, notice that prior authorization may be required by the Plan, and a clear statement about the option to obtain care from an in-network provider and that obtaining services from an in-network provider would result in no balance billing.

The notice must be provided to you at least 72 hours before an appointment (if the appointment is scheduled at least 72 hours in advance) or at least three hours before an appointment (if the appointment is scheduled fewer than 72 hours in advance).

Consent must be provided voluntarily, and the signed consent must contain a clear statement that the patient understands the consequences of receiving out-of-network services instead of in-network services, such as balance billing. The notice and consent must be made available upon request in the 15 most common non-English languages in the state or geographic region, or for other languages, the services of a qualified interpreter must be provided to help the patient

understand the notice and consent. The consent must state the time and date of the patient's receipt of the written notice described above and the time and date of the consent.

Finally, for coverage of out-of-network Air Ambulance Services, the Plan will cover such services as if they were in-network services (i.e., without balance billing but still subject to the Plan's cost sharing rules) but only to the nearest health care facility qualified to provide Medically Necessary treatment for an Emergency or a provider-initiated transfer to another health care facility qualified to provide Medically Necessary treatment. Air Ambulance Services are only covered if Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would result in a serious adverse impact on the patient's health status.

Under the Act, claims involving whether the Plan is complying with the surprise billing protections described above (and only these types of claims) are subject to an external review process as part of the Plan's claim and appeal procedures. This external review process works as follows.

- **Standard External Review**

    - *Request for External Review*: You have four months to file a request for external review after the date of a final adverse benefit determination involving the surprise billing protections described above.

    - *Preliminary Review*: The Plan must complete its preliminary review within five business days after receiving your request and inform you within one business day after the preliminary review whether your claim is eligible for external review. If the preliminary review decision cannot be made because your request is not complete, the Plan will provide a notice describing the missing information and materials needed. You may then revise your complaint within the original four-month external review filing period or within 48 hours of receipt of the Plan's notice, whichever is later.

    - *Referral to Independent Review Organization*: If your request is eligible for external review, it will be assigned to one of three independent review organizations ("IROs"), to whom the Plan assigns external review requests on a rotating basis. The IRO will notify you of your right to submit additional information in writing for its consideration of your request and notify the Plan within one day of receipt of any additional information that you provide. If the Plan reverses its denial of your claim based on the new information, external review is complete.

    - *IRO Review of Information and Documentation*: The IRO will review your claim without giving any weight to the previous decision of the Plan to deny your claim. The IRO will review, as relevant, your medical records, the attending health care professional's recommendation, reports from other health care professionals and documents submitted by you (or your treating provider) and the Plan, the written Plan terms, appropriate practice guidelines, and any appropriate clinical review criteria developed and used by the Plan.

    - *Written Notice of IRO's Decision*: The IRO will notify you and the Plan of its decision on your claim within 45 days after receiving the request for external review. The IRO will send you a written decision containing a description of the claim, the date the IRO received the external review assignment, the relevant evidence and documentation for the claim that the IRO relied on when making its decision, a discussion of the reasons for the IRO's decision, a statement that the IRO's decision is binding on you and the Plan (unless provided otherwise by law), a statement that you may seek judicial review of the claim, and current contact information for health insurance consumer assistance or ombudsmen, as appropriate.

- **Expedited External Review**

  - *Request for External Review*: You may file a request for expedited external review of an adverse benefit determination involving the surprise billing protections described above if:

    - An adverse benefit determination involves a medical condition where the timeframe for completing the expedited internal appeal process would seriously jeopardize your life, health, or ability to regain maximum function, and you have filed a request for an expedited internal appeal;

    - A final internal adverse benefit determination relates to a medical condition where the timeframe for completing the standard external review process would seriously jeopardize your life, health, or ability to regain maximum function; or

    - A final internal adverse benefit determination concerns an admission, availability of care, continued stay, or a health care item or service for which you received Emergency Services, but you have not been discharged from a facility.

  - *Preliminary Review*: The Plan must complete its preliminary review immediately after receiving your request and inform you whether your claim is eligible for external review.

