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

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

IMPORTANT NOTICE

Summary of Material Modifications

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

FROM: The Board of Trustees

DATE: August 2020

This is a Summary of Material Modifications (SMM) regarding the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan (Plan). The Board of Trustees has amended the Summary Plan Description and Plan Document (amended and restated April 1, 2018) as indicated below.

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

Effective March 18, 2020, the Plan has been amended to provide coverage at 100% (no member cost share) claims for the diagnostic test and administration of the test required to determine if an individual has COVID-19. The Plan will also cover at 100% (no member cost share) items and services received during health care provider office visits (both in-person and telehealth visits) urgent care visits, and emergency room visits that result in an order for or administration of the test required to determine if an individual has COVID-19.

Effective March 18, 2020, the Plan expanded the definition of Sickness for the duration of the public health emergency related to COVID-19 for purposes of Accident and Sickness Benefits Sickness to include the inability of an Eligible Employee to work due to the advice of a health care provider to self-quarantine due to concerns related to COVID-19 or experiencing symptoms of COVID-19 and seeking a medical diagnosis.

Amendment No. 6: Coverage for Telehealth

Effective March 1, 2020, the Plan has been amended to provide coverage for telehealth visits.

Amendment No. 7: Exclusion of Sales Tax and Shipping for Durable Medical Equipment

Effective July 1, 2020, the Plan has been amended to exclude sales tax and shipping and handling related to the purchase or rental of durable medical equipment from coverage.

Amendment No. 8: Coverage for Wigs and Toupees

Effective July 1, 2020, the Plan has been amended to provide coverage for wigs and toupees.

Amendment No. 9: Remove Claim Carry-Over Provisions

Effective July 1, 2020, the Plan has been amended to remove the carry-over provision that allowed Covered Expenses incurred during the last three months of the Calendar Year to be applied towards the deductible for the following year.

Amendment No. 10: Extension of Timeframes for Outbreak Period

Effective January 1, 2020, the Plan has been amended to allow Employees who are only receiving Plan 2's Life, Accidental Death and Dismemberment, and Employee Assistance Program Benefits to continue these benefits.

Effective May 4, 2020, the Plan has been amended to adopt the Department of Labor's regulations regarding extending timeframes for special enrollment, COBRA coverage, submitting claims, and appealing an adverse benefit determination.

The Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the following timeframes are disregarded and will resume at the end of the "Outbreak Period."

- The sixty (60) day window (or thirty (30) day window in the case of acquiring a new Dependent) in which you must request special enrollment under the Plan;
- The sixty (60) day window in which the Fund Office must be notified of a COBRA Qualifying Event;
- The sixty (60) day window in which you may elect for COBRA continuation coverage;
- The forty-five (45) day deadline to make the initial Self Payment, and the thirty (30) day grace period for making subsequent self-payments;
- The 12-month deadline for filing a post-service claim; and
- The one hundred eighty (180) day window in which a claimant may file an appeal of a denial of benefits

Please update your Summary Plan Description and Plan Document booklet (dated April 1, 2018) to reflect these changes by inserting replacement pages ii, v, 2, 2A, 5, 5A, 6, 6A, 19, 19A, 23, 23A, 31, 37, 37A, 46, 48, 53, 85, and 85A into your booklet to replace existing pages.

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

GRANDFATHERED STATUS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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

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

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: (a) Pre-admission testing. (b) Hospice Care. (c) Home health care, up to a maximum of 40 visits per person per Calendar Year[2]. (d) Doctor on Demand visits. For such services, the Plan pays 100% of Reasonable Expenses incurred.		
Effective March 1, 2020, and continuing through December 31, 2020, telehealth visits with providers other than Doctor on Demand will be a Covered Expense under the Plan, subject to Deductible and Coinsurance amounts.		

[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.

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
Effective March 1, 2020, and continuing through December 31, 2020, telehealth visits with providers other than Doctor on Demand will be a Covered Expense under the Plan, subject to Deductible and Coinsurance amounts.	

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[1]

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

[1] 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.

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.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the 60-day window (or 30-day window in the case of acquiring a new Dependent) in which you must request special enrollment under the Plan for the circumstances listed above is disregarded and resumes at the end of the Outbreak Period.

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

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.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the 60-day window in which the Plan Administrator must be notified of a COBRA Qualifying Event is disregarded and resumes at the end of the Outbreak Period.

(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.

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(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.

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(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.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the 30-day grace period to make the initial Self Payment is disregarded and resumes at the end of the Outbreak Period.

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;

(iii) Medical Benefits, Dental Care, Vision Care, Life, and Accidental Death and Dismemberment Benefits; or

(iv) Life Benefits only.

Employees continuing coverage are not eligible for Accident and Sickness Benefits; Employees continuing coverage under Plan 2 are not eligible for Vision Care Benefits; Employees receiving only Plan 2's Life, Accidental Death and Dismemberment, and Employee Assistance Program Benefits are eligible to continue Life, Accidental Death and Dismemberment and Employee Assistance Program 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.

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.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the 12-month deadline for filing a claim is disregarded and resumes at the end of the Outbreak Period.

Incomplete Claims. If an Eligible Person sends a claim to the Plan Administrator and the claim cannot be processed because information is missing, the Eligible Person will receive a notice stating why the claim cannot be completed and what additional information is needed. It is the Eligible Person's responsibility to send this information to the Plan Administrator.

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.

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.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the 180-day window in which an Eligible Person may file an appeal of a denial of benefits is disregarded and resumes at the end of the Outbreak Period.

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

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

(m) **COVID-19**. Effective March 18, 2020 and for the duration of the public health emergency concerning COVID-19, the Plan will cover at 100% (no member cost share) the cost of diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized by an applicable government agency, as well as the administration of such diagnostic products. The Plan will also cover at 100% (no member cost share) items and services furnished to you during health care provider visits (including both in-person and telehealth visits), urgent care center visits, and emergency room visits as described above, to the extent such items and services relate to the furnishing or administration of such product

(n) **Wigs and Toupees or Other Cranial Prosthesis** prescribed by Your physician to remediate hair loss caused by a medical condition such as chemotherapy, alopecia, trichotillomania, or other medical conditions will be covered up to

a maximum of $300 per year. Your annual deductible and coinsurance will apply.

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

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.

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.

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.

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

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

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

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

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

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

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

(b) pre-admission testing;

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

(d) second surgical opinions;

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

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

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

(h) Effective March 18, 2020 and for the duration of the public health emergency concerning COVID-19, the Plan will cover at 100% (no member cost share) the cost of diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized by an applicable government agency, as well as the administration of such diagnostic products. The Plan will also cover at 100% (no member cost share) items and services furnished to you during health care provider visits (including both in-person and telehealth visits), urgent care center visits, and emergency room visits as described above, to the extent such items and services relate to the furnishing or administration of such product.

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.

(jjj) Sales tax, mailing, delivery charges, or service call charges for Medically Necessary durable medical equipment.

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

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

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

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

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

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

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

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

Sickness means a disease, disorder, or condition (including pregnancy and childbirth and any related conditions) which requires treatment by a Physician. For purposes of Accident and Sickness Benefits, and for the duration of the public health emergency related to COVID-19, Sickness will also include the inability of an Eligible Employee to work due to the advice of a health care provider to self-quarantine due to concerns related to COVID-19 or experiencing symptoms of COVID-19 and seeking a medical diagnosis. This amendment is effective March 18, 2020.

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