The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $750,000.

Your health insurance coverage, offered by the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of:

- **$250,000 on all key covered benefits under Plan II;**
- **$250,000 on all key covered benefits under Plan III; and**
- **$2,000 on genetic testing benefits.**

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least $750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing $750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact the Plan Office at (952) 854-0795 or 1-800-535-6373.

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

IMPORTANT NOTICE TO PARTICIPANTS

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

FROM: The Board of Trustees

DATE: May 13, 2011

The Board of Trustees has amended the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan (the "Plan"). This notice summarizes the changes to the Plan. **The changes took effect on March 1, 2011.**

PURPOSE OF THE CHANGES

The Patient Protection and Affordable Care Act (the "PPACA"), commonly referred to as healthcare reform, was signed into law on March 23, 2010. The PPACA requires health care plans to change certain plan provisions. Most notably, the PPACA is intended to expand dependent coverage for adult children, limit the rescission of health coverage, and limit lifetime and annual dollar limits on fundamental health care services. The Plan has been amended to comply with the requirements of the PPACA.

GRANDFATHERED STATUS

Under the PPACA, plans that were in effect on March 23, 2010 and have not been significantly changed since are not required to comply with certain provisions of the PPACA. These plans are commonly referred to as "grandfathered" health plans. The Trustees believe the Plan is a grandfathered health plan. Therefore, the Plan does not include certain consumer protections of the PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, the Plan does include certain other consumer protections in the PPACA, such as the elimination of lifetime limits on key 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 (952) 854-0795 or 1-800-535-6373. You may also 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.

DEPENDENT COVERAGE

The PPACA requires any health plan that provides dependent coverage for children to make the dependent coverage available to dependent children until they reach age 26. An exception to this rule provides that grandfathered health plans are not required to make dependent coverage available to any child under age 26 who is eligible to enroll in an employer-sponsored health plan other than the plan of any of his parents.

The definition of a "Dependent" under the Plan has been amended to comply with this requirement. The new definition of a "Dependent" became effective March 1, 2011.

Under the new definition, the child of an employee is eligible for coverage under the Plan as a Dependent if the child is:

- Under 26 and is not eligible to enroll in any health plan maintained by an employer other than the health plan of any of his parents;
- Under age 25, is eligible to enroll in a health plan maintained by an employer other than the health plan of any of his parents, and would be a full-time student but for the fact that he is on a medically necessary leave of absence from school; or
- Handicapped due to developmental cognitive disability or physical handicap.

The new definition of a "Dependent" allows your children to be covered under the Plan until they reach age 26 only if they are not eligible for coverage under another employer-sponsored health plan other than a parent's plan. For example, your child is not eligible for coverage under the Plan if she is eligible to enroll in a health plan through her own employer. Similarly, she is not eligible to enroll in the Plan if she is eligible to enroll in her spouse's employer's plan. If your child is under age 25 and is on a medically necessary leave from full-time enrollment in school, she is eligible for coverage under the Plan regardless of whether she is eligible to enroll in another employer-sponsored plan.

The definition of your "children" has also been expanded. For purposes of the new definition of a "Dependent," the following individuals are considered to be your "children":

- Your biological children;
- Children adopted by you or placed with you for adoption;
- Your stepchildren (i.e., any child of your current spouse);
- Foster children placed with you by an authorized placement agency or a court; and
- Unmarried children named in a Qualified Medical Child Support Order,

Therefore, effective March 1, 2011, the current marital status and financial support requirements for certain children do not apply.

RECISSION OF COVERGE AND NOTIFICATION OBLIGATION

The PPACA also limits the situations in which the Plan can retroactively cancel—"rescind"—your coverage. Under the current Plan rules, the Plan can terminate your coverage or your Dependents' coverage going forward for a number of particular reasons. For example, your Dependents' coverage terminates if they no longer meet the eligibility requirements of the Plan. In these situations, coverage is generally terminated on a prospective basis, meaning it is terminated for future time periods.