  - *Referral to Independent Review Organization*: If your request is eligible for external review, it will be assigned to one of three independent review organizations, to whom the Plan assigns external review requests on a rotating basis. The Plan will assign the IRO and transmit all necessary documents and information considered in the adverse benefit determination or final internal adverse benefit determination as expeditiously as possible, whether via email, telephone, fax, or another means.

  - *IRO Review of Information and Documentation*: The IRO will consider your medical records and other documents to the extent appropriate.

  - *Notice of Final External Review Decision*: The IRO will notify you and the Plan of its decision on your claim as expeditiously as possible as your medical condition or circumstances require, but in no event later than 72 hours after it receives the request for expedited external review.

Amendment No. 4: Over-the-Counter COVID-19 Test Coverage

The United States government is providing free at-home COVID test kits. Please visit www.covidtests.gov or call 1-800-232-0233 (TTY 1-888-720-7489) to order up to two sets of four free tests per household. The test kits will ship through the USPS and are expected to ship out seven to 12 days after the order date to most residential addresses.

Effective January 15, 2022, the Plan was amended to provide coverage for at-home over-the-counter ("OTC") COVID-19 test kits. The Plan will provide coverage for at-home OTC COVID-19 test kits purchased on and after January 15, 2022 subject to the following provisions.

- ***The Plan will only cover COVID-19 test kits available "over the counter" that have been approved by the FDA for use at home or elsewhere without involvement of a health care provider*** purchased January 15, 2022 through the end of the COVID-19 Public Health Emergency that was declared by the Department of Health and Human Services. Please go to www.fda.gov to learn which tests are currently FDA approved or check the packaging on the test kit before purchasing.

- The Plan will cover 100% of the cost (no Deductible or Copay) for up to eight at-home OTC COVID-19 test kits per Covered Person under the Plan every 30 days.

    - You must purchase the OTC COVID-19 test at the pharmacy counter of a pharmacy in the Sav-Rx network and present your Plan Prescription card at the time of purchase. If the in-network pharmacy is set up to process test kits in the same manner as a prescription, you will not pay any amount for the OTC COVID-19 test kits at the time of purchase.

    - Some pharmacies in the Sav-Rx network are not set up to process at-home OTC COVID-19 test kits in the same manner as a prescription. You must pay 100% of the cost for at-home OTC COVID-19 test kits you purchase at one of these pharmacies. The Plan will reimburse you for the entire cost of these at-home OTC COVID-19 test kits if you save your receipt of purchase and submit the receipt along with the form to Sav-Rx. Reimbursement request forms are available at www.savrx.com.

    - Plan reimbursement for at-home OTC COVID-19 test kits that you do not purchase at a Sav-Rx in-network pharmacy will be limited to the cost of the test or $12, whichever is less. You are responsible for any amount that you pay in excess of $12 for an at-home OTC COVID-19 test kit purchased at a pharmacy that is not in the Sav-Rx network, or any other retailer or supplier.

    - The Plan will cover only OTC COVID-19 test kits for at-home medical use by you or your covered household family members. Tests for employment purposes or resale will not be covered or reimbursed under this program.

The above provisions only apply to at-home OTC COVID-19 test kits and do not affect previous Plan provisions regarding coverage of non-at-home OTC COVID-19 test kits.

Amendment No. 5: Medical Necessity Determinations

Effective April 5, 2022, the Plan was amended to state that whether a covered item or service is Medically Necessary will be determined in accordance with UnitedHealthcare's medical policy.

Please update your Summary Plan Description and Plan Document booklet (dated March 1, 2021) to reflect these changes by inserting replacement and supplemental pages i, iA, iv, 1, 1A, 37, 37A, 37B, 37C, 37D, 41, 41A, 47, 53, 65, 74, 79, 83, 83A, 89, 89A, 90, 90A, 90B, 90C, 90D, 91, 94, 94A, 98, 98A, 100, and 100A into your booklet to replace and supplement the existing pages.

If you have any questions about these changes to the Plan, please contact the Plan Administrator, Wilson-McShane Corporation, at (952) 854-0795 or 1-800-535-6373.

