Minneapolis Retail Meat Cutters & Food Handlers Health and Welfare Plan

Plan Document and Summary Plan Description

Amended and Restated as of September 1, 2017

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MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS HEALTH AND WELFARE FUND

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

(AMENDED AND RESTATED AS OF SEPTEMBER 1, 2017)

MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS HEALTH AND WELFARE FUND

INTRODUCTION

To All Participants:

The Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund ("Plan") is developed and maintained pursuant to the Restated Agreement and Declaration of Trust of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund ("Trust Agreement"). Benefits originally were provided according to a mini-premium arrangement with BlueCross BlueShield.

Effective April 1, 1985, the Board of Trustees ("Trustees") cancelled BlueCross BlueShield Master Insurance Policy No. AS314 and began providing health care benefits directly from Plan assets according to the Plan Document and Summary Plan Description, which has been amended from time to time. The benefits and other provisions were continued without modification or change. Life Insurance and Accidental Death and Dismemberment Benefits are insured through Fidelity Security Life Insurance Company subject to Master Insurance Policy No. SL3R1099.

Effective May 1, 2008, the Trustees restated the entire Plan Document. The Trustees have decided to restate the Plan Document as a Plan Document and Summary Plan Description, effective September 1, 2017. The restated Plan Document and Summary Plan Description incorporates all amendments adopted through August 28, 2017. This Plan continues in force until amended by the Trustees or terminated pursuant to the terms of the Trust Agreement. As future changes to the Plan are adopted by the Trustees, amendments will be incorporated into this Plan Document and Summary Plan Description, which then will constitute a continuously updated restatement of the Plan Document and Summary Plan Description.

Yours sincerely,

THE BOARD OF TRUSTEES

THE BOARD OF TRUSTEES

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SECTION 1 DEFINITIONS

Words used in the masculine or feminine gender will be construed as the feminine gender or masculine gender, respectively, where appropriate. Words used in singular or plural form will be construed as plural or singular, respectively, where appropriate.

1.1. AVERAGE WEEKLY WAGE

"Average Weekly Wage" means the average weekly amount earned by an Eligible Employee during the last four (4) weeks before the Eligible Employee became Totally Disabled. Such wage does not include overtime or bonuses.

1.2. BENEFICIARY

"Beneficiary" means a person designated by a Participant or by the terms of the Plan (such as a Dependent or member of the family of a Participant) who is or may become entitled to a benefit under this Plan.

1.3. CALENDAR YEAR

"Calendar Year" means January 1 through December 31 of each year.

1.4. DENTAL HYGIENIST

"Dental Hygienist" means any person who is currently licensed (if licensing is required by the state) to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene and who works under the supervision or direction of a Dentist.

1.5. DENTIST

"Dentist" means a doctor of dental surgery or doctor of dental medicine who is currently and duly licensed to practice dentistry under the laws of the state where the Dentist's practice is located and who is acting within the usual scope of such practice.

1.6. DEPENDENT

A. "Dependent" means:

1. Spouse; or

2. Child who is:

a. Under twenty-six (26) years of age; or

b. Incapable of self-sustaining employment by reason of developmental cognitive disability or physical handicap and

i. Who became so incapable prior to attaining age twenty-six (26); and

ii. Who is primarily financially dependent upon the Eligible Employee.

The Eligible Employee must furnish due proof of the incapacity to the Trustees within thirty-one (31) days after: (i) the Child's attainment of age twenty-six (26); or (ii) the full-time Eligible Employee's receipt of notification of the Dependent Child's incapacity. Proof of the continued existence of the incapacity and dependency must be furnished to the Trustees from time to time at their request.

B. For purposes of the definition of a Dependent, the term "Child" means:

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 total or partial support of a child in anticipation of the legal adoption of the child by the Eligible Employee. Placement for adoption will terminate upon the termination of the 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 who:

   a. Was born to such Spouse;

   b. Was legally adopted by such Spouse;

   c. Has been placed for adoption with such Spouse; or

   d. Is a foster child placed with such Spouse by an authorized placement agency or a court.

   In order to have coverage for the stepchild, the Eligible Employee or the Employee's Spouse must provide the following to the Plan when requested by the Plan:

   a. A copy of the divorce decree showing which natural parent has the primary obligation to provide health care coverage for the stepchild; and

   b. A copy of the stepchild's birth certificate or adoption decree showing the stepchild is the Child of the Eligible Employee's Spouse when requested by the Plan.

   The Eligible Employee and the Employee's Spouse must cooperate fully with the Plan in obtaining these documents, including but not limited to, having the non-custodial parent of the stepchild authorize in writing the

release of information requested by the Plan and cooperating with the Plan in obtaining this information.

4. Any foster child placed with an Eligible Employee by an authorized placement agency or the court.

5. Any grandchild of an Eligible Employee or Spouse if:

   a. Legal guardianship of the grandchild has been awarded to the Eligible Employee or Spouse; or

   b. The parent of the grandchild is: (a) unmarried; (b) an Eligible Dependent; and (c) under age nineteen (19).

   If, as of February 28, 2011, a grandchild of an Eligible Employee was enrolled in this Plan and the parent of the grandchild was over age eighteen (18) and an Eligible Dependent by reason of his or her enrollment as a full-time student or by reason of a developmental cognitive disability or physical handicap, the grandchild will remain an Eligible Dependent until the parent of the grandchild would have ceased to be an Eligible Dependent under the terms of this Plan that were in effect on February 28, 2011.

   Both the parent and the grandchild must be primarily financially dependent upon and reside with the Eligible Employee, unless guardianship or adoption of the grandchild has been awarded to the Eligible Employee or Spouse.

6. A child who is named in a Qualified Medical Child Support Order with which an Eligible Participant and the Plan are obligated to comply.

1.7. ELIGIBLE EMPLOYEE

"Eligible Employee" means any Employee, former Employee, or retiree of an Employer, who is eligible for benefits in accordance with the Eligibility Rules of the Plan described in Section 4.

1.8. ELIGIBLE PERSON

"Eligible Person" means either the part-time or full-time Eligible Employee or the Eligible Dependent of a full-time Eligible Employee or the Dependent Child of a part-time Eligible Employee (if applicable).

1.9. EMPLOYEE

"Employee" means:

A. Any employee represented by the Union and working for an Employer and with respect to whose employment an Employer is required to make contributions into the Trust Fund.

B. A full-time officer or employee of the Union who has been proposed for benefits under the Plan by the Union and who has been accepted by the Trustees and for whom the Union agrees in writing to contribute to the Plan at the rate fixed for contributions for other Employers.

C. Employees of the Plan, if any, who are not employed by an Employer as defined in Section 1.10, but who are proposed and accepted for Plan benefits by the Trustees. Any Trustee who is not already receiving full-time pay from an Employer or Association of Employers, whose employees are Participants in the Plan or from an employee organization whose members are Participants in the Plan may be considered as an employee of the Plan for the limited purpose of the definition of Employee under this Plan. As to persons described in this paragraph, the Trustees will be deemed to be an Employer within the meaning of the Trust Agreement and may provide benefits for such employees.

D. Any other employees that the Trustees may agree to include and on whose behalf contributions are made to the Trust Fund and whose inclusion will not impair the tax-exempt status of the Fund or contributions to the Fund, but not including any owner-operator, partner, independent contractor, self-employed person, subject to the modification that, unless prohibited by law from being covered under the Fund, the definition of Employee will not exclude any person who works regularly as a food employee.

1.10. EMPLOYER

"Employer" means:

A. An employer who is bound by a collective bargaining agreement with the Union that provides for the making of payments to the Trust Fund with respect to Employees represented by the Union.

B. The Union, but only with respect to the Employees of the Union for whom the Union contributes to the Trust Fund and only for the limited purpose of making the required contributions into the Trust Fund.

Employers as described in this Section will, by the making of payments to the Trust Fund pursuant to such collective bargaining or other written agreements, be deemed to have accepted and be bound by the Trust Agreement.

1.11. ESSENTIAL HEALTH BENEFITS

"Essential Health Benefits" means any benefits covered by the Plan that constitute Essential Health Benefits as that term is defined under the Patient Protection and Affordable Care Act ("Affordable Care Act") or related regulations, rules, or guidance. As defined under the Affordable Care Act, Essential Health Benefits include, at minimum:

A. Ambulatory patient services;

B. Emergency services;

C. Hospitalization;

D. Maternity and newborn care;

E. Mental health and substance use disorder services, including behavioral health treatment;

F. Prescription drugs;

G. Rehabilitative and habilitative services and devices;

H. Laboratory services;

I. Preventive and wellness services and chronic disease management; and

J. Pediatric services, including oral and vision care.

In no situation will Essential Health Benefits mean any medical services that are not Essential Health Benefits under the Affordable Care Act or any amended version of the Affordable Care Act or any medical services the payment for which is not otherwise eligible for payment under the Plan.

1.12. EXPERIMENTAL OR INVESTIGATIVE

"Experimental" or "Investigative" means the use of any treatment (which includes use of any treatment procedures, facility, drug, equipment, device, or supply) if:

A. The use is not yet generally recognized as accepted medical practice;

B. The 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

C. The use is not supported by "reliable" evidence which shows that, as applied to a particular condition, it:

1. Is generally recognized as a safe and effective treatment of the condition by those practicing the appropriate medical specialty;

2. Has a definite positive effect on health outcomes; and

3. 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).

Reliable evidence includes only:

A. Published reports and articles in authoritative medical and scientific literature;

B. The written investigational or research protocols and/or written informed consent used by the treating facility or of another facility that is studying the same service, supply, or procedure; and

C. Compilations, conclusions, and other information that is available and may be drawn or inferred from Paragraphs A and B above.

Consideration may be given to the following:

A. Whether the treatment can be lawfully marketed without approval of the U.S. Food and Drug Administration and whether approval for marketing has not been given at the time the treatment is provided;

B. Whether reliable evidence shows that the treatment is the subject of ongoing Phase I, II, or III clinical trials and is under study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with standard means of treatment or diagnosis;

C. Whether reliable evidence shows that the consensus among experts regarding the treatment is that further studies or clinical trials are necessary to determine tolerated doses, toxicity, safety, efficacy, or 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, Illness, or condition as compared with rates for similarly situated patients using no treatment or using existing treatments that are generally accepted by the Food and Drug Administration; and the number of patients who have received the treatment for the same Injury, Illness, or condition.

The final determination of whether the use of a treatment is Experimental or Investigative will rest solely with the Trustees.

1.13. HEALTH SERVICE

"Health Service" means any service, supply, drug, or equipment provided to an Eligible Person for diagnosis, relief, or treatment of an Illness or Injury. Health Service also includes services and supplies for reconstructive surgery that are incidental to, or follow surgery resulting from, Illness.

1.14. HOME HEALTH CARE AGENCY

"Home Health Care Agency" means a public or private organization that is primarily engaged in providing skilled nursing and therapeutic services on an at-home basis. A Home Health Care Agency must be supervised by professional medical personnel and be licensed or approved by the state or locality in which it operates.

1.15. HOSPICE PROGRAM

"Hospice Program" means a program that:

A. Has received necessary authorization from the applicable governmental authority to initiate hospice care in a given area;

B. Is eligible to satisfy accreditation requirements developed by the National Hospice Organization and the Joint Commission on the Accreditation of Hospitals; and

C. Meets the following criteria:

1. The patient and family are seen as the unit of care;

2. An integrated, centralized administrative structure ensures continuity of care for home care and inpatient care;

3. Direct provision of care is provided by an interdisciplinary team consisting of Physicians, nurses, social workers, chaplains, and volunteers;

4. Volunteers are used to assist paid staff members; and

5. Service is available twenty-four (24) hours a day, seven (7) days a week.

1.16. HOSPITAL

"Hospital" means an establishment that meets all of the following requirements:

A. Holds a license as a Hospital (if licensing is required in the state in which it is located);

B. Operates primarily for the reception, care, and treatment of sick, ailing, or injured persons as inpatients;

C. Provides nursing services by registered nurses (R.N.) twenty-four (24) hours a day;

D. Has a staff of one (1) or more licensed Physicians available at all times;

E. Provides organized facilities for diagnostic and major surgical facilities; and

F. Is not primarily a clinic; nursing, rest, or convalescent home; or similar establishment.

"Hospital" also includes:

A. A Residential Treatment Facility that is licensed by the Commissioner of Public Welfare (or other equivalent officer) for the state in which it is located for the treatment of emotionally handicapped Dependent Children under age eighteen (18) as defined by the rules of such Commissioner;

B. A free-standing ambulatory surgical center that is approved as such by the applicable state; and

C. A free-standing ambulatory medical center staffed to provide care twenty-four (24) hours a day, seven (7) days a week that is approved as such by the applicable state.

1.17. ILLNESS

"Illness" means a bodily disorder or disease, pregnancy, or mental infirmity.

1.18. INJURY

"Injury" means accidental bodily damage that requires treatment by a Physician and that results in a loss separate from Illness and other causes.

1.19. INTENSIVE CARE UNIT

"Intensive Care Unit" means a special area of a Hospital exclusively reserved for critically-ill patients requiring constant observation that, in its normal course of operation, provides:

A. Personal care by specialized R.N.s and other nursing care twenty-four (24) hours a day;

B. Special equipment and supplies that are immediately available on a standby basis; and

C. Care that is required but not provided in the general surgical or medical nursing units of the Hospital.

The term "Intensive Care Unit" also includes an area of the Hospital designated and operated exclusively as a Coronary Care Unit, Cardiac Care Unit, or Neonatal Intensive Care Unit.

1.20. LICENSED PSYCHOLOGIST, LICENSED CONSULTING PSYCHOLOGIST, AND LICENSED SOCIAL WORKER

"Licensed Psychologist," "Licensed Consulting Psychologist," and "Licensed Social Worker" mean a person who is duly licensed as such by, and qualified under, the laws of the state in which the eligible Health Services are personally provided by such person.

1.21. MEDICALLY NECESSARY

"Medically Necessary" means only those services, treatments, or supplies that:

A. Are provided by a Hospital, a Physician, or other qualified provider of medical services or supplies;

B. Are required, in the judgment of the Trustees based on the opinion of a qualified medical professional, to identify or treat an Eligible Person's Injury or Illness;

C. Are consistent with the symptoms or diagnosis and treatment of the Eligible Person's condition, disease, ailment, or Injury;

D. Are appropriate according to standards of good medical practice;

E. Are not solely for the convenience of the Eligible Person (including the Eligible Person's family or caregiver), Physician, or Hospital;

F. Are the most appropriate that can be safely provided to the Eligible Person;

G. Are not deemed to be Experimental or Investigative; and

H. Are not furnished in connection with medical or other research.

1.22. MENTAL HEALTH FACILITY

"Mental Health Facility" means a community mental health clinic that is established for the purpose of providing consultation, diagnosis, and treatment of a mental illness or nervous disorder, and that is approved as such by the state in which it is located.

1.23. NON-RESIDENTIAL TREATMENT PROGRAM

"Non-residential Treatment Program" means a facility that is licensed or approved by the state in which it is located for treatment of alcoholism on an outpatient basis, chemical dependency, or substance addiction.

1.24. NURSE ANESTHETIST

"Nurse Anesthetist" means a licensed R.N. who has gained additional knowledge and skills through an organized program of study and clinical experience and who meets the criteria for a Nurse Anesthetist established by the professional nursing organization having authority to certify a licensed R.N. in advanced nursing practice.

1.25. NURSE MIDWIFE

"Nurse Midwife" means a licensed R.N. who has gained additional knowledge and skills through an organized program of study and clinical experience and who meets the criteria for a Nurse Midwife established by the professional nursing organization having the authority to certify the licensed R.N. in advanced nursing practice.

1.26. OPTICIAN, OPTOMETRIST, AND OPHTHALMOLOGIST

"Optician," "Optometrist," and "Ophthalmologist" mean any person who is qualified and currently licensed (if licensing is required in the state) to practice the profession by the appropriate governmental authority having jurisdiction of the licensure and practice of the profession and who is acting within the usual scope of such practice.

1.27. PARTICIPANT

"Participant" means any Employee or former Employee of an Employer who is or may become eligible to receive a benefit of any type form this Plan or whose Beneficiaries may be eligible to receive any such benefit.

1.28. PHARMACY

"Pharmacy" means a facility licensed by the state in which it is located to dispense Prescription Medication by licensed pharmacists.

1.29. PHYSICIAN

"Physician" means any individual who is licensed to practice medicine by the governmental authority having jurisdiction over such licensure and who is acting within the usual scope of such practice. "Physician" will be interpreted to include, but will not be limited to, a doctor of medicine,

chiropractor, osteopath, podiatrist, optometrist, doctor of dental surgery, Nurse Anesthetist providing anesthesia services, and Nurse Midwife providing obstetrical services. The Physician must be duly licensed and qualified under the laws of the state in which the eligible Health Services are performed.

1.30. PLAN YEAR

"Plan Year" means the twelve (12)-month period beginning March 1 and ending February 28.

1.31. PREDETERMINATION

"Predetermination" means the pretreatment review that is used to determine the eligibility of the individual and the amount of coverage for services in accordance with the Schedule of Benefits.

1.32. PREFERRED PROVIDERS

A "Preferred Provider" means any of the following who alone or as part of a group enter into a contact with the Trustees agreeing to be compensated for their services and supplies that are covered under this Plan in accordance with the terms of such contract:

A. Physician, Dentist, R.N., physical therapist, or other licensed health care Provider;

B. Hospital;

C. Alcohol and substance abuse treatment facility;

D. Hospice facility or Program;

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.

Current types of Preferred Providers include the following:

A. Preferred Provider Prescription Drug Program. Preferred Providers under the Preferred Provider Prescription Drug Program include Pharmacies in the Prime Therapeutics Select Care Network.

B. Preferred Provider Network. The Preferred Provider Network includes only those Hospitals, Physicians, and other health care professionals in the BlueCross BlueShield of Minnesota Network.

C. Delta Dental Network. The Delta Dental Network includes the Preferred Providers of Dental Care Benefits.

1.33. PRESCRIPTION MEDICATION

"Prescription Medication" means a drug or biological obtained or dispensed only by a Prescription Order of a Physician (except for insulin).

1.34. PRESCRIPTION ORDER

"Prescription Order" means a Physician's written order for dispensing a Prescription Medication.

1.35. PREVENTIVE CARE

"Preventive Care" means products and services for which the Plan may not impose cost-sharing requirements under Section 2713 of the Public Health Services Act and its implementing regulations. Preventive Care includes:

A. Preventive care recommended by the United States Preventive Services Task Force;

B. Immunizations for children, adolescents, and adults recommended by the advisory committee on Immunization Practices of the Centers for Disease Control and Prevention; and

C. Preventive care and screenings for infants, children, adolescents, and women recommended by the Health Resources and Services Administration.

