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

## Summary Plan Description and Plan Document

## April 1, 2018

# HEALTH CARE PLAN
# SUMMARY PLAN DESCRIPTION/
# PLAN DOCUMENT

**For members of**
**United Food and Commercial Workers Union Local 1189**
**and St. Paul Food Employers Health Care Plan**

**Effective Date: April 1, 2018**

# SCHEDULE OF BENEFITS

## PLAN 1 AND PLAN 2

### For Employees Only

| | Plan 1 | Plan 2 |
|---|---|---|
| **LIFE INSURANCE BENEFITS** | $20,000 | $5,000 |
| **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS** | | |
| Principal sum | $12,000 | $1,000 |
| **ACCIDENT AND SICKNESS BENEFITS** | | |
| Percentage of Weekly Earnings | 60% | Not Applicable |
| Maximum weekly amount | $ 300 | Not Applicable |
| Maximum number of weeks per disability | 26 | Not Applicable |

### For Dependents of Full-Time Employees Only

| | Plan 1 | Plan 2 |
|---|---|---|
| **LIFE INSURANCE BENEFITS** | | |
| Spouse | $ 2,000 | Not Applicable |
| Dependent Children – Up to 14 days | Not Applicable | Not Applicable |
| 14 days and older | $ 1,000 | Not Applicable |

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

| COMPREHENSIVE MAJOR MEDICAL BENEFITS | Plan 1 | Plan 2 |
|---|---|---|
| Comprehensive Major Medical Benefits cover Reasonable Expenses related to Hospital services, Physicians' services, x-ray and laboratory services, and other covered items and services when Medically Necessary. | | |
| Deductible amount per person per Calendar Year | $ 300 | $ 300 |
| Maximum Deductible amount per family per Calendar Year (For Plan 1 only) | $ 900 | Not Applicable |
| Plan's Coinsurance of Reasonable Expenses (unless otherwise specified)[1] | 80% | 80% |
| Annual out-of-pocket maximum for Covered Expenses per Calendar Year, including the Deductible amount (but NOT including the cost of services for infertility treatment) | | |
| Per person | $2,500 | $2,500 |
| Per family (For Plan 1 only) | $5,000 | Not Applicable |
| Plan pays 100% of Covered Expenses in excess of the out-of-pocket maximum for the remainder of that Calendar Year. | | |
| Under Plans 1 and 2, the Deductible and Coinsurance amounts are waived for Covered Expenses related to the following services:<br>(a) Pre-admission testing.<br>(b) Hospice Care.<br>(c) Home health care, up to a maximum of 40 visits per person per Calendar Year[2].<br>(d) Doctor on Demand visits.<br>For such services, the Plan pays 100% of Reasonable Expenses incurred. | | |

[1] The Plan's Coinsurance will be increased to 90% for maternity-related Covered Expenses if the Eligible Person has enrolled in and completed the Blue Cross Blue Shield Healthy Start Prenatal Support Program.

[2] The Trustees may extend this maximum as they deem appropriate based on medical necessity.

| COMPREHENSIVE MAJOR MEDICAL BENEFITS (continued) | Plan 1 | Plan 2 |
|---|---|---|
| The following are specific maximum amounts which Plans 1 and 2 pay for certain services and supplies covered under Comprehensive Major Medical Benefits provisions: | | |
| (a) Hospital room and board expense | | |
| : for general and acute care | up to admitting Hospital's Semi-Private Room rate | |
| : for intensive or coronary care | up to twice admitting Hospital's Semi-Private Room rate | |
| (b) Emergency room visits<br>First 3 emergency room visits per person per Calendar Year covered subject to Deductible, Coinsurance, and out-of-pocket maximum. After these 3 visits, separate Copayment per emergency room visit (which applies to out-of-pocket maximum but not Deductible) and then Deductible and Coinsurance apply. Waived if admitted to Hospital from the emergency room. | $ 250 | $ 250 |
| (c) Skilled Nursing Home care | | |
| Maximum confinement per person per period of disability | 30 days | 30 days |
| (d) Chiropractic fees | | |
| Plan's maximum per visit | $ 35 | $ 35 |
| Plan's maximum per person per Calendar Year | $900 | $ 900 |
| (e) Artificial life support | | |
| Limited to first five days after death up to maximum | $ 5,000 | $ 5,000 |
| (f) Infertility treatment (For Plan 1 Employees and spouses and Plan 2 Employees) | | |
| Separate Deductible amount per person (once per Lifetime) | $ 100 | $ 100 |
| Plan's Coinsurance ***(Eligible Person's Coinsurance share will NOT be applied toward out-of-pocket maximum)*** | 80% | 80% |
| Lifetime maximum per person | $10,000 | $10,000 |
| (g) Genetic testing | | |
| Calendar Year maximum per person | $ 2,000 | $ 2,000 |

| DENTAL CARE BENEFITS | Plan 1 | Plan 2 |
|---|---|---|
| Percentage payable: | | |
| Diagnostic and preventive services[1] | 80% | 80% |
| Basic and special services[1] | 80% | 80% |
| Special restorative services | 80% | 80% |
| Prosthetics | 80% | 50% |
| Maximum per Calendar Year[2] | $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 |
|---|---|---|
| Eye examinations, lenses, frames, and contact lenses | | |
| Plan's Coinsurance | 80% | Not Applicable |
| Aggregate maximum per person per Calendar Year[3] (In lieu of all other benefits for lenses, frames, and contact lenses, laser eye surgery will be covered up to the aggregate maximum.) | $300 | Not Applicable |

| PREFERRED PROVIDER PHARMACY PRESCRIPTION DRUG BENEFITS | Plan 1 | Plan 2 |
|---|---|---|
| Eligible Person's Copayment per prescription for up to a 31-day supply at a retail pharmacy (or, for maintenance drugs, up to a 90-day supply at a retail pharmacy that participates in the Prime Extended Supply Network). Specialty drugs limited to a 31-day supply through AllianceRx Walgreens Prime only. | 20% with a $10 minimum Copayment and a $50 maximum Copayment[4] | 20% of the discounted cost[4] |

[1] For Plans 1 and 2: If an Eligible Person utilizes a dental provider who participates in the DeltaPreferred Option network, benefits are payable as follows:
For diagnostic and preventive services: 100%; and
For basic and special services, including endodontics, periodontics, and oral surgery: 90%.

[2] The maximum per Calendar Year does not apply to the following Dental Care Benefits for eligible Dependent children under age 19: routine oral examinations; sealants; dental prophylaxis; and topical fluoride treatments.

[3] For eligible Dependent children under age 19: the aggregate maximum per person per Calendar Year does not apply to eye examinations; and after the $300 maximum, glasses for such Dependents are covered at 50%.

[4] When a generic is available, but the pharmacy dispenses the brand name drug for any reason other than a Physician's "dispense as written" or equivalent instructions, the Eligible Person must pay the difference between the cost of the brand name drug and the generic drug in addition to the brand name Copayment.

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

| **COMPREHENSIVE MAJOR MEDICAL BENEFITS** | |
|---|---|
| Deductible amount per Calendar Year | |
| Per person | $ 100 |
| Per family | 3 individual Deductibles |
| Plan's Coinsurance | 75% of first $10,000 of Reasonable Expenses per person per Calendar Year; then 100% for remainder of Calendar Year for such person |
| Annual out-of-pocket maximum for Covered Expenses per person per Calendar Year, including the Deductible amount | $2,500 |
| Deductible and Coinsurance requirements waived: | |
| Outpatient surgery | 100% |
| Pre-admission testing | 100% |
| Routine physical examinations (one per Calendar Year for each Employee and each spouse) | 100% |
| Second surgical opinions | 100% |
| Hospice Care | 100% |
| Home health care | 100%, up to 40 visits per person per Calendar Year[1] |
| Doctor on Demand visits | 100% |
| Coinsurance requirement only waived: | |
| Emergency first-aid | 100% |
| After the first 3 emergency room visits per person per Calendar Year, separate Copayment per emergency room visit (which applies to out-of-pocket maximum but not Deductible) and then still covered at 100% after Deductible. Waived if admitted to Hospital from the emergency room. | $ 250 |
| Chiropractor visits | |
| Plan's maximum per visit | $ 35 |
| Plan's maximum per person per Calendar Year | $ 900 |

| **PREFERRED PROVIDER PHARMACY PRESCRIPTION DRUG BENEFITS** | **Plan 3** |
|---|---|
| Eligible person's copayment per prescription for up to a 31-day supply at a retail pharmacy (or, for maintenance drugs, up to a 90-day supply at a retail pharmacy that participates in the Prime Extended Supply Network). Specialty drugs limited to a 31-day supply through AllianceRx Walgreens Prime only. | 25% of the discounted cost[2] |

[1] The Trustees may extend this maximum as they deem appropriate based on medical necessity.

[2] When a generic is available, but the pharmacy dispenses the brand name drug for any reason other than a Physician's "dispense as written" or equivalent instructions, the Eligible Person must pay the difference between the cost of the brand name drug and the generic drug in addition to the brand name Copayment.

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## 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") effective April 1, 2018. In easy-to-understand language, it tells you how to become and remain eligible for benefits, explains the benefits available, and gives you instructions on how to apply for benefits. This Summary is both the Plan's Summary Plan Description and Plan Document. The Trustees in their sole discretion have the right to change, add, or to delete benefits, self-payment rates, Eligibility Rules, or any other provisions relating to the operation of the Plan.

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

The Eligibility Rules and benefits are maintained at levels in line with Trust Fund income and assets and they are reviewed regularly to protect the Fund's financial position. All Plan provisions are updated as necessary to comply with legal requirements, including the Patient Protection and Affordable Care Act and the Mental Health Parity and Addiction Equity Act of 2008.

Please see pages 26 and 27 for details of the arrangement the Plan has with Blue Cross Blue Shield of Minnesota, which offers a network of Hospitals and Physicians that gives the Plan and its members preferred rates. If you or an eligible Dependent must see a Physician or go to the Hospital, we strongly urge you to go to a Blue Cross Blue Shield of Minnesota AWARE Network PPO provider. Both you and the Plan will save money. ***Remember: You can use your identification card for all services, including Blue Cross Blue Shield of Minnesota AWARE Network, TEAM, and Prime Therapeutics Retail Network Pharmacies.***

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

Yours sincerely,
**The Board of Trustees**

| **Employer Trustees** | **Union Trustees** |
|---|---|
| Kent Dixon | Jennifer Christensen |
| Tracy McDonald | Mike Dreyer |
| Michael Oase | James Gleb |
| Chris Thienes | Jeanine Owusu |
| Jon Born, Alternate | Bob Klingner, Alternate |

The addresses of the Trustees are found on page 74.

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

## GRANDFATHERED STATUS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Trustees believe this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that already was in effect when that law was enacted. Being a grandfathered health plan means that your Plan is not required to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of Lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at: United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan, 3001 Metro Drive, Suite 500, Bloomington, MN 55425, (952) 854-0795 or 1-800-535-6373. You also may contact the Employee Benefits Security Administration, U.S. Department of Labor at: 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

# ELIGIBILITY RULES

The following Rules 1-17 govern eligibility for Plan benefits.

## 1. Who Is Eligible?

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

## 2. When Are Employer Contributions First Payable?

Your Employer first is obligated to contribute in your behalf according to the current Collective Bargaining Agreement or Participation Agreement.

## 3. What Is the Effective Date of My Eligibility?

You become eligible under either Plan 1 or Plan 2 on the first day of the month following satisfaction of the following eligibility requirements:

(a) You will become eligible under Plan 1 (Full-Time Employees) provided that during your initial period of employment you have eight weeks of full-time Contributions made to the Plan in your behalf during a 12-consecutive-week period.

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

If the Employer is not required to make a Contribution to the Health Fund in your behalf for six months in a row, then you must begin again the 12-month period of employment with Employer Contributions to the Health Fund.

You will become covered under the part-time provisions of the Health Care Plan on the first of the month following completion of the eligibility requirements.

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

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

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

*See also "Special Enrollment Events" on page 2.*

## 4. What Is the Effective Date of My Dependents' Eligibility?

Coverage for Dependents is provided under Plan 1 only. Dependents become eligible following your satisfaction of the eligibility requirements stated in Eligibility Rule 3.

If you acquire a new Dependent after your effective date, he will be covered on the date he becomes such a Dependent.

***Special Enrollment Events for Employees and Dependents:*** *Notwithstanding any other provision of the Plan to the contrary, you or your Dependent(s) are entitled to special enrollment rights under the Plan as required by HIPAA under any of the following circumstances:*

*(a) Your 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.*

*(b) 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.*

*(c) If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your Dependent. However, you must request enrollment within 30 days after the date of marriage, birth, adoption, or placement for adoption.*

## 5. What Is Required To Remain Eligible?

Your continued eligibility is determined weekly. Once you have established eligibility, it continues so long as Employer Contributions to the Plan are made in your behalf for each subsequent week. The amount of the Employer Contribution is specified by the Collective Bargaining Agreement or Participation Agreement in effect at the time the Contributions are earned. The amount contributed determines the Plan under which you are covered.

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

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

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

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

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

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

(b) If you have had more than six months in a row for which no Employer Contributions are required in your behalf, and you are

not on an approved leave of absence from your Employer, you must begin again the 12-month period of employment to regain eligibility.

