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

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

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: March 2023

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. 6:

Routine Maintenance for Dental Implants

Effective February 17, 2022, the Plan has been amended to include coverage for the routine cleaning and maintenance of dental implants.

Early Retirement - Non-Medicare Eligible

Effective November 1, 2022, early retirement – non-Medicare eligible coverage will be terminated to new entrants.

Effective April 1, 2023, early retirement – non-Medicare eligible coverage benefits will be terminated for all participants.

If you are a Retiree who was covered under the Plan at the time of retirement but are not entitled to Medicare at the time of your retirement, you will have the option to elect COBRA continuation coverage. If you were covered under the Plan at the time of your retirement and were not entitled to Medicare at the time of your retirement, you will have a one-time option within six months of attaining Medicare eligibility to purchase a Medicare Supplement policy through a provider with which the Plan has contracted. You will not be allowed to purchase a Medicare Supplement policy through the provider with which the Plan has contracted at a later date. You also have a one-time option to cancel these benefits if you elect them.

Sav-Rx Closed Specialty Drug Program and High Impact Advocacy - 90 Program

Effective November 2, 2022, the Plan has been amended to implement the Sav-Rx Closed Specialty Drug List Program and the High Impact Advocacy - 90 (HIA-90) Program.

The Closed Specialty Drug List Program manages high-cost drug therapies with specific criteria for use and helps to ensure that these medications are being prescribed appropriately through a clinical review process. The Save-Rx Closed Specialty Drug List Program can assist you by referring you to manufacturer assistance programs. Copay assistance can provide financial support to you by covering all or most of your cost share for select specialty medications. The Save-Rx Closed Specialty Drug List Program will assist you in obtaining copay assistance from drug manufacturers to reduce your cost share for eligible specialty medications resulting is reducing out-of-pocket expenses. Participation in the program will require certain

data to be shared with the administrators of these copay assistance programs. You can be assured that the sharing of your personal information is done in compliance with HIPAA.

The Sav-Rx Closed Specialty Drug List Program drug list may be updated periodically by the Plan. Please consult Sav-Rx at 800-228-3108 or www.savrx.com for the current list of specialty drugs that are subject to the Sav-Rx Closed Specialty Drug List Program.

The HIA-90 Program allows certain selected specialty drugs obtained through the program to be filled up to a 90-day supply. Please consult Sav-Rx at 800-228-3108 or www.savrx.com for the current list of specialty drugs that are eligible for the HIA-90 Program.

Special Enrollment Rights

Effective November 2, 2022, the Plan has been amended to update the special enrollment rights. If you and/or your dependent(s) had other health insurance or group health plan coverage and you lose that coverage as a result of the following events:

a) legal separation,
b) divorce,
c) cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan),
d) death of an employee,
e) termination of employment,
f) reduction in the number of hours of employment, and
g) any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing reason

You may enroll yourself and/or your dependent(s) in the applicable health benefits under the Plan if you and/or your dependent(s) satisfy the eligibility requirements under the Plan.

Please update your Summary Plan Description and Plan Document booklet (dated March 1, 2021) to reflect these changes by inserting replacement and supplemental pages iii, 5, 5A, 18A, 18B, 19, 19A, 52, 52A, and 54 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.

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, Wilson-McShane Corporation, 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: (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.

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	50%	50%
• Lifetime maximum	$1,000	$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. Up to a 90-day supply for certain specialty drugs through the Sav-Rx HIA-90 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

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.

A. 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 yourself and 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.

4. If you decline enrollment for yourself or your Dependents (including your spouse) in the group health benefits provided under this Plan because you and/or your Dependent(s) had other health insurance or group health plan coverage, and you and your Dependents lose that coverage (or if the employer stops contributing towards your Dependents' other coverage) as a result of any of the following:

    h) legal separation,
    i) divorce,
    j) cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan),
    k) death of an employee,
    l) termination of employment,
    m) reduction in the number of hours of employment, and
    n) any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing reason

You may enroll yourself and your Dependents in the applicable group health benefits in this Plan if you and your Dependents otherwise satisfy the eligibility requirements of the Plan. (NOTE: An increase in the cost of coverage in the plan that covers your Dependents does not provide a right of special enrollment.) You must request enrollment in the applicable health benefits in this Plan within 30 days of losing eligibility for the other coverage (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.

For periods of COBRA continuation coverage following the Subsidy Period, Assistance Eligible Individuals who remain eligible for and continue COBRA continuation coverage must make the applicable required Self-Payment in accordance with the Plan's regular COBRA Self-Payment rules.