Effective March 1, 2011, the Plan can retroactively cancel your coverage or your Dependents' coverage if you, any of your Dependents, or anyone acting on behalf of you or your Dependents:

- 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 you or any of your Dependents engage in one of these acts, your coverage and your Dependents' coverage may be treated as void from the time of the fraudulent act, practice, or omission or intentional misrepresentation. Additionally, you and your Dependents may be

required to repay any benefits that you or your Dependents' received after the time of the fraudulent act, practice, or omission or intentional misrepresentation. This change does not affect the Plan's ability to retroactively cancel your coverage if you or your employer fails to make required contributions or premium payments.

For example, suppose that your spouse's child (your stepchild, but not biological child) is currently covered as a Dependent. Further, suppose that you legally separate from your spouse on December 1, 2011, but you intentionally do not inform the Plan that you have separated from your spouse so that the child can continue to be covered as a Dependent. The child is not eligible to be covered under the Plan, and therefore, this would be considered a fraudulent omission. The Plan could therefore rescind your coverage. Even if the Plan does not discover your separation until a much later date, the Plan could cancel your coverage and your Dependents' coverage effective December 1, 2011 and require you to repay all of the benefits that you and your Dependents received after December 1, 2011.

Additionally, under the new Plan rules, you have an affirmative obligation to notify the Plan Administrator of any event or change in circumstances that affects:

- Your eligibility for coverage under the Plan or your Dependents' eligibility for coverage under the Plan; or
- Your, or your Dependents', eligibility to receive payment from the Plan for a claim for benefits.

You must notify the Plan Administrator of any such event or change in circumstances within 20 days of the event or change in circumstances.

LIFETIME AND ANNUAL LIMITS

Plan I previously imposed a $1 million overall lifetime limit on the benefits that may be paid to a participant, and Plans II and III previously imposed a $250,000 overall lifetime limit on the benefits that may be paid to a participant. The Plan also imposes lesser annual and lifetime dollar limits on specific benefits. The PPACA restricts the lifetime and annual dollar limits that the Plan can apply to certain Plan benefits.

The PPACA divides Plan benefits into two categories—essential health benefits and non-essential health benefits. The PPACA states that "essential health benefits" include:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

All other benefits are considered non-essential health benefits.

Effective March 1, 2011, the Plan's overall lifetime limits only apply to non-essential health benefits. Essential health benefits are not be subject to a lifetime dollar limit. Essential health benefits are however subject to an overall annual dollar limit during the next three Plan Years. During the Plan Year that began on March 1, 2011, essential health benefits are subject to the following overall annual dollar limits:

- Essential health benefits under Plan I are subject to a $1 million overall annual limit; and
- Essential health benefits under Plans II and III are subject to a $250,000 overall annual limit.

In order to comply with additional requirements of the PPACA, the Plan has also been amended in the following ways:

- Genetic testing benefits are no longer subject to a $2,000 lifetime limit. Instead, genetic testing benefits are now subject to a $2,000 annual limit.
- With regard to Plan I, eye examinations for Dependent Children under 19 years of age are no longer subject to a $300 annual limit.
- Routine dental examinations, sealants, dental prophylaxis, and topical fluoride treatments for Dependent Children under 19 years of age are no longer subject to the annual limit for dental care benefits.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Federal agencies have provided only limited guidance regarding the specific requirements of the PPACA. Additional guidance is anticipated in the future. While the Board of Trustees has taken care to ensure that the terms of the Plan comply with the requirements of the PPACA, a significant amount of ambiguity regarding these requirements remains.

The terms and provisions of the Plan will be construed, to the extent possible, to comply with the PPACA, and any related regulations. If it is determined that any term or provision of the Plan cannot reasonably be construed to comply with the PPACA, that term or provision will not be enforced to the extent that it does not comply with the PPACA. A determination that a term or provision of the Plan cannot reasonably be construed to comply with the PPACA will not affect any other term or provision of the Plan.

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