## 6. What Coverage Is Provided in the Event My Health Care Plan Changes?

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

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

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

## 7. How Are Grace Weeks Used To Continue Coverage?

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

## 8. May I Make Self-Payments To Maintain Coverage?

When circumstances described in this Rule cause a reduction in or a loss of coverage, some of the coverages in effect at the time may be continued by making Self-Payments. The intent of these Eligibility Rules is to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended in all respects, including those changes required by the Omnibus Budget Reconciliation Acts of 1989, 1991, and 1993 (OBRA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any future IRS guidance will be incorporated even if it conflicts with existing Plan provisions.

You and your Dependents may, as Plan Participants or as Qualified Beneficiaries, continue coverage and eligibility for certain benefits subject to the following conditions.

### (a) Qualifying Events

Certain events which cause you, as an Employee, or your Dependent to lose eligibility under the Plan are Qualifying Events.

(1) For Employees eligible because of Employer Contributions, Qualifying Events occur when coverage is reduced or terminated because of:

(i) a reduction in hours of Covered Employment for any reason, including transitioning from full-time to part-time, disability, or Sickness; or

(ii) voluntary or involuntary termination of Covered Employment for any reason (except gross misconduct on your part), including disability, Sickness, or retirement.

(2) For spouses and Dependent children who are covered under Plan 1, Qualifying Events occur when coverage is terminated due to any of the following events occurring while you as an Employee are eligible because of Employer Contributions or the application of grace weeks:

(i) termination or reduction of your employment for any reason (except gross misconduct on your part) including disability, Sickness, or retirement;

(ii) your death;

(iii) divorce or legal separation from you;

(iv) your entitlement to Medicare (under Part A, Part B, or both); or

(v) a Dependent ceasing to meet the definition of Dependent under the Plan.

You or your Dependent become a Qualified Beneficiary for a specific period of time when a Qualifying Event occurs. A Dependent child who is born to or placed for adoption with you during your period of COBRA continuation coverage will be treated as a Qualified Beneficiary.

**(b) Notifications and Due Dates**

(1) Qualified Beneficiary's Responsibility To Notify the Trustees of a Qualifying Event

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

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

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

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

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

Beneficiary) must be provided to the Plan Administrator.

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

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

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

(3) Trustees' Responsibility to Notify a Qualified Beneficiary When Other Qualifying Events Occur

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

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

(4) Due Date for Qualified Beneficiary's Response

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

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

(5) Due Date for Initial Self-Payment

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

(6) Due Dates for Subsequent Self-Payments

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

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

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

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

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

**(c) Coverages and Options**

(1) In the event an Employee, Participant, or Qualified Beneficiary elects to continue coverage, the following benefits are available except as specified:

(i) Medical Benefits only;

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

(iii) Medical Benefits, Dental Care, Vision Care, Life, and Acci dental Death and Dismemberment Benefits.

Employees continuing coverage are not eligible for Accident and Sickness Benefits; Employees continuing coverage under Plan 2 are not eligible for Vision Care Benefits; and Retirees are not eligible to continue Life or Accidental Death and Dismemberment Benefits.

(2) In the event a Dependent elects to continue coverage, the same choices are available except Employee Life Benefits are not available and Dependent Life Benefits are available.

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

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

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

**(d) Cost of Continuation Coverage**

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

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

**(e) Duration of Continuation Coverage**

When eligibility is lost due to termination of employment or reduction in hours, a Qualified Beneficiary may continue eligibility for up to 18 consecutive months from the date employment terminated or hours were reduced. This 18-month period may be extended to 36 months for the spouse and Dependent children if a second Qualifying Event [e.g. Employee's death, divorce or legal separation from the Employee, Employee's coverage by Medicare (under Part A, Part B, or both), or a Dependent child ceasing to meet the definition of Dependent under the Plan] occurs during the 18-month period. These Events can be a second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. A Qualified Beneficiary must notify the Plan Administrator within 60 days after a second Qualifying Event occurs if he wants to extend his continuation coverage and must provide any supporting documentation the Plan may request. This provision does not apply in the case of a reduction in work hours followed by a termination of employment.

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

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

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

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

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

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

general rules are applied to specific circumstances as follows.

(1) Change in Eligibility From Plan 1 to Plan 2

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

(2) Ceasing Active Work

If you become eligible for leave under the Family and Medical Leave Act of 1993 (FMLA), refer to Eligibility Rule 17 to determine the effect of the FMLA on the provisions of this section.

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

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

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

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

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

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

(v) If you cease work because of retirement, coverage may be continued under the Plan according to the following provisions.

Retirees at retirement will have the option of either choosing COBRA continuation coverage or continuing to pay a nonsubsidized rate for the Plan 3 Retiree benefit level immediately upon retirement, provided they are under age 65.

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. 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.

As a Retiree, once you become entitled to Medicare at age 65, Medical Benefits under the Plan cease. If you retire at or after age 65, no Medical Benefits are available under the Plan. In either case, the Trustees recommend you purchase a Medicare Supplement policy through a provider that the Plan has contracted with. If you do so if you are a Full-Time Employee, you will have a one-time option at attainment of age 65 or your retirement, whichever is later, to continue Dental Care and Vision Care Benefits under the Plan. If you are a Part-Time Employee, you will have a one-time option at attainment of age 65 or your retirement, whichever is later, to continue Dental Care Benefits under the Plan. You will not be allowed to add these benefits at a later date. You will not have the option to continue these benefits under the Plan if you do not purchase the recommended Medicare Supplement policy. You also have a one-time option to cancel these benefits if you elect them.

Employees 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 in their behalf will reduce the amount of the full-time or part-time Self-Payment otherwise due.

**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.**

*If you decide to enroll in Medicare Prescription Drug Benefits and drop your prescription drug coverage under the Plan, be aware that you and your Dependents may not be able to get this coverage back. Please contact the Plan Administrator for more information about what happens to your coverage if you enroll in Medicare Prescription Drug Benefits.*

(3) Loss of Dependent Status

(i) If family coverage ceases due to your death, divorce or legal separation, coverage may be continued by your spouse and Dependent children for up to 36 months. However, if a retired Employee who is covered under Plan 3 dies, his surviving spouse and Dependent children who were covered under the Plan at the time of his death may continue Plan coverage by making Self-Payments. This right terminates if the surviving spouse becomes covered under another health plan with comparable coverage or, in the case of a Dependent child, such child ceases to be a Dependent as defined on pages 78 and 79.

(ii) If a Dependent child's coverage ceases because the Dependent child ceases to meet the definition of Dependent under the Plan, the

former Dependent's coverage may be continued for up to 36 months.

**(f) Multiple Qualifying Events**

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

**(g) Termination of Self-Payment Provisions for Qualified Beneficiaries**

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

(1) the Plan no longer provides health care coverage to any Eligible Employee;

(2) the required notice of a Qualifying Event is not provided by the Qualified Beneficiary within 60 days of its occurrence;

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

(4) the initial Self-Payment is not paid 45 days from the date the Qualified Beneficiary opts to continue coverage;

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

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

(7) the maximum continuation coverage period is reached;

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

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

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

Additionally, there may be other coverage options for you and your family. You are able to buy coverage through the Health Insurance Marketplace (also known as the "Exchanges"). In the Marketplace, depending on your household income, you may be eligible for a new kind of tax credit that lowers your monthly premiums right away. Being eligible for COBRA coverage does not limit your eligibility for coverage or for a tax credit through the Marketplace. You also can see what your premium, Deductibles, and out-of-pocket costs will be before you make a decision to enroll in the Marketplace, and you may have multiple coverage options in the Marketplace. Finally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if a plan generally does not accept late enrollees, if you request enrollment within 30 days.

## 9. How Can I Reinstate My Coverage?

If you are terminated from employment (as that process is defined by the Collective Bargaining Agreement or Participation Agreement), you have exhausted all grace weeks of coverage, and you have not continued coverage with Self-Payments, you will be required to regain eligibility under the terms of Eligibility Rules 3 and 5 of this Plan before becoming entitled to participate again.

## 10. Is Coverage Provided in the Event I Am Disabled?

All Employees who become eligible to receive Accident and Sickness Benefits from this Plan or Worker's Compensation Benefits will continue coverage for a period extending for the shorter of: 13 weeks from the date eligibility otherwise would cease; or the date eligibility for Accident and Sickness Benefits or Worker's Compensation Benefits ceases. Employees working under the Minneapolis Retail Meat Cutters and Food Handlers Contract will be entitled to receive up to an additional 13 weeks of coverage extension for the period they remain eligible for Worker's Compensation Benefits. You must notify the Plan Administrator when you are receiving Worker's Compensation Benefits in order to receive the extension of coverage. In no case will benefits be extended beyond 13 weeks for a Grocery Employee or 26 weeks for a Meat Employee.

The extension of eligibility under this provision is provided at Trust Fund expense. After the applicable extension period expires, you may use any accumulated grace weeks and then must make Self-Payments as described in Eligibility Rule 8 to continue eligibility.

## 11. When Does My Coverage Terminate?

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

(a) the date the Plan terminates;

(b) the end of the period for which Contributions were made in your behalf, grace weeks have been exhausted, and Self-Payment rights have expired;

(c) the date you enter the armed forces of any country; or

(d) the date you cease to be eligible according to these Eligibility Rules.

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

## 12. What Is a Rescission of Coverage?

An Eligible Person and persons seeking coverage on behalf of an Eligible Person may not engage in any fraudulent act, practice, or omission in connection with coverage

under the Plan or make an intentional misrepresentation of material fact in connection with coverage under the Plan. If an Eligible Person or a person seeking coverage on behalf of an Eligible Person engages in such act, practice, omission, or misrepresentation, the Eligible Person's coverage (including the coverage of any Dependents in the case of an Eligible Employee and the coverage of the Eligible Employee in the case of a Dependent) may be retroactively terminated or cancelled.

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

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

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

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

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

(a) timely update his or her enrollment status;

(b) report to the Plan:

(1) his or her divorce;

(2) his or her legal separation;

(3) the death of a Dependent; or

(4) his or her loss of custody of a Dependent child;

(c) satisfy his or her notification obligations under this Plan; or

(d) honor the Plan's right of subrogation and reimbursement or otherwise failing to cooperate with the Plan, as stated on pages 56 through 58.

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

## 13. What Are My Notification Obligations?

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

(a) any Eligible Person's eligibility for coverage under the Plan; or

(b) any Eligible Person's eligibility for payment of any specific claim for benefits.

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

## 14. Are My Dependents Covered if My Spouse and I Divorce?

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

Your former spouse is entitled to continue coverage by making required Self-Payments according to Eligibility Rule 8. If either of these events occurs, Self-Payments in the full

amount determined by the Trustees will be required for the remainder of the 36 months. This provision does not allow coverage to be extended beyond the period specified in Eligibility Rule 8.

## 15. What Happens in the Case of a Newly Participating Employer?

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

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

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

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

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

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

## 16. What Happens When an Employee Enters Military Service?

*[The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provisions will control in the event there are any inconsistencies between the Act and the Plan.]*

### (a) Eligibility Status

(1) 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.

(2) 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.

(3) 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, your and your eligible Dependents' coverage will be continued as though you are actively at work for the duration of such leave.

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

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

**(b) Continuation of Coverage**

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

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

(3) You will have the option of applying accumulated grace weeks, if available, to continue coverage. If grace weeks are not available or you choose not to use them, you are required to make timely Self-Payments at the COBRA rate to be determined by the Trustees from time to time to purchase COBRA continuation coverage. If you elect to use grace weeks to pay for

continuation coverage and you exhaust your grace weeks prior to the end of the maximum coverage period described in the following paragraph (5), you may make Self-Payments to continue coverage through the end of your maximum coverage period.

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

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

(i) the date that the Plan no longer provides group health care coverage to any Employees;

(ii) the day after the date you fail to elect continuation coverage as required by the COBRA continuation coverage election rules;

(iii) the first day of the month for which a timely Self-Payment has not been received and your grace weeks have been exhausted;

(iv) 24 months from the first date of absence due to Military Service; or

(v) the day after the date you fail to apply for reemployment with a Participating Employer within the applicable time period allowed under the following subsection (c) or otherwise cease to have USERRA reemployment rights.

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

**(c) Status Upon Return from Military Service**

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

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

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

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

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

If you exhaust your grace weeks prior to your return from Military Service and you do not have USERRA reemployment

rights, you will be treated as a new Employee. *If you exhaust your grace weeks prior to your return from Military Service and you satisfy the USERRA reemployment requirements, you will be eligible for benefits on the date of your return to work within the required time periods, provided you make Self-Payments required to continue eligibility under the Self-Payment provisions. If you fail to make Self-Payments as required upon reinstatement in the Plan, your eligibility for coverage will terminate as of the last date of the period for which a timely payment was received and you then will be treated as a new Employee.*

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

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

## 17. Is Coverage Provided While I Am On Family and Medical Leave?

If you become eligible for leave according to the Family and Medical Leave Act of 1993 (FMLA), your coverage under the Plan may be continued for up to 12 or 26 weeks (depending on the reason for the leave), provided your Employer is subject to the Act, makes the required contribution (or you do so), and files the appropriate notification and certification forms with the Plan Administrator. To be subject to the Act, an Employer must have at least 50 Employees within 75 miles. If your leave is eligible under the FMLA, and you do not return to work after the leave, then for COBRA continuation coverage purposes under Eligibility Rule 8, the date of the Qualifying Event will be the last day of your FMLA leave. For additional information regarding your rights under the Family and Medical Leave Act, see pages 69 and 70.