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. Whether a covered item or service is Medically Necessary will be determined in accordance with UnitedHealthcare's medical policy.		
Deductible amount per Calendar Year • Per person • Per family (Plan 1 only) • Per group (Plan 2 only, if Dependent Child coverage purchased)	 $300 $900 N/A	 $300 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 • Per family (Plan 1 only) • Per group (Plan 2 only, if Dependent Child coverage purchased)	 $2,500 $5,000 N/A	 $2,500 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 are waived 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).

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. Whether a covered item or service is Medically Necessary will be determined in accordance with UnitedHealthcare's medical policy.	
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 o 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%

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 (except for later changes adopted by the Board of Trustees, with effective dates described in a Summary of Material Modification provided by the Plan Administrator).

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 the Trustees determine appropriate to comply with legal requirements, including the Patient Protection and Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and the Consolidated Appropriations Act, 2021.

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**
Laura Daly	Tami Denn-Bauer
Kent Dixon	James Gleb
Michael Oase	Robert Jordan
Chris Thienes	Abraham Wangnoo
Jon Born, Alternate	Raymond Gandy, Alternate
Fred Miller, Alternate	James Westin, Alternate

The addresses of the Trustees are found on page 79.

Contact information for the Plan Administrator appears on the following page.

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

ARTICLE VII

MAJOR MEDICAL BENEFITS

Plans 1, 2 and 3

A. Preferred Provider Network Benefits

1. Preferred Providers

The Board of Trustee has entered into a Preferred Provider arrangement 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 Preferred provider or a non-Preferred Provider each time you need medical services. Your current Hospital or Physician already may be a member of this network.

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 Preferred 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. Preferred Providers automatically will file your claim for you if you present your Participant identification card and sign the appropriate form.

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 Provider in your network, please contact the Fund Office.

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

2. Non-Preferred Providers

Generally, for charges incurred with non-Preferred Providers, the Plan will pay the Reasonable Expense or, if applicable, a separately negotiated amount to the non-Preferred Provider. The Plan may accept an assignment of these claims to make payment directly to the non-Preferred Provider. You will be responsible for applicable Deductibles, Coinsurance, Copayments, maximum benefit limitations, or other similar limitations under the Plan and may be billed for the balance by the non-Preferred Provider (except in certain circumstances described in the next subsection).

3. Certain Non-Preferred Provider Services Treated as Preferred Provider Services

Effective March 1, 2022, subject to the Plan's standard cost sharing requirements (Coinsurance, Copayments, and Deductibles) and coordination of benefits rules, the Plan will cover certain claims for services provided by non-Preferred Providers as if the services were provided by Preferred Providers (i.e., you will not be subject to balance billing). This rule applies only

to: (i) claims for Emergency Services provided by a non-Preferred Provider and/or at a non-Participating Health Care Facility; (ii) claims for certain non-Emergency Services furnished to you by a non-Preferred Provider at a Participating Health Care Facility; and (iii) claims for non-Preferred Provider Air Ambulance Services. The exact costs payable by you and the Plan for such claims will be determined in accordance with rules and regulations established pursuant to the Consolidated Appropriations Act, 2021.

a. **Emergency Services Provided by a Non-Preferred Provider and/or At a Non-Participating Health Care Facility.** Emergency Services provided by a non-Preferred Provider and/or at a non-Participating Health Care Facility will be covered as if provided by a Preferred Provider at a Participating Health Care Facility. This may include costs for additional services after the patient stabilizes, such as post-stabilization outpatient observation or inpatient or outpatient stays with respect to the visit for which the Emergency Services were initially furnished. Post-stabilization items and services will not be treated as in-network Emergency Services, however, if both of the following are true:

   i. The attending Emergency Physician or treating Provider determines that the individual is able to travel using nonmedical transportation or nonemergency medical transportation to an available Preferred Provider or Participating Health Care Facility located within a reasonable travel distance, taking into account the individual's medical condition; and

   ii. Except in cases where unforeseen, urgent medical needs arise, the non-Preferred Provider or non-Participating Health Care Facility furnishing the post-stabilization items or services satisfies the notice and consent criteria described below for non-Emergency Services provided by a non-Preferred Provider at a Participating Health Care Facility, but subject to the following additional conditions:

