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: March 2020

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 (Plan). The Board of Trustees has amended the Summary Plan Description and Plan Document (amended and restated April 1, 2018) as indicated below.

Amendment No. 5: Coverage for COVID-19 Testing and Diagnosis

Effective March 13, 2020, the Plan will cover at 100% (no member cost share) claims incurred on or before April 30, 2020 for COVID-19 testing and diagnosis as well as the related office visit, urgent care visit, or emergency department visit during which the treating health care provider determined such testing was medically necessary and appropriate according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health.

Effective March 13, 2020, the Plan has been amended to expand the definition of Sickness to include the following language: "For purposes of Accident and Sickness Benefits, Sickness will also include quarantine or self-quarantine for individuals whose treating health care provider has provided written documentation stating that such quarantine is medically necessary or appropriate according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health because the individual has had exposure or suspected exposure to COVID-19."

Please update your Summary Plan Description and Plan Document booklet (dated April 1, 2018) to reflect these changes by inserting replacement pages 37, 37A, 48, 85, and 85A into your booklet to replace existing pages.

If you have any questions about these changes to the Plan, please contact the Plan Administrator 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 at: United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan, 3001 Metro Drive, Suite 500, Bloomington, MN 55425, (952) 854-0795 or 1-800-535-6373. You also may contact the Employee Benefits Security Administration, U.S. Department of Labor at: 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

in Plan 2. As specified on page iii of the Schedule of Benefits, these benefits are subject to a separate $100 Deductible which must be satisfied once per Lifetime before any benefits are payable under this subsection. This Deductible is in addition to any other Deductible(s) required under the Plan. Also, your Coinsurance of Covered Expenses for infertility treatment will not be applied toward satisfaction of your annual out-of-pocket maximum required under Comprehensive Major Medical Benefits.

Covered Expenses for infertility treatment include diagnostic testing, Physicians' office visits, related prescription drugs, artificial insemination, and invitro-fertilization.

The aggregate maximum amount payable for infertility treatment will not exceed the amount stated in the Schedule of Benefits.

(i) Genetic Testing and Counseling, provided services are rendered for one or more of the following reasons:

(1) You and/or your Dependents suffer from a hereditary disease;

(2) A strong family history of hereditary disease is present even though neither you or your Dependent spouse has the disease (a strong family history means at least one first-degree relative or at least two second-degree relatives of you or your Dependent spouse has been diagnosed with a hereditary disease);

(3) You and/or your Dependent spouse has produced a child with intellectual disability, a hereditary disease, or a birth defect; or

(4) You and/or your Dependent spouse has had two or more miscarriages or babies who died in infancy.

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

(j) Routine Physical Examinations when a Plan 1 Employee or Dependent spouse or Plan 2 Employee incurs expenses for an examination, x-rays, and laboratory tests for a routine physical examination performed by a Physician in a Hospital, clinic, or Physician's office. Routine mammography and PSA screening are covered under this subsection.

(k) Well Baby/Well Child Care for Plan 1 eligible Dependent children as defined on pages 78 and 79. Covered Expenses include routine examinations and related x-ray and laboratory charges.

(l) Routine Immunizations including, but not limited to supplies to prevent diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, influenza, and pneumonia. Benefits are not provided under this subsection for: services rendered or supplies dispensed before the Employee or Dependent is an Eligible Person, whether or not a series of treatments for immunization continues after such person is an Eligible Person; treatment related to allergy; medications not normally prescribed or administered by a Physician or paramedical personnel, such as vitamins;
or any charges in connection with the administration of the immunization.

(m) COVID-19. The Plan will cover at 100% (no member cost share) claims incurred on or before April 30, 2020 for COVID-19 testing and diagnosis as well as the related office visit, urgent care visit, or emergency department visit during which the treating health care provider determined such testing was medically necessary and appropriate according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health.

Alternative Ways of Obtaining Care

Deductibles and Coinsurance are waived for the following benefits available under Comprehensive Major Medical Benefits to encourage you and your Physician to consider their use. If you and your Physician use these less costly systems and facilities for appropriate treatment, you will help keep your own and Plan costs under control. These benefits are subject to all other provisions of the Plan unless otherwise specified.

(a) 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.

A prophylactic oophorectomy will be covered when an Eligible Person has:

- tested positive for the BRCA1 or BRCA2 gene mutation; or
- a strong family history of ovarian cancer.

A "strong family history" means that at least two of your first degree relatives or three second degree relatives have been diagnosed with such cancer. The term "first degree relatives" means your mother or sisters. The term "second degree relatives" means your aunts or grandmothers.

(k) Dental services rendered by a Physician, Dentist, or dental Surgeon within six months of an Injury to the jaw or natural teeth, including their initial replacement and any dental x-rays.