# YOUR RESPONSIBILITIES UNDER THE PLAN

**1. Notify the Plan Administrator Immediately Regarding Any Change in Address.**

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

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

So don't lose out. Remember: The responsibility for advising the Plan Administrator of your new address is yours, and you must do so in writing.

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

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

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

*Mail your new address and/or Beneficiary designation to the Plan Administrator.*

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

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

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

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

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

Self-Payment notices are not sent and you are responsible to make the Self-Payments no later than the first of each month. Failure to pay the required amount on time will lead to a loss of eligibility. Remember: The responsibility for making timely Self-Payments is yours.

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

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

**6. Notify the Plan Administrator of Other Group Health Care Coverage.**

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

# INSTRUCTIONS FOR FILING A CLAIM

## Deadlines for Filing Claims

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.

**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.

## Filing a Claim for Benefits

**(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.

**(b)** **Waiver of Prior Authorization Requirements for Urgent Care Claims.** The Plan will waive its prior authorization requirements for urgent care claims. Even so, the Eligible Person or his medical provider must notify the Plan as soon as reasonably possible after the emergency medical care or treatment is provided.

**(c)** **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 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.

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

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

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

## Claim Procedure

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

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

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

(b) Employee's name and identification number;

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

(d) Name and address of the service provider;

(e) Federal tax identification number of provider;

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

(g) Procedure or nature of the treatment;

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

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

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

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

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

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

# CLAIMS REVIEW AND APPEAL PROCEDURES AS REQUIRED BY ERISA

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

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

## Time Frames for Initial Claims Decision

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

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

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

**(d)** **Disability Claims.** The Plan will notify the Employee of a disability claim denial within 45 days of receiving a claim. The Plan may extend this deadline up to 30 days if the extension is due to matters beyond the Plan's control as long as the Plan notifies the Employee of the reason for the extension (and the expected decision date) within 45 days after receiving the claim. The Plan may extend this extended deadline up to an

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

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

## Contents of Claim Denial Notices

If the Plan denies coverage for your claim, the denial is called an adverse benefit determination as defined under the U.S. Department of Labor Regulations. An adverse benefit determination includes a rescission of your coverage under the Plan, except in the case of fraud or intentional misrepresentation of a material fact. An example of fraud or intentional misrepresentation of a material fact includes a fraudulent or intentional misrepresentation about your past medical history. The Regulations define a rescission as a cancellation or discontinuance of coverage that has a retroactive effect. The following retroactive terminations of coverage in the normal course of business are not considered rescissions under the Regulations even though retroactive:

(a) Retroactive termination to the extent attributable to failure to pay a timely premium (Self-Payment) towards coverage.

(b) Retroactive elimination of coverage back to the date of termination of employment, due to delays in administrative recordkeeping.

(c) The Plan's termination of coverage retro-active to the date of a divorce.

To clarify, this means that, in general, the Plan cannot terminate your coverage retroactively. However, the Plan may do so under the circumstances enumerated and in other instances as may be prescribed in the Regulations.

If an Eligible Person's claim is partly or completely denied, the Plan's adverse benefit determination will be in writing and will:

(a) Provide the specific reasons for the adverse benefit determination.

(b) Refer to the specific Plan provision(s) on which the adverse benefit determination was based.

(c) Describe any additional material or information needed to perfect the claim and explain why the material or information is necessary.

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

(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 benefit determination.

(f) If the adverse benefit determination was 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 the Eligible Person can obtain that explanation,

upon request and free of charge, from the Plan.

(g) If the claim involves urgent care, describe the Plan's expedited review process for urgent care claims.

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

(i) Include a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

## Appointing an Authorized Representative to Act on Your Behalf

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

## Deadline for Filing Claim Appeals

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

## Claim Appeal Rights Under Federal Law

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

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

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

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

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

(e) If the appeal involves a claim for urgent care, the request for an expedited appeal can be submitted orally or in writing, and all information will be transmitted between the

Eligible Person and the Plan by telephone, fax, or similar method, including the appeal decision.

## 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.

## Contents of Appeal Denial Notices

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

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

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

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

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

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

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

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

# YOUR FAMILY ASSISTANCE PROGRAM
# PLANS 1, 2, AND 3

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

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

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

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

For example, your counselor possibly can help you find a nursing home for your mother, recommend a psychologist or psychiatrist, provide short-term counseling for a chemically dependent person in your family, locate a marriage counselor for long-term counseling, or find a financial counselor to help you plan your budget.

**How To Use Your Family Assistance Program**

If you think you need help with a problem, just dial the confidential hotline at (651) 642-0182 or 1-800-634-7710.

Some problems can be resolved with a counselor over the phone. Or, you may choose to schedule a meeting with a counselor at TEAM.

At the first meeting, which will last about one hour, your counselor will discuss your problems with you and determine the type of assistance you need. More meetings with your same counselor can be made, or, if you and the counselor decide that long-term counseling or treatment is needed, a referral to the appropriate agency will be made.

Your counselor will follow up with you to make sure that you were satisfied with the service received and that your problem is being resolved.

The assessment, short-term counseling, and referral services are paid for by your Health Care Plan. If you are referred for long-term counseling or treatment, you are responsible for the cost of these services. Your Health Care Plan may or may not cover some of these costs. Your counselor will consider your particular employee benefits situation when suggesting a referral.

# BLUE CROSS BLUE SHIELD OF MINNESOTA PREFERRED PROVIDER ARRANGEMENT AND HEALTH PROMOTION PROGRAMS

The Board of Trustees has entered into a Preferred Provider arrangement with "Blue Cross Blue Shield of Minnesota AWARE Network (BCBSM)." BCBSM 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 BCBSM/PPO provider or a non-PPO provider each time you need medical services. Your current Hospital or Physician already may be a member of this network. A BCBSM provider list is available upon request, without charge, from the Plan Administrator. You also may contact BCBSM at 1-800-810-2583 or visit their website at www.bcbs.com.

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.

PPO providers automatically will file your claim for you if you present your identification card and sign the appropriate form.

For charges incurred with PPO providers, the Plan will pay a discounted amount. These providers have agreed to accept payment from the Plan as payment in full, except for applicable Deductibles, Coinsurance, maximum benefit limitations, or other similar limitations under the Plan.

For charges incurred with non-PPO providers within the geographic area of the BCBSM AWARE Network, the Plan will pay the Reasonable Expense or, if applicable, a separately negotiated amount to the non-PPO provider. The rules applicable to the network provide that the Plan is not permitted to accept an assignment for these charges. Rather, the Plan is supposed to pay you directly and then you will be responsible for paying the non-PPO provider for the charges and the Plan will make no further payment. Additionally, you will be responsible for applicable Deductibles, Coinsurance, maximum benefit limitations, or other similar limitations under the Plan and may be billed for the balance by the non-PPO provider.

Charges incurred with non-PPO providers outside the geographic area of the BCBSM AWARE Network will come through Blue Cross' Blue Card program. The Plan will pay the Reasonable Expense as provided by the Blue Card Host Plan in the Blue Card system or, if applicable, an amount separately negotiated with the non-PPO provider. The Plan may accept an assignment of these claims to make payment directly to the non-PPO provider. You will be responsible for applicable Deductibles, Coinsurance, maximum benefit limitations, or other similar limitations under the Plan and may be billed for the balance by the non-PPO provider.

### Case Management

BCBSM also provides case management services. If a catastrophic or other suitable case (such as an organ transplant) is referred to them, BCBSM will review the case to determine if case management is appropriate. If so, BCBSM will contact you, your Physician, and the Plan Administrator to discuss treatment options and to identify available community resources. If you and your Physician approve, they will coordinate the necessary services. It is often hard to make decisions about ongoing care. Case management allows you to discuss your concerns openly and makes you aware of all your options. Also, both you and the Fund may save money if a less costly setting is appropriate and you choose to use it. But remember, the choice is yours. The case manager will offer you alternatives, but you and your Physician have the final decision. If you think you or one of your Dependents could benefit from working with a case manager, call toll-free at 1-800-961-4758 for more information.

## Blue Cross Blue Shield Healthy Start Prenatal Support Program

You and your eligible Dependents have access to the Healthy Start Prenatal Support Program offered by Blue Cross Blue Shield of Minnesota. This program is designed to assess, educate, and support pregnant women to achieve an optimal childbirth outcome. The Plan pays for the cost of participation and a $50 gift card will be sent to those completing the program. In addition, enrollment and completion of the program will reduce out-of-pocket maternity-related Covered Expenses under Comprehensive Major Medical Benefits to 10% instead of 20%. If you are expecting, call 651-662-1818 or toll-free at 1-866-489-6948.

## Stop-Smoking Program

You and your eligible Dependents also have access to the Stop-Smoking Program offered by Blue Cross Blue Shield of Minnesota. It is a phone-based counseling program to help you quit smoking at your own pace. The program provides a Quit Coach who works with you over the phone to create your own personal "game plan." In addition, the Plan will provide benefits for certain over-the-counter (OTC) quit aids, including gum, patches, and lozenges. You must pick up your quit aids at a Preferred Provider Pharmacy and submit your receipts to the Plan Administrator for reimbursement. In order to qualify for reimbursement for your quit aids, you must participate in the Stop-Smoking Program. There is a 16-week limit for these medications per Calendar Year. Your Quit Coach will provide you with information on how to obtain and use these OTC medications and the Plan will cover 100% of the eligible cost for them. If you smoke and are thinking about quitting, call 1-888-662-BLUE (2583).

## Fitness Program Discount
## Plans 1 and 2 Only

Up to two eligible adults per household (you, your spouse, or adult child) can receive up to a $20.00 monthly credit off their fitness center monthly fee when you exercise at a network facility at least 12 times per month. You should have received a packet from Blue Cross which includes a list of network facilities and information on how to receive the credit. For information on how to register, go to www.ufcw1189benefits.com and click on "BCBS Discount Fitness Program."

*We are hoping with the implementation of these health promotion programs that you will take a proactive approach to maintaining a healthier lifestyle which we believe will help reduce both your and the Plan's health care expenses.*

# BENEFITS FOR PLAN 1 AND PLAN 2

## Life Insurance Benefits

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

*The Life Insurance Benefit is fully insured through a policy with United of Omaha Life Insurance Company. The following is only a summary of the provisions of the life insurance benefit, which is fully governed by the relevant insurance policy. If there is any conflict between the Summary and the insurance policy, the insurance policy will govern.*

### Your Life Insurance

If you die from any cause, your Beneficiary on record at the Plan Administrator will be paid the amount of insurance specified in the Schedule of Benefits.

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

(a) to your surviving spouse; if none, then

(b) to your surviving natural and/or adopted children; if none, then

(c) to your surviving parent(s); if none, then

(d) to your estate.

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

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

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

### Total Disability Benefit

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

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

(b) the date you convert your group insurance.

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

### Continuation of Life Insurance

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

To continue Life Insurance Benefits, you must send the Plan Administrator written notice that you wish to continue life insurance along with the first monthly premium, payable at the Plan's full cost.

You must do so within 60 days after written notification is sent from the Plan Administrator of your right to continue, including the premium amount and due date.

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

Continued Life Insurance Benefits end on the earliest of:

(a) the day insurance has been continued for 18 months;

(b) the day a conversion policy is obtained;

(c) the day you obtain coverage under another group policy, contract, or plan; or

(d) the day insurance otherwise would end according to policy provisions.

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

### Conversion Privilege

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

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

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

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

## Dependent Life Insurance
### Plan 1 Only
### For Dependents of Full-Time Employees Only

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

(a) you;

(b) your spouse;

(c) your children, including legally adopted children; or

(d) your Dependent’s estate.

If two or more of your children are entitled to benefits, they will share equally.

If both you and your spouse are eligible as Employees, both may enroll for Life Insurance Benefits and Accidental Death and Dismemberment Benefits. However, if you are insured as an Employee, you will not be eligible to also be insured as a Dependent for Dependent Life Insurance Benefits.

### Conversion Privilege

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

The personal policy may be of any type other than term insurance and without disability benefits in an

amount up to the amount of your Dependent's life insurance coverage in force at the time of death. You or your Dependent must apply for the personal policy and pay the first premium within 31 days after your Dependent's Life Insurance Benefits end. Premiums for the personal policy will be determined at the time of conversion by your Dependent's class of risk, the type and amount of insurance, and his age. The personal policy will not become effective before the end of the 31-day conversion period.

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

***Please Note: According to provisions of the Small Business Job Protection Act, death benefits are taxable effective August 20, 1996. Please consult your tax advisor as these death benefits are taxable for federal and state tax purposes.***

## Accidental Death and Dismemberment Benefits

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

If, while you are covered, you suffer bodily Injury caused by accidental means and the Injury causes your death or the loss of a limb or the sight of an eye within 90 days of the date of the accident, the following benefits are payable based on the principal sum specified in the Schedule of Benefits:

(a) the principal sum for loss of life;

(b) one-half of the principal sum for loss of one hand by severance at or above the wrist, or loss of one foot by severance at or above the ankle, or irrecoverable loss of the sight of one eye;

(c) the principal sum for loss of more than one of the prior dismemberments; or

(d) one-quarter of the principal sum for loss of thumb and index finger of either hand.

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

### Limitations

In addition to the Plan's General Limitations, which begin on page 49, Accidental Death and Dismemberment Benefits do not cover losses from:

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

(b) war or any act of war;

(c) military, naval, or air service; or

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

## Accident and Sickness Benefits

**Plan 1 Only**
**For Full-Time Employees Only**

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

The day of disability on which benefits begin is:

(a) For an accident: first day of disability.