      A. If the Hospital or Independent Freestanding Emergency Department is a Participating Health Care Facility but the Provider is a non-Preferred Provider, the written notice must contain a list of any Preferred Providers at the Participating Health Care Facility who are able to furnish the items and services involved and must notify the patient that he or she may be referred, at his or her option, to such a Preferred Provider; or

      B. If the Hospital or Independent Freestanding Medical Department is not a Participating Health Care Facility, the written notice must include a good faith estimate of the charges for items or services furnished by the facility or Providers for the visit (and any items or services reasonably expected to be furnished by the facility or non-Preferred Providers in conjunction with those items or services).

b. **Non-Emergency Services Provided by a Non-Preferred Provider at a Participating Health Care Facility.**

i. When an Eligible Person receives non-Emergency Services covered by the Plan at a Participating Health Care Facility, the Plan will treat the following as Covered Expenses provided by Preferred Providers (provided that all other criteria for coverage are met, e.g., the services are Medically Necessary):

A. Ancillary services, which are:

I. Items and services related to Emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner;

II. Items and services provided by assistant surgeons, hospitalists, and intensivists;

III. Diagnostic services, including radiology and laboratory services; and

IV. Items and services provided by a non-Preferred Provider if there is no Preferred Provider who can furnish such item or service at such facility; and

B. Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-Preferred Provider satisfied the notice and consent criteria described below.

ii. Non-Emergency Services provided by a non-Preferred Provider at a Participating Health Care Facility will not be treated as Covered Expenses if the Provider or the Participating Health Care Facility (on behalf of the Provider) satisfies notice and consent criteria by:

A. Providing the patient a written notice within the time frame noted below, in paper form or, as practicable, electronic form (as selected by the patient); provided separately from other documents; and containing the following information:

I. A statement that the Provider is a non-Preferred Provider;

II. A good faith estimate of the charges for the items and services involved or reasonably expected to be provided,

III. Notice that the estimate of charges or the patient's consent to be treated by the non-Preferred Provider

is not a contract for the estimated charges or a contract to be treated by that Provider or facility;

IV. A statement that prior authorization or other care management limitations may be required before receiving further items or services at the facility; and

V. A clear statement that consent to receive items or services from the non-Preferred Provider is optional; that the patient may instead seek care from an available Preferred Provider; and that in such cases, cost sharing would be limited to Preferred Provider cost sharing amounts;

B. Providing the written notice:

I. Not later than 72 hours before the date on which the individual is furnished the items or services, when the appointment is scheduled at least 72 hours in advance; or

II. Not later than three hours before the appointment, when the appointment is not scheduled at least 72 hours in advance;

C. Obtaining from the patient (or Participant, Beneficiary, or other authorized representative) a signed consent that is current (i.e., has not been revoked), that was obtained voluntarily (i.e., the individual must be able to consent freely, without undue influence, fraud, or duress), and that is in a form specified by the Department of Health and Human Services. The consent must:

I. Acknowledge in clear and understandable language that the patient (or Participant or Beneficiary) has been provided the written notice described above in the form (mail or email) he or she selected and informed that the payment of non-Preferred Provider charges might not count toward a deductible, out-of-pocket maximum, or other cost sharing limitation;

II. State that by signing the consent, the individual agrees to be treated by the non-Preferred Provider and understands that he or she may be balance billed and subject to cost sharing requirements that apply to services furnished by the non-Preferred Provider; and

III. Document the time and date of receipt of the written notice described above and the time and date of the signed consent;

D. Providing the patient with a copy of the signed written notice and consent in person, by mail, or by email; and

E. Making the notice and consent available upon request in any of the 15 most common languages in the state or geographic region and, for other languages, if the individual does not understand the notice and consent, obtaining the services of a qualified interpreter to assist the individual with understanding the notice and consent.

c. **Non-Preferred Provider Air Ambulance Services.** Air Ambulance Services provided by a non-Preferred Provider may be treated as Preferred Provider Covered Expenses as described below in Section C.10.