(l) Drugs and medicines legally obtained from a licensed pharmacist only upon a Physician's prescription which are obtained at a pharmacy which does not participate in the Preferred Provider Pharmacy network. Benefits for prescriptions drugs payable under the Preferred Provider Pharmacy Benefits are described on pages 43 through 45. Those drugs or other forms of medication which may be obtained without a prescription, even though they may be so prescribed, are excluded. Drugs prescribed for treatment of infertility are specifically excluded under this section (see pages 36 and 37 for coverage of such prescription drugs).

The following Reasonable Expenses also are Covered Expenses, but which have the Deductible and Coinsurance requirements waived as specified in the Schedule of Benefits:

(a) outpatient services in connection with a surgical operation or related charges incurred within 48 hours after the surgery is performed;

(b) pre-admission testing;

(c) routine physical examinations (one exam per Calendar Year for each Employee and each spouse);

(d) second surgical opinions;

(e) Hospice Care for Terminally Ill Eligible Persons during the time they otherwise would have to be Hospital-confined;

(f) home health care in lieu of confinement in a Hospital or Skilled Nursing Home, up to 40 visits per person per Calendar Year. Benefits are payable for additional visits exceeding the 40-visit maximum provided the Trustees determine such visits to be Medically Necessary, cost-effective, and the most appropriate course of treatment based upon recommendations of the case manager; and

(g) Doctor On Demand visits (see page 39 for details).

(h) The Plan will cover at 100% (no member cost share) claims incurred on or before April 30, 2020 for COVID-19 testing and diagnosis as well as the related office visit, urgent care visit, or emergency department visit during which the treating health care provider determined such testing was medically necessary and appropriate according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health.

support described in Section 1908 of the Social Security Act; and

(f) has been determined to be a Qualified Medical Child Support Order under reason-able procedures adopted and uniformly applied by the Plan. A copy of the written procedures for determining whether or not an order is "qualified" is available from the Plan Administrator upon request at no charge.

Reasonable Expense(s) means the fees and prices regularly and customarily charged for the medical services and supplies generally furnished for cases of comparable nature and severity in the particular geographic area concerned. Reasonableness is determined by comparisons with fees and charges by other providers for similar services and supplies as authorized by the Trustees and may include data obtained from Context (a division of ADP) for relevant zip codes at the percentile Trustees adopt (currently the 90th percentile) or from guidelines obtain from other sources as well. Eligible expenses are limited to those incurred by you or your Dependents while covered under the Plan as a result of Injury or Sickness; expense is considered to be incurred on the date the service or supply is rendered or obtained.

Retiree means an individual who was an Eligible Employee under this Plan on the day preceding the date of his or her retirement and who is now retired either under the retirement provisions of a pension plan negotiated or sponsored by the Union or under the provisions of the Social Security Program.

Self-Funded Plan means a group health care plan in which the Plan assumes the financial risk for providing health care benefits to its Employees. Instead of paying a fixed premium to an insurance company to pay the claims, a Self-Funded Plan directs Employer Contributions, Self-Payments, and investment earnings into a Trust Fund that is overseen by strict federal government regulation. The Plan pays claims directly from accumulated Trust Fund assets.

Self-Payment(s) are payments made to the Trust Fund by Eligible Persons and Retirees on their own behalf for the purpose of maintaining coverage under the Plan. Payments made to the Trust Fund for continuation coverage under COBRA are an example of Self-Payments.

Semi-Private Room means the daily room and board charge which an institution applies to the greatest number of beds in its Semi-Private Rooms containing two or more beds. If the institution has no Semi-Private Rooms, the semi-private rate will be the daily room and board rate most commonly charged for Semi-Private Rooms with two or more beds by similar institutions in the area. The term "area" means a city, county, or any greater area necessary to obtain a representative cross section of similar institutions.

Sickness means a disease, disorder, or condition (including pregnancy and childbirth and any related conditions) which requires treatment by a Physician. For purposes of Accident and Sickness Benefits, Sickness will also include quarantine or self-quarantine for individuals whose treating health care provider has provided written documentation stating that such quarantine is medically necessary or appropriate according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health because the individual has had exposure or suspected exposure to COVID-19.

Skilled Nursing Home means an institution which fully meets each of the following requirements:

(a) is regularly engaged in providing skilled nursing care for injured and sick persons at the patient's expense;

(b) requires that patients regularly be attended by a Physician and that medications be given only on the order of the Physician;

(c) maintains a daily medical record of each patient;

(d) continuously provides nursing care under 24-hour-per-day supervision by a registered nurse;

(e) is not, except incidentally, a place for the aged, a rest home, or the like;

(f) is not, except incidentally, a place for treatment of substance addiction, alcoholism, or

mental illness;

(g) is currently licensed as a Skilled Nursing Home, if licensing is required in the area where it is located, and is classified as a Skilled Nursing Home under Medicare;

(h) has permanent facilities for the care of six or more resident patients; and