The recommendations that define Preventive Care change regularly. Products and services described in new recommendations will be covered as Preventive Care beginning on the first day of the Plan Year following the date the recommendation was issued. When a recommendation is retracted, the Plan will immediately cease covering the recommended products or services as Preventive Care. To the extent that Preventive Care recommendations do not specify the method, treatment, or setting for the provision of Preventive Care, the Plan will establish reasonable medical management conditions for Preventive Care. If you incur costs for a product or service in a manner that is inconsistent with the Plan's medical management conditions, the Plan will not treat the product or service as Preventive Care. For more information regarding Preventive Care or to determine whether a product or service is currently covered as Preventive Care, contact the Plan Administrator.

1.36. PROVIDER

"Provider" means an institution, organization, or person that furnishes Health Services either directly or pursuant to a prescription or directive from a person licensed by the state to make such a prescription or directive.

1.37. QUALIFIED MEDICAL CHILD SUPPORT ORDER

"Qualified Medical Child Support Order" ("QMCSO") is 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 having the force and effect of law under applicable state law that:

A. Either:

1. Provides for child support payments related to health benefits with respect to a Child of an Eligible Employee or requires health benefit coverage of the Child by the Plan and is ordered under state domestic relations law; or

2. Enforces applicable state law relating to medical child support payments with respect to the Plan; and

B. Creates or recognizes the right of a Child as an alternate recipient who is recognized under the order as having a right to be enrolled under the Plan to receive benefits derived from the Child's relationship to a full-time Eligible Employee who is a Participant in the Plan; and

C. Includes the following:

1. The name and last known mailing address (if any) of the Participant from whom the Child's status as an alternate recipient under this Plan is derived and the name and mailing address of each alternate recipient covered by the order, except that, if provided in the order, the name and mailing address of an official of a state or a political subdivision of the state may be substituted for the mailing address of any such alternate recipient;

2. A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient or the manner in which the type of coverage is determined; and

3. The period for which coverage must be provided; and

D. 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 1903 of the Social Security Act; and

E. Has been determined by the Plan Administrator to be a Qualified Medical Child Support Order under reasonable procedures adopted and uniformly applied by the Plan.

1.38. RESIDENTIAL TREATMENT PROGRAM

"Residential Treatment Program" means a facility licensed by the state in which it is located for the treatment on an inpatient basis of alcoholism, chemical dependency, or substance addiction.

1.39. SELF-FUNDED PLAN

"Self-Funded Plan" means a group health care plan in which the plan assumes the financial risk for providing health care benefits to Eligible Persons. 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 regulations. A Self-Funded Plan pays claims directly from accumulated trust fund assets.

1.40. SINGLE PROCEDURE

"Single Procedure" means a dental service to which a separate procedure code is assigned by the Plan.

1.41. SKILLED NURSING HOME

"Skilled Nursing Home" means an institution that meets each of the following requirements:

A. Is regularly engaged in providing skilled nursing care for ill and injured persons at the patient's expense;

B. Requires that patients be regularly attended by a Physician and that medications be given only on the order of such Physician;

C. Maintains a daily medical record of each patient;

D. Continuously provides nursing care that is supervised by an R.N. twenty-four (24) hours a day;

E. Is not, except incidentally, a facility for the aged, a rest home, or a similar institution;

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 such 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 (6) or more resident patients; and

I. Requires a Physician's certification that confinement is Medically Necessary.

1.42. SPOUSE

"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 Fund Office before claims for such Spouse will be processed.

1.43. TOTAL DISABILITY

"Total Disability" means any physical condition that begins after the Eligible Person becomes covered under the Plan, results from Injury or disease, and wholly and continuously prevents the Eligible Employee from engaging in his regular or customary occupation or, in the case of a Dependent, prevents the Dependent from engaging in substantially all of the normal activities of a person of like age and sex in good health. An Eligible Employee's Total Disability status must be verified periodically by an attending Physician's statement that the Eligible Employee remains Totally Disabled.

1.44. TREATMENT PLAN

"Treatment Plan" means a written report showing the recommended treatment of any dental disease, defect, or Injury prepared by a Dentist as a result of the Dentist's examination of an Eligible Person.

1.45. TRUST AGREEMENT

"Trust Agreement" means the Restated Agreement and Declaration of Trust of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund, including all amendments and modifications as may from time to time be made.

1.46. TRUSTEES

"Trustees" means the Board of Trustees designated in the Trust Agreement of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund, together with their successors designated and appointed in accordance with the terms of the Trust Agreement. The Trustees, collectively, will be the "Administrator" of this Plan.

1.47. TRUST FUND

"Trust", "Trust Fund" or "Fund" means the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund.

1.48. UNION

"Union" means any of the following locals:

A. The United Food and Commercial Workers Union District Local 653 and the Food Handlers Division of District Local 653, Section A (including former Local 615 and 653B);

B. Any other Local Union that is or may become a part of the United Food and Commercial Workers Union District Local 653 and the Food Handlers Division of District Local 653, Section A; and

C. Any Local Union that represents Employees of any employer who is required to become a Contributing Employer to this Plan.

1.49. USUAL AND CUSTOMARY CHARGE

"Usual and Customary Charge" means the Provider's normal charge for a service or supply, but not more than the prevailing charge in the area for a like service or supply.

A. A "like service" is of the same nature and duration, requires the same skill, and is performed by a Provider of similar training and experience.

B. A "like supply" is one that is identical or substantially equivalent.

C. "Area" means the municipality (or, in the case of a large city, the subdivision of the city) in which a service or supply is actually provided, or such greater area, as determined by the Plan, that is necessary to obtain a representative cross section of charges for a like service or supply.

SECTION 2 SCHEDULE OF BENEFITS

2.1. COMPREHENSIVE MAJOR MEDICAL BENEFITS

Below is the schedule of benefits for "Comprehensive Major Medical Benefits."

Deductible amount per Calendar Year	
Per Eligible Person	$750
Per Family	$2,250
Copayment	$25 per office visit $50 per specialist visit $250 per emergency room visit
Plan's Coinsurance (including In-Hospital and Physician's Services and Out-of-Hospital Major Medical Services)	Plan pays 80%
Out-of-pocket maximum per Calendar Year (including the deductible)	
Per Eligible Person	$3,000
Per Family	$6,000
The Plan generally pays 100% of covered expenses in excess of the out-of-pocket maximum for remainder of that Calendar Year	
Preventive Care (including routine immunizations that are Preventive Care)	Plan pays 100%
Routine Physical Examinations that are not Preventive Care per Eligible Person per Calendar Year	Plan pays 100%
Doctor on Demand	Plan pays 100%

The following are specific maximum amounts applicable to certain services and supplies covered under the Plan's Comprehensive Major Medical Benefits provisions.

Organ Transplants (other than Essential Health Benefits) Maximum for professional services per transplant per donor Maximum for private nursing care per transplant per donor	 $10,000 $10,000
Skilled Nursing Home Care Maximum number of days per Eligible Person per confinement	 30
Chiropractic Care Maximum number of visits per Eligible Person per Calendar Year	 20
Genetic Testing and Counseling (other than amniocentesis, Preventive Care, and Essential Health Benefits) Maximum per Eligible Person per calendar year	$2,000
Hearing Aid Appliances Maximum per ear per benefit period	$500
Wigs and Toupees Maximum per lifetime per Eligible Person	$300

2.2. PRESCRIPTION DRUG BENEFITS

Only Prescription Medication purchased through the Prime Therapeutics Select Care Network will be covered. Prescription Medication filled at Walgreens, Walmart, Target, Hy-Vee, Sam's Club, Costco, and Coburns will not be covered or reimbursed. Below is the schedule of benefits for "Prescription Drug Benefits."

Out-of-pocket maximum per Calendar Year	
Per Eligible Person	$3,600
Per Family	$7,200
Prescription	**Plan's Coinsurance**
Prescriptions purchased at a retail pharmacy, except as otherwise specifically stated	Plan pays 80%
OTC Prilosec and OTC Loratadine upon a Physician's written prescription	Plan pays 100%
Prescriptions purchased through the Preferred Provider Mail Service Pharmacy, for each 90-day supply	Plan pays 80%
Prescriptions purchased through the Specialty Drug Program	Plan pays 80%

2.3. VISION CARE BENEFITS

Below is the schedule of benefits for "Vision Care Benefits."

Services and Supplies	Maximum Plan Payment
Examination	
One per Eligible Person over age 19 per Calendar year	$50
One per Dependent Child under age 19 per Calendar year	100%
Lenses	
One set per Eligible Person per Calendar Year	
Single, each lens	$37
Bifocal, each lens	$64
Trifocal, each lens	$78
Lenticular, each lens	$140
Contacts, per set (or disposable contacts)**	$87
Frames	
One set per Eligible Person per Calendar Year	$70
Maximum payment per set	

The amounts in the Maximum Plan Payment column show what the Plan will pay toward the listed services and supplies. The Eligible Person is responsible for all additional amounts and other charges.

** The contact lens benefit is in lieu of all other lens and frame benefits for the Calendar Year.

2.4. DENTAL CARE BENEFITS

"Dental Care Benefits" are payable for full-time Eligible Employees and their Eligible Dependents and part-time Eligible Employees (and their Dependent Children, if applicable). The maximum dollar limits described in this Section do not apply to the following Dental Care Benefits for Eligible Dependent Children under age nineteen (19):

A. Routine dental examinations;

B. Sealants;

C. Dental prophylaxis; and

D. Topical fluoride treatments.

Below is the schedule of benefits for Dental Care Benefits for Eligible Persons.

Deductible amount per Eligible Person per Calendar Year for restorative and prosthetic services, including oral surgery	$25
Plan's Coinsurance Diagnostic and Preventive Services Restorative Services Prosthetic Services	 Plan pays 100% Plan pays 80% Plan pays 80%
Calendar Year maximum aggregate amount payable per Eligible Person for diagnostic and preventive, restorative, and prosthetic services	$1,250
Orthodontics Deductible Amount Plan's Coinsurance Orthodontic Lifetime maximum amount payable per Eligible Person Orthodontics services are available only for Eligible Dependents who are ages 8 through 18.	 No Deductible Plan pays 50% $1,500

2.5. WEEKLY DISABILITY INCOME BENEFITS

"Weekly Disability Income Benefits" are only available for full-time Eligible Employees.

Percentage of Average Weekly Wage	Plan pays 60%
Maximum weekly amount	$300
Maximum number of weeks	26

2.6. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

"Accidental Death and Dismemberment Benefits" are available for part-time Eligible Employees only and are insured through Fidelity Security Life Insurance Company.

Principal sum	$1,000

2.7. LIFE INSURANCE BENEFITS

"Life Insurance Benefits" are available for full-time Eligible Employees and their Dependents and part-time Eligible Employees (and their Dependent Children, if applicable) and are insured through Fidelity Security Life Insurance Company.

Full-time Eligible Employee	$25,000
Full-time Eligible Employee's Spouse	$2,000
Full-time Eligible Employee's Dependent Children:	
Fourteen (14) days to one (1) month	$400
One (1) month to two (2) months	$800
Two (2) months to three (3) months	$1,200
Three (3) months to four (4) months	$1,600
Four (4) months to nineteen (19) years (or twenty-five (25) years if full-time student and primarily financially dependent upon Employee)	$2,000
Part-time Eligible Employee	$10,000

SECTION 3 PREFERRED PROVIDER NETWORKS

3.1. PREFERRED PROVIDER PRESCRIPTION DRUG PROGRAM

When a full-time Eligible Employee or Eligible Dependent or a part-time Eligible Employee (and their Dependent Children, if applicable) opts to purchase Prescription Medications through the Preferred Provider Prescription Drug Program, benefits are payable subject to the following terms and conditions.

The Preferred Provider for the Prescription Drug Program is Prime Therapeutics ("Select Care Network"). Only prescriptions that are purchased through this network will be covered.

3.1.1. Payment of Benefits

An Eligible Person must show his or her I.D. card at the network retail pharmacy to receive discounts through the Preferred Provider Prescription Drug Program and pay the required coinsurance at the time of purchase. Benefits are payable at the coinsurance stated in the Schedule of Benefits.

Eligible Persons have the option of purchasing maintenance Prescription Medications through the mail-order service, up to a ninety (90) day supply of medication for each brand name or generic Prescription Medications, payable at the coinsurance level in the Schedule of Benefits. The Eligible Person must pay the coinsurance before the Prescription Medications will be mailed.

The Plan will provide coverage for specialty Prescription Medications through the specialty drug network. Benefits are payable at the coinsurance stated in the Schedule of Benefits.

3.1.2. Eligible Expenses

The expenses for Prescription Medications that are provided in Comprehensive Major Medical Benefits are also covered under the Preferred Provider Prescription Drug Program, except that injections and injectables are covered through the Specialty Drug Program.

3.2. PREFERRED PROVIDER NETWORK

The Plan uses BlueCross BlueShield of Minnesota as its Preferred Provider Network. Although the Plan covers services at in-network and out-of-network Hospitals and services provided by Preferred Providers ("PPO Provider") and non-participating providers ("Non-PPO Provider"), you will generally pay less if you use an in-network or PPO Provider.

3.2.1. Payment of Benefits

Benefits will be payable for Hospital and Physician services and supplies at the Plan's coinsurance, applied to the Hospital's or Physician's negotiated charge according to the contract in effect at the time charges are incurred. The PPO network also offers a smoking cessation program and a Healthy Start Prenatal Support Program.

For charges incurred with PPO Providers, the Plan will pay a discounted amount. Such providers have agreed to accept payment from the Plan as payment in full, except for

applicable deductibles, coinsurance, copayments, maximum benefit limitations or other similar limitations under the Plan.

For charges incurred with Non-PPO Providers within the geographic area of the BlueCross BlueShield of Minnesota AWARE Network, the Plan will pay the Usual and Customary Charge or, if applicable, a separately negotiated amount to the Non-PPO Provider. Additionally, the Eligible Person will be responsible for applicable deductibles, coinsurance, copayments, maximum benefit limitations, and 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 BlueCross BlueShield of Minnesota AWARE Network will come through BlueCross' Blue Card Program. The Plan will pay the reasonable expense, as defined in the Blue Card Host Plan in the Blue Card System or, if applicable, an amount separately negotiated with the non-PPO Provider. The Eligible Person will be responsible for applicable deductibles, coinsurance, copayments, maximum benefit limitations, or other similar limitations under the Plan and may be billed for the balance by the non-PPO Provider

3.2.2. BlueCross BlueShield Healthy Start Prenatal Support Program

Employees and Eligible Dependents have access to the Healthy Start Prenatal Support Program offered by BlueCross BlueShield of Minnesota. This program is designed to assess, educate, and support pregnant women to achieve an optimal childbirth outcome.

The Plan will pay for the cost of participation and a $50.00 gift card sent to those completing the program.

Additionally, if an Eligible Person enrolls in the Healthy Start Prenatal Support Program prior to the second trimester of pregnancy, the Plan will pay benefits for such pregnancy and delivery-related expenses at ninety percent (90%) instead of eighty percent (80%).

If an Eligible Person is expecting, she should call Healthy Start at 651-662-1818 or 866-489-6948 before the second trimester to enroll and obtain the maximum benefits possible.

3.3. ELIGIBLE PERSON'S CHOICE OF COVERED HEALTH CARE PROVIDER

Eligible Persons will have the sole right to select their own Physician, Dentist, Hospital, and other covered health care Providers.

SECTION 4 ELIGIBILITY RULES

Employees become eligible for Plan benefits as either a full-time Eligible Employee or a part-time Eligible Employee. If an Eligible Employee's status is subject to change because of a change of classification, the change will take effect on the first day following the eight (8) week grace period after the change of classification. If the amount of benefits of a modified part-time Eligible Employee's status is subject to change because of a change of classification to a full-time Eligible Employee, the change will take effect on the first day of the month following receipt of eight (8) weeks of full-time contributions. A change in classification will be applicable only to claims commencing after the change of classification.

4.1. INITIAL ELIGIBILITY

A. An Employee is eligible to receive benefits if employed by an Employer that pays contributions to the Plan on the Employee's behalf as required by a collective bargaining agreement or other written agreement.

B. An Employer is obligated to contribute on an Employee's behalf at such time as the Trustees will specify by rules and regulations or as may be provided in the applicable collective bargaining agreement.

C. Full-time Eligible Employees. An Employee becomes eligible as a full-time Eligible Employee if, during the initial period of employment, the Employee has eight (8) weeks of full-time contributions made on the Employee's behalf during a consecutive twelve (12) week period.

Coverage will begin on the first day of the first month following the month in which the Employee completes these eligibility requirements.

A full-time Employee who is transferred from St. Paul to Minneapolis while working for the same Employer will be eligible under this Plan immediately after the Employer has made (8) weeks of full-time contributions on the Employee's behalf and, provided the Eligible Employee is eligible under the UFCW 1189 Health Care Plan immediately preceding transfer.

D. Part-time Eligible Employees. An Employee becomes eligible as a modified part-time Employees only after working twelve (12) months for an Employer, during which the Employer makes at least one (1) contribution on the Employee's behalf in each of the twelve (12) months. If during the twelve (12) month period, Employer contributions are not received by the Plan for six (6) consecutive months or more, a new twelve (12) months of contributions will be required.

Coverage will begin on the first day of the first month following the month in which the Employee completes these eligibility requirements.

A modified part-time Employee who is transferred from St. Paul to Minneapolis while working for the same Employer will be eligible under this Plan immediately after the Employer has made eight (8) weeks of part-time contributions on the Eligible Employee's behalf and, provided the Employee is eligible under the UFCW 1189 Health Care Plan immediately preceding transfer.

A modified part-time Employee will become eligible as a part-time Eligible Employee even if an occasional full-time contribution is made on behalf of such Employee.

4.2. EFFECTIVE DATE OF ELIGIBILITY

A. An Employee becomes eligible under the Plan on the first day of the first month following satisfaction of the provisions in Section 4.1.C or 4.1.D.

B. Coverage for Dependents is provided for full-time Eligible Employees only. Dependents become eligible under the Plan on the first day of the first month following the month the Employee satisfies the provisions in Section 4.1.C. If an Employee acquires a Dependent after his or her effective date, the new Dependent will be covered on the date he or she becomes such a Dependent.

Part-time Eligible Employees may purchase coverage for their Dependent Children only. If a part-time Eligible Employee purchases coverage for a Dependent Child, the Dependent Child will be covered under the Plan on the first day of the first month following receipt of the part-time Eligible Employee's payment for such coverage.

Parents and other relatives are not eligible for Dependent coverage even if they are supported by the Eligible Employee.

C. Opt-Out. An Eligible Employee may choose to "opt out" of coverage under the Plan for the Eligible Employee and his or her Dependents by completing and submitting the form designated by the Trustees to the Plan Administrator if both of the following circumstances are met:

1. The Eligible Employee has satisfied the initial eligibility provisions under the Plan; and

2. The terms of the collective bargaining agreement requiring contributions on behalf of the employee provide an "opt out of coverage" option.

If an Eligible Employee opts out of Plan coverage for himself or herself and his or her Dependents due to enrollment in other health insurance or group health insurance coverage, the Eligible Employee must state in writing that the Plan coverage is being declined due to enrollment in other health coverage at the time the Eligible Employee exercises his or her right to opt out of coverage under the Plan.