B. Payment Terms

When you or your Dependent requires 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.

10. Ambulance and Medical Transportation

The following Reasonable Expenses for ambulance and medical transportation are covered subject to the Plan's generally applicable cost sharing and coordination of benefits provisions:

- Local professional ground ambulance service to the nearest health care facility that is qualified to provide Medically Necessary treatment for an Emergency or acute illness, or for a Provider-initiated inter-health care facility transfer to the nearest health care facility qualified to provide the Medically Necessary treatment.
- The Plan also will cover, subject to the Plan's generally applicable cost sharing and coordination of benefits provisions, Medically Necessary Air Ambulance Services to the nearest health care facility qualified to provide Medically Necessary treatment for an Emergency. The Plan also will cover, subject to the Plan's generally applicable cost sharing and coordination of benefits provisions, a Provider-initiated inter-health care facility transfer to the nearest health care facility qualified to provide the Medically Necessary treatment. Charges are payable for Medically Necessary Air Ambulance Services subject to the Plan's Deductible and Coinsurance, as stated in the Schedule of Benefits, and the reimbursement terms available to the Plan through the Preferred Provider's contract. Air Ambulance Services will be provided only as Medically Necessary:
    - Due to inaccessibility by ground transport; and/or
    - If the use of ground transport would result in a serious adverse impact on the Eligible Person's health status.
- Out-of-network Air Ambulance Services will be covered, subject to the Plan's generally applicable cost sharing and coordination of benefits provisions, in accordance with the Consolidated Appropriations Act, 2021. The cost sharing requirements will be the same as Air Ambulance Services provided by a Preferred Provider. The cost sharing amounts paid by you for out-of-network Air Ambulance Services will apply to your Deductible and out-of-pocket maximum in the same manner as if the services were provided by a Preferred Provider.
- Charges for ambulance service by railroad, ship, bus, or other common carrier are not Covered Expenses.
- Expenses incurred for transportation and/or ambulance services, including Air Ambulance Services, are not covered if such services are incurred for the convenience of the Eligible Person, the Eligible Person's health care provider, or the Eligible Person's family or another individual involved in the Eligible Person's care. Expenses for any transportation and/or ambulance services are not covered if the Plan determines that the transportation and/or ambulance services are not Medical Necessary.

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) subject to the Plan's generally applicable cost sharing and coordination of benefits provisions:

- 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.

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 an 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 and subject to the Plan's generally applicable cost sharing and coordination of benefits provisions.

26. Implantable Hearing Devices

Implantable hearing devices are covered if Medically Necessary, subject to the Plan's generally applicable cost sharing and coordination of benefits provisions.

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.

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 Serotonin 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.

G. Over-the-Counter COVID-19 Test Kits

Effective January 15, 2022, and for the duration of the public health emergency concerning COVID-19, the Plan will provide coverage for at-home over-the-counter ("OTC") COVID-19 test kits, subject to the following rules. The Plan will only cover COVID-19 test kits available "over-the-counter" that have been approved by the U.S. Food and Drug Administration for use at home or elsewhere without involvement of a health care provider or an individualized clinical assessment. The Plan will provide coverage for up to eight at-home COVID-19 test kits per Eligible Person covered under the Plan every 30 days. The Plan will cover 100% of the cost of an at-home OTC COVID-19 test kit purchased at a Preferred Provider pharmacy. Plan reimbursement for at-home OTC COVID-19 test kits that are not purchased at a Preferred Provider pharmacy will be limited to the cost of the test or $12, whichever is less. The Eligible Person is responsible for any amount in excess of $12 for an at-home OTC COVID-19 test kit purchased at a non-Preferred Provider pharmacy or any other retailer or supplier.

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 exclusions 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 Services 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

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.

K. Consolidated Appropriations Act, 2021

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Consolidated Appropriations Act, 2021 ("CAA"). The Plan has been amended to comply with the requirements of the CAA as of the effective date of Amendment No. 3: March 1, 2022.