(b) For a Sickness or pregnancy: first day of inpatient Hospital confinement or eighth consecutive day of disability, whichever is earlier.

(c) For surgical procedures performed on an outpatient basis: eighth day of disability (however, if the disability extends past the seventh day, benefits are paid retroactively to the first day, provided you

submit a Physician's written certification of Total Disability).

Accident and Sickness Benefits are subject to federal Social Security taxes and federal and state unemployment taxes.

### Limitations

In addition to the Plan's General Limitations, which begin on page 49, Accident and Sickness Benefits are not payable:

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

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

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

(d) If you are eligible for and/or collecting unemployment.

(e) If you are receiving a pension.

## Comprehensive Major Medical Benefits
### Plans 1 and 2
### For Full-Time Employees and Their Dependents and Part-Time Employees

When you or your Dependent require covered services or supplies which are Medically Necessary because of Injury or Sickness, benefits are payable as stated in the Schedule of Benefits, provided you have satisfied any required Deductible. If there are limitations for a particular benefit, they are explained with each benefit. General Limitations for the Plan begin on page 49.

### 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. If you use the cost-effective alternatives the Trustees have approved as described on pages 37 through 39, the Deductible is waived. Also, there is no Deductible required for prescription drugs obtained at a Preferred Provider pharmacy as described on pages 43 through 45.

The Deductible applies only once in any Calendar Year even though you may have several different disabilities. So that you do not have to satisfy your Deductible late in one Calendar Year and again early the following Calendar Year, any Covered Expenses incurred and applied toward the Deductible in the last three months of a Calendar Year also may be used toward satisfying the Deductible in the next Calendar Year.

Normally, the Deductible is applied separately to each Eligible Person in a family. But, if two or more eligible members of a family under Plan 1 are injured in the same accident, only one Deductible will be charged against all resulting Covered Expenses, regardless of the number of family members injured. A combined Deductible also will apply to Covered Expenses related to such common accident which are incurred in subsequent Calendar Years when new Deductible amounts otherwise would apply.

### Coinsurance

After you satisfy the Deductible amount, the Plan pays Covered Expenses at the Coinsurance percentage stated in the Schedule of Benefits. The balance of charges is payable by you. If you use the cost-effective alternatives the Trustees have approved as described on pages 37 through 39, the Coinsurance is waived.

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

Covered Expenses incurred and paid by you during the last three months of a Calendar Year will be counted toward your out-of-pocket maximum for the following Calendar Year.

Covered Expenses incurred for infertility treatment will not be applied toward your out-of-pocket maximum.

## Covered Expenses

Benefits are payable for Reasonable Expenses incurred for the following services and supplies which are Medically Necessary for the treatment of an Injury or Sickness.

**(a) Hospital Services** recommended by the attending Physician for the following:

(1) Room and board expense, up to the admitting Hospital's Semi-Private Room rate.

(2) Confinement in an intensive care or coronary care unit, but not to exceed twice the admitting Hospital's Semi-Private Room rate.

(3) Confinement of 24 or more consecutive hour's duration in a recovery room of a Hospital if you receive the same care and services as those normally provided in the intensive care unit of the Hospital, but not to exceed twice the admitting Hospital's Semi-Private Room rate.

(4) Drugs, medicines, diagnostic x-rays and laboratory tests, and other Hospital miscellaneous services and supplies not included in the room charges (including the anesthetist's fee when charged by the Hospital), if used while confined in the Hospital as a resident patient. See pages 37 and 38 for coverage of pre-admission testing expenses.

(5) Outpatient services in connection with emergency first-aid treatment resulting from Injury or Sickness, provided such services are rendered after the first appearance of the symptoms of a Sickness or within 24 hours after an accident.

The first three emergency room visits per Eligible Person per Calendar Year will be covered subject to the Deductible, Coinsurance, and out-of-pocket maximum. After these first three visits, there will be a separate Copayment per emergency room visit as stated in the Schedule of Benefits (which will apply to the out-of-pocket maximum but not the Deductible) and then the Deductible, Coinsurance, and out-of-pocket maximum will apply. This separate Copayment will be waived if you are admitted to the Hospital from the emergency room.

(6) A newborn Dependent child of a Plan 1 Eligible Person during the period his mother is Hospital-confined as the result of giving birth to the child and after the mother's discharge if the newborn has a condition which necessitates further Hospital confinement.

The Plan generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a Hospital length of stay not in excess of these periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable.

(7) The room cost for up to two consecutive days and up to a total of six days during one period of disability for an Eligible Person, undergoing inpatient treatment for a nervous or mental condition, when temporarily released for therapeutic reasons.

(8) Outpatient services in connection with dental procedures when Medically Necessary due to the patient's age or health.

In-Hospital benefits are not payable for hospitalizations starting on weekends for treatment or surgery scheduled to begin the

following Monday or later, unless scheduled to begin before 6:00 a.m. Monday morning.

See subsection (d) on this page for coverage of Hospital confinements, partial hospitalization, and care in a residential treatment facility related to treatment of nervous and mental disorders, abuse of substances, and alcoholism.

**(b) Skilled Nursing Home Care** in a licensed Skilled Nursing Home for up to 30 days of confinement per period of disability, provided:

(1) you are transferred to the Skilled Nursing Home within 24 hours of Hospital discharge;

(2) you were hospitalized immediately before transfer to the Skilled Nursing Home;

(3) the attending Physician certifies this care is Medically Necessary and recertification is made every seven days;

(4) further hospitalization would be necessary if not for Skilled Nursing Home confinement; and

(5) the daily room rate does not exceed that established by the Minnesota Department of Health and Social Services or by a similar agency if in another state.

**(c) Physicians' and Others' Services** include charges for:

(1) Surgery by a Physician, including charges for outpatient surgery, home deliveries, circumcision of an eligible newborn Dependent child of a Plan 1 Eligible Person, and the surgical removal of impacted wisdom teeth. For organ transplant surgery and related items, see pages 35 and 36.

Sex reassignment surgery is covered only when Medically Necessary according to specified guidelines, and determined to be the most appropriate treatment choice for the Eligible Person's gender dysphoria.

(2) Anesthetic and its administration by a professional anesthetist when the charge for those services is not included in the Hospital's charges.

(3) Medical services rendered during in-Hospital, outpatient, office, and home visits; examination of an eligible newborn Dependent child of a Plan 1 Eligible Person when the examination is performed within 48 hours of birth by a Physician; and a simple office visit related to a pap test.

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

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

See the following section for coverage of Physicians' services for outpatient treatment for nervous and mental disorders, abuse of substances, and alcoholism. See page 37 for coverage of Physicians' services for routine physical examinations and page 39 for Doctor on Demand visits.

**(d) Inpatient and Outpatient Expenses Related to Treatment for Nervous and Mental Disorders, Abuse of Substances, and Alcoholism** are payable the same as for any other disability.

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

Psychological testing over five hours will be reviewed for medical necessity.

**(e) Diagnostic X-Ray and Laboratory Services,** including the pap test regardless of the purpose for which it is performed and for amniocentesis. Genetic testing, other than amniocentesis, is payable only under specific parameters described under subsection (i) on page 37. Expenses for dental x-rays [unless rendered for dental treatment of temporo-mandibular joint disorder (TMJ) or a fractured jaw or Injury to natural teeth within six months after an accident] or allergy tests are excluded.

**(f) Other Covered Expenses** include the following:

(1) Other Hospital services or supplies incurred as an outpatient.

(2) Services of a qualified physiotherapist, occupational therapist, speech therapist, registered nurse (R.N.), or licensed practical nurse (L.P.N.). Benefits are payable for services of a licensed speech therapist under the supervision of a Physician for a condition resulting from an Injury, Sickness, or congenital disorder such as cleft lip or palate. However, benefits are not payable for speech therapy for a condition resulting from learning disabilities or a personality disorder. Occupational and speech therapy are covered for developmental delays if Medically Necessary as defined by case management and provided school programs have first been utilized to the fullest.

(3) Local professional ground ambulance service to the nearest Hospital that is equipped to provide the Medically Necessary treatment.

The Plan also will cover Medically Necessary professional ambulance service by air or helicopter if an Injury or Sickness requires special and unique Medically Necessary treatment that is not available in a local area Hospital. The Physician providing services related to a medical emergency will select the Hospital, provided it is equipped to furnish the treatment, is the nearest Hospital, or is within 60 miles of the location of the treating Physician, whichever is greater.

Medically Necessary emergency transport by air and helicopter ambulance charges are subject to the Deductible and Coinsurance as stated in the Schedule of Benefits and the reimbursement terms available to the Plan through the Preferred Provider's contract. In the case of a non-Preferred Provider, reimbursement terms are limited to the reasonable and customary charge allowed by the Plan.

Charges for ambulance service by railroad, ship, bus, or other common carrier are not Covered Expenses.

Benefits are not payable for transportation or transfer based solely on your or your Physician's convenience, personal preference, or any reason other than medical necessity.

(4) Charges for the following additional services and supplies: 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; 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; dental services (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; 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 Eligible Person per Calendar Year; Medically Necessary durable medical equipment; 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; and blood glucose meters.

(5) For individuals receiving mastectomy-related benefits, coverage will be provided on the same basis as other medical and surgical procedures covered by the Plan and in a manner determined in consultation with the attending Physician and the patient for: all stages of reconstruction of the breast and nipple of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance; treatment of physical complications at all stages of the mastectomy, including lymphedemas; breast prostheses; and two mastectomy bras per Eligible Person per Calendar Year.

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

- Tested positive for the BRCA1 or BRCA2 gene mutation; or
- a history of cancer in the contralateral breast; or
- a strong family history of breast cancer.

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.

(6) Drugs and medicines requiring the written prescription of a Physician and dispensed by a licensed pharmacist which are obtained at a pharmacy that does not participate in the Preferred Provider Pharmacy network.

Benefits for prescription drugs payable under the Preferred Provider Pharmacy Benefits are described on pages 43 through 45.

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

See pages 37 through 39 for coverage of routine immunizations, Hospice Care, and home health care.

**(g)** **Organ and Tissue Transplant Surgery** and related covered costs including human organ or tissue transplants during the transplant benefit period to a recipient who is an Eligible Person. A transplant benefit period consists of five days before and eighteen months after the date of a transplant. If the transplant decision has been approved as specified later in this section, but the eligible transplant procedure has to be delayed for reasons such as the recipient's medical condition or the unavailability of an organ, the transplant benefit period may be extended to include

more than five days prior to the transplant. Organ transplant benefits are payable provided each of the following conditions is satisfied:

(1) You or your Dependent must have been eligible under the Plan for at least 24 consecutive months immediately prior to incurring Covered Expenses. Newborn Dependent children covered under Plan 1 will be eligible for organ transplant benefits provided the parent who is an Employee has been a Full-Time Employee for at least 24 months immediately prior to the newborn organ transplant.

(2) You receive two written opinions by board-certified specialists in the involved field of surgery on the necessity for transplant surgery.

(3) The specialists certify in writing that alternative procedures, services, or courses of treatment would not be effective in the treatment of your condition.

(4) All decisions related to the transplant surgery satisfy applicable state requirements.

(5) You must contact the Plan Administrator for prior approval for all organ transplants.

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

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

Postoperative followup expenses, including immunosuppressant drug therapy, are covered the same as for any other disability.

All other Covered Expenses for the recipient will be payable under the Plan the same as for any other Injury or Sickness.

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

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

No organ transplant benefits are payable for:

(1) services not ordered by a Physician;

(2) any expenses for a transplant when approved alternative courses of treatment are available or when other specified conditions are not satisfied;

(3) animal or mechanical organs for transplantation;

(4) investigational drugs;

(5) any items specified in the Plan's General Limitations which begin on page 49;

(6) purchase of the organ or tissue;

(7) the use of Experimental mechanical equipment;

(8) donor-related services for: testing; life support; transportation; organ and tissue procurement; and expenses related to the treatment of a condition resulting from the donation of an organ or tissue; or

(9) transportation, lodging, and meals for the recipient or other person to and from the transplant site.

**(h)** **Infertility Treatment** for 80% of Reasonable Expenses incurred by Employees and Dependent spouses in Plan 1 and Employees

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.

## 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.

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

(1) you are scheduled for Hospital admission and the scheduled admission occurs;

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

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

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

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

(2) a Hospital bed is not available; or

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

**(b) Hospice Care**

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

(1) Physicians' visits;

(2) care provided by registered nurses (R.N.), licensed practical nurses (L.P.N.), and home health care aides;

(3) assessment visit by a Hospice Program staff member;

(4) physical, occupational, speech, and respiratory therapy; and

(5) drugs and supplies prescribed by a Physician.

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

**(c) Home Health Care**

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

(1) hospitalization or confinement in a Skilled Nursing Home would be required in the absence of home health care;

(2) the patient's family or persons residing with the patient cannot provide necessary care and treatment without causing an undue hardship; and

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

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

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

Covered home health care services include:

(1) part-time or intermittent nursing care under the supervision of a registered nurse (R.N.), including services of a licensed practical nurse (L.P.N.) when prescribed by a Physician;

(2) Medically Necessary home health aide services (part-time or intermittently) solely for the care of the patient and under the supervision of a R.N. or a medical social worker;

(3) physical, respiratory, occupational, or speech therapy;

(4) medical supplies, drugs, and medications prescribed by a Physician and necessary laboratory services to the extent they would have been covered during a Hospital confinement;

(5) nutritional counseling by a registered dietitian when Medically Necessary; and

(6) evaluation of the need for development of a plan for home health care by a R.N., Physician extender, or medical social worker when requested or approved by the attending Physician.