Except as provided in Section 4.2.D below, an Eligible Employee that opts out of Plan coverage for himself or herself and his or her Dependents will not be entitled to re-enroll in the Plan's coverage.

D. Special Enrollment Rights.

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your

Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within thirty (30) days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within thirty (30) days after the date of marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at (844) 468-5917.

Notwithstanding any other provision of the Plan to the contrary, an Eligible Employee or Dependent is entitled to special enrollment rights under the Plan as required by applicable law under the following circumstances:

1. An Employee or 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 the Employee or Dependent requests coverage under the Plan not later than sixty (60) days after the date of termination of such coverage.

2. An Employee or Dependent becomes 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 and the Employee or Dependent requests coverage under the Plan not later than sixty (60) days after the date the Employee or Dependent is determined to be eligible for the assistance.

4.3. CONTINUATION OF ELIGIBILITY THROUGH EMPLOYMENT

An Employee's continued eligibility is determined weekly. Once an Employee has established eligibility, it will continue so long as required Employer contributions to the Plan are made on the Employee's behalf for each subsequent week.

The amount of the Employer contribution is based on the number of hours worked per week, the Employee classification and the weekly rate specified by the collective bargaining agreement in effect at the time the contributions are earned. The collective bargaining agreement requires Employer contributions to be paid when an Employee meets the criteria for a specified employment classification (full-time Employee or modified part-time Employee) and works a specified amount of required hours. Generally, the amount of the Employer contribution determine whether the Employee is covered under as a full-time Eligible Employee or a part-time Eligible Employee.

If, in any week, an Employer does not make either the modified part-time or full-time contribution, as applicable, on an Employee's behalf because the Employee has not worked the required number of hours, the Employee may pay that weekly contribution himself to continue coverage, but only if actively working or scheduled to work.

In the event the minimum hourly requirements are not satisfied and all grace weeks have been used, the Employee will lose eligibility unless the Employee makes self-payments as provided in Section 4.5.

Continued eligibility will be given to Employees who are absent from active work due to work-related Injury up to a total of twenty-six (26) weeks inclusive of any Family and Medical Leave contribution requirement under Section 4.13.

4.4. EFFECTIVE DATE OF CHANGE IN COVERAGE

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

4.4.1. Full-Time Employees

If a full-time Eligible Employee works only the number of hours that require the Employer to make modified part-time contributions on the Employee's behalf, the plan of benefits that covers the Employee will change. In that event, the change in benefits will become effective on the first day following the end of the Employee's eight (8) week grace period (reduced by the number of grace weeks previously used).

If the full-time Eligible Employee continues to work part-time under the terms of the collective bargaining agreement with modified part-time contributions made on the Employee's behalf, the Eligible Employee will be eligible for modified part-time Eligible Employee benefits.

When the full-time Eligible Employee becomes eligible for modified part-time Eligible Employee benefits, he or she may purchase coverage for their Dependent Children only.

4.4.2. Part-Time Employees

In the event that a modified part-time Eligible Employee works the number of hours that require the Employee's Employer to make full-time contributions on the Employee's behalf, the Eligible Employee and the Employee's Dependents will become eligible for full-time benefits if the Eligible Employee is reclassified by the Employer as full-time and has eight (8) weeks of full-time contributions within a twelve (12) week period. Full-time coverage will become effective on the first day of the first month following the month in which the Employer paid contributions for eight (8) full-time weeks in a consecutive twelve (12)-week period.

4.5. CONTINUATION OF ELIGIBILITY THROUGH SELF-PAYMENTS AND COBRA CONTINUATION RIGHTS

When circumstances described in this Section cause a reduction in, or a loss of, coverage, some of the coverages in effect at the time can be continued by making self-payments. The following terms incorporate COBRA and HIPAA requirements as amended in all respects. Any future IRS guidance will be incorporated even if it conflicts with existing Plan provisions.

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

4.5.1. Qualifying Events

"Qualifying Events" are events that cause an Employee or Dependent to lose eligibility under the Plan.

A. For Employees, Qualifying Events occur when coverage is reduced or terminated because of:

1. A reduction in hours of covered employment; or

2. Voluntary or involuntary termination of covered employment for any reason (except gross misconduct on the Employee's part), including disability, Illness, or retirement.

B. For Spouses and Dependent Children, Qualifying Events occur when coverage is terminated due to any of the following events that occur while the Employee is eligible because of Employer contributions or the application of grace weeks:

1. Termination or reduction of the Employee's employment for any reason (except gross misconduct) including disability, Illness, or retirement;

2. Death of the Employee;

3. Divorce or legal separation from the Employee;

4. Employee's entitlement to Medicare (under Part A, Part B, or both); or

5. A Dependent Child ceases to meet the definition of Dependent.

An Employee or Dependent becomes a "Qualified Beneficiary for a specific period of time (the COBRA continuation period) when a Qualifying Event occurs. A Dependent Child who is born or placed for adoption with an Employee during the Employee's period of COBRA continuation coverage will be treated as a Qualified Beneficiary.

4.5.2. Notifications and Due Dates

A. Qualified Beneficiary's Responsibility to Notify the Trustees of a Qualifying Event. When the Qualifying Event relates to the Employee's death, divorce, or legal separation, or to a Dependent Child ceasing to meet the definition of Dependent, the Qualified Beneficiary must notify the Fund Office within sixty (60) days of the Qualifying Event so the Fund Office may provide proper notices and explanations to Qualified Beneficiaries about continued eligibility. This notice can be provided to the Fund Office by telephone, facsimile, or in writing by mail. The Fund Office will advise the Qualified Beneficiary if additional supporting documentation is required, such as a copy of the divorce or legal separation decree. Failure to notify the Fund

Office within sixty (60) days of the Qualifying Event will cause a person to lose the opportunity to continue coverage.

Employers notify the Trustees of Qualifying Events, such as a reduction in an Employee's hours and an Employee ceasing active work, through the Employer Reports. Notices explaining the right to continue coverage will be furnished to Employees and Dependents when such a Qualifying Event occurs.

B. The Trustees' Responsibility to Notify a Qualified Beneficiary When the Qualifying Event is Loss of Coverage Due to the Employee's Death, Divorce, or Legal Separation or a Dependent Child No Longer Meets the Definition of Dependent. Not later than fourteen (14) days after receipt of notice from an Employee or Dependent, the Fund Office will advise the Qualified Beneficiary of the coverages, options, costs, self-payment due dates, and duration of self-payment privileges.

C. The Trustees' Responsibility to Notify a Qualified Beneficiary When Other Qualifying Events Occur. Not later than thirty (30) days after receipt of notice of an Employee's loss of coverage from the Employer or by examining monthly contribution reports, the Fund Office will advise the Qualified Beneficiary of the coverages, options, costs, self-payment due dates, and duration of self-payment privileges.

D. Due Date for Qualified Beneficiaries' Response. A Qualified Beneficiary has sixty (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 must be communicated to the Fund Office in writing on an Election Form. Each Employee, Spouse, and Dependent Child has the right to make an 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. Failure to state the election to the Fund Office within sixty (60) days from the date of coverage termination or the receipt of the COBRA notice, whichever is later, terminates rights to continued coverage.

E. Due Dates for Self-Payments.

1. The required initial self-payment must be made to the Fund Office not later than forty-five (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 later of the Qualifying Event or loss of eligibility and will cause loss of all continuation coverage rights under the Plan. The amount of the first self-payment is for the time period beginning with the date of the Qualifying Event and extending through the month in which payment is made.

2. Subsequent monthly self-payments must be made to the Fund Office by the first day of the month for that month of coverage. The Plan allows a thirty (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 you do not make your self-payment by the due date, your (and your Dependents) coverage will be suspended as of the due date for the self-payment. If you then make your self-payment by the end of the grace period, your (and your Dependents) coverage will be retroactively reinstated to the first day of the coverage period. 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 Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund and sent to the Fund Office. Failure to make self-payments in the amounts and by the due dates required will cause loss of coverage that cannot be reinstated.

4.5.3. Coverages and Options

The Health Care, Vision Care, and Dental Care Benefits a Qualified Beneficiary may continue are the same as those in effect the day before the Qualifying Event and are identical to similarly-situated Employees or family members for whom a Qualifying Event has not occurred. In the event coverage under the Plan is modified for similarly-situated Employees, the Qualified Beneficiary's coverage also will be modified.

If a Qualified Beneficiary elects to continue coverage, the Qualified Beneficiary may elect to continue the coverage in effect on the day before the Qualifying Event or lesser coverage, which may include:

A. Health Care Benefits only;

B. Health Care Benefits plus Vision Care and Dental Care Benefits;

C. Health Care Benefits plus Vision Care and Dental Care Benefits, Life Insurance and Accidental Death and Dismemberment; or

D. Life Insurance Benefits only.

Employees continuing coverage are not eligible for Weekly Disability Income Benefits. Part-time Employees are eligible to continue Accidental Death and Dismemberment Benefits.

The coverage selected may not be changed. However, coverage may be added for a new Spouse or a new Dependent Child upon the Child's birth or placement for adoption with the Employee during the Employee's period of COBRA continuation coverage.

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

4.5.4. Cost of Continuation Coverage

The self-payment amount will depend upon which benefits are continued. The cost is determined annually by the Trustees. The Fund Office will notify you of the self-payment amount and due dates. For individuals who are eligible for a disability extension, the cost for the disability extension (the 19th through the 29th month) will be a separate cost.

4.5.5. Duration of Continuation Coverage

Generally, a Qualified Beneficiary may continue coverage under the Plan for up to eighteen (18) consecutive months from the date employment terminated or hours were reduced or lost because of the Employee's termination of employment or reduction in hours and for up to twenty-nine (29) months in certain disability cases. In the event the Employee declines continuation coverage, the Spouse and Dependent Children may continue coverage for up to eighteen (18) months from the time coverage ceases, or the Spouse and Children may continue coverage for up to thirty-six (36) consecutive months for all other Qualifying Events. This eighteen (18) month period may be extended to up to thirty-six (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 eighteen (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 Fund Office within sixty (60) days after a second Qualifying Event occurs if he or she wants to extend the his or her coverage and must provide any supporting documentation the Plan requests. Extended continuation coverage due to a second Qualifying Event is not available in the case of a reduction in work hours followed by a termination of employment. Failure to provide notice of a second Qualifying Event may 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), a Dependent Child ceasing to meet the definition of Dependent under the Plan, the Spouse and eligible Dependents may continue coverage for up to thirty-six (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 eighteen (18) months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the Employee lasts until thirty-six (36) months after the date of Medicare Entitlement.

These general rules apply to specific circumstances as follows:

A. Change in Status from Full-Time Eligible Employee to Part-Time Eligible Employee. If, after being covered as a full-time Eligible Employee, an Employee becomes eligible as a part-time Eligible Employee because of a reduction in hours, coverage as a full-time Employee may be retained for a minimum of up to eighteen (18) months. However, an Employee who has been involuntarily reduced from full-time to part-time employment may continue full-time Eligible Employee coverage through self-payments indefinitely, if:

1. The Employee has remained continuously employed by the same Employer; and

2. The Employee is ready, willing, and able to return to full-time employment when it becomes available.

B. Cessation of Active Work.

1. If an Employee ceases active work due to lay-off, work stoppage, resignation, or dismissal, coverage may be continued for up to eighteen (18) months from the time coverage ceases.

2. If an Employee ceases active work due to a disability or sick leave:

(a) The Employee may continue coverage for of eighteen (18) months; or

(b) The Employee (or any other Qualified Beneficiary) may continue coverage for him or herself and his or her Dependents for up to twenty-nine (29) months of disability if:

i. The Social Security Administration (SSA) determines that any of the Qualified Beneficiaries are disabled under the Social Security Act either: (i) at the time employment terminated or hours were reduced; or (ii) at any time within sixty (60) days of the Qualifying Event;

ii. The disability lasts at least until the end of the eighteen (18) month period of continuation coverage; and

iii. The Qualified Beneficiary notifies the Fund Office in writing within sixty (60) days of the SSA determination and before the end of the first eighteen (18) months of continuation coverage and provides a copy of the Social Security Disability Determination to the Fund Office.

Each Qualified Beneficiary who has elected continuation coverage will be entitled to the eleven (11) month disability extension if one (1) of them qualifies. If the Qualified Beneficiary is determined by SSA to no longer be disabled, the Qualified Beneficiary must notify the Fund Office within thirty (30) days after the SSA determination.

Failure to provide notice of a disability may affect the right to extend the period of continuation coverage.

3. If an Eligible Employee ceases active work due to a non-medical leave of absence, the Employee may continue coverage by making self-payments for up to eighteen (18) consecutive months.

4. If an Employee ceases active work due to retirement from an Employer:

   (a) Before age sixty-five (65):

      i. The Employee may continue coverage for the first eighteen (18) months subject to COBRA and then subject to terms and conditions the Trustees may adopt;

      ii. No benefits are available for weekly disability income or dental care;

   (b) At or after age sixty-five (65).

      Coverage under this self-funded Plan will terminate at or after age sixty-five (65). Coverage is available through a fully-insured Medicare-Supplement Plan selected by the Trustees for retirees who have attained age sixty-five (65) and have Medicare Parts A and B.

      Spouses and Dependent Children not eligible for Medicare may continue Plan coverage for up to thirty-six (36) months from the Employee's retirement subject to COBRA, provided the appropriate self-payments are made.

   Except when otherwise prevented by law, retiree coverage is subject to change or discontinuation based on Trustee review. The Trustees retain the right in their sole discretion to modify or discontinue, in part or in whole, retiree eligibility rules, types and amount of benefits, terms and conditions under which benefits are payable, and self-payment rates.

C. Loss of Dependent Status.

1. If family coverage ceases due to the Employee's death, divorce, or legal separation, coverage may be continued by the Spouse and Dependent Children for up to thirty-six (36) months.

2. If a Dependent Child's coverage ceases because of a change in the Child's Dependent status due to age, coverage may be continued for up to thirty-six (36) months.

4.5.6. Multiple Qualifying Events

As a Qualified Beneficiary, a Spouse or Dependent Child may experience more than one (1) Qualifying Event. The combined continuation coverage period for all such events

may not exceed thirty-six (36) consecutive months from the date of the original Qualifying Event. If a second or later Qualifying Events occur within the initial continuation period as a result of the original Qualifying Event, the Qualified Beneficiary will be entitled to continue coverage for an additional period, but not longer than thirty-six (36) months form the date of the original Qualifying Event. This extension is not available will not apply in the case of a reduction in work hours followed by a termination of employment.

4.5.7. Termination of Self-Payment Provisions for Qualified Beneficiaries

Self-payments will no longer be accepted, and continued eligibility under this provision will terminate on behalf of all Qualified Beneficiaries (unless specifically stated otherwise) when:

A. The Plan no longer provides group health care coverage to any Eligible Employee;

B. The Qualified Beneficiary does not provide the Fund Office notice of the Qualifying Event within sixty (60) days of its occurrence;

C. The election for continuation is not received by the Fund Office within sixty (60) days following the date of coverage termination or the receipt of the COBRA Notice, whichever is later;

D. The initial self-payment is not paid by the due date explained in Section 4.5.2.E.1;

E. Subsequent self-payments are not paid by the due date explained in Section 4.5.2.E.2;

F. A Qualified Beneficiary first becomes covered after electing continuation coverage under another group health care plan that does not impose any pre-existing condition exclusion for pre-existing conditions of the Qualified Beneficiary;

G. A Qualified Beneficiary first 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 will not terminate automatically because of eligibility for Medicare. In the case of ESRD, the Fund will be the primary source of coverage for up to thirty (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 Fund with COBRA continuation coverage. In the event the Fund's liability as the primary source of coverage for ESRD ends before the COBRA continuation period expires, the Fund will become secondary to Medicare for the balance of the continuation coverage for such person;

H. The maximum continuation coverage period is reached; or

I. For a Qualified Beneficiary who was entitled to the additional eleven (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.

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

4.6. REINSTATEMENT OF COVERAGE

4.6.1. Full-Time Eligible Employees

If a full-time Eligible Employee's coverage terminates, the Employee may be reinstated on the first of the month following the date when eight (8) weeks of Employer full-time contributions have been paid to the Fund on the Employee's behalf during a consecutive twelve (12) week period.

4.6.2. Part-Time Eligible Employees

If a part-time Eligible Employee loses eligibility, but does not incur a break in service (as defined below), he may regain eligibility by completing twelve (12) consecutive weeks of employment during which at least eight (8) weeks of part-time contributions are made to the Plan.

A break in service is the longer of: (A) a period of six (6) consecutive months during which no Employer contributions are made on an Employee's behalf; or (B) the length of an approved leave of absence. If an Employee loses eligibility after having incurred a break in service, he may regain eligibility by once again satisfying the requirements for initial eligibility. Part-time eligibility credit for months preceding a break in service is forfeited and does not count for purposes of obtaining eligibility.

4.7. TERMINATION OF EMPLOYMENT

In the event an Eligible Employee's employment is terminated, the Employee's eligibility will continue under the Plan for the number of grace weeks the Employee has accrued (as provided below).

Each Eligible Employee who has qualified for health care benefits, for either full-time or modified part-time coverage, will accumulate a total of eight (8) grace period weeks. The Fund Office will use one (1) grace week whenever a current weekly contribution is not received for the coverage in effect. When all of the grace weeks have been used and there are no current contributions, the Employee's full-time or modified part-time coverage, whichever applies, will be terminated. However, the Employee still has, the option of continuing coverage.

It is each Employee's responsibility to keep track of any grace weeks used. An Employee may make contributions on his or her behalf in lieu of using any grace weeks OR may buy back any grace weeks used. However, such option must be exercised within sixty (60) days of the date the Eligible Employee is notified of either the Employee's termination of coverage or the Employee's reduction to modified part-time Employee status. Employees who are currently working or

scheduled to work will be allowed to buy back grace weeks after the sixty (60) day window at the rate in effect at the time of purchase.

4.8. TERMINATION OF ELIGIBILITY

An Eligible Person's coverage automatically terminates on the earliest of the following dates, subject to the Eligible Person's 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 on the Employee's behalf;

C. The date the Employee enters the armed forces on full-time active duty (according to the provisions of Section 4.14);

D. The date the Employee ceases to be eligible for coverage according to the Plan's Eligibility Rules and all grace weeks are exhausted;

E. The date a Dependent ceases to be an Eligible Dependent;

F. The date the full-time or part-time Eligible Employee's coverage terminates; or

G. The date coverage is effectively rescinded under Section 4.9; or

H. The sooner of exhaustion of grace weeks or the first day of the month following the date you sign the completed Opt-Out Form.

4.9. 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 Dependent 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 consequences:

A. Any loss, expense, or charge incurred as a result of the act, practice, omission, or misrepresentation will not be covered;

B. The Eligible Person (including any Dependent 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 the act, practice, omission, or misrepresentation; and

C. The Trustees of the Plan may treat the Eligible Person's coverage (including the coverage of any Dependent in the case of an Eligible Employee and the coverage

of the 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:

A. Intentionally or fraudulently failing to timely update an Eligible Person's enrollment status;

B. Intentionally or fraudulently failing to report the following to the Plan:

1. The Eligible Employee's divorce;

2. The Eligible Employee's legal separation;

3. The death of a Dependent; or

4. A Dependent ceasing to satisfy the requirements of a Dependent under this Plan;

C. Intentionally or fraudulently failing to satisfy the Notification Obligations under this Plan; or

D. Intentionally or fraudulently failing to honor the Plan's right of subrogation and reimbursement or otherwise failing to cooperate with the Plan, as set out in Section 8.7.