ARTICLE XIII

INFORMATION ABOUT THE PLAN

A. Names and Addresses of the Trustees

Employer Trustees

Laura Daly
UNFI
11840 Valley View Road
Eden Prairie, MN 55344

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

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

Robert Jordan
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

Raymond Gandy, 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. Name 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

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 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 urgent 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, inpatient 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.

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. If applicable, describe the Plan's external review procedures and the time limits for those procedures, and state that the Eligible Person has the right to bring a civil action under Section 502(a) of ERISA (following external review, if applicable).

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.

F. External Review Procedure

The Plan must implement an external review process for certain adverse benefit determinations involving items and services within the scope of the surprise billing and cost sharing protections of Sections 716 and 717 of ERISA and the regulations issued thereunder, as provided by the Consolidated Appropriations Act, 2021 (the "Surprise Billing Provisions," described below).

The Plan's external review process is limited to the review of adverse benefit determinations involving consideration of whether the Plan is complying with the Surprise Billing Provisions. Under the Surprise Billing Provisions, the Plan must generally cover as in-network any non-Preferred Provider Emergency Services, non-Emergency Services furnished to you by a non-Preferred Provider at a Participating Health Care Facility, and non-Preferred Provider Air Ambulance Services, subject to any other terms and conditions stated elsewhere in this SPD; the Consolidated Appropriations Act, 2021; or the regulations issued pursuant to that act. Generally, under the Surprise Billing Provisions, the cost sharing requirements for these specific out-of-network services will be no greater than would apply if the services were provided by Preferred Providers, and cost sharing paid by you for these services will apply in the same manner as if the services were provided by Preferred Providers.

The Plan must provide benefits pursuant to an independent review organization ("IRO") decision without delay and regardless of whether the Plan intends to seek a judicial review of the external review decision and unless or until there is a judicial review otherwise.

1. Standard External Review

a. **Request for External Review.** You may file a request for external review of an adverse benefit determination involving consideration of whether the Plan is complying with the Surprise Billing Provisions within four months after the date you received notice from the Plan of a final adverse benefit determination involving the Surprise Billing Provisions.

b. **Preliminary Review.**

i. The Plan must complete its preliminary review within five business days following receipt of the external review request to determine whether:

A. You were covered under the Plan at the time the health care service or item in question was requested, or in the case of

a retrospective review, if you were covered under the Plan at the time the health care service or item was provided;

B. The adverse benefit determination or final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan and involves consideration of whether the Plan is complying with the Surprise Billing Provisions;

C. You have exhausted the Plan's internal appeal process, unless you are not required to do so under the appeals rules; and

D. You have provided all the information and forms required to process an external review.

ii. Within one business day of completing its preliminary review, the Plan will notify you in writing if:

A. Your request is eligible for external review;

B. Your request is complete, but it is not eligible for external review, in which case the Plan will provide you with the reasons it has determined that you are ineligible for external review, along with the contact information for the Department of Labor's Employee Benefits Security Administration (toll-free (866) 444-3272); or

C. Your request is not complete, in which case the notice will describe the missing information and materials needed to make the request complete, in which case you may revise your complaint within the four-month external review filing period or within 48 hours after receipt of the notice, whichever is later.

c. **Referral to IRO.** If your request is eligible for external review, the matter will be assigned to an IRO that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. The Plan has contracted with three IROs and rotates external review assignments among them. The IRO will be required to:

i. Timely notify you in writing concerning your request's eligibility and acceptance for external review and provide you information on submitting additional information;

ii. Use legal experts, where appropriate, to make coverage determinations under the terms of the Plan;

iii. Notify you of your right to submit additional information in writing for the IRO to consider in making its decision; and

iv. Notify the Plan of and provide to the Plan, within one day of receipt, any additional information you provide regarding your claim appeal, in which case if the Plan reverses its denial and provides coverage or payment based on this additional information, then the external review can be terminated.