**Limitations:** Home health care benefits are not provided for:

(1) food, housing, homemaker services, or home-delivered meals;

(2) Custodial Care;

(3) services or supplies not included in the Home Health Care Plan established for the patient;

(4) services provided by the patient's family or anyone residing with the patient; or

(5) any services not specifically listed in this section.

**(d) Doctor On Demand**

Doctor On Demand visits offered by Blue Cross Blue Shield of Minnesota are payable at 100% for you and your Dependents.

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

(1) Urgent care: cough, cold, flu, rash, pink eye, sports Injury, bug bite, urinary tract infection, vomiting, travel issues, and sore throat.

(2) Mental health: depression, anxiety, work-related stress, relationship issues, smoking cessation, ADHD, mood changes, trauma, and eating disorders.

(3) Lactation consulting: latch issues, milk supply, mastitis, thrush, plugged ducts, transitioning back to work, and pumping questions.

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

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

### Comprehensive Major Medical Benefits Limitations

In addition to the Plan's General Limitations which begin on page 49 and other limits that apply to specific benefit provisions as described in those sections, Comprehensive Major Medical Benefits do not cover:

(a) ambulance service by railroad, ship, bus, or other common carrier, or for air ambulance service, except as specifically provided;

(b) dental treatment, dental implants, or dental x-rays, except as specifically provided;

(c) purchase of radioactive materials for x-ray, radium, or cobalt treatment;

(d) examination for correction of vision or fitting of glasses or contact lenses, except as specifically provided;

(e) care in a rest home other than in a Hospital;

(f) any loss caused by or resulting from mental deficiency, intellectual disability, develop-mental deficiencies, or any treatment for learning disabilities;

(g) counseling or treatment for conditions not supported by a bona fide medical diagnosis, such as aptitude testing and marriage counseling;

(h) hospitalizations starting on weekends for treatment or surgery scheduled to begin the following Monday or later, unless scheduled to begin before 6:00 a.m. Monday morning;

(i) services provided by a person who ordinarily resides in your home or is a member of your immediate family (comprised of your spouse and your and your spouse's children, brothers, sisters, and parents); or

(j) routine care for Dependent children (except well baby/well child care is covered for eligible Dependent children who are covered under Plan 1).

## Dental Care Benefits

### Plans 1 and 2
### For Full-Time Employees and Their Dependents and Part-Time Employees

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 DeltaPreferred 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.

### What Do Your Dental Care Benefits Cover?

Benefits are payable for the following dental procedures performed, up to the maximum and at the applicable percentages stated in the Schedule of Benefits. The maximum does not apply to the following Dental Care Benefits for eligible Dependent children under age 19:

(a) routine oral examinations;

(b) sealants;

(c) dental prophylaxis; and

(d) topical fluoride treatments.

**Regular Diagnostic and Preventive Services**

Regular diagnostic and preventive services include:

(a) oral examinations, but not more than two in 12 months, including bitewing x-rays once each six months;

(b) full mouth x-rays once each three years, unless special need is shown;

(c) dental prophylaxis as prescribed by the Dentist, but not more than two in 12 months;

(d) topical fluoride applications as prescribed by the Dentist, but not more than once each 12 months;

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

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

**Basic and Special Restorative Services**

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

*Basic services include:*

(a) emergency treatment for relief of pain;

(b) amalgam, preformed crowns, and synthetic porcelain restorations; plastic or composite restorations for anterior teeth only;

(c) routine oral surgery: provides for tooth removal (including alveolectomy, where indicated), including pre- and post-operative care;

(d) endodontics: includes pulpal therapy and root canal filling; and

(e) sealants: coverage limited to once per Lifetime of permanent molars of eligible Dependent children under age 19.

*Special services include:*

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

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

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

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

(c) All other oral surgery not herein mentioned, subject to coordination of benefits provisions.

(d) Non-surgical dental treatment of temporo-mandibular joint disorder (TMJ) and craniomandibular disorder, subject to coordination of benefits provisions.

*Special restorative services include:*

(a) Procedures to restore lost tooth structure as a result of tooth decay or fracture.

(b) Gold or cast restorations when the teeth cannot be restored with another filling material.

(c) Crowns when the teeth cannot be restored with a filling material.

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

(d) Filled composite resin restorations for posterior teeth.

**Limitations:**

(1) Posterior teeth will have a composite restoration maximum of three surfaces; and

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

**Prosthetics (Removable and Fixed)**

Prosthetics includes coverage for:

(a) repairs and adjustments to prosthetic appliances; and

(b) bridges, partial dentures, and complete dentures for the replacement of fully extracted or missing permanent teeth.

*Replacement Benefits*

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

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

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

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

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

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

## Dental Care Benefits Limitations

In addition to the Plan's General Limitations which begin on page 49, Dental Care Benefits are not payable for:

(a) services performed for purely cosmetic purposes, or to correct congenital conditions other than by orthodontic care;

(b) charges for dental services which were completed prior to the date the person became covered under this Plan;

(c) services of anesthesia, except by a Dentist or by an employee of the Dentist when the service is performed in his office, all in conjunction with covered services;

(d) charges for any services not specifically covered under this Plan, including any Hospital charges or prescription drug charges (new or Experimental dental techniques or procedures may be denied until there is, to the satisfaction of the Trustees, an established scientific basis for recommendation);

(e) services performed other than by a licensed Dentist, his employees, or agents;

(f) procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and Gnathologic recordings (if these services are performed, cost responsibility would be that of the patient, unless provided under orthodontic provisions of the Plan);

(g) direct diagnostic or treatment procedures applied to body joints or muscles, except as provided under orthodontic provisions of the Plan;

(h) implants (artificial materials implanted or grafted into or onto bone or soft tissue) or surgical removal of implants;

(i) veneers (bonding of coverings to the teeth); or

(j) orthodontic treatment procedures, unless specified as a covered dental benefit.

*Alternative Treatment Plans*

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

*Reconstructive Surgery*

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

## Vision Care Benefits

**Plan 1 Only**
**For Full-Time Employees and Their Dependents Only**

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

### Eye Examinations

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

### Lenses and Frames

Each Eligible Person is entitled to one set of lenses and one set of frames or contact lenses each Calendar Year. Fees for professional services for fitting and adjusting also are covered.

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

### Laser Eye Surgery

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

### Limitations

In addition to the Plan's General Limitations which begin on page 49, Vision Care Benefits are not payable for:

(a) sunglasses;

(b) safety lenses and goggles;

(c) orthoptics, vision training, or aniseikonia; or

(d) any refraction made or material furnished as the result of a refraction which began before eligible under this Plan.

## Preferred Provider Pharmacy Prescription Drug Benefits

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

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

(a) federal legend drugs;

(b) insulin;

(c) OTC and legend inhaler-assisting devices;

(d) Buproprion and Zyban (smoking deterrents);

(e) antihemophilia agents;

(f) OTC and legend diabetic supplies/insulin needles, syringes;

(g) androgenic agents;

(h) drugs to treat impotency;

(i) contraceptives requiring a written prescription executed by a Physician and dispensed by a licensed pharmacist;

(j) daily low dose erectile dysfunction drugs (other erectile dysfunction medications limited to 10 pills per month);

(k) multivitamins with fluoride and prenatal vitamins;

(l) injectables;

(m) growth hormones;

(n) migraine therapy medications;

(o) hormone replacement therapy; and

(p) acne-related products such as Retin-A, Accutane, and Azelex.

Prior authorization is required for certain medications.

You can find a participating network pharmacy by calling: Prime Therapeutics or visiting: www.myprime.com.

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

(a) Present the identification card to the pharmacist with the prescription.

(b) Verify and sign the pharmacy prescription signature log prepared by the pharmacist.

(c) Pay the pharmacy your Copayment stated in the Schedule of Benefits.

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

## Dispensing Limitations

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

Maintenance drugs may be purchased in a 90-day supply at a retail pharmacy that participates in the Prime Extended Supply Network.

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

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

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

## Compound Management

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

## Specialty Drugs

The Plan covers specialty drugs through AllianceRx Walgreens Prime up to a 31-day supply. Specialty drugs are drugs prescribed for people with complex and ongoing medical conditions, such as multiple sclerosis or rheumatoid arthritis. Specialty drugs only may be purchased through AllianceRx Walgreens Prime.

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.

## 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.

## Limitations

In addition to the Plan's General Limitations which begin on page 49, Preferred Provider Pharmacy Prescription Drug Benefits are not payable under this section for:

(a) drugs which are lawfully obtainable without a prescription, except insulin and insulin syringes;

(b) administration of prescription legend drugs or injectable insulin or implantable/injectable contraceptives;

(c) drugs labeled: "Caution - limited by federal law for investigational use," or Experimental drugs, even though a charge is made to the individual;

(d) refilling of a prescription in excess of the number specified by a Physician or Dentist;

(e) 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;

(f) drugs prescribed for treatment of infertility (see pages 36 and 37 for coverage of such prescription drugs);

(g) cosmetic drugs, except where classified as "prescription legend drugs;" or

(h) emergency contraceptive kits; drugs whose sole purpose is to promote or stimulate hair growth (such as Rogaine); Renova; alcohol wipes and insulin pump supplies for diabetics; smoking cessation gums, inhalers, sprays, and patches; abortifacients (Mifeprex); nutritional supplements and combo nutritional products; ostomy supplies; dental fluoride products; Synagis/Respigam; hyperglycemics, oral (OTC); HSDD agents – mixed Seratonin agonist/Antagonist (i.e. Addyi); allergy sera; blood or blood plasma products; and 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. Propecia (to stimulate hair growth) also requires prior authorization.

# BENEFITS FOR PLAN 3

## Comprehensive Major Medical Benefits

### Plan 3
### For Retirees and Their Dependents Who Are Not Medicare-Eligible

Comprehensive Major Medical Benefits include substantial coverage for the catastrophic or disaster type Injury or Sickness which involves Hospital, surgical, and medical expenses.

### Deductible

The Deductible is the amount of Covered Expenses which you pay before you are entitled to Comprehensive Major Medical Benefits. The Deductible per person and per family per Calendar Year is stated in the Schedule of Benefits.

The Deductible amount is applicable each Calendar Year. Any Covered Expense incurred and applied toward the Deductible during the last three months of any Calendar Year also is applied to the Deductible requirements for the following year.

If two or more members of your family are injured in the same accident, only one Deductible will be charged against all such expenses incurred during the Calendar Year in which the accident occurred and the next succeeding Calendar Year, regardless of the number of family members injured.

### Coinsurance

The Plan will pay 75% of the first $10,000 of Covered Expenses per person per Calendar Year; then the Plan will pay 100% of Covered Expenses for the remainder of that Calendar Year for such person. Covered Expenses incurred during the last three months of the preceding Calendar Year which you had to pay are counted toward your $2,500 out-of-pocket maximum for the following Calendar Year.

### Description of Benefits

Benefits are payable at the rate and up to the limits specified in the Schedule of Benefits for Covered Expenses which include Reasonable Expenses for the following services and supplies which are Medically Necessary for the treatment of an Injury or Sickness:

(a) Hospital and convalescent Hospital room and board (up to average Semi-Private Room rate or double that amount if in an intensive care unit), services and supplies, including care for nervous or mental disorders, alcoholism, and substance abuse. The Plan encourages non-weekend admissions whenever possible.

The Plan generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a Hospital length of stay not in excess of these periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable.

NOTE: The Coinsurance is waived for emergency treatment of injuries incurred within 24 hours after the Injury is sustained. See the Schedule of Benefits for the separate Copayment requirement after the first three emergency room visits per Eligible Person per Calendar Year.

(b) Partial hospitalization expenses at an approved Hospital for treatment of nervous and mental conditions, alcoholism, and substance abuse, payable the same as for any other disability.

(c) Care in a residential treatment facility in lieu of full hospitalization for treatment of nervous and mental conditions, alcoholism, and substance abuse, payable the same as for any other disability.

(d) Physicians' services for:

(1) in-Hospital Physician visits (limit one visit per day) and office visits;

(2) surgical procedures, including pre- and post-operative care;

(3) in-Hospital consultation when requested by attending Physician;

(4) anesthesia;

(5) emergency treatment of Injury or Sickness;

(6) outpatient treatment of nervous and mental disorders, including consultation, diagnosis, and treatment if services are furnished by a Hospital, community mental health center, or mental health clinic approved or licensed by the commissioner of public welfare or other authorized state agency, psychiatrist, or licensed consulting psychologist, payable the same as for any other disability; and

(7) outpatient treatment of alcoholism and substance abuse, provided such treatment is rendered by a Physician or is furnished at a Hospital or licensed treatment facility, payable the same as for any other disability.

(e) Services of a licensed chiropractor acting within the usual scope of chiropractic practice, up to the per visit and maximum per person per Calendar Year, stated in the Schedule of Benefits, payable the same as for any other disability.

(f) Services of registered nurses, physical therapists, and licensed speech therapists (under the supervision of a Physician for a condition resulting from an Injury, Sickness, or congenital disorder), except services provided by a person who ordinarily resides in your home or is a member of your immediate family.