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

4.10. NOTIFICATION OBLIGATION

An Eligible Person 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 twenty (20) days of any such event or change in circumstances.

4.11. COVERAGE FOR DEPENDENTS IN EVENT OF FULL-TIME EMPLOYEE'S DIVORCE

In the event of divorce or legal separation, an Eligible Employee's former Spouse is entitled to continue coverage for him or herself and the Eligible Employee's Dependent Children who no longer meet the Plan's definition of "Dependent" as a result of the divorce or legal separation by

making required self-payments according to the COBRA continuation coverage provisions specified under Section 4.5.

4.12. PROVISIONS IN THE CASE OF A NEWLY PARTICIPATING EMPLOYER

The following provisions apply only to Eligible Employees who were covered under their Employer's former policy or plan immediately prior to the effective date of their Employer participating under this Plan and become covered under this Plan on the effective date of their Employer's participation. Payment of benefits under this Plan may be in lieu of payment under the former policy or plan when coverage under the prior plan is not extended after policy termination.

A. If an Employee is otherwise eligible, the Employee's coverage will become effective on the date the Employer becomes a participating Employer.

B. If an Employee is not eligible for coverage under this Plan due to an effective date provision, it is the intent of this provision that the Employee will not lose all coverage solely because the Employee's Employer becomes a participating Employer. However, it is not the intent of this provision that an Employee will receive greater benefits than the Employee had under the former plan. Therefore, if an Employee is not eligible under the Plan due to an effective date provision, benefits payable under this Plan will be the lesser of:

1. The amount of benefits payable by the former plan under any provision of such plan that would not violate the Affordable Care Act reduced by the amount paid or payable by that plan; or

2. The amount of benefits provided by this Plan.

If an Eligible Employee had applied medical expenses toward the deductible amount requirements under the former plan for the Calendar Year during which the Employer becomes a participating Employer, the deductible amount requirements under this Plan for that Calendar Year will be reduced by the same amount.

4.13. COVERAGE WHILE ON FAMILY AND MEDICAL LEAVE

If an Employee becomes eligible for leave according to the Family Medical Leave Act of 1993 (FMLA), the Employee's coverage under the Plan may be continued for up to twelve (12) weeks (or up to twenty-six (26) weeks in limited circumstances related to care for a military service member), if:

A. The Employer is subject to the FMLA;

B. The Employer or the Employee makes the required contribution; and

C. The Employer files the appropriate notification and certification forms with the Fund Office.

4.14. COVERAGE FOR EMPLOYEES AND THEIR DEPENDENTS WHEN EMPLOYEE ENTERS MILITARY SERVICE

This Section 4.14 is intended to comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). The USERRA provisions will control in the event there are any inconsistencies between USERRA and the Plan.

4.14.1. Eligibility Status

A. An Employee or appropriate officer must submit advance notice of military service to the Fund Office (unless circumstances of military necessity as determined by the Defense Department make it impossible or unreasonable to give such advance notice).

B. If an Employee or appropriate officer does not submit such notice, the Employee's accumulated grace weeks, if any, will be applied until exhausted to further extend the Employee's eligibility and the eligibility of the Employee's Dependents. The Employee's coverage will terminate on the date all accumulated grace weeks have been exhausted. If the Employee subsequently submits notice in a reasonable time period, the use of his or her grace weeks will cease.

C. For military leaves that are less than thirty-one (31) days in duration and for which the Employee, an appropriate officer, or an Employer submits the required notice and satisfies the reemployment requirements described below, coverage for the Employee and the Employee's Eligible Dependents will be continued as though the Employee was actively at work for the duration of such leave.

D. For military leaves that are thirty-one (31) or more days in duration and for which the Employee, an appropriate officer, or an Employer submits the required notice, coverage for the Employee and the Employee's Eligible Dependents will cease and the Employee's eligibility status will be frozen as of the date the Eligible Employee leaves employment to enter military service with the uniformed services of the United States, unless the Employee elects to continue coverage as described in Subsection 4.14.2. An Employee may elect to not continue coverage and not use his or her grace weeks. In such case, the Eligible Employee will have his or her accumulated grace weeks available to re-establish eligibility upon the Employee's return from military leave.

E. The Employee's eligibility will be reinstated on the date the Eligible Employee returns to work for a participating Employer (or upon making himself available for work if no such work is available) within the applicable time limits stated in Subsection 4.14.3, provided the Eligible Employee otherwise satisfies the reemployment requirements necessary to qualify for reemployment rights under The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") (e.g., provides evidence of honorable discharge, cumulative military service of no longer than five (5) years). If all grace weeks have been exhausted, the Eligible Employee will

be allowed to make self-payments to be immediately reinstated in the Plan until the Eligible Employee has sufficient grace weeks to sustain Plan coverage.

4.14.2. Continuation of Coverage

A. If an Employee fails to provide advanced notice of the Employee's military service, the Employee's coverage will terminate on the date all accumulated grace weeks have been exhausted and the Eligible Employee will not be eligible to continue coverage under this Section unless the Employee's failure to provide advanced notice is excused. The Trustees, in their sole discretion, will determine if the failure to provide advance notice is excusable under the circumstances and may require that documentation be provided to support the excuse. If the Trustees excuse the failure to provide advance notice, the Employee may elect to continue coverage, in accordance with this Subsection, retroactive to the date the Eligible Employee left employment for military service, provided that the Employee elects such coverage and pays all amounts required for the continuation of coverage.

B. When the Fund Office has been notified that an Employee is entering military service, the Employee will be given the option of continuing the same class of coverage under the Plan. Continuation coverage under this Subsection 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 an Employee does not elect continuation coverage and does not submit payment for all amounts required to continue coverage within the applicable COBRA timeframe, the Eligible Employee will lose his or her right to continue coverage under this Subsection and such right will not be reinstated.

C. The Employee will have the option of applying accumulated grace weeks, if available, to continue coverage. If the Employee does not have any grace weeks available or chooses not to use them, the Eligible Employee will be required to make timely self-payments at the COBRA rate, as determined by the Trustees from time to time, to purchase COBRA continuation coverage. If an Employee elects to use his or her grace weeks to pay for continuation coverage and exhausts his or her grace weeks prior to the end of the maximum coverage period described in the Subsection (E) below, the Eligible Employee may make self-payments to continue coverage through the end of the Employee's maximum coverage period.

D. The COBRA continuation coverage rules apply to payment for continuation coverage under this Subsection, provided that the COBRA payment rules do not conflict with USERRA. The Employee must make all required self-payments within the COBRA timeframe described under the self-payment provisions to continue coverage unless the COBRA payment rules conflict with USERRA.

E. The Employee and the Employee's Eligible Dependents may continue coverage for a period ending the earlier of:

1. The date that the Plan no longer provides group health care coverage to any Employees;

2. The day after the date the Employee fails to elect continuation coverage as required by the COBRA continuation of coverage election rules;

3. The first day of the month for which a timely self-payment has not been received and grace weeks have been exhausted;

4. Twenty-four (24) consecutive months from the first date of absence due to military service (or eighteen (18) consecutive months for any military leave that began before December 10, 2004); or

5. The day after the date the Employee fails to apply for reemployment with a participating Employer within the applicable time period allowed under Subsection 4.14.3 or otherwise ceases to have USERRA reemployment rights.

The right to freeze eligibility and make self-payments will cease when the Employee provides notice that the Eligible Employee does not intend to return to work for a participating Employer after military service.

4.14.3. Status Upon Return from Military Service

If an Employee is eligible for benefits when the Eligible Employee enters military service and has sufficient grace weeks or makes timely self-payments to maintain coverage upon the Employee's return to work, the Employee and the Employee's Eligible Dependents again will be eligible for benefits on the date of the Employee's return to work for a participating Employer, if the Eligible Employee satisfies the other reemployment requirements of USERRA and returns to work for a participating Employer within the following time frames:

A. For periods of military service of less than thirty-one (31) days, the Employee 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 (8) hours. The eight (8) hour period begins after a period allowing for safe transportation from the place of military service to the Employee's residence.

B. For periods of military service of more than thirty (30) days but less than one hundred eighty-one (181) days, the Employee must apply for reemployment not later than fourteen (14) days after military service is completed.

C. For periods of military service of more than one hundred eighty (180) days, the Employee must apply for reemployment not later than ninety (90) days after military service is completed.

Such time periods may be extended up to two (2) years for Injuries or Illnesses, as determined by the Secretary of Veteran Affairs that were incurred or aggravated during the Employee's military service.

If an Employee exhausts his or her grace weeks prior to the Employee's return from military service and does not have USERRA reemployment rights, the Eligible Employee will be treated as a new Employee.

If the Employee exhausts his or her grace weeks prior to return from military service and satisfies USERRA reemployment requirements, the Employee will be eligible for benefits on the date of the Employee's return to work within the required time periods, provided the Eligible Employee makes the self-payments necessary to continue eligibility under the self-payment provisions. If the Eligible Employee fails to make self-payments as required upon reinstatement in the Plan, the Employee's eligibility for coverage will terminate as of the last date of the period for which a timely payment was received. The Employee then will be treated as a new Employee.

The Plan will provide continuation coverage and reinstatement rights to the extent required by USERRA. The Employee 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 an Employee remains eligible simultaneously for both COBRA and USERRA continuation coverage, the Eligible Employee will receive the more generous benefits rights that apply under those statutes. COBRA and USERRA continuation periods will run concurrently.

4.15. MEDICARE PROVISIONS

Eligible Persons who are retired or disabled are required to enroll in Part A and Part B of Title XVIII of the Social Security Amendments of 1965 (more commonly known and described as "Medicare") in the event they become entitled to such coverage by reason of attained age, qualifying disability, or End State Renal Disease (ESRD). Eligible Persons who are eligible for Medicare also may become eligible for Medicare Prescription Drug Benefits. Unlike Medicare Benefits, retirees are not required to enroll in Medicare Prescription Drug Benefits. If an Eligible Person chooses to enroll in Medicare Prescription Drug Benefits and drop the Employee's prescription drug coverage under the Plan, the Eligible Employee may not be able to reinstate such coverage.

Neither the Eligible Person nor the Plan will be responsible for paying any charges which exceed legal limits set by the Medicare Physician Payment Reform Act, which limits the amount the Physicians can bill Medicare patients above the Medicare allowance for a particular procedure or service, unless services are privately contracted.

4.15.1. Persons Initially Entitled to Medicare by Reason of Attained Age or Qualifying Disability (Other than ESRD) and Eligible Under the Plan Through Self-Payments

If a person who is eligible under the Plan solely because of self-payments becomes initially entitled to Part A or Part B of Medicare because they have attained age sixty-five (65),

his/her coverage under this Plan will end, and he/she will no longer be eligible for coverage under the Plan.

If a person who is eligible under the Plan solely because of self-payments becomes initially entitled to Part A or Part B of Medicare due to a qualifying disability (other than ESRD), benefits payable under this Plan will be reduced by the amount of benefits paid or payable under Part A or Part B of Medicare. In other words, Medicare will be primary, and the Plan will be secondary.

In the event the person subsequently becomes entitled to Medicare due to ESRD, Medicare will continue to be the primary source of coverage.

4.15.2. Persons Initially Entitled to Medicare by Reason of Attained Age or Qualifying Disability (Other than ESRD) and Eligible Under the Plan Through Employer Contributions

Plan benefits will not be reduced for active Employees and their Spouses who are eligible under the Plan 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 thirty (30) month coordination period specified in the following Subsection 4.15.3.

However, an active Employee or Spouse eligible under the Plan through Employer contributions who becomes initially entitled to Medicare due to attained age will have the right to reject the Plan and retain Medicare as their primary source of coverage. In such case, the Plan is legally prohibited from supplementing Medicare coverage.

4.15.3. Persons Initially Entitled to Medicare by Reason of ESRD and Eligible Under the Plan Through Either Self-Payments or Employer Contributions

In the event an Eligible Person becomes initially entitled to Part A or Part B of Medicare because of ESRD (or when ESRD-based Medicare entitlement occurs simultaneously with attained age or other qualifying disability-based entitlement), benefits will be provided subject to the following terms:

A. The Plan will be the primary source of coverage for covered charges incurred for up to thirty (30) consecutive months from the date of ESRD-based Medicare entitlement.

B. Benefits payable under the Plan beginning with the thirty-first (31st) month of ESRD-based Medicare entitlement will be reduced by the amount of benefits paid or payable under Part A or Part B of Medicare.

The same terms will apply in the event an Eligible Person becomes initially entitled to Medicare due to ESRD and subsequently becomes entitled to Medicare due to attained age or another qualifying disability.

In no event will benefits paid by the Plan exceed the applicable amounts stated in the Schedule of Benefits, nor will the combined amounts payable under Part A and Part B of Medicare and the Plan exceed the eligible expenses incurred by the Eligible Person as

the result of any accidental bodily Injury or Illness. For the purpose of this Section, benefits payable under Part A or Part B of Medicare will include those that would have been payable if the Eligible Person had properly enrolled, when eligible to do so.

For Eligible Persons for whom Medicare is the primary source of coverage, the benefits payable under this Plan for services incurred at a Veterans Administration (VA) facility for non-service-connected disabilities will be reduced by the amount that would have been payable by Medicare had the services been rendered by a Medicare-approved facility.

For Eligible Persons for whom Medicare is the primary source of coverage and who have enrolled in a Medicare Advantage plan, the benefits payable under this Plan for services otherwise covered by Medicare, but that are not covered under the Medicare Advantage plan because the Eligible Person did not obtain services at a network provider and/or did not comply with that plan's managed care requirements, will be limited to the amount that would have been payable by the Plan had the services been payable by Medicare.

To facilitate Plan payments in the absence of Medicare payments, it may be necessary for the Trustees to estimate Medicare payments.

No benefits will be payable under this Plan if an Eligible Person for whom Medicare is the primary source of coverage incurs services otherwise covered by Medicare, but that are not covered by Medicare because of a private contract with a Provider.

SECTION 5 BENEFIT DESCRIPTIONS

Benefits payable under this Plan are subject to the terms and provisions of the Plan in the amounts specified in this Section or in the applicable Schedule of Benefits.

5.1. COMPREHENSIVE MAJOR MEDICAL BENEFITS

Comprehensive Major Medical Benefits are payable for full-time Eligible Employees and their Eligible Dependents and part-time Eligible Employees (and their Dependent Children, if applicable), subject to the conditions of this Section.

5.1.1. Cost-Sharing

A. Deductible. The Deductible Amount must be satisfied each Calendar Year for each Eligible Person before expenses will be payable under this Section for the Eligible Person. The deductible amount per Eligible Person and per family for each Calendar Year is stated in the Schedule of Benefits.

B. Copayments. A copayment, which is a fixed dollar amount you pay toward a Health Service, is required for some Health Services, such as office, specialist, and emergency room visits. Copayments do not count toward the deductible or coinsurance and are stated in the Schedule of Benefits.

C. Coinsurance. After satisfaction of the required deductible amount, the Plan provides for payment of covered expenses at the coinsurance percentage stated in the Schedule of Benefits. The Eligible Person is responsible for the balance of covered expenses.

D. Out-of-Pocket Maximum. When the out-of-pocket expenses in any one (1) Calendar Year reaches the maximum stated in the Schedule of Benefits, the Plan generally pays one hundred percent (100%) of the balance of covered expenses that exceed the out-of-pocket maximum for the remainder of that Calendar Year. The out-of-pocket maximum includes the deductible amount.

5.1.2. Covered Health Services

Benefits are payable for the Usual and Customary Charges incurred by an Eligible Person for the following services and supplies that are Medically Necessary for the treatment of an Injury or Illness (including pregnancy).

A. Hospital inpatient services recommended by the attending Physician for:

1. Room and board expenses, up to the semi-private room rate and isolation when Medically Necessary. This benefit is also payable for a newborn Dependent Child of a part-time Eligible Employee during the period the mother of the Child is Hospital-confined as the result of giving birth to such Child, even though part-time Eligible Employees are not provided Dependent coverage (unless coverage for the Dependent Child is purchased by the part-time Eligible Employee). If the newborn Dependent Child has a condition (such

as Injury, Illness, congenital defect, or premature birth) that requires treatment, no coverage will be provided for any expenses incurred by the newborn Dependent Child including charges for Hospital confinement.

2. Confinement in an Intensive Care Unit, including confinement in duration of twenty-four (24) or more consecutive hours in a recovery room of a Hospital if the Eligible Person receives the same care and services as those normally provided in the Intensive Care Unit of the Hospital.

3. Drugs, medicines, diagnostic x-rays, and laboratory tests, and other miscellaneous Hospital 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 or while in the outpatient department of the Hospital when outpatient surgery is performed (see paragraph (h) (vi) for coverage of pre-admission testing).

4. Services for confinement in a Hospital and services provided in an intensive day treatment program that are related to treatment of mental Illness or nervous disorders. These services are payable the same as for any other disability.

5. Services provided for treatment during confinement in a Hospital or Residential Treatment Program for the treatment of alcoholism, chemical dependency, and substance abuse are payable the same as for any other disability.

   Inpatient charges incurred at a detoxification center are not covered unless the center is located within a Hospital or Residential Treatment Program and appropriate medical or psychiatric care is being provided. Confinement strictly for custodial care is not covered.

Under federal law, The Plan generally may not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) or ninety-six (96) hours, as applicable.

Successive Hospital confinements will be considered one (1) confinement unless they are due to entirely unrelated causes or:

1. If the Eligible Person is an active Eligible Employee, the Eligible Person has returned to active work for at least one (1) full working day before the subsequent confinement begins; or

2. If the Eligible Person is a retired Employee who is not eligible for Medicare or a full-time Eligible Employee's Dependent, the confinements are separated by three (3) months.

B. Skilled Nursing Home care in a licensed Skilled Nursing Home for up to the maximum number of days per confinement as stated in the Schedule of Benefits, but only if:

1. The Eligible Person is transferred to the Skilled Nursing Home within twenty-four (24) hours of Hospital discharge;

2. The attending Physician certifies that the Skilled Nursing Home care is Medically Necessary and recertification is made every seven (7) days; and

3. Further hospitalization would be necessary if not for Skilled Nursing Home confinement.

C. Physicians' services for:

1. Inpatient and outpatient surgery by a Physician or surgeon including charges for:

(a) Home deliveries.

(b) Circumcision of a full-time Employee's eligible newborn Dependent.

(c) Prophylactic mastectomies when warranted by a history of cancer in the contralateral breast or a "strong family history of breast cancer" (meaning two (2) first degree relatives (sibling or parent) or multiple second degree relatives with breast cancer). Prior authorization is required for such procedures.