9. Temporary Extension of COBRA Election Period

Any individual who, as of April 1, 2021, would be an Assistance Eligible Individual except for the fact that he or she has does not have a COBRA continuation coverage election in effect or has discontinued COBRA continuation coverage before April 1, 2021 prior to the expiration of his or her initial COBRA continuation coverage period, is eligible to elect (or re-elect, as the case may be) COBRA continuation coverage during the period from April 1, 2021 through the date that is 60 days after the date that the Plan Administrator provides the individual with the notice required by Article I, Section H.12.

If a qualified beneficiary elects (or re-elects) COBRA continuation coverage pursuant to the extended election period described in this section, such COBRA continuation coverage will become effective on the first date of the coverage period that begins on or after April 1, 2021, but such COBRA continuation coverage will not extend beyond the last date that such Assistance Eligible Individual would have been eligible for COBRA continuation coverage in the absence of the temporary extended election period described in this section.

10. Notice to Assistance Eligible Individuals

The Plan Administrator is required to provide Assistance Eligible Individuals and individuals described in Article I, Section H.11 who become entitled to elect COBRA continuation coverage before April 1, 2021 with notice of the availability of and information about COBRA continuation coverage Self-Payment assistance, along with the forms required to establish eligibility for Self-Payment assistance, no later than 60 days after April 1, 2021.

11. Requirement to Report Notice of Eligibility for Another Group Health Plan or Medicare

Any Assistance Eligible Individual who becomes ineligible for the temporary waiver of the requirement to make COBRA continuation coverage Self-Payments during the Subsidy Period under Article I, Section H.10.a, due to eligibility for another group health plan or Medicare, must notify the Plan in accordance with rules established by the Plan Administrator.

12. Assistance Eligible Individual

An Assistance Eligible Individual is, with respect to any period of COBRA continuation coverage during the period beginning on April 1, 2021 and ending on September 30, 2021, a COBRA Qualified Beneficiary who elects COBRA continuation coverage and became eligible for COBRA continuation coverage due to a loss of coverage resulting from either the Employee's termination of employment (other than the Employee's voluntary termination of employment or involuntary termination of employment due to the Employee's gross misconduct) or a reduction in the Employee's hours of employment.

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. Effective November 1, 2022, Early Retirement - non-Medicare Eligible Coverage will be terminated to new entrants. Effective April 1, 2023, Early-Retirement – non-Medicare coverage benefits will be terminated for all participants.

Retirees who were covered under the Plan at the time of retirement but who were not entitled to Medicare at the time of his or her retirement will have the option to elect COBRA continuation coverage. Retirees who were covered under the Plan at the time of retirement but who were not entitled to Medicare at the time of his or retirement will have a one-time option within six months of attaining Medicare eligibility to purchase a Medicare Supplement policy through a provider with which the Plan has contracted. You will not be allowed to purchase a Medicare Supplement policy through the provider with which the Plan has contracted at a later date. You also have a one-time option to cancel these benefits if you elect them.

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, you may purchase a Medicare Supplement policy through a provider with which the Plan has contracted. If you retired from Full-Time Employee status, and you purchase the Medicare Supplement policy made available through the Plan you will have a one-time option at your retirement to continue Dental Care and Vision Care Benefits under the Plan for the period of time that you maintain the Medicare Supplement policy. If you retired from Part-Time Employee status and you purchase the Medicare Supplement policy made available through the Plan, you will have a one-time option at your retirement to continue Dental Care Benefits under the Plan for the period of time that you maintain the Medicare Supplement policy. 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.

D. Specialty Drugs

Specialty drugs are drugs prescribed for people with complex and ongoing medical conditions, such as multiple sclerosis or rheumatoid arthritis. The Plan covers specialty drugs through Sav-Rx Specialty Pharmacy up to a 31-day supply of most specialty drugs. The Plan has implemented the Sav-Rx Closed Specialty Drug List Program which is designed to manage high-cost drug therapies with specific criteria for use and helps to ensure that these medications are being prescribed appropriately through a clinical review process. The Save-Rx Closed Specialty Drug List Program assists members by referring them to enroll in manufacturer assistance programs. Copay assistance is a process in which drug manufacturers provide financial support to participants by covering all or most of the patient cost share for select specialty medications. The Save-Rx Closed Specialty Drug List Program will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible specialty medications resulting is reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

The Sav-Rx Closed Specialty Drug List Program drug list may be updated periodically by the Plan. Please consult Sav-Rx at 800-228-3108 or www.savrx.com for the current list of specialty drugs that are subject to the Sav-Rx Closed Specialty Drug List Program.

Selected specialty drugs obtained through the Sav-Rx High Impact Advocacy – 90 Program (HIA-90 Program) may be filled up to a 90-day supply. Please consult Sav-Rx at 800-228-3108 or www.savrx.com for the current list of specialty drugs that are eligible for the HIA-90 Program.

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;

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:

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