(g) Non-genetic diagnostic x-rays and laboratory tests (excluding allergy tests) and amniocentesis, provided such testing and x-rays are Medically Necessary, authorized by a Physician, and performed while you or your Dependent are not confined within a Hospital as a resident patient.

(h) Ambulance service.

(i) Additional services and supplies, including anesthetics and oxygen; rental of iron lung and other equipment for therapeutic treatment (or the purchase of such device if the rental would exceed the purchase price); initial artificial limbs or 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; initial pair of podiatric orthotic appliances when prescribed by a Physician and Medically Necessary replacements; custom-made stockings, such as Jobst stockings, up to two pair per Eligible Person per calendar year; over-the-counter splints, 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.

(j) For individuals receiving mastectomy-related benefits, coverage will be provided on the same basis as other medical and surgical procedures covered by the Plan and in a manner determined in consultation with the attending Physician and the patient: all stages of reconstruction of the breast and nipple of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance; treatment of physical complications at all stages of mastectomy, including lymphedemas; breast prostheses; and two mastectomy bras per Eligible Person per Calendar Year.

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

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

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).

# GENERAL PROVISIONS

## General Limitations

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

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

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

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

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

(d) Services or supplies:

(1) for which no charge is made;

(2) for which you are not required to pay;

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

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

(5) for marriage counseling, except as provided by TEAM;

(6) for artificial life support after legal or clinical death, except as provided on page 35; or

(7) which are not Medically Necessary, as defined on page 82.

(e) Hearing aids, hearing aid batteries, and repairs.

(f) Cosmetic surgery unless:

(1) necessary for repair or alleviation of damage resulting from an Injury; or

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

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

Benefits are payable for: reconstructive surgery following a covered mastectomy, including reconstruction of the contralateral breast to produce symmetrical appearance; and for a prophylactic mastectomy or prophylactic oophorectomy as provided on pages 35, 47, and 48.

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

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

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

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

(k) Application of podiatric orthotic appliances.

(l) Artificial insemination, including related services and supplies, and invitro-fertilization, except as provided on pages 36 and 37.

(m) Reversal or attempted reversal of a previous sterilization procedure.

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

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

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

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

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

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

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

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

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

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

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

(y) Charges incurred for any special education rendered to any Eligible Person, regardless of the type of education, the purpose of the education, except for a single nutritional consultation session recommended by the attending Physician.

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

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

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

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

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

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

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

(gg) Charges incurred for confinement and services at a halfway house or group home.

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

(ii) Charges for injections prescribed or administered by a chiropractor.

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

(kk) Charges for special home construction to accommodate a disabled Eligible Person.

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

(mm) Charges incurred for hypnosis.

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

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

(pp) Court-ordered treatment/confinement unless there is substantiation of medical necessity.

(qq) Shipping and handling for charges incurred on Covered Expenses.

(rr) Radial Keratotomy or laser eye surgery, except as otherwise specified under Vision Care Benefits on page 43.

(ss) Services of a massage therapist.

(tt) All expenses associated with personal blood storage.

(uu) Homeopathic providers, services, and supplies.

(vv) Breast pumps.

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

(xx) Any loss, expense, or charge for which a Third Party may be liable and for which either:

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

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

(yy) Any losses, expenses, or charges incurred by an Eligible Person at a time that an Eligible Person owes a payment to the Plan, or to any losses, expenses, or charges incurred by an individual who performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact in connection with coverage under the Plan, including failure to honor the Plan's right of subrogation or reimbursement or otherwise cooperate with the Plan as specified.

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

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

(2) has recovered from a Third Party; or

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

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

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

the illegal act is related to a physical or mental health condition of the Eligible Person.

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

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

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

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

(4) Where a no-fault carrier discontinues benefits prior to the exhaustion of no-fault coverage and the Eligible Person fails to arbitrate the notice of discontinuance. No further benefits will be paid for Injuries of conditions sustained as a result of the accident until such time as the arbitration proceedings are complete and an award issued.

(5) 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.

(6) 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 (ww), (xx), and (zz) 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.

(ddd) 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:

(1) as to which the Plan has agreed to a settlement of that right;

(2) the Eligible Person has recovered payment from a Third Party; or

(3) 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.

(eee) Habilitation services.

(fff) Long-term care.

(ggg) Non-emergency care when traveling outside the United States.

(hhh) Private-duty nursing.

(iii) Routine foot care.

## Coordination of Benefits

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

If the other group plan does not contain a coordination of benefits or similar provision, then that plan always will calculate and pay its benefits first. When duplicate coverage arises and both plans contain a coordination of benefits or similar

provision, this Plan has established the following rules to decide which group plan will calculate and pay its benefits first:

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

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

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

(1) The plan of the parent having custody pays first.

(2) If the parent having custody has remarried, the order is:

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

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

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

(e) Coordination of Benefits with Automobile Insurance

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

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

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

(f) Coordination of Benefits With Other Types of Insurance

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

might be payable under another insurance policy will not be paid by this Plan merely because the Eligible Person has not made a claim under the other insurance policy.

(g) Order of Benefit Calculation if Entitled to Medicare

Eligible Persons who are retired or disabled and become entitled to Part A and Part B of Title XVIII of the Social Security Amendments of 1965 (more commonly known and described as "Medicare") by reason of attained age, qualifying disability, or End Stage Renal Disease (ESRD) are required to enroll in Medicare. The Plan will coordinate its benefits with Medicare as described in this section.

(1) For Persons Initially Entitled to Medicare by Reason of Attained Age or Qualifying Disability (other than ESRD) and Eligible Due to Employer Contributions. Plan benefits are not reduced for persons eligible through Employer Contributions even though they also may become initially entitled to Part A or Part B of Medicare due to attained age or a qualifying disability (other than ESRD). In the event such person subsequently becomes entitled to Medicare due to ESRD, the Plan will continue to be the primary source of coverage for the full 30-month coordination period.

This Plan may pay before Medicare pays for Eligible Persons entitled to Medicare due to End Stage Renal Disease (ESRD) if that person is eligible under the Plan through either Self-Payments or Employer Contributions. In the event an Eligible Person is required to enroll in Part A and Part B of Medicare solely because of End Stage Renal Disease, benefits payable under the Plan will be limited to the covered charges incurred during the initial 30 consecutive months of treatment, beginning with either: (i) the first month in which renal dialysis treatment is initiated; or (ii) in the case of a transplant, the first month in which the individual could become entitled to Medicare, providing a timely application was filed.

(2) Private Physician Contracts in Lieu of Medicare. For Eligible Persons who are enrolled, or eligible for enrollment, in Medicare and for whom Medicare is or would have been the primary source of coverage, the benefits payable under this Plan for services otherwise covered by Medicare, but which are privately contracted with a provider will be limited to the amount that would have been payable by the Plan had the services been payable by Medicare.

(h) Right to Receive and Release Necessary Information

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

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

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

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

## Right of Subrogation and Reimbursement

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

First priority right of subrogation and reimbursement means that if the Plan pays benefits which are, in any way, compensated by a Third Party, such as an insurance company, you agree that when a recovery is made from that Third Party, the Plan is fully reimbursed out of that recovery for the benefits the Plan previously paid. If you do not agree to the Plan's subrogation and reimbursement rules, benefits will not be paid.

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

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

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

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

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

(c) **Plan Paid First:** Amounts recovered or recoverable by or on the Eligible Person's behalf are paid to the Plan first, to the full extent of its subrogation and reimbursement rights, and the remaining balance, if any, to the Eligible Person. The Plan's subrogation and reimbursement right comes first even if the Eligible Person is not paid for all of their claims for damages. If the Plan's subrogation and reimbursement rights are not fully satisfied directly by a Third Party, the Plan's right to reimbursement may be enforced to the full extent of any recovery that the Eligible Person may have received or may be entitled to receive from the Third Party.

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

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

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

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

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

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

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

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

recovery, an Eligible Person will reimburse or indemnify the Plan for any such amounts.

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

## Right of Recovery

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

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

(b) any insurance companies; or

(c) any other organizations.

## Termination of Plan

This Plan may be terminated:

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

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

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

In the event of termination, the Trustees will:

(a) make provision out of the Trust Fund for the payment of expenses incurred up to the date of termination of the Trust and the expenses incidental to such termination;

(b) arrange for a final audit and report of their transactions and accounts, for the purpose of termination of their Trusteeship;

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

(d) give any notices and prepare and file any reports which may be required by law.

## Trustee Interpretation, Authority, and Right

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

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

The right to change or eliminate any and all aspects of benefits provided for Retirees is a right specifically reserved to the Trustees, since the

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

## Prohibition Against Assignment to Providers

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

(a) receive benefits;

(b) claim benefits in accordance with Plan procedures and/or federal law;

(c) commence legal action against the Plan, Trustees, Trust Fund, its agents, or Employees;

(d) request Plan documents or other instruments under which the Plan is established or operated;

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

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

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

## HIPAA Security Regulations

The federal Department of Health and Human Services adopted regulations governing the Plan's obligation to maintain the security of your health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These regulations work in conjunction with the Medical Data Privacy Regulations. While the Plan always has taken care to secure your health information, the new regulations require the Plan, along with the Administrative Manager, to take some additional steps, in addition to those required by the Privacy Regulations, to maintain the electronic, physical, and technical security of your protected health information. The following information outlines the additional steps the Plan has taken to secure your health information in compliance with the HIPAA Security Regulations.

***Policies to Protect Electronic Health Information:*** The Plan, in conjunction with the Administrative Manager, has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of protected health information (PHI) in electronic form (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these regulations) that they create, receive, maintain, or transmit on behalf of the Plan. The Trustees will report to the Plan any security incident of which they become aware.

***Business Associates:*** The Plan will enter into agreements with other entities known as "Business Associates" to perform functions as part of the administration of the Plan. The Plan's agreements with its Business Associates will require that the electronic, physical, and technical security of your electronic PHI be maintained.

***Access to ePHI for Plan Administrative Functions:*** The Plan will give access to PHI to the Board of Trustees. Any such disclosures of your electronic PHI to the Trustees are supported by reasonable and appropriate security measures. If any Trustee fails to comply with these provisions, the Board of Trustees will provide a mechanism for resolving issues of noncompliance.

***If You Have Any Questions:*** The Administrative Manager is largely responsible for maintaining the security of your electronic PHI. If you have any questions regarding the security of your electronic PHI, you may contact the Administrative Manager.

***For more technical details on HIPAA compliance:*** Please see Appendix A of this Summary booklet.

## Genetic Information Nondiscrimination Act

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

## 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.

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The **United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan** (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI);

2. Your privacy rights with respect to your PHI;

3. The Plan's duties with respect to your PHI;

4. Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and

5. The person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all health information that identifies you transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

## SECTION 1
## NOTICE OF PHI USES AND DISCLOSURES

### A. Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

### B. Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations

The Plan and its business associates will use PHI without your authorization or opportunity to agree or object to carry out treatment, payment and health care operations. When required by law, we will restrict disclosures to the Limited Data Set, or if necessary, to the minimum necessary information to accomplish the intended purpose. The Plan and its business associates (and any health insurers providing benefits to Plan Participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

*Treatment* is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating Physician the name of your treating radiologist so that the Physician may ask for your x-rays from the treating radiologist.

*Payment* includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

*Health care operations* include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

*Treatment Alternatives or Health-Related Benefits and Services.* The Plan may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

*To Business Associates.* The Plan may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, the Plan may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with the Plan.

*As Required by Law.* The Plan will disclose your protected health information when required to do so by federal, state, or local law. For example, the Plan may disclose your protected health information when required by national security laws or public health disclosure laws.

*To Avert a Serious Threat to Health or Safety*. The Plan may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a Physician.

## C. Uses and Disclosures That Require Your Written Authorization

The Plan will obtain your written authorization before releasing your PHI in those circumstances where the law or the Plan's privacy practices do not otherwise permit disclosure. For example, your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you prepared by your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. Your written authorization also is required to use or disclose your PHI for marketing purposes and for disclosures that constitute a sale of PHI.

**D. Uses and Disclosures That Require That You be Given an Opportunity to Agree or Disagree Prior to the Use or Release**

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

1. The information is directly relevant to the family member or friend's involvement with your care or payment for that care; and

2. You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Additional rules and exceptions apply with family members. You may request additional information from the Plan.

The Plan may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. The Plan will provide you with an opportunity to agree or object to such a disclosure whenever the Plan practically can do so.

**E. Uses and Disclosures for Which Your Consent, Authorization or Opportunity to Object Is Not Required**

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.

2. Enrollment information can be provided to the Trustees.

3. Summary health information can be provided to the Trustees for the purposes previously designated.

4. When required by law.

5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions

are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. When authorized by and to the extent necessary to comply with Worker's Compensation or other similar programs established by law.

13. If you are an organ donor and if it is necessary to be given to organizations that handle organ procurements of organ, eye or tissue transplantation, or to an organ donation bank in order to facilitate organ or tissue donation and transplantation.

14. When you are a member of the armed forces, foreign or domestic, disclosure is permitted when required by military command authorizes and appropriate foreign military authority.

15. When the Secretary of the United States Department of Health and Human Services is investigating or determining the Plan's compliance with the HIPPA privacy rule.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

## SECTION 2
## RIGHTS OF INDIVIDUALS

### A. Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict or limit the uses and disclosures of your PHI. However, the Plan is not required to agree to your request.

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

The Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations purposes if you paid for these services in full, out of pocket.