(d) Following a mastectomy, the following are covered on the same basis as other surgical procedures covered by the Plan and in a manner determined in consultation with the attending Physician and the patient:

i. Reconstruction of the breast and nipple on which the mastectomy has been performed and of the contralateral breast to produce symmetrical appearance; and

ii. Treatment of physical complications of all stages of mastectomy, including lymphedemas.

(e) Organ transplants. Separate maximums are stated in the Schedule of Benefits for professional services (including,

but not limited to, fees for surgeons, Physicians, and anesthetists) and for private nursing care for donors only.

In the event that multiple surgeries are performed during the same anesthesia period, payment will be based on the Usual and Customary guidelines adopted by the Trustees.

2. Services rendered by an assistant surgeon.

3. Anesthesia and the administration of anesthesia by a professional anesthetist or Nurse Anesthetist when the charge for such services is not included in the Hospital's charges.

4. Medical services rendered by a Physician during in-Hospital, office, and home visits, including newborn consultations for full-time Employees.

5. Chiropractic care, including acupuncture for pain relief. Benefits will be payable up to the maximum number of visits stated in the Schedule of Benefits.

6. Inpatient services rendered by a Licensed Psychologist or Licensed Consulting Psychologist that are within the scope of the Licensed Psychologist or Licensed Consulting Psychologist's license and ordered by a Physician.

7. Consultation, diagnosis, and treatment of any mental illness or nervous disorder rendered on an outpatient basis in a Mental Health Facility or Hospital or by a Physician, Licensed Psychologist, Licensed Consulting Psychologist, or clinical social worker certified by the Academy of Certified Social Workers ("ACSW"). Benefits for such services are payable the same as for any other disability.

8. Outpatient treatment of alcoholism, chemical dependency, and substance abuse provided in a Non-Residential Treatment Program. Benefits are payable the same as for any other disability.

D. Diagnostic x-ray and laboratory services, when performed by or under the supervision of a Physician, excluding any charges incurred for dental x-rays, unless rendered for treatment of a fractured jaw or Injury to natural teeth within three (3) months after the date of the accident.

E. Prescription Medication prescribed by a Physician for treatment of a non-occupational Injury or Illness. Prescriptions must be dispensed by a pharmacy, a Physician, or the pharmacy of a Hospital. Each time a Prescription Order is filled, it will be limited to a ninety (90) day supply.

An Eligible Person may elect to purchase Prescription Medications through the Preferred Provider Prescription Drug Program as specified in Section 3.1.

Prescription Medication services do not include the following:

1. Supplies or appliances that are not Prescription Medication, even if obtained with a Prescription Order, such as devices, bandages, heat lamps, braces, splints, artificial appliances, diaphragms, and syringes for use with insulin;

2. Drugs and medications that can be obtained without a Prescription Order, except insulin and smoking cessation medications obtained through the Preferred Provider's Smoking Cessation Program (and OTC Prilosec and Loratadine upon a Physician's written prescription through the Preferred Provider Prescription Drug Program);

3. Cost of administering a Prescription Medication;

4. Cost of Prescription Medications for use while the Eligible Person is confined in a Hospital;

5. Any Prescription Medication that is not approved for sale by the United States Government;

6. PCSK9 drugs and drugs containing bulk powders;

7. Cosmetic drugs;

8. Health and beauty aids, cosmetics, and dietary supplements;

9. State-restricted drugs;

10. Impotence medications; and

11. Injections and injectables, except insulin when prescribed by a Physician and prescriptions obtained through the Preferred Provider's Specialty Drug Program.

F. Hospice care for terminally ill Eligible Persons who otherwise, upon the recommendation of their Physician, would be required to be Hospital-confined. Benefits are payable for home care administered under an approved Hospice Program or Home Health Care Agency at the patient's home, for care in a hospice unit of a Hospital, or for care in a separate hospice facility.

The following hospice care services are covered during the period the Eligible Person otherwise would have to be Hospital-confined:

1. Physicians' visits;

2. Care provided by an R.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.

G. Genetic testing and counseling, provided services are rendered for one (1) or more of the following reasons:

1. The Eligible Employee and/or the Employee's Dependents suffer from a disease that is known to have a genetic cause;

2. A strong family history of a disease that is known to have a genetic cause is present even though neither the Eligible Employee, nor the Employee's Spouse has the disease. A strong family history means at least one (1) first-degree relative or at least two (2) second-degree relatives of the Employee or Spouse has been diagnosed with a disease that is known to have a genetic cause;

3. The Eligible Employee and/or Spouse has produced a Child with mental retardation, a disease known to have a genetic cause, or a birth defect; or

4. The Eligible Employee and/or a Spouse has had two (2) or more miscarriages or babies who died in infancy.

Genetic testing, except for amniocentesis and genetic testing that qualifies as Preventive Care, is subject to the separate annual maximum stated in the Schedule of Benefits.

H. Other covered expenses for:

1. Maternity and obstetrical services performed by a Nurse Midwife.

2. Local ground and air ambulance services to the nearest Hospital equipped to furnish the Medically Necessary treatment in a medical emergency, not for family convenience.

3. Blood and blood plasma.

4. Health Services provided for the treatment of a full-time Employee's emotionally handicapped Dependent Children and furnished by a Residential Treatment Facility (included in the inpatient maximum stated in the Schedule of Benefits).

5. Outpatient surgery performed in the outpatient department of a Hospital.

6. Outpatient pre-admission tests and exams provided that:

   (a) The surgery for which the tests or exams are furnished is performed within seventy-two (72) hours of the date on which they were given; and

   (b) The Eligible Person is confined as an inpatient in the Hospital immediately following the surgery.

7. Emergency room treatment for accidental Injury or acute medical emergency. Diagnoses that generally would not qualify as acute medical emergencies include:

   (a) Scheduled diagnostic procedures;

   (b) Follow-up visits for further injections, such as antibiotics;

   (c) Suture removal; and

   (d) Urgent but not life-threatening conditions that are normally treated in a Physician's office, such as, but not limited to, ear ache, sore throat, upper respiratory infections, flu syndrome, and migraine headaches.

8. Services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for private duty nursing, other than a nurse who ordinarily resides in the Eligible Employee's home or is a member of the Employee's immediate family.

9. Artificial limbs or eyes to replace natural limbs or eyes, provided that replacement occurs promptly following the loss and in no event longer than twelve (12) months from the date of the loss, and repair or replacement of artificial limbs or eyes when Medically Necessary.

10. Casts, splints, trusses, braces, crutches, surgical dressings, and prosthetic appliances used only for medical treatment.

11. Rental of Hospital-type bed, wheelchair, iron lung, or other durable medical equipment. (The purchase of such device is covered if the rental would exceed the purchase price. However, the Fund Office must approve the purchase of any durable medical equipment.)

12. X-ray, radium, or cobalt treatment, including the services of a radiologist and the rental, but not the purchase, of such radioactive materials.

13. Outpatient radiation and chemotherapy treatment services.

14. Oxygen and the rental of equipment for its administration. (The purchase of such equipment is covered if the rental would exceed

the purchase price. However, the Fund Office must approve such purchase.)

15. Physical therapy provided by a physical therapist and occupational therapy provided by an occupational therapist who is someone other than a person who ordinarily resides in the Eligible Employee's home or is a member of the Employee's immediate family.

16. Speech therapy provided by a licensed speech therapist under the supervision of a Physician when Medically Necessary for a condition resulting from an Injury, Illness, or congenital disorder such as a cleft lip or palate. However, benefits are not payable for speech therapy for a condition resulting from developmental or learning disabilities or a personality disorder.

17. Hearing aid appliances prescribed by a Physician, up to the maximum stated in the Schedule of Benefits per ear per benefit period. Coverage is provided for one (1) hearing aid per ear with replacement every three (3) years. This replacement provision affects any hearing aid appliance received by an Eligible Person prior to the Employee's effective date of coverage under the Plan. The benefit period begins on the date the hearing aid is received. Covered charges will include repair and servicing of the hearing aid. Batteries for a hearing aid are not covered.

18. Breast prostheses following a mastectomy.

19. Wigs and toupees when hair loss is the result of a disease or medical treatment up to the lifetime maximum stated in the Schedule of Benefits.

20. Diabetic, cardiac, and obesity self-management education programs, provided the program is Medically Necessary and prescribed by a Physician.

21. Routine colonoscopy.

22. Special medical foods or oral nutrition therapy (for which there is no over-the-counter alterative), prescribed for the treatment of inborn errors of the metabolism resulting in disorders that cause the excessive accumulation of an amino acid. Such disorders include phenylketonuria (PKU), citrullinemia, cystinosis, homocystinuria, methylmalonic academia, maple syrup urine disease (MSUD), histidinemia, and tyrosinemia.

23. Physician-prescribed custom-molded inserts and orthotics: one (1) pair only, until worn out and another pair is prescribed by a Physician.

24. Mastectomy bras, up to two (2) per Eligible Person per Calendar Year.

25. Jobst stockings, up to two (2) pair per Eligible Person per Calendar Year.

26. Discounted charges for walk-in clinics in retail settings.

5.1.3. Preventive Care and Other Routine Care

The deductible is waived for covered expenses related to the routine services described below. The Plan pays one hundred percent (100%) of the Usual and Customary Charges for products and services that meet the definition of Preventive Care. There is no cost-sharing for Preventive Care.

A. Routine physical examinations including charges for an examination, x-rays, and laboratory tests performed by a Physician or surgeon in a Hospital, clinic, or Physician's office. Covered expenses include:

1. For Eligible Dependents of an Eligible Employee, only routine office visits for the ongoing care of a well-baby and routine well child care, including professional services or supplies related to routine immunizations of Dependent Children. With respect to childhood immunizations, the Plan will cover those recommended by the American Academy of Pediatrics and those that satisfy the definition of Preventive Care.

2. Examinations required by third parties, including, but not necessarily limited to, schools, employers, insurance companies, camps, and adoption agencies.

3. Examinations for the purpose of contraceptive management, including a pelvic examination and pap-smear.

Benefits are not payable under this Routine Physical Examination Benefit for:

1. Routine immunizations or vaccinations, except as specifically stated;

2. Eye or dental examinations; or

3. Routine colonoscopy unless the colonoscopy is Preventive Care.

B. Routine immunizations. With respect to childhood immunizations, the Plan will cover those recommended by the American Academy of Pediatrics, including but not limited to, those to prevent diphtheria, pertussis, tetanus, polio, measles, mumps, and rubella, and those that satisfy the definition of Preventive Care.

With respect to adult immunizations, the Plan will cover those that satisfy the definition of Preventive Care.

Benefits are not provided for:

1. 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;

2. Treatment related to allergy;

3. Medications not normally prescribed or administered by a Physician or paramedical personnel, such as vitamins; or

4. Immunizations strictly for travel.

5.1.4. Comprehensive Major Medical Benefits Limitations

In addition to the General Exclusions in Section 6, Comprehensive Major Medical Benefits do not cover any charges caused by, incurred for, or resulting from:

A. Services performed on or to the teeth, nerves of the teeth, gingiva or alveolar processes, except:

   1. To tumors or cysts; or

   2. As required because of Injury to sound natural teeth, provided such services are performed promptly following the accidental Injury and in no event longer than twelve (12) months from the date of such Injury.

B. Cosmetic surgery, except:

   1. To repair a defect caused by an accidental Injury;

   2. To repair a congenital anomaly of a full-time Employee's Eligible Dependent Child under twenty-six (26) years of age; or

   3. For breast reconstruction due to a documented need for a prophylactic mastectomy as specified in Section 5.1.2.C.1.

C. Reconstructive surgery, except:

   1. To correct a functional physical defect resulting from a congenital anomaly of a full-time Employee's Eligible Dependent Child;

   2. To correct a functional physical defect that is incidental to, or follows surgery resulting from, Illness of the involved body part; or

   3. As specified in Section 5.1.2.C.1.

D. Recreational or educational therapy, and all forms of non-medical self-care or self-help, except as specifically stated.

E. Application of orthotic appliances and other non-surgical treatment of temporomandibular joint (TMJ) syndrome or any other cranial facial or cervical pain syndrome.

F. Eye refractions, eyeglasses, or the fitting of eyeglasses. (See Section 5.2 for Vision Care Benefits.)

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

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

I. All expenses associated with personal blood storage.

J. Health club memberships.

K. Services of a massage therapist.

L. Charges in excess of Usual and Customary Charges for the service.

5.2. VISION CARE BENEFITS

Vision Care Benefits are payable for full-time Eligible Employees and their Eligible Dependents and part-time Eligible Employees (and any Dependent Children, if applicable), subject to the conditions of this Section, provided such services are rendered or supplies are furnished by an Optician, Optometrist, or Ophthalmologist, and the expenses for services and supplies are incurred while the Eligible Person is covered under the Plan.

5.2.1. Payment of Benefits

Benefits will be payable for the below up to the maximum amounts stated in the Schedule of Benefits. These maximums and limitations in the Schedule of Benefits do not apply to eye examinations for Eligible Dependent Children under nineteen (19) years of age.

A. Eye Examinations. Each Eligible Person will be entitled to one (1) complete eye examination each Calendar Year. A complete eye examination includes, but is not necessarily limited to, the following:

1. Complete case history;

2. Measuring and recording visual acuity, corrected and uncorrected;

3. Examination of fundus, media, crystalline lens, optic disc, and pupil reflex for pathology, anomalies, or Injury;

4. Corneal curvature measurements;

5. Retinoscopy;

6. Fusion determination, distance and near;

7. Subjective determination, distance and near;

8. Stereopsis determination, distance and near;

9. Color discrimination;

10. Amplitude or accommodation;

11. Analysis of findings;

12. Determining of prescription, if needed; and

13. Measuring and recording visual acuity, distance and near, with new prescription, if required.

B. Lenses and Frames. Each Eligible Person will be entitled to one (1) set of lenses and one (1) set of frames each Calendar Year if warranted by prescription. Fees for professional services for fitting and adjusting are also covered, including but not limited to, the following:

1. Professional advice on frame selection;

2. Facial measurements and preparation of specifications for optical laboratory;

3. Verifying and fitting of prescription glasses;

4. Reevaluation and progress report two (2) to four (4) weeks after fitting of new prescription; and

5. Subsequent servicing.

C. Contact Lenses. In lieu of conventional lenses and frames, an Eligible Person will be entitled to one (1) set of contact lenses each Calendar Year

(or disposable contacts up to the contact lenses maximum), including professional fees and materials.

5.2.2. Limitations

In addition to the General Exclusions in Section 6, Vision Care Benefits do not cover any expenses caused by, incurred for, or resulting from:

A. Any medical or surgical treatment of the eye;

B. Sunglasses, plain or prescription, or safety lenses or goggles;

C. Orthoptics, vision training, or aniseikonia;

D. Services or supplies that are payable or furnished by any other group policy or prepayment plan (excluding individual policies);

E. Contact lens care kit and asceptors (heating units); and

F. Insurance contracts for contacts, lenses, and frames.

5.3. DENTAL CARE BENEFITS

Dental Care Benefits are payable for full-time Eligible Employees and their Eligible Dependents and part-time Eligible Employees (and their Dependent Children, if applicable). Dental Care Benefits are payable subject to a preferred provider arrangement selected by the Trustees, currently the Delta Dental Network.

5.3.1. Selecting a Dentist

You have the choice of receiving care from a Dentist participating in the Delta Dental Network (a "Network Dentist") or a Dentist that does not participate in the Delta Dental Network (a "Non-Network Dentist"). Although you have the freedom to choose your Dentist, there are advantages to choosing a Dentist who participates in the Delta Dental Network. Network Dentists agree to provide Dental Care Benefits to Eligible Persons at a reduced rate. You will not be responsible for any fees in excess of the allowable charge, other than any amounts required to satisfy the deductible or coinsurance requirements stated in the Schedule of Benefits. Your Plan identification card will alert your Dentist that you are entitled to discounts through the Delta Dental Network.

You can find a Network Dentist by visiting www.deltadentalmn.org.

Eligible Persons may select any Dentist on a treatment-by-treatment basis, whether or not the Dentist is included in the Delta Dental Network.

IT IS IMPORTANT TO REMEMBER YOUR OUT-OF-POCKET COSTS MAY BE LOWER WHEN YOU SEE A NETWORK DENTIST.

5.3.2. Network Dentist

You are free to go to the Dentist of your choice. If your Dentist is in the Delta Dental Network, the Dentist has agreed to accept direct payment from the Plan on a usual, customary, and reasonable (UCR) fee basis. The Network Dentist will charge you only for coinsurance amounts, deductibles, and services not covered by the Plan. You will receive an Explanation of Benefits form indicating the amount the Plan has paid to the Network Dentist and the amount, if any, you owe the Dentist.

5.3.3. Non-Network Dentist

If your Dentist is not in the Delta Dental Network, payment will be calculated on a UCR fee basis. If the fee charged is not allowed in full, the Plan is not implying that the Dentist is overcharging. Dental fees vary based on the Dentist's overhead, skill, and experience. Therefore, not every Dentist will have fees that fall within the allowable UCR fee range.

For Dental Care Benefits provided by an out-of-state Dentist, the Plan will make payment directly to the Dentist. The difference between the Plan's payment and the out-of-state Dentist's full fee is your financial responsibility.

5.3.4. Filing Claims

Claims for Dental Care Benefits should be made according to the Plan's procedures provided in Section 7.

5.3.5. Predetermination of Benefits

After an examination, your Dentist will recommend a treatment plan. If the services involve crowns, fixed bridgework, dental implants, partial/complete dentures, or orthodontics, ask your Dentist to send the treatment plan to the Plan, including x-rays. The available Dental Care Benefits will be calculated and printed on a predetermination of benefits form, which will be returned to your Dentist.

Before you schedule dental appointments, you should discuss with your Dentist the amount to be paid by the Plan and your financial obligations for the proposed treatment. A predetermination of benefits is valid for ninety (90) days from the date of issue, provided you maintain your eligibility under the Plan.

5.3.6. Optional Treatment

In all cases in which an Eligible Person selects a more expensive service than is customarily provided, or for which the Plan does not believe a valid need is shown, the Plan will pay the applicable percentage of the fee for the service that is adequate to restore the tooth or dental arch to contour and function. The Eligible Person is responsible for the entire remainder of the Dentist's fee.

5.3.7. Description of Services

Dental Care Benefits are subject to the maximums stated in the Schedule of Benefits in Section 2.4, the limitations described within each coverage category, and the exclusions specified in Section 5.3.8.

A. Diagnostic and Preventive Services. The below diagnostic and preventive services are covered.

1. Examinations, no more frequently than two (2) in a twelve (12) month period. Coverage will be provided for two (2) additional oral examinations each twelve (12) month period, provided such services are medically necessary due to a systemic disorder. Such services will require predetermination.

2. Full mouth x-rays once each three (3) years.

3. Two (2) bitewing x-rays, no more frequently than twice in a twelve (12) month period.

4. Panagraphic x-rays once each three (3) years unless special need is indicated.

5. Dental prophylaxis (teeth cleaning), limited to two (2) in a twelve (12) month period. Coverage will be provided for two (2) additional prophylaxis each twelve (12) month period, provided such services are medically necessary due to a systemic disorder. Such services will require predetermination.