d. **Timely Review All Information and Documentation.** In reaching its decision, the IRO will review the claim *de novo* and will not be bound by any prior decisions or conclusions reached during the Plan's internal claims review and appeals procedures. The IRO will consider the following in reaching a decision:

i. Your medical records;

ii. The attending health care professional's recommendation;

iii. Reports from appropriate health care professionals and other documents submitted by the Plan, you, and your treating provider;

iv. The terms of the Plan to ensure that any decision reached is not contrary to the Plan's terms unless the terms are inconsistent with law;

v. Appropriate practice guidelines, which must include applicable evidenced-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;

vi. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

vii. The opinion of the IRO's clinical reviewer(s) after considering the information described in this notice, to the extent the information or documents are available and the clinical reviewer considers appropriate.

e. **Written Notice of IRO's Final Decision.** The IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO received the initial request for external review. The IRO's decision will contain:

i. A general description of the reason for the request for external review, including the date(s) of service, the health care provider, the claim amount, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial;

ii. The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, that the IRO relied on in making its decision;

iv. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

v. A statement that the IRO's determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan;

vi. A statement that judicial review may be available to you; and

vii. Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

f. **Maintaining Records.** After the IRO reaches its final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six years. The IRO must make all such records available for examination by you, the Plan, and any state or federal oversight agency, upon request, except if such disclosure would violate state or federal privacy laws.

g. **Reversal of Plan's Decision.** The Plan, upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final adverse benefit determination, will immediately provide coverage or payments for the claim.

2. Expedited External Review

a. **Request for Expedited External Review.** The Plan will allow you to make a request for an expedited external review at the time you receive:

i. An adverse benefit determination involving consideration of whether the Plan is complying with the Surprise Billing Provisions if it involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal;

ii. A final internal adverse benefit determination involving consideration of whether the Plan is complying with the Surprise Billing Provisions if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; or

iii. A final internal adverse benefit determination involving consideration of whether the Plan is complying with the Surprise Billing Provisions if it concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but you have not been discharged from a facility.

b. **Preliminary Review.** Immediately upon receipt of a request for an expedited internal external review, the Plan will determine whether the request meets the reviewability requirements and send written notice to you regarding whether you are eligible for an expedited external review.

c. **Referral to IRO.** Upon determining that a request is eligible for external review, following the preliminary review, the Plan will assign an IRO and provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO as expeditiously as possible, including, but not limited to, by email, telephone, or fax.

d. **Review of Documents.** In reaching its decision, the IRO will consider your medical records and other documents to the extent appropriate.

e. **Notice of Final External Review Decision.** The IRO will provide notice of its final expedited external review decision as expeditiously as possible as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

The decision of the IRO will be binding on the Plan as well as you, except to the extent other remedies are available under federal or state law.

G. Legal Action

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 (and external review, if applicable) 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 (or, if applicable, pursuant to the decision of an IRO as described in the Plan's external review provisions). Except to the extent decision-making authority is given to an IRO pursuant to the Plan's external review provisions, 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.

Air Ambulance Services means medical transport by a rotary wing air ambulance or fixed wing air ambulance for patients.

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

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.

Emergency means:

1. a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

    a. placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

    b. serious dysfunction of any bodily organ or part; or

    c. serious impairment of bodily functions; or

2. with respect to a pregnant woman who is having contractions:

    a. that there is inadequate time to effect a safe transfer to another Hospital before delivery; or

    b. that transfer may pose a threat to the health or safety or the woman or the unborn child.

Emergency Services means:

1. an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department and ancillary services routinely available to the emergency department to evaluate such Emergency medical condition; and

2. such further medical examination and treatment to stabilize the patient as are within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department (regardless of the department of the Hospital in which such further examination or treatment is furnished).

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:

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.

Independent Freestanding Emergency Department means a health care facility that is geographically separate and distinct and licensed separately from a Hospital under applicable state law and provides any Emergency Services.

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:

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.

Participating Health Care Facility means any health care facility that has a contractual relationship directly or indirectly with the Plan setting forth the terms and conditions on which a relevant item or service is provided to an Eligible Person under 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;