**B. Right to Request Confidential Communications**

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

**C. Right to Inspect and Copy PHI**

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

*"Protected Health Information"* (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

*"Designated Record Set"* includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.

**D. Right to Amend PHI**

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

**E. Right to Receive an Accounting of PHI Disclosures**

At your written request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made as authorized by law. For example, the accounting will not include disclosures made: (1) to carry out treatment, payment or health care operations (including to Business Associates pursuant to a Business Associate agreement and to the Trustees as authorized by the Plan or the HIPAA privacy regulations) except as provided as follows; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; (5) disclosures made to friends or family in your presence or because of an emergency; and (6) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Your request for an accounting of disclosures should be made to the Plan’s Privacy Official.

**F. Right to be Notified of a Breach**

You have the right to be notified in the event that the Plan (or a Business Associate) discovers a breach of unsecured protected health information.

**G. Right to Receive a Paper Copy of This Notice Upon Request**

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

**H. A Note About Personal Representatives**

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. A power of attorney for health care purposes, notarized by a notary public;

2. A court order of appointment of the person as the conservator or guardian of the individual; or

3. An individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

## SECTION 3
## THE PLAN'S DUTIES

The Plan is required by law to maintain the privacy of PHI and to provide individuals (Participants and Beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all Participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

### A. Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than a Limited Data Set, or if necessary, the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

1. Disclosures to or requests by a health care provider for treatment;

2. Uses or disclosures made to the individual;

3. Disclosures made to the Secretary of the U.S. Department of Health and Human Services;

4. Uses or disclosures that are required by law; and

5. Uses or disclosures that are required for the Plan's compliance with legal regulations.

### B. De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

### C. Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by Participants and excludes identifying information in accordance with HIPAA.

## SECTION 4
## YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

## SECTION 5
## WHOM TO CONTACT AT THE PLAN FOR MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at:

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

## CONCLUSION

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

# YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act of 1993 (FMLA) requires covered Employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" Employees for certain family and medical reasons. Employees are eligible if they have worked for the same covered Employer for at least one year, and for 1,250 hours over the previous 12 months. See page 16 for an explanation of what constitutes a "covered" Employer.

## Reasons for Taking Leave

Unpaid leave must be granted for up to 12 weeks for any of the following reasons:

(a) to care for the Employee's child after birth, or placement of a child with the Employee for adoption or foster care;

(b) to care for the Employee's spouse, son or daughter, or parent who has a serious health condition;

(c) for a serious health condition that makes the Employee unable to perform his job; or

(d) because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the Employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. The Secretary of Labor will issue regulations defining "any qualifying exigency."

Unpaid leave must be granted for up to 26 weeks in a single 12-month period for an Eligible Employee who is the spouse, son, daughter, parent, or next of kin of a covered service member to care for the service member while recovering from a serious Sickness or Injury sustained in the line of duty on active duty. This military caregiver leave is available during "a single 12-month period" during which an Eligible Employee is entitled to a combined total of 26 weeks of all types of FMLA leave.

At the Employee's or Employer's option, certain kinds of paid leave may be substituted for unpaid leave.

## Advance Notice and Medical Certification

The Employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

(a) The Employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."

(b) An Employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the Employer's expense) and a fitness for duty report to return to work.

## Job Benefits and Protection

(a) For the duration of FMLA leave, the Employer must maintain the Employee's health coverage under any "group health plan."

(b) Upon return from FMLA leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

(c) The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

## Unlawful Acts by Employers

FMLA makes it unlawful for any Employer to:

(a) interfere with, restrain, or deny the exercise of any right provided under FMLA; or

(b) discharge or discriminate against any person for opposing any practice made unlawful by

FMLA or for involvement in any proceeding under or relating to FMLA.

## Enforcement

(a) The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.

(b) An Eligible Employee may bring a civil action against an Employer for violations.

FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or Collective Bargaining Agreement which provides greater family or medical leave rights. Certain states, including Minnesota, have laws providing additional rights concerning parental leave.

**FOR ADDITIONAL INFORMATION: Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under "U.S. Government, Department of Labor." For information on the Minnesota parental leave law, contact the Minnesota Department of Labor and Industry.**

# INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

## Statement of Participants' Rights Under ERISA

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

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

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

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

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

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

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

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

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

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

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

(1) Your request should be in writing.

(2) It should specify what materials you wish to look at.

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

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

(e) You may obtain copies of any Plan document governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary upon written request to the Trustees, addressed to

the Plan Administrator. ERISA provides that the Trustees may make a reasonable charge for the actual cost of reproducing any document you request. However, you are entitled to know what the charge will be in advance. Just ask the Plan Administrator.

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

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

(h) In accordance with Section 503 of ERISA and related regulations, the Trustees have adopted certain procedures to protect your rights if you are not satisfied with the action taken on your claim. These procedures appear on pages 21 through 24 of this booklet. These procedures are designed to give you a full and fair review and to provide maximum opportunity for all the pertinent facts to be presented in your behalf.

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

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

(i) In addition to creating rights for Plan Participants, ERISA also defines the obligations of people involved in operating employee benefit plans. These persons are known as “fiduciaries.” They have the duty to operate your Plan with reasonable care and look out for your best interests as a Participant under the Plan and the best interests of other Plan Participants and Beneficiaries under the Plan. The duties of a fiduciary are complex and are constantly changing as new laws and regulations are adopted applicable to employee benefit plans. Be assured that the Trustees of this Plan will do their best to know what is required of them as “fiduciaries” and to take whatever actions are necessary to ensure full compliance with all state and federal laws.

(j) Under ERISA, you may take certain actions to enforce the rights previously listed.

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

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

(i) the request actually was received;

(ii) the material was mailed to the right address; or

(iii) the failure to send the material was not due to circumstances beyond the Trustees’ control.

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

(2) Although the Trustees will make every effort to settle any disputed claims with Participants fairly and promptly, there always is the possibility that differences cannot be resolved satisfactorily.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court if you feel that you have been improperly denied a benefit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

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

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

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

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

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

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

## Other ERISA Information

### 1. Names and Addresses of the Trustees

**Employer Trustees**

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

Tracy McDonald
SUPERVALU, Inc.
11840 Valley View Road
Eden Prairie, MN 55344

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

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

Jon Born, Alternate
SUPERVALU, Inc.
11840 Valley View Road
Eden Prairie, MN 55344

**Union Trustees**

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

Mike Dreyer
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

Jeanine Owusu
UFCW Union Local 1189
266 Hardman Avenue North
South St. Paul, MN 55075

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

### 2. Names and Address of Plan Administrator

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

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

### 3. Type of Plan

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

### 4. Plan Sponsor

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

**5. Type of Plan Administration**

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

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

**6. Parties to the Collective Bargaining Agreement**

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

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

**7. Internal Revenue Service Employer and Plan Identification Numbers**

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

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

Matt Winkel
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Service of legal process also may be made upon any Plan Trustee.

**9. Eligibility Requirements**

The Plan's requirements with respect to eligibility for benefits are shown in the Eligibility Rules on pages 1 through 16. Circumstances which may cause the Participant to lose eligibility also are explained in the Eligibility Rules.

**10. Sources of Trust Fund Income**

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

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

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

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

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

The Trustees maintain an Excess Risk Indemnification Agreement which limits Trust Fund liability for claims to an annual aggregate maximum. The aggregate maximum and other provisions are determined in accordance with

the agreement which is part of and attached to the administration services contract in effect between Trustees and the contracting claims administrator.

**11. Method of Funding Benefits**

All Plan benefits except Life Insurance Benefits for Plans 1 and 2 and Accidental Death and Dismemberment Benefits for Plan 1 are self-funded from accumulated assets and are provided directly from the Trust Fund. A portion of Plan assets is allocated for reserves to carry out the objectives of the Plan. Self-Funded benefits payable are limited to Plan assets available for such purposes. All assets of the Plan are held by a custodian (bank) selected by the Trustees. US Bank Trust is currently the custodian of Plan assets. Assets not needed for the immediate payment of benefits and other Plan expenses are invested by an investment consultant hired by the Trustees in accordance with guidelines established and monitored by the Trustees. The current Investment Consultant is DiMeo Schneider & Associates, L.L.C.

Benefits for Life Insurance for Plans 1 and 2 as described on pages 28 through 30 and Accidental Death and Dismemberment Benefits for Plan 1 as described on page 30, are provided subject to Master Insurance Policy No. GLUG-PJ60 through United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175. Benefits eligible under the Life Insurance and Accidental Death and Dismemberment policy are submitted to the Plan Administrator and paid by United of Omaha directly to you, if living, otherwise to your Beneficiary.

**12. Fiscal Year of the Plan**

The Plan's fiscal year begins March 1 and ends February 28.

**13. Procedures To Be Followed in Presenting Claims for Benefits Under the Plan**

The procedures for filing for benefits are described on pages 19 and 20.

If a Participant wishes to appeal a denial of a claim in whole or in part, certain procedures for this purpose are found on pages 21 through 24.

# GENERAL DEFINITIONS

Wherever used in this Summary, the following definitions apply.

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

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

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

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

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

**Collective Bargaining Agreement** means the negotiated labor agreement between the Union and an Employer or Employer Association requiring the Employer or Employer Association to make Contributions to the Plan's Trust Fund in 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 in 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:

(a) 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;

(b) provides for patient services under the full-time supervision of a Physician or registered nurse;

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

(d) maintains complete medical records on each patient;

(e) has an effective utilization review plan; and

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

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

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

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

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

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

**Dependent** means an Eligible Employee's:

(a) Spouse (or former spouses as provided for under Eligibility Rule 14). Spouse means an individual who is the legally recognized spouse of an Employee under the laws of the state in which the marriage or civil union was established. For this purpose, a legal civil union will be considered a legal marriage. A certified copy of the marriage certificate or other documentation substantiating status as a spouse may be required to be on file at the Plan Administrator before claims for such spouse will be processed.

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

(b) Child (or children) who is under 26 years of age. Age 26 is the "termination age." Attainment of age 26 will cause loss of eligibility except as described as follows.

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

(1) Any biological child of an Eligible Employee.

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

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

(i) who was born to such spouse;

(ii) who was legally adopted by such spouse;

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

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

The Plan's obligation to provide benefits will be secondary to any obligation of either or both of the natural parents created by court order or judgment of divorce or legal separation. The stepparent must promptly provide a copy of any such court order or judgment and, if one or more of the parents is under such an obligation, the stepchildren first must seek payment or provision of benefits pursuant to the obligation of the parent(s). If collection under, or enforcement of, that obligation is impossible or impracticable in the judgment of the Trustees, this Plan will

provide benefits the same as for legally adopted children in accordance with the terms and conditions of the Summary, provided that, as a condition precedent to such provision of benefits, the Participant will assign to the Plan in writing the right to enforce such obligation so as to entitle the Plan to obtain reimbursement from the responsible parent or parents, or from their insurer, for benefits provided.

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

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

(6) Any child incapable of self-sustaining employment by reason of developmental cognitive disability or physical handicap, and who became so incapable prior to attainment of the termination age stated previously and who is primarily financially Dependent upon the Eligible Employee, provided the Eligible Employee furnishes due proof of such incapacity to the Trustees within 31 days of the date such child's coverage otherwise would terminate due to attainment of the termination age.

Proof of the continued existence of such incapability and dependency must be furnished to the Trustees from time to time at their request.

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

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

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

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

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

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

**Employer 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:

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

(b) has a definite positive effect on health outcomes;

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

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

"Reliable evidence" includes only:

(a) published reports and articles in authoritative medical and scientific literature;

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

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

Consideration may be given to whether:

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

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

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

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

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

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

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

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

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

(c) Maintains a complete medical record on each individual; and

(d) Has a full-time administrator.

**Home Health Care Plan** means a program for care and treatment of the individual established and approved in writing by the individual's attending

Physician. The attending Physician must certify that the proper treatment of the Sickness or Injury would require confinement as a resident inpatient in a Hospital or Convalescent Facility in the absence of the services and supplies provided as part of the Home Health Care Plan.

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

**Hospice Care Agency** is an agency or organization which:

(a) Has Hospice Care available 24 hours a day;

(b) Meets any licensing or certification standards set forth by the jurisdiction where it is located;

(c) Provides skilled nursing services, medical social services, psychological and dietary counseling, and bereavement counseling for the immediate family;

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

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

(f) Has established policies governing the provision of Hospice Care;

(g) Assesses the patient's medical and social needs;

(h) Develops a Hospice Program to meet the patient's medical and social needs;

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

(j) Permits all area medical personnel to utilize its services for their patients;

(k) Keeps medical records on each patient;

(l) Utilizes volunteers trained in providing services for non-medical needs; and

(m) Has a full-time administrator.

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

(a) Mainly provides inpatient Hospice Care to Terminally Ill individuals;

(b) Charges its patients for expenses incurred;

(c) Meets any licensing or certification standards set forth by the jurisdiction where it is located;

(d) Keeps medical records on each patient;

(e) Provides an ongoing quality assurance program, including reviews by Physicians other than those who own or direct the facility;

(f) Is run by a staff of Physicians and at least one such Physician must be on call at all times;

(g) Provides 24 hour a day nursing services under the direction of a registered nurse (R.N.); and

(h) Has a full-time administrator.

**Hospice Program** means a program which has received a certificate of need from the state or locality in which it operates to initiate Hospice Care in a given area; is eligible to satisfy accreditation requirements as developed by Medicare and/or the Joint Commission on the Accreditation of Health Care Organizations; and meets all of the following criteria:

(a) The patient and family are seen as the unit of care.