6. Topical fluoride treatments for Eligible Persons under age nineteen (19), limited to once in a twelve (12) month period. Coverage will be provided for two (2) additional prophylaxis each twelve (12) month period, provided such services are medically necessary due to a systemic disorder. Such services will require predetermination.

7. Oral hygiene instruction when prescribed by a Dentist but limited to once in a twelve (12) month period.

8. Sealants for Eligible Persons under age nineteen (19). No charges for dental fillings or reapplications of sealants will be payable within three (3) years after the initial sealant has been applied.

B. Restorative Services. The below restorative services are covered.

1. Emergency treatment for the relief of pain.

2. Space maintainers.

3. Restorations of amalgam, silicate, synthetic porcelain, acrylic, plastic, resin (white), or composite type filling material. Gold foil

restorations, inlays, or onlays will be covered when the tooth, because of extensive caries or fracture, cannot be restored with other types of filling material. All gold restorations, onlays, and porcelain restorations require predetermination.

4. Single crowns (not part of a bridge) of metal, plastic, porcelain, or gold. All single crowns require predetermination. Gold crowns can be used only when another material cannot restore the tooth.

5. Dental implants in lieu of crowns, but only up to the usual and customary charge for single crowns (i.e., not part of a bridge). All dental implants require predetermination.

6. Re-cementing of crowns and/or inlays (fillings) when necessary.

7. Repairs of the alveolar processes, excision of tumors, cysts, neoplasm or bone tissue, surgical incision for removal of foreign bodies, or drainage of abscess.

8. Endodontic services to include the pulpal therapy and root canal therapy.

9. Routine oral surgery for tooth removal.

10. General anesthesia for covered oral surgical procedures performed in a dental office.

11. Periodontics, surgical, and adjunctive services. Except for periodontal scaling, these services all require predetermination.

12. Tests and laboratory examinations when necessary.

C. Prosthetic Services. The below prosthetic services are covered.

1. Complete or partial denture. Replacement of existing complete or partial dentures will be covered only if the denture is five (5) years old or more and cannot be made serviceable. Such services require predetermination.

2. Denture refining and rebasing. For the purpose of this Plan, rebasing is considered a new denture and the same limitations described in the preceding Paragraph (1) apply.

3. Denture adjustments when necessary.

4. Bridges, bridge abutment crowns, bridge pontics, and retainers. Replacement of such appliances will be covered only if the current prosthetic appliance is five (5) years old or more and cannot be made serviceable. All of these procedures require predetermination.

5. Repairs to crowns, bridges, and dentures.

6. Temporomandibular joint (TMJ) stress-breakers when necessary. Requires predetermination.

D. Orthodontic Services. The below orthodontic services are covered for Children ages eight (8) through eighteen (18) who are Dependents of Eligible Employees.

1. Orthodontic appliances and treatment related services for orthodontic purposes, including examinations, x-rays, extractions, photographs, study models, etc.

2. Orthodontic treatment in progress. Liability for orthodontic treatment in progress extends only to the unearned portion of the treatment in progress. The Plan will be the sole determinant of the unearned amount eligible for coverage.

Repair or replacement of orthodontic appliances is not covered.

If orthodontic treatment is stopped for any reason before it is complete, the Plan will pay only for services and supplies actually received. There are no benefits available for charges made after coverage stops.

The Plan calculates all orthodontic treatment schedules according to the following formula: 25% of the total case fee is considered the initial payment to be paid by the Plan and the patient at the stated coinsurance percentage. The remainder of the allowed fee is divided by the months of treatment. Monthly payments are made by the Plan at the stated copayment percentage, up to the orthodontic maximum benefit.

5.3.8. Exclusions

Coverage is NOT provided under the Plan for:

A. Dental services provided primarily for cosmetic purposes, except following an accidental Injury, provided the services are performed promptly following the accidental Injury and in no event longer than twelve (12) months from the date of the Injury.

B. Charges for failure to keep a scheduled visit with a Dentist.

C. Charges for the completion of any insurance forms.

D. Prescription drugs.

E. Services or supplies that do not meet accepted standards of dental practice including charges for services and supplies that are experimental in nature.

F. Upgrading of serviceable dentistry.

G. Services performed before the effective date of the Eligible Person's coverage under this Plan.

H. Charges for dental services performed after the termination of the Eligible Person's coverage under this Plan, except for services performed within thirty (30) days after such termination, that are needed to complete a single procedure commencing on or before the termination date.

I. Charges for dental treatment in excess of the usual and customary charge or in excess of the maximum benefit payable as indicated in the Schedule of Benefits.

J. Charges for any dental procedures performed solely because the Eligible Person has changed Dentists.

K. Composite resin or acrylic restorations in occlusal and proximal surfaces of posterior teeth. An allowance will be made for amalgam restorations for those areas.

L. Crowns and dental implants when used as abutments for prosthetics.

M. Orthodontic services other than for eligible Dependent Children.

N. Restorations for identification purposes.

O. Repair or replacement of a retainer, even if lost or stolen.

5.4. WEEKLY DISABILITY INCOME BENEFITS

Only full-time Eligible Employees are eligible for Weekly Disability Income Benefits, which are subject to the conditions of this Section.

5.4.1. Payment of Benefit

The Weekly Disability Income rate is stated in the Schedule of Benefits. The Weekly Disability Income Benefit is payable when a full-time Eligible Employee who is covered under the Plan becomes Totally Disabled because of a non-occupational Injury or Illness that prevents the Employee from working. The Totally Disabled Employee must be under the care of a Physician to receive the benefit. The Schedule of Benefits states how the benefit is calculated, the maximum weekly amount, and the maximum number of weeks the benefit is payable for any one (1) period of disability.

Weekly Disability Income Benefits begin with:

A. The first (1^{st}) day of disability due to an Injury; or

B. The eighth (8^{th}) day of disability due to an Illness.

5.4.2. Successive Periods of Disability

Successive periods of disability separated by less than fourteen (14) days of continuous active employment will be considered one (1) period of disability unless they are due to separate and unrelated causes, in which case, the periods of disability will be deemed separate if the Employee returns to active work for at least one (1) day.

5.4.3. Maximum Payment Amount

Once the maximum benefit has been paid and the Eligible Employee has returned to work, the Employee will not be eligible for any further Weekly Disability Income Benefits until twelve (12) months from the date the Employee was paid the maximum benefit.

5.4.4. Limitations

Weekly Disability Income Benefits are not payable when the:

A. Eligible Employee is not under the care of a Physician;

B. Disability is due to a self-inflicted Injury, except when caused by or resulting from a physical or mental condition of the Eligible Employee;

C. Injury or illness arises out of, and in the course of, any occupation or employment for wage or profit; or

D. Eligible Employee has applied for pension benefits.

NOTE: Weekly Disability Income Benefits cannot be continued through self-payments. However, an Employee may continue to self-pay for all other coverage while collecting Weekly Disability Income Benefits.

5.5. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Accidental Death and Dismemberment Benefits are available for part-time Eligible Employees only and are insured through Fidelity Security Life Insurance Company. In cases of conflict between this Summary Plan Description and the group policy, the group policy will govern.

5.5.1. Determination of Benefit Amount

If you suffer bodily injury caused by accidental means while you are a part-time Eligible Employee and the injury causes your death or any of the following specified losses within ninety (90) days of the date of the accident, the following benefits are payable based on the principal sum stated in the Schedule of Benefits:

A. The principal sum for loss of life;

B. The principal sum for loss of two (2) limbs, sight of both eyes, or one limb and sight of one eye;

C. One-half of the principal sum for loss of one hand by severance at or above the wrist, loss of one foot by severance at or above the ankle, or irrecoverable loss of the entire sight of one eye; or

D. One-quarter of the principal sum for loss of thumb and index finger of either hand.

If you suffer more than one (1) loss in an accident, payment will be made only for the loss for which the larger amount is payable. The Trustees may, at their own expense, require a physical examination while considering your claim or, if you die, an autopsy where law permits.

5.5.2. Limitations

Accidental Death and Dismemberment Benefits do not cover losses from:

A. Intentionally self-inflicted injury or suicide, except when caused by or resulting from a physical or mental condition of the Eligible Employee;

B. Insurrection, war, or any act of war;

C. Participation in a riot;

D. Commission of an assault or felony;

E. Disease of the body, mental infirmity, bacterial infection (unless the infection is a result of accidental injury), or the taking of poison.

5.6. LIFE INSURANCE BENEFITS

Life Insurance Benefits are available for full-time Eligible Employees and their Dependents and part-time Eligible Employees (and their Dependent Children, if applicable) and are insured through Fidelity Security Life Insurance Company. In cases of conflict between this Summary Plan Description and the group policy, the group policy will govern.

If you die from any cause, on or off the job, your Beneficiary will be paid the amount of insurance stated in the Schedule of Benefits. The benefit will be paid in full according to the terms of the policy upon receipt of your claim form, death certificate, and any other required supporting documentation.

Your Beneficiary designation and any change in Beneficiary must be filed in writing with the Fund Office 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. Your Beneficiary designation will be made available to you upon request at the Fund Office.

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, from the Life Insurance Benefit. A satisfactory receipt will be proof of expense. The balance of the Life Insurance Benefit will be paid to your Beneficiary.

5.6.1. Designation of Beneficiary

If you do not designate a Beneficiary or if your Beneficiary does not outlive you, the life insurance amount will be paid in a single sum to the first of the following classes that survives you:

A. Spouse;

B. Children;

C. Parents;

D. Brothers and sisters; or

E. Executors or administrators of your estate.

5.6.2. Coverage During Total Disability

If you become Totally Disabled before age sixty (60) and remain disabled, your Life Insurance Benefits may be continued with no additional cost to you as long as the disability continues. You must provide the Fund Office with written proof of your Total Disability within one (1) year of the date the disability begins, or as soon as reasonably possible. After the first two (2) years of disability, written proof of disability may be requested annually by Physicians chosen by Fidelity Security Life Insurance Company. Fidelity Security Life will pay for all such exams. Contact the Fund Office for details and appropriate forms to apply for waiver of premiums.

If you die within one (1) year after the date of termination of your insurance under the group life policy, but before written proof of your Total Disability has been received, then written proof that your Total Disability continued uninterrupted until the date of your death must be furnished within one year after your death occurs.

If an individual policy of life insurance has become effective for a Totally Disabled person according to the provisions of the conversion privilege set forth in the group life policy, the Total Disability benefits will apply to that person only if the individual policy is surrendered to the Company without claim thereunder other than for return of the premiums paid, less any indebtedness.

All rights under the Total Disability provisions listed in the group life policy will automatically and immediately cease on the earliest of the following dates:

A. The date your Total Disability no longer exists;

B. The date you fail to submit to the required medical examination; or

C. The date you fail to submit any required proof of the uninterrupted existence of your Total Disability.

If a death benefit is paid under the Total Disability section of the group policy, it will be in lieu of all other life insurance benefits provided by the group life insurance.

5.6.3. Employee Continuance of Life Insurance

If 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 Dependents for as long as eighteen (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, you must send the Fund Office 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 sixty (60) days of written notification from the Fund Office of your right to continue, including the premium amount and due date.

Continued life insurance ends on the earliest of:

A. The day insurance has been continued for eighteen (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.

See the following section regarding conversion privilege when continued life insurance ends.

5.6.4. Conversion Privilege

If your life insurance terminates as a result of termination of employment, transfer to a class of employees not eligible under the policy, or your disability, you may convert your insurance (and insurance on your Spouse and Children if you are a full-time Employee) to any form of individual policy of life insurance (without double indemnity or disability riders) then customarily issued by Fidelity Security Life, except a policy of term insurance.

If the Master Policy terminates or is amended so as to terminate your insurance, and you have been insured under the policy for at least five (5) years, you may convert your insurance (and your Dependents' insurance if you are a full-time Employee) for an amount not in excess of the smaller of:

A. $5,000 for Employees and $2,000 for Dependents; or

B. The amount of your terminated insurance, less any amount of life insurance for which you may be eligible under any other group policy that replaces it within thirty-one (31) days.

You have thirty-one (31) days to make application for conversion and pay the required premium following termination of your insurance. If you should die during this thirty-one (31)-day period, the amount of insurance that you would have had under the conversion

privilege will be paid to your Beneficiary. The premium will be set according to your age and class of risk. No evidence of insurability is required.

If your life insurance is paid under the group policy, payment will not be made under the converted policy and premiums paid for the converted policy will be refunded.

5.6.5. Life Insurance Benefits for Dependents of Full-Time Employees Only

If, while covered as a full-time Eligible Employee, one of your Eligible Dependents dies, Life Insurance Benefits, as stated in the Schedule of Benefits, will be payable to you as the Beneficiary. If you do not survive the insured Dependent, payment will be made to your Spouse, if living, or otherwise to your estate.

A Dependent's life insurance will terminate on the first of the following events to occur:

A. Termination of your insurance;

B. Modification of the policy to terminate Dependents' insurance;

C. As to any particular Dependent, termination of the status of eligible Dependent;

D. The date the group policy terminates;

E. The date the Dependent enters the armed forces (does not apply to temporary duty of thirty (30) days or less); or

F. The end of the period for which the premium has been paid by you or your Dependent.

If a Dependent's life insurance terminates by reason of termination of your insurance under this policy, such Dependent may use the conversion privilege previously described.

If the age of a Dependent Child is misstated and if, had the age not been misstated, the insurance on the life of such Dependent Child would have been terminated, the insurance on the life of such Dependent Child will be continued only until the end of the period for which premium has been paid.

If the age of a Spouse is misstated, there will be no adjustment in either premium or amount of insurance because the age of the Spouse has no effect on premium or amount of insurance.

5.7. EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (“EAP”) and Work/Life Program provided by T.E.A.M. provide confidential assessment, short term counseling, and referral services for all Eligible Persons to help resolve personal problems that may affect life at work and at home. Skilled counselors are available to talk with an Eligible Person about personal issues in confidence.

The EAP can help with a variety of situations, such as:

A. Stress;

B. Relationship or family problems;

C. Grief;

D. Workplace concerns; or

E. Alcohol or substance abuse.

Sessions are focused on problem resolution and/or appropriate referral to community resources, support groups, or professional counselling services. In addition, T.E.A.M. also provides specialty work-life services, such as child care and elder care referrals and legal and financial resources.

5.8. DOCTOR ON DEMAND

The Plan covers telemedicine services provided through Doctor on Demand at no cost to you. Doctor on Demand is a healthcare service that provides access to physicians, psychologists, and psychiatrists from any device with a front-facing camera (e.g., smartphone, tablet, or computer). Doctor on Demand is intended to complement existing care, not replace it. For emergency and chronic conditions, you should still visit your primary care provider or hospital.

Your Doctor on Demand appointment will be scheduled with a physician or psychologist who is part of the Doctor on Demand network and who is appropriately licensed and credentialed for the state you are in at the time of your visit. Doctor on Demand can treat most common non-emergency medical and mental health issues through live, face-to-face visits and may be used to treat both adults and children. Common medical issues treated include cold and flu, allergies, skin and eye issues, sore throat, pediatric issues, prescription refills, sports injuries, and UTI and yeast infections. Common mental health issues treated include stress, anxiety, relationship issues, depression, and addictions. Doctor on Demand physicians are able to prescribe a wide range of drugs; however, Doctor on Demand providers do not prescribe narcotics or pain medications that have been designated as controlled substances.

For more information about Doctor on Demand, contact the Plan Administrator or visit www.DoctorOnDemand.com.

SECTION 6 GENERAL EXCLUSIONS AND LIMITATIONS

The Plan will not cover services, supplies, or treatment for:

A. Accidental bodily Injury, Illness, disease, mental or nervous disorder:

1. That is covered under any worker's compensation law or similar law;

2. For which coverage was required to have been provided under any worker's compensation law or similar law even if it was not actually provided;

3. For which coverage could have been elected under any worker's compensation law or similar law even if it was not actually elected by the person who could have done so (even if that person was not the covered individual); or

4. That was otherwise sustained while the individual was performing any act of employment or doing anything pertaining to any occupation or employment for remuneration or profit.

B. Accidental bodily Injury, Illness, disease, mental or nervous disorder that arises out of, and in the course of, any occupation or employment for wage or profit or that 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 Employee signs a subrogation agreement with the Plan.

C. Any loss or services to treat Injuries or Illnesses incurred in, or aggravated during, performance of service in the uniformed services.

D. Charges incurred for care for service-connected disabilities furnished within any facility of, or provided by, the United States Veterans Administration or Department of Defense.

E. Charges incurred for non-service-connected conditions furnished within any facility of, or provided by, the United States Veterans Administration or Department of Defense if the required details and supporting papers have not been furnished to the Fund Office.

F. Experimental or Investigative medical or surgical procedures or treatments, except as may be specifically provided under the Plan or as may be authorized by the Board of Trustees pursuant to advice provided by a competent medical authority retained by the Trustees as medical consultant.

G. Any services or supplies that are not Medically Necessary, as determined by a Physician.

H. Services required while incarcerated in a federal, state, or local penal institution or while in custody of federal, state, or local law enforcement authorities.

I. Surrogate maternity services.

J. Services for which the Eligible Person is not required to pay.

K. Transportation, except local emergency ambulance services.

L. Abortions.

M. Reversal or attempted reversal of a previous sterilization procedure.

N. Any services and supplies for, or related to, artificial insemination, invitro-fertilization services, or other treatment in an attempt to achieve pregnancy.

O. Services to the clergy during normal duty when a charge usually would not be made.

P. All treatment for, and related to, sex transformations.

Q. Any diagnostic Hospital admission that can be performed on an outpatient basis.

R. The first $20,000 of charges incurred as a result of any automobile accident if:

1. The Eligible Person fails to maintain the statutory minimum level of no-fault automobile medical insurance protection, provided that the Eligible Person is required by applicable state law to maintain the protection;

2. There is applicable no-fault coverage but the Eligible Person has failed to apply for coverage;

3. A no-fault insurer has determined charges not to be Medically Necessary or Usual and Customary; or

4. In states without a no-fault statute, the Eligible Person does not first exhaust medical payment coverage on the vehicle(s) involved in the accident.

In cases where a no-fault carrier disputes coverage of the Eligible Person, the Plan may subrogate its interest in the payment of charges.

S. Costs associated with the removal of organs from a transplant donor who is a living Eligible Person or who was an Eligible Person prior to his or her death.

T. Services privately contracted with a provider that otherwise would be covered by Medicare that are incurred by an Eligible Person for whom Medicare is the primary source of coverage.

U. Charges incurred for obtaining additional medical records.

V. Claims submitted later that fifteen (15) months from the date incurred.

W. Medical Expenses a third party (such as the driver of a car that caused an accident for which medical expenses were incurred) was responsible for paying if the Eligible Employee or Dependent, whether or not a minor, did not comply with the subrogation provisions of this Plan stated in Section 8.7.

X. Charges incurred for any special education rendered to any Eligible Person, regardless of the type of education, except for education that qualifies as Preventive Care or as otherwise specifically stated.

Y. Charges for telephone conversations and/or telephone consultations, unless covered through Doctor on Demand.

Z. Charges for special home construction to accommodate a disabled Eligible Person.

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

BB. Any losses incurred by an Eligible Person at a time the Eligible Person owes payment to the Plan because of benefit payments made in reliance upon incorrect, misleading, or fraudulent statements or representations by the Eligible Person, or where such person has failed to honor the Plan's right of subrogation or reimbursement or otherwise failed to cooperate with the Plan as specified.

CC. Radial keratotomy or Lasik surgery.

DD. State and local taxes (other than those mandated by law that the Plan must pay, such as MinnesotaCare tax) or shipping and handling charges incurred on covered expenses.

EE. Drugs or medicines prescribed by a Physician that are available as over-the-counter (OTC) purchases, including but not limited to, cough medicine, vitamin supplements, etc. (except as specifically provided through the Preferred Provider Pharmacy Program for OTC Prilosec and Loratadine), unless the prescription qualifies as Preventive Care.

FF. Charges incurred for travel, whether or not recommended by a Physician, except if specified as a covered expense under the Plan.

GG. Charges incurred for gambling addiction in a residential treatment program.

HH. Any loss caused by, or resulting from, mental deficiency, mental retardation, developmental deficiencies, genetics, or any treatment for learning disabilities, except as otherwise specifically stated.

II. Any loss, expense, or charge for which:

1. A third party may be liable; and

2. Either:

   a. 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); or

   b. The Plan deems 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. As used in this Section, the term "third party" 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 under-insured motorist coverages.

JJ. Any loss, expense, or charge incurred as the result of any Injury, occurrence, conditions or circumstance for which the injured 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 the loss, expense, or charge prior to resolution of the third party claim.

KK. Charges for Injury or Illness resulting from the Eligible Person's participation in a riot or the Eligible Person's commission of any act that may be charged as a felony or gross misdemeanor offense, except in circumstances involving domestic violence or when the commission of the gross misdemeanor or felony is caused by a mental health condition.

LL. Charges for any Injury or Illness that results from an incident occurring on any property where the lessee or lessor or owner of the property is responsible for Injury or Illness or what otherwise is covered under homeowner's insurance. However, the Plan will consider the charges if: no insurance or other form of compensation is available to the Eligible Person; and the Eligible Employee signs a subrogation agreement in the form designated by the Trustees with the Plan.

SECTION 7 CLAIMS, REVIEW, AND APPEAL PROCEDURES

7.1. CLAIMS PROCEDURE

The following procedures have been established by the Trustees for processing claims. For claims involving Plan benefits that are insured, the terms of the insurance policy will govern in the event of a conflict.

7.1.1. Notice of Claim

A. Pre-Service Claims. An Eligible Person must obtain:

1. Prior authorization for prophylactic mastectomies;

2. Certification of Medical Necessity for chiropractic visits exceeding twenty (20) per Eligible Person per Calendar Year;

3. Prior approval for the purchase of certain durable medical equipment specified in Subsection 5.1.2.H.11; and

4. Predetermination for certain dental services as specified in Section 5.3.

The claims listed above are called "pre-service claims," which are claims that require approval of the benefit in advance of obtaining medical care. Claims requiring prior authorization must be submitted in writing to the Fund Office.

There are special provisions in the Claims Procedure Regulations for "urgent care claims" (referred to under the Plan as "emergencies"), but, by definition, these provisions do not apply because the Plan does not require prior authorization of emergency admissions.

B. Post-Service Claims. Any Claim for benefits that is not a pre-service claim is considered a "post-service claim." An Eligible Person must submit all post-service claims in writing within ninety (90) days of the occurrence of the accident or Illness or as soon as reasonably possible. In no event (except in the absence of legal capacity) can a claim be submitted later than fifteen (15) months from the date of service.

7.1.2. Filing Claims for Benefits

If an Eligible Person uses a Preferred Provider and presents his or her medical card, the Preferred Provider will automatically file the claim. Eligible Persons must submit all other post-service claims in writing to the Fund Office (c/o Wilson-McShane Corporation, 3001 Metro Drive, Suite 500, Bloomington, Minnesota 55425) on forms provided by the Trustees unless otherwise authorized by administrative rule. All applicable questions and information requested on the form must be answered and provided by the Eligible Person or other provider of service. Claims should be complete. At minimum, they should contain:

A. Plan name (Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund);

B. Employee's name and Social Security number;

C. Full name (including "Jr.," if applicable) and the 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, including ICD-10 codes;

G. Procedure or nature of the treatment, including CPT or HCPCS codes;

H. Date of, and place where, the procedure or treatment was 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 reasonable understandable format and is in compliance with all applicable law.

In order for Weekly Disability Income Benefits to be processed, the Physician must complete the "Attending Physician's Statement", and the Employer must complete the "Employer's Statement."

In order for prescription medication claims to be processed (other than prescriptions filled through the Preferred Provider Prescription Drug Program), the Eligible Person needs a receipt form the pharmacist that contains the following information: patient's name; date the prescription was filled; prescription number; name of drug dispensed; amount of dosage/supply; name and address of the pharmacy; and cost of the prescription drug. Cash register receipts are not acceptable.

Claims will not be deemed submitted unless and until they are received at the correct address. A general request for an interpretation of Plan provisions will not be considered a claim for benefits. Pre-determined amounts an Eligible Person must pay, such as prescription drug coinsurance or copayment, will not be considered a claim for benefits subject to the claims procedures. However, if an Eligible Person feels he or she has been

charged an improper dollar copayment or percentage coinsurance (for example through the Preferred Provider Prescription Drug Program), he or she may submit a formal appeal to have his or her claim reviewed according to the claims review and appeal procedure. The appeal must be submitted to the Fund Office in writing within one hundred eighty (180) days of being charged the coinsurance or copayment.

7.1.3. Determination of Eligibility

On receipt of the completed claim form, the Fund Office will determine, based upon Trust Plan records, whether the claimant was eligible for benefits at the time the charges were incurred. The Fund Office also will assist Eligible Persons in obtaining benefits to which they are entitled.

7.1.4. Determination of and Amount of Benefits Payable

The determination of benefits payable will be based upon the claimant's eligibility and the provisions of the Plan. The amount of benefits payable will be based on the Schedule of Benefits in effect for the applicable class of Eligible Person when the covered charges were incurred.

The determination of the type of benefits payable, if any, and the amount of benefits payable will be the function and responsibility of the claims agent named by the Trustees.

7.1.5. Distribution of Benefits Payments

Generally, benefits the Fund Office determines are payable are automatically paid directly to the provider of service if: (i) the charges were incurred with PPO Providers or Non-PPO Providers outside the geographic area of the Blue Cross Blue Shield of Minnesota Aware Network; and (ii) the Fund Office accepts a request to pay the claims directly to the Providers. The Eligible Person will be sent a copy of the processed claim payment for the Eligible Person's records. If the Fund Office does not accept a request to pay the providers directly, or the charges were incurred with Non-PPO Providers within the geographic area of the Blue Cross Blue Shield of Minnesota Aware Network, benefits will be paid directly to the Eligible Person upon proper submission of the claim and proof of payment.

Although the Plan may make payments directly to providers, such payments do not make a provider an assignee for any purposes or otherwise confer on the provider any rights under the Plan or ERISA. Any attempt to assign any rights, claims or causes of action to any person or entity will be null and void absent written consent by the Plan.

7.2. CLAIMS REVIEW PROCEDURE

When a claim for benefits is submitted to the Fund Office, the Fund Office will determine eligibility and calculate the amount of benefit payable, if any.

If the claimant feels that the action taken on his eligibility or claim is incorrect, the claimant immediately must ask the Fund Office to review the claim with him. In some cases, the Fund Office may request additional information that might enable the Fund Office to reevaluate its decision.

7.2.1. Pre-Service Claims

The Plan will notify an Eligible Person whether or not a claim is approved within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after the Plan's receipt of the claim. If an Eligible Person fails to follow the Plan's procedures for filing a claim, the Eligible Person will be notified of the failure and the proper procedures as soon as possible, but no later than five (5) days following the failure. The Plan will notify the Eligible Person verbally, unless the Eligible Person requests that the Plan notify him in writing.

7.2.2. Post-Service Claims

The Plan will notify an Eligible Person of an adverse benefit determination within a reasonable period of time, but not later than thirty (30) days of the Plan's receipt of a claim.

7.2.3. Claim Extension

If the Plan needs additional time to determine whether a claim is a covered expense for reasons beyond the Plan's control, the Plan may take one (1) fifteen (15) day extension. The Plan will notify the Eligible Person prior to the expiration of the initial fifteen (15) or thirty (30) day notification period, as applicable, of the circumstances requiring the extension and the date by which the Plan expects to make a decision. If an extension is needed due to an Eligible Person's failure to submit necessary information to decide the claim, the Plan will specifically describe the required information needed in the notice of extension.

The time period for making the determination is suspended from the date on which the notice of the necessary information is sent until the date the Eligible Person responds. An Eligible Person has at least forty-five (45) days from the receipt of the notice to respond to the request for information. Once the Eligible Person responds, the Plan will decide the claim within the fifteen (15) day extension period. The claim will be denied if the Eligible Person does not respond in a timely manner.

The Plan may take only one (1) extension for group health claims and may not further extend the time for making its decision unless the Eligible Person agrees to a further extension.

7.2.4. Concurrent Care Claims

A concurrent care claim is a claim that is reconsidered after the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments and the reconsideration results in the reduction or termination of the treatment (other than by the Plan amendment or termination) before the scheduled end of treatment. If the Plan reduces or terminates treatment before the end of the course of treatment, the Plan will notify the Eligible Person far enough in advance of the determination or reduction of treatment to allow him to appeal the adverse benefit determination and obtain a determination on review before the termination or reduction takes effect.

7.2.5. Adverse Benefit Determination

The Plan will notify an Eligible Person of an adverse benefit determination within a reasonable period of time, but not later than thirty (30) days after the Plan's receipt of a claim or fifteen (15) days after the Plan's receipt of claim in the case of a pre-service claim.

If, for any reason, a claim is denied, in whole or in part, the Fund Office will provide the Eligible Employee, Eligible Dependent, Beneficiary, or authorized or legal representatives ("claimant"), as may be appropriate, with written notice of adverse benefit determinations within the time frames previously stated. Notices will contain the following information stated in an easily understandable manner:

A. The date of service, the health care provider, the claim amount (if applicable), the diagnosis code, the treatment code, and the corresponding meanings of these codes;

B. The specific reason or reasons for the adverse benefit determination.

C. Reference to specific Plan provisions on which the adverse benefit determination is based.

D. A description of additional information, if any, necessary to complete the claim and why the material or information is necessary;

E. A description of the Plan's internal and external review procedures, how to initiate an appeal, and the time limits applicable to the review procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;

F. If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such criterion will be provided free of charge to the claimant upon request;

G. If the adverse benefit determination was based on a Medical Necessity or Experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge to the claimant upon request;

H. If a medical or vocational expert's advice was obtained on behalf of the Plan in connection with a claim, a statement that the claimant may request the identity of the expert, regardless of whether the advice was relied upon; and

I. Contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

7.3. APPEAL PROCEDURE

If all or part of a claim is denied, if a claimant is otherwise dissatisfied with the determination made by the Plan, or if the claimant has not received the notice of denial of the claimant's claim within the applicable time limits after the Plan has received all necessary claim information, the claimant has the right to appeal the decision and request a review of the claim. The Plan will provide for a full and fair review of a claim and adverse benefit determination, pursuant to the following:

A. A claimant will have one hundred eighty (180) days after the claimant receives the notice of an adverse benefit determination to file the claimant's appeal in writing to the Fund Office, and it must include the specific reasons the claimant feels denial was improper.

B. A claimant will be allowed the opportunity to submit written issues and comments, documents, records, and other information relating to the claim for benefits that may have been requested in the notice of denial or that the Eligible Employee may consider desirable or necessary, but neither the claimant nor representative of the claimant will have the right to appear in person before the Board of Trustees.

C. A claimant or duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all designated, pertinent documents, records, and other information relevant to the Employee's claim for benefits.

D. The review will take into account all comments, documents, records, and other information related to the claim that are submitted by the claimant, whether or not such information was submitted or considered in the initial benefit determination.

E. The Board of Trustees, as an appropriate named fiduciary for the Plan, will be the assigned decision maker on appealed claims.

F. The Plan will consult with appropriate health care professionals in deciding appealed claims that are based in whole or in part on medical judgment, including determination of experimental or investigational treatments and Medical Necessity.

Such health care professionals will have appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted for the appeal of an adverse benefit determination will be someone who was not consulted in the initial adverse benefit determination or the subordinate of such individual.

G. If a medical or vocational expert's advice was obtained on behalf of the Plan in connection with a claim, the claimant may request the identity of the expert, regardless of whether the advice was relied on.

H. For appeals of pre-service claims, the Plan will notify the claimant of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receiving the appeal request.

I. The Board of Trustees will review post-service claim appeals at their next regularly scheduled Board of Trustees' meeting (at least quarterly) that follows the receipt

of the request for review. However, if the request is filed within thirty (30) days of the date of the meeting, the determination may be made no later than the date of the second meeting following the receipt of the request for review. If special circumstances require a further extension, the appeal decision can be pushed back to the third meeting following the appeal request. However, prior to the extension, the Plan must notify the claimant of the extension, the special circumstances, and the date as of which the determination will be made.

The Plan will provide the claimant with written notice of an adverse benefit determination as soon as possible but within five (5) days of the decision being made. The notice will include the following information stated in an easily understandable manner:

1. The date of service, the health care provider, the claim amount (if applicable), the diagnosis code, the treatment code, and the corresponding meanings of these codes;

2. The specific reason or reasons the claim was denied, including (if applicable) the denial code and its corresponding meaning;

3. Reference to the specific Plan provision(s) on which the adverse benefit determination is based;

4. A statement that the claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his/her claim for benefits;

5. A description of the Plan's internal and external review procedures and the time limits applicable to the review procedures;

6. A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA after the claimant has exhausted the Plan's claims review and appeal procedure;

7. If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such criterion will be provided free of charge to the claimant upon request;

8. If the adverse benefit determination was based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific of clinical judgment of the Plan in applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge to the claimant upon request; and

9. Contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

7.4. EXTERNAL REVIEW

The Plan will permit external review of benefit determinations in accordance with Section 2719 of the Public Health Service Act and its implementing regulations. If the Plan denies your claim and your appeal, you may seek external review of the Plan's decision. To seek external review, you must file a request with the Fund Office within four (4) months from the date your receive notice that the Plan denied your appeal. For more information on external review, contact the Fund Office.

7.5. PHYSICAL EXAMINATIONS

The Plan, at its own expense, will have the right and opportunity to examine an Eligible Person whose Illness is the basis of a claim when, and as often as, it may reasonably require during pendency of a claim under the Plan.

7.6. RECORDS

Each Eligible Person authorizes and directs any provider that has attended, examined, or treated him to furnish the Fund, at any time upon its request, any and all information and records or copies of records relating to provided services. The Fund agrees that any information and records obtained pursuant to this Section will be considered confidential and will be protected in accordance with HIPAA requirements and Section 10.2.

7.7. ACTIONS AGAINST THE PLAN

No Eligible Person may bring an action at law or in equity, including proceedings before administrative agencies, to recover from the Plan until the Claims Review and Appeal Procedure stated in Section 7.2 has been exhausted. No action may be brought at all unless it is brought within two (2) years from the time the claim was required to be filed with the Plan.

7.8. ASSIGNMENT OF RIGHTS AND APPOINTING AN AUTHORIZED REPRESENTATIVE TO ACT ON YOUR BEHALF

An authorized or legal representative may act on behalf of a claimant in filing a claim or pursing an appeal of an adverse benefit determination. The claimant must first submit a signed letter to the Fund Office specifically identifying the person as the authorized or legal representative of the claimant. Neither the claimant nor any duly authorized representative will have the right to make a personal appearance before the Board of Trustees or any committee created by the Board of Trustees. Although a claimant may appoint an authorized representative to act on their behalf, under no circumstances may a claimant assign any rights under the Plan or ERISA, including any rights to appeal adverse benefit determinations or any causes of action that may arise after the denial of benefits.

SECTION 8 PAYMENT OF BENEFITS

8.1. COORDINATION OF BENEFITS (COB)

This Section is applicable to all Eligible Persons.

8.1.1. Summary.

Benefits payable under this Plan will be coordinated with benefits payable under any "Other Group Plan," as defined in this Section, so that the aggregate amount paid under this Plan and by any "Other Group Plan" does not exceed one hundred percent (100%) of the charge incurred. In no event will this Plan's payment exceed the amount that 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 was actually filed.

8.1.2. Definitions

A. "Other Group Plan," as used in these COB provisions, means any plan providing benefits or services for, or by reason of, medical, dental, or vision care or treatment or healing under:

1. Group, blanket, franchise, or any other arrangement for coverage of individuals in a group whether on an insured or non-insured basis;

2. Group Blue Cross Blue Shield or other prepayment coverage provided on a group basis;

3. Group-Type Contracts other than individual insurance issued on a franchise basis, with "Group-Type Contract" meaning a contract that is not available to the general public and can only be obtained and maintained through membership or affiliation with a particular organization or group;

4. Any group or group-type and individual automobile "no-fault" and traditional automobile "fault" type contracts;

5. A school or other education institution that covers grammar, high school, and college students for accidents, including athletic injuries, either on a twenty-four (24) hour basis or on a "to and from school" basis;

6. Any federal or state or other governmental programs, except Medicare, and any coverage required or provided by statute;

7. A labor-management trusteed plan, union welfare plan, employer organization plan, or employee benefit organization plan; and

8. Medicare, both Part A and Part B, whether or not the Eligible Individual is enrolled in both parts.

The above list of "Other Group Plans" is only intended to provide particular examples and is not meant to include every possible type of plan that qualifies. However, "Other Group Plan" will not mean:

1. A state plan under Medicaid;

2. Benefits under a law or plan when, by law, its benefits are excess to those of any private insurance plan;

3. Individual or family coverage, except those Plans described above

4. Medicare with respect to: (i) an actively employed Employee age sixty-five (65) or older or the Spouse of an actively employed Employee age sixty-five (65) or older; or (ii) a disabled Eligible Individual who is making Self-Contributions to This Plan and who has exhausted benefits available to active participants as described in the Summary of Benefits; or

5. A group Hospital Indemnity Plan of $100.00 per day or less.

B. The term "Other Group Plan" will be construed separately as to each policy, contract, or other arrangement for benefits or services and separately as to any part of a plan that may consider benefits or services of other plans in determining its benefits and any part that does not. An individual may have other health plan coverage containing a provision commonly known as a "wrap around" provision, "sub-plan" provision, or some similar provision whose purpose is to provide primary coverage only for a small amount of expenses, well below the maximum benefit available under the plan if no other coverage is available (collectively, a "Sub-Plan Provision"). The effect or intent of a plan with a Sub-Plan Provision is to transfer the much larger secondary coverage to the other health plan with which such plan is coordinating benefits. In the event this Plan is coordinating benefits with a plan containing a Sub-Plan Provision, the Sub-Plan Provision will be treated as arbitrary and capricious and a scheme and will be ignored, resulting in coordination of benefits with the plan, sub-plan, or similar provision that would apply if the Eligible Person did not have coverage under this Plan.