(b) An integrated, centralized administrative structure ensures continuity for home care and inpatient care.

(c) There is direct provision of care by an interdisciplinary team consisting of Physicians, nurses, social workers, chaplains, and volunteers.

(d) Volunteers are used to assist paid staff members.

**Hospital** means an establishment which meets each of the following requirements:

(a) is operating lawfully in the jurisdiction where it is located;

(b) operates primarily for the reception, care, and treatment of injured or sick persons as inpatients;

(c) provides 24-hour-per-day nursing service by registered nurses;

(d) has a staff of one or more licensed Physicians available at all times; and

(e) provides organized facilities for diagnostic, therapeutic, and surgical services.

"Hospital" also will include:

(a) a residential primary treatment program licensed by the Minnesota Department of Health for the treatment of alcoholics or substance addicts;

(b) a residential treatment facility licensed by the Minnesota Commissioner of Public Welfare for the treatment of emotionally handicapped children;

(c) a community health center or mental health clinic approved or licensed by the Commissioner of Public Welfare or other authorized state agency; and

(d) a free-standing ambulatory surgical center or other facility offering ambulatory medical services 24 hours per day, seven days per week, which is not part of a Hospital but has been reviewed and approved by the State Board of Health to provide specified health care treatments or services.

"Hospital" will not include an institution operated primarily as a clinic, nursing, rest, or convalescent home or similar establishment.

**Injury** means bodily harm caused by external means due to an accident which requires treatment by a Physician and which results in loss independently of Sickness and other causes.

**Lifetime,** with reference to benefit maximums and limitations, means aggregate Covered Expenses incurred while an Eligible Person is both alive and covered under the Plan.

**Medically Necessary** means those services, treatment, or supplies provided by a Hospital, Physician, or other qualified provider of medical services or supplies that are required to identify or treat an Eligible Person's Injury or Sickness and which:

(a) are consistent with the symptoms or diagnosis and treatment of the Eligible Person's condition, disease, ailment, or Injury;

(b) are appropriate according to professional standards of medical practice;

(c) are not solely for the convenience of the Eligible Person (including his family or caregiver), Physician, or Hospital;

(d) are the most appropriate which can be provided safely to the Eligible Person;

(e) are not deemed to be Experimental or Investigative; and

(f) are not furnished in connection with medical or other research.

The Trustees will make the final determination regarding questions of medical necessity.

**Military Service** or **Military Leave** means service or leave to serve in the United States Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps, or the Public Health Service, and any other category of persons

designated by the President in time of war or emergency.

**Non-Bargaining Unit Employee** means an Employer's Employees who perform work which is not covered by a labor contract requiring Contributions to this Plan and who are, therefore, not represented by a labor organization.

**Outpatient Psychiatric Facility** means a Hospital, community mental health center, day care center, or night care center associated with a Hospital and licensed as required by applicable law. It does not include institutions or facilities primarily engaged in providing services which are custodial, recreational, social, or educational in nature. An approved Outpatient Psychiatric Facility will be recognized only if there is either a psychiatric Physician or a licensed psychologist present in the facility on a regularly scheduled basis who assumes the overall responsibility for coordinating the care of all patients. Services must be available through the professional staff of the facility, as needed, from a psychiatric Physician, licensed psychologist, registered nurse, and psychiatric social worker. Emergency medical care must be accessible through formal agreement with a Hospital.

**Part-Time Employee** means a Bargaining Unit Employee (other than bagger/carryout/part-time maintenance Employees) who works less than 32 hours per week (excluding Sunday and holiday hours) for a Participating Employer.

**Participant** means any Employee or former Employee of an Employer or a Dependent who is eligible to receive any benefit from this Plan in accordance with the Eligibility Rules or other regulations that the Trustees may establish from time to time.

**Participating Employer** means any Employer which:

(a) 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

(b) is required by the terms of a Collective Bargaining Agreement or other written agreement to make Contributions to the Plan.

**Participation Agreement** means a written agreement between the Trustees and an Employer in which the Trustees approve the Employer's participation in the Plan and the Employer agrees to make and the Trustees agree to accept Contributions to the Trust Fund in 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 form 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 February 28th.

**Preferred Provider** means a:

(a) Physician, Dentist, registered nurse, physical therapist, or other licensed health care provider;

(b) Hospital;

(c) alcohol and substance abuse treatment facility;

(d) hospice;

(e) laboratory;

(f) outpatient surgical facility;

(g) pharmacy;

(h) business establishment selling or renting durable medical equipment; or

(i) any other source for services or supplies covered under this Plan;

who/which alone, or as part of a group, enter into a contract with the Trustees and who/which agree to be compensated for their services and supplies as are covered under this Plan according to the terms of the contract. Such parties are Preferred Providers while such contract is in effect.

Current types of Preferred Providers include the following:

(a) "Preferred Provider Hospital" or "Contract Hospital" or "Preferred Provider Physician" means any of the Hospitals or Physicians which contract with the Trustees through their agent from time to time. This Preferred Provider arrangement is provided through Blue Cross Blue Shield of Minnesota. The network of Hospitals and Physicians are named in a directory given to Eligible Persons.

(b) "Family Assistance Program (FAP) Manager" means the organization which contracts with the Trustees to provide specified family assistance services. The current FAP manager is TEAM.

(c) "Preferred Provider Pharmacy (PPRx)" means the pharmacy which is party to contract with the Trustees. Currently, Prime Therapeutics is the PPRx.

**Qualified Medical Child Support Order (QMCSO)** means any court judgment, decree, or order, including a court's approval of a domestic relations settlement agreement, or any judgment, decree, or order issued through an administrative process established under state law which has the force and effect of law under applicable state law, that:

(a) provides for child support payments related to health benefits with respect to a child or requires health benefit coverage of such child by the Plan, and is ordered under state domestic relations law; or

(b) enforces a state law relating to medical child support payments with respect to the Plan; and

(c) creates or recognizes the right of a child as an alternative recipient who is recognized under the order as having a right to be enrolled under the Plan to receive benefits derived from such child's relationship to an Eligible Employee who is a Participant in the Plan; and

(d) includes the name and last known address of the Participant from whom such child's status as an alternate recipient under this Plan is derived and of each alternate recipient, a reasonable description of the type of coverage to be provided by the Plan, and the period for which coverage must be provided; and

(e) does not require or purport to require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child

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

(f) has been determined to be a Qualified Medical Child Support Order under reasonable 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 90$^{th}$ 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.

**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

(i) requires a Physician's certification that confinement is Medically Necessary.

**Terminally Ill** means an individual's medical prognosis indicates a life expectancy of six months or less.

**Third Party** includes, but is not limited to, all individuals, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, Worker's Compensation, premises liability, no-fault, uninsured or underinsured motorist insurers), who is or may be in any way legally obligated to reimburse, compensate, or pay for a Eligible Person's losses, damages, injuries, or claims relating in any way to the Injury, occurrence, conditions, or circumstances leading to the Plan's provision of medical, dental, or disability benefits.

**Totally Disabled** or **Total Disability** means:

(a) An Eligible Employee is Totally Disabled if he or she is completely unable to perform substantially all of the essential functions of his or her occupation or employment, with or without a reasonable accommodation, because of an accidental bodily Injury or Sickness; and

(b) A Dependent is Totally Disabled if he or she is completely unable to perform the normal activities of a person of like age and sex in good health because of a non-occupational accidental bodily Injury or Sickness.

**Trust Agreement** means the "Agreement and Declaration of Trust" including all restatements, amendments, and modifications as may from time to time be made.

**Trust Fund** or **Fund** means the entire trust estate of the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan as it may from time to time be constituted, including but not limited to policies of insurance, investments, and the income from any and all investments, Employers' Contributions, and any and all other assets, property, or money received by or held by the Trustees for the uses and purpose of this Trust.

**Trustee(s)** or **Board of Trustees** means the Board of Trustees of the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan equally representing the Union and the Employer.

**Weekly Earnings** means an average of the five weeks in which the highest wages or salary were received from a Participating Employer during the eight-week period immediately prior to the date the disability began, exclusive of commissions, bonuses, overtime, or any other additional remunerations.

**Union** refers to the United Food and Commercial Workers Local No. 1189 and such other local Unions as may from time to time become a party to the Trust Agreement.

**You** and **your** generally have the same meaning as Employee or Retiree, as applicable.

# Appendix A
# HIPAA Plan Amendment

For purposes of this section, the Board of Trustees is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability Act of 1996, 45 C.F.R Parts 160 and 164 (the "Privacy Regulations") and security regulations, 45 C.F.R. Parts 160, 162, and 164 (the "Security Regulations"), which are incorporated by reference. The capitalized terms of art used herein are as defined by the Privacy Regulations and Security Regulations. The following provisions address disclosures of PHI to the Plan Sponsor for Plan administration purposes.

## Disclosure of PHI to the Plan Sponsor

(a) Disclosures by Plan. The Plan may disclose PHI to the Plan Sponsor to the extent necessary for the Plan Sponsor to perform Plan administration functions that qualify as Payment or Health Care Operations.

(b) Disclosures by Business Associates. The Plan's Business Associates may disclose PHI to the Plan Sponsor to the extent necessary for the Plan Sponsor to perform Plan administration functions that qualify as Payment or Health Care Operations.

(c) Disclosures by Other Covered Entities. A Covered Entity that provides health insurance benefits to individuals covered by the Plan may disclose PHI to the Plan Sponsor to the extent necessary for the Plan Sponsor to perform the following Plan administration functions:

(1) the Plan's Payment activities;

(2) those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan; and

(3) all of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

## Uses and Disclosures of PHI by the Plan Sponsor

The Plan Sponsor will use and/or disclose PHI only to the extent necessary to perform Plan administration functions that qualify as Payment or Health Care Operations, or as otherwise permitted or required by the Privacy Regulations.

## Privacy Safeguards

The Plan Sponsor agrees to:

(a) Not use or further disclose PHI other than as permitted or required under the Plan or as required by law.

(b) Ensure that any subcontractors or agents to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

(c) Not use or disclose PHI for employment-related actions and decisions, unless authorized by the individual who is the subject of the PHI.

(d) Not use or disclose PHI in connection with any other employee benefit plan, unless authorized by the individual who is the subject of the PHI or as permitted under the Privacy Regulations.

(e) Report to the Plan any use or disclosure of PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for in the Plan.

(f) Make PHI available to an Eligible Person in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures.

(g) Make PHI available for amendment and incorporate any amendments to PHI in

accordance with the Privacy Regulations and the Plan's privacy policies and procedures.

(h) Make available the information required to provide an accounting of disclosures in accordance with the Plan's Privacy Regulations and the Plan's privacy policies and procedures.

(i) Make internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations.

(j) If feasible, return or destroy all PHI that the Plan Sponsor maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Plan Sponsor. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained.

(k) Ensure that adequate separation between the Plan and the Plan Sponsor is established, described as follows.

## Security Safeguards

The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162, and 164 (the "Security Regulations"). The following provisions apply to Electronic Protected Health Information ("ePHI") that is created, received, maintained, or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI: (a) it receives pursuant to an appropriate authorization [as described in 45 C.F.R. section 164.504(f)(1)(ii) or (iii)]; or (b) that qualifies as Summary Health Information and that it receives for the purpose of either (i) obtaining premium bids for providing health insurance coverage under the Plan, or (ii) modifying, amending, or terminating the Plan (as authorized under 45 C.F.R. section 164.508). The Security Regulations are incorporated herein by reference. The capitalized terms are defined by the Security Regulations.

## The Plan Sponsor agrees to:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

(b) Ensure that an adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, by supporting reasonable and appropriate security measures.

(c) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect electronic PHI.

(d) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

## Adequate Separation

Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees may be given access to PHI:

(a) the Administrator; and

(b) staff designated by the Administrator.

## Limitations of PHI Access and Disclosure

The persons previously described only may have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan as described herein.

## Noncompliance Issues

If the persons described herein do not comply with these privacy requirements, the Plan Sponsor will

provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

For purposes of complying with the HIPAA privacy rules, this Plan is a Hybrid Entity because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other plan functions or benefits.

Plan Administrative Manager
**Wilson-McShane Corporation**
3001 Metro Drive, Suite 500
Bloomington, MN  55425

Plan Legal Counsel
**Attorney David S. Anderson**
**Kutak Rock LLP**
60 South Sixth Street, Suite 3400
Minneapolis, MN  55402-4400

Plan Consultant
**Lee Jost and Associates**
One Park Plaza
11270 West Park Place, Suite 950
Milwaukee, WI 53224

Life and Accidental Death and Dismemberment
Underwritten and Insured by
**United of Omaha Life Insurance Company**
Mutual of Omaha Plaza
Omaha, NE  68175

Plan Preferred Provider Network
**Blue Cross Blue Shield of Minnesota**
P.O. Box 64560
St. Paul, MN 55164-0560

Plan Preferred Provider Pharmacy Network Manager
**Prime Therapeutics LLC**
8400 Normandale Lake Boulevard, Suite 700
Bloomington, MN 55437

Plan Family Assistance Program Provider
**TEAM**
1970 Oakcrest Avenue, Suite 200
Roseville, MN 55113

Plan Dental Provider Network
**Delta Dental of Minnesota**
P.O. Box 9304
Minneapolis, MN 55440-9304