C. "Allowable Expense" means any necessary, reasonable, and customary item of expense, at least a part of which is covered under one of the plans covering the Eligible Person for whom a benefit request is made. If a plan provides benefits in the form of services or supplies, instead of payment in cash, the reasonable monetary value of the service rendered and supplies furnished (if otherwise an Allowable Expense) will be considered both an Allowable Expense and a benefit paid.

8.1.3. Method of Application

In the case of duplicate group coverage for an Eligible Person, the Eligible Employee must report the duplicate group health insurance coverage on the claim form that is submitted to secure reimbursement of Allowable Expenses incurred.

If the other group plan does not contain a coordination of benefits or similar provision, then that plan will always 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 a dependent in one plan and a non-dependent (e.g., employee, retiree, insured) in another, the plan covering the patient other than as a dependent will be considered primary and will determine its benefits first.

B. If a patient is eligible as a dependent child in two (2) plans, the plan covering the patient as a dependent of the parent whose date of birth, excluding the year of birth, occurs earlier in a Calendar Year will pay its benefits first.

Note: If a plan containing this "birthdate rule" is coordinating with a plan that contains the "gender-based rule" and as a result the plans do not agree on the order of benefit determination, the gender-based rule will determine the order.

C. When parents are divorced or separated, the order of benefit determination is as follows:

1. The plan of the parent having custody of the dependent child pays first.

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

(a) The plan of the parent having custody;

(b) The plan of the Spouse of the parent having custody;

(c) The plan of the parent not having custody; then

(d) The plan of the Spouse of the parent not having custody.

If there is a Qualified Medical Child Support Order that directs that one (1) of the parents is responsible for the child's health care expenses, the plan of that parent will pay first and will supersede any conflicting provision in this subsection.

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 first. Exception: A plan that covers a person as an active employee (or a dependent of such person) will determine its benefits before a plan that covers the person as a laid-off or retired employee (or a dependent of such person).

E. 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.

Additionally, this Plan expressly limits its secondary coverage available to the Eligible Person to the same dollar amount contained in, or calculated under, the Sub-Plan Provision if: (i) a Sub-Plan exists; (ii) the Sub-Plan is not or cannot be ignored pursuant to Section 8.1.2.B; and (iii) the Sub-Plan is found by the Board or a court of competent jurisdiction to apply.

F. For active Eligible Employees, who are age sixty-five (65) and over and are performing covered employment, this Plan is the primary payor, and Medicare is the secondary payor. However, such active Eligible Employee or Spouse will have the right to reject this Plan and retain Medicare as their primary source of coverage. In such event, this Plan is legally prohibited from supplementing Medicare coverage.

The Board and its designees have discretion to interpret the Plan and determine whether benefits are payable under the Plan. This discretion will include, but not be limited to, discretion to interpret the language of other plans and also to determine whether the other plans consist of a single plan or multiple plans. The discretion also will include, but not be limited to, discretion to determine whether a Sub-Plan provision exists. The Board's determination in this regard will be binding and final for all purposes, including but not limited to, all coordination of benefit purposes, and will only be reversed if a court of competent jurisdiction determines that the Board's determination is arbitrary and capricious.

Regardless of any other rule stating otherwise, all benefits payable under this Plan will be limited to being in excess of the benefits that are payable by any other plan or group insurance policy that 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.

8.2. COORDINATION OF BENEFITS WITH AUTOMOBILE INSURANCE

This Plan will coordinate benefits with automobile insurance carriers as follows:

A. This Plan is not in place of and does not affect the requirement for coverage under any plan of no-fault automobile insurance or other automotive insurance that provides medical coverage and does not affect any legal requirement that an individual maintain a certain minimum automobile insurance overage within the jurisdiction in which that individual resides. That type of insurance is deemed to be primary for any claims arising out of the maintenance or use of an automobile.

B. 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. The amount of benefits payable by this Plan

will be coordinated so that the total amount paid will not exceed one hundred percent (100%) of the expenses incurred.

C. Benefits that otherwise might be payable under no-fault or other automobile insurance will not be payable by the Plan merely because no claim for benefits was filed. If an Eligible Person fails to maintain the legally required amount of no-fault or other automobile insurance within the jurisdiction where he or she resides, Plan benefits will not be payable for amounts the automobile insurance would have paid.

D. An Eligible Person must arbitrate any discontinuance of no-fault benefits before a claim related to the automobile accident will be considered under this Plan.

8.3. COORDINATION OF BENEFITS WITH OTHER TYPES OF INSURANCE

Coverage under this Plan is deemed to be secondary coverage to any plan or policy of insurance that may pay medical expenses for a specific risk, including but not limited to, for example, any automobile policy, homeowner's policy, or premises insurance policy. The Plan may require that the Eligible Person show that the Eligible Person has made a reasonable effort to find out if there is another applicable insurance policy.

8.4. RIGHT TO RECEIVE OR RELEASE NECESSARY INFORMATION

To determine the applicability of and to implement the terms of the Plan's coordination of benefits provisions or any provision of similar purpose in any other plan, the Trustees may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or persons any information with respect to any person that the Trustees deem to be necessary for this purpose. Any person claiming benefits under this Plan will furnish the Trustees the information that is necessary to implement this provision.

8.5. FACILITY OF PAYMENT

Whenever payments that should have been made under this Plan in accordance with the Plan's coordination of benefits provisions have been made under any other plans, the Trustees will have the right, exercisable alone and in their sole discretion, to pay to any organization making the other payments any amounts they will determine to be warranted in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under this Plan, and, to the extent of the payments, the Plan will be fully discharged from liability under this Plan.

8.6. RIGHT OF RECOVERY

Whenever the Plan has made Payments with respect to Allowable Expenses in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of the Plan's Coordination of benefits provisions, the Trustees will have the right to recover the overpayments from among one (1) or more of the following sources:

A. Any persons to, for, or with respect to whom the payments were made, including by making deductions from benefits that may be payable to, or on behalf of, an Eligible Person in the future;

B. Any insurance companies; or

C. Any other organizations.

8.7. SUBROGATION AND REIMBURSEMENT

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

This means that if the Plan pays benefits that are, in any way, compensated by a third party, such as an insurance company, the Eligible Person agrees 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 the Eligible Person does not agree to the Plan's subrogation and reimbursement rules, benefits will not be paid. For example, the subrogation and reimbursement rights may apply if an Eligible Person is 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. The Eligible Person receives payment only after the Plan is fully reimbursed.

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

8.7.1. 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 described in this Subrogation and Reimbursement Section. Further, the Eligible Person will 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 acknowledgement form is not on file for the Eligible Person. Benefits may not be paid if the Eligible Person refuses to sign the acknowledgement. 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 acknowledgement. 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.

8.7.2. 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.

8.7.3. 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 rights 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 the Eligible Person has received or may be entitled to receive from the third party.

8.7.4. Right to Take Action

The Plan's rights of subrogation and reimbursement are equitable and apply to all categories of benefits paid by the Plan. The Plan and any other Plan member 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 its 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 its subrogation and reimbursement rights. The subrogation and reimbursement rights apply to claims of Eligible Dependents covered by the Plan regardless of whether the Dependent is legally obligated for expenses of treatment.

8.7.5. 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.

8.7.6. 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.

8.7.7. Full Cooperation

The Eligible Person will 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 forty-five (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.

8.7.8. 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, Illness, or death. The Eligible Person also must periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of their claims.

8.7.9. Third-Parties

Third parties include, but are 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. These rights of subrogation and reimbursement exists regardless of whether the policy of insurance is owned by the Eligible Person.

8.7.10. Apportionment, Comparative Fault, Contributory Negligence, Equitable Defenses Do Not Apply

The Plan's subrogation and reimbursement rights include all portions of the Participant's or Beneficiary's claims 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.

8.7.11. Attorneys' Fees

The Plan is not responsible for any attorneys' 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. If any attorney's fees or costs are awarded to the Eligible Person's attorney from the Plan's recovery, the Eligible Person will indemnify and reimburse the Plan for the attorney's fees or costs.

8.7.12. Course and Scope of Employment:

If the Plan has paid benefits for any Injury that arises out of and in the course and scope of employment, the Plan's rights 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 will reimburse the Plan for the attorney's fees.

8.8. EFFECT ON WORKER'S COMPENSATION

The Plan is not in place of and does not affect any requirements for coverage by worker's compensation law, occupational disease law, or similar law. Benefits that otherwise would be payable under the provisions of these laws will not be paid by the Plan merely because the Eligible Person did not file a claim for benefits under the rules of those laws.

The Plan will use its Right of Recovery if an Eligible Person is provided services or is paid benefits under the Plan due to Injury or Illness for which the Eligible Person is, or may become, entitled to benefits under the applicable worker's compensation law, occupational disease law, or similar

law. An Eligible Person who receives services or benefits from the Plan under these circumstances must sign and deliver all related papers or forms to the Plan and must do whatever else is necessary to help the Plan administer this recovery provision. An Eligible Person must not do anything or sign anything after that impairs the Plan's right to recover provided services or benefits paid by the Plan after a loss.

SECTION 9 ADMINISTRATION OF THE PLAN

9.1. GENERAL PLAN INFORMATION

A. Name of Plan: Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund.

B. Plan Sponsor: The Plan Sponsor is the Board of Trustees of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund. 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 Fund Office.

C. Employer Identification Number (EIN): 41-0905139.

D. Plan Number (PN): 501.

E. Type of Plan: This Plan is a group health plan. Its purpose is to provide Health Care, Prescription Medication, Vision Care, Dental Care, Weekly Disability Income, and Group Life Insurance Benefits for Eligible Employees and Eligible Dependents of full-time Employees, as stated in the Schedule of Benefits. This Plan is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

F. Plan Year and Fiscal Year: The Plan year and fiscal year begin on the first day of March and end on the last day of the following February.

G. Claim Procedure: The procedures for filing for benefits are described in Section 7. If you wish to appeal a denial of a claim, in whole or in part, certain procedures for this purpose are found in Section 7.2.

H. Name, Address, and Telephone Number of the Plan Administrator (also called the "Fund Office"):

Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Phone: (952) 851-5797
Fax: (952) 854-1632

I. Agent for Service of Legal Process: Legal process may be served upon the Plan Administrator or upon any Trustee of the Plan.

9.2. ADMINISTRATION BY THE TRUSTEES

The Plan is administered solely by the Trustees, and decisions of the Trustees in all matters pertaining to Plan administration are final. Employees and agents of the Trustees, including the Plan Administrator or Fund Office, act as authorized by the Trustees.

9.3. INTERPRETATION BY TRUSTEES

The Trustees have the Authority to determine eligibility for benefits and construe the terms of the Plan, and all Plan documents, rules, and procedures. Their interpretation is final and binding on all persons 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 the decision will be upheld unless it is determined 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. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them.

9.4. COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any collective bargaining agreement 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 Fund Office.

9.5. AMENDMENT TO THE PLAN

The Plan may be amended by action of the Board of Trustees at any time.

9.6. TERMINATION OF PLAN

This Plan may be terminated:

A. As to Employees (and their eligible Dependents) in the collective bargaining unit, by agreement of the Union(s) and Employer Association (or individual Employers, where applicable) that negotiate the labor agreements covering such collective bargaining unit; or

B. 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 to Eligible Persons under the Trust Agreement or under the Plan Document and Summary Plan Description.

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 the termination;

B. Arrange for a final audit and report of their transactions and accounts for the purpose of terminating their Trusteeship;

C. Apply the Trust Fund to pay for 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 any reports that may be required.

9.7. FUNDING OF BENEFITS

Contribution payments are received and accepted by the Trustees from Employers party to collective bargaining agreements requiring the payment of contributions to this Plan in the amounts specified in the collective bargaining agreements. Self-payments from Eligible Employees with insufficient Employer contribution hours to maintain eligibility, former Employees, and retirees are received and accepted by the Trustees in amounts established by the Trustees from time to time. Investment earnings are used exclusively for providing benefits to Eligible Persons.

Benefits are provided directly from Plan assets, except that Life Insurance and Accidental Death and Dismemberment Benefits are provided through an insurance contract with Fidelity Security Life Insurance Company, 3130 Broadway, Kansas City, MO 64111-2406. Benefits eligible under the life insurance and accidental death and dismemberment policy are submitted to and paid by Fidelity Security Life.

All assets of the Plan are held by a custodian selected by the Trustees. A portion of Plan assets are allocated as reserves to provide future benefits under the Plan. The Trustees may, in their discretion, hire investment managers to invest any assets not needed for the immediate payment of benefits and other Plan expenses.

9.8. FUND RESERVES

The Trustees maintain a reserve that, 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, extensions of coverage for benefits if provided in the Plan, and any other data the Trustees may consider necessary.

9.9. LIMIT OF FUND LIABILITY

The Trustees maintain an excess Risk Indemnification Agreement that limits Plan liability for claims to an annual individual maximum. The individual maximum and other provisions are determined in accordance with the agreement, which is a part of the contract in effect between the Trustees and the contracting insurance carrier.

9.10. LIMITATION OF BENEFITS PAYABLE

Benefits otherwise payable under this Plan will be limited by the Plan's assets, regardless of accumulated eligibility.

SECTION 10 MISCELLANEOUS PROVISIONS

10.1. EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974 (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 welfare plans. The law also spells out certain rights and protections to which you are entitled as a Participant.

The Trustees of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund want you to be fully aware of your rights. As a Participant in the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund, you have the below rights:

A. You automatically will receive a Summary Plan Description (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.

C. Each year you automatically will receive a summary of the Plan's latest annual financial report. A copy of the full report is also available upon written request.

D. You may examine, without charge, all documents relating to the operation of this Plan. These documents include: the legal Plan Document and Summary Plan Description, insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the Department of Labor or the Internal Revenue Service, such as the latest annual report (Form 5500 Series) and Plan descriptions. Such documents may be examined at the Fund Office (or at other specified locations such as worksites or Union halls) during normal business hours.

E. 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 that you should follow:

   1. Your request should be in writing;

   2. Your request should specify what materials you wish to review; and

   3. Your request should be received at the Fund Office at least three (3) days before you want to review the materials at the Fund Office.

   Although all pertinent Plan documents are on file at the Fund Office, arrangements can be made upon written request to make the documents you want available at any worksite or Union location at which fifty (50) or more Participants report to work. Allow ten (10) days for delivery.

F. 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 Plan Description upon written request to the Trustees, addressed to the Fund Office. 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 Fund Office.

G. You have the right to continue health care coverage for yourself, your Spouse, your 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 Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

H. No one, including your Employer, your Union, for any other person, may fire you or otherwise discriminate against you in any way or take any action that would prevent you from obtaining a benefit to which you may be entitled or from exercising any of your rights under ERISA.

I. 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 in Section 7.2 and are designed to give you a full and fair review and provide maximum opportunity for all the pertinent facts to be presented on your behalf. In summary, they provide that:

1. If your claim for a health care benefit is denied or ignored, 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 claim review and appeal procedures.

J. In addition to creating rights for Plan Participants, ERISA also defines the obligations of people responsible for operating employee benefit plans. These persons are known as "fiduciaries." They have the duty to operate the Plan prudently and with reasonable care and to look out for your best interests as a Participant under the Plan and the best interests of other Participants and Beneficiaries under the Plan.

K. The duties of a fiduciary are complex and are constantly changing as new laws and regulations applicable to employee benefit plans are adopted. 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.

L. Under ERISA, you may take certain actions to enforce the rights previously listed.

1. For instance, if you make a written request for a copy of Plan documents or the latest annual report from the Trustees and do not receive them within thirty (30) days of the Plan’s receipt of your request, you may file suit in federal court.

Before taking such action, it may be beneficial to check with the Fund Office to make sure that the request actually was received, the material was mailed to the right address, and 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 is always the possibility that differences cannot be resolved satisfactorily.

   If you have a claim for benefits that 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.

10.2. MEDICAL DATA PRIVACY

The Plan will use Protected Health Information (“PHI”) to the extent of and according to the uses and disclosures allowed by the Medical Data Privacy Regulations (“Privacy Regulations”) and the HIPAA Security regulations (“Security Regulations”) adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including purposes related to health care treatment, payment, and health care operations.

The Plan, in conjunction with the Plan Administrator, has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI in electronic form (other than enrollment/disenrollment information and summary health information, which are not subject to such 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.

The Plan will enter into agreements with other entities, known as “business associates” to perform some functions on behalf of the Plan. The Plan’s agreements with its business associates will require that the electronic, physical, and technical security of electronic PHI be maintained. Each business associate will be allowed to use and disclose only the minimum amount of PHI needed to perform the business associate’s duties on behalf of the Plan. The Plan’s agreements with its business associates also must meet the other requirements of the Privacy Regulations.

10.2.1. Use of PHI for Treatment Purposes

"Treatment" includes the activities relating to providing, coordinating, or managing health care and related services. It also includes, but is not limited to, consultations and referrals between one (1) or more providers. As a health plan, the Plan is generally not involved in treatment situations but, from time-to-time, may release PHI to assist providers in an Eligible Person's treatment.

10.2.2. Use of PHI for Payment

"Payment" includes the Plan's activities to obtain premiums, contributions, self-payments, and other payments to determine or fulfill the Plan's responsibility for coverage and providing benefits under the Plan. It also includes the Plan obtaining reimbursement for providing health care that has been provided. These activities include, but are not limited to, the following:

A. Determining eligibility or coverage under the Plan;

B. Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);

C. Subrogation;

D. Coordination of benefits;

E. Establishing self-payments by persons covered under the Plan;

F. Billing and collection activities;

G. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to Eligible Persons' inquiries about payments;

H. Obtaining management under stop-loss or similar reinsurance;

I. Reviewing whether claims are payable under the Plan, including whether they are Medically Necessary, Usual and Customary, or otherwise payable;

J. Reviewing coverage under the Plan, appropriateness of care, or justification of charges;

K. Utilization review, including precertification, preauthorization, concurrent review, and retrospective reviews;

L. Disclosing to consumer reporting agencies certain information related to collecting contributions or reimbursement (information that may be released is: name and address, date of birth, Social Security number, payment history, account number, and name and address of provider and/or health plan); and

M. Reimbursement to the Plan.

10.2.3. Use of PHI for Health Care Operations

"Health Care Operations" can include any of the following activities. While the Plan does not currently use or release PHI for all of these activities, it may do so in the future to perform health care operations of the Plan:

A. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines as long as general knowledge is not the primary purpose of these studies; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

B. Reviewing the competency or qualifications of health care professionals and evaluating provider performance, accreditation, certification, licensing or credentialing activities;

C. Underwriting, premium rating, and other activities relating to creating, renewing, or replacing a health insurance contract (or reinsurance) or health benefits under the Plan;

D. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

E. Planning and development, such as conducting cost-management and planning-related analyses relating to managing and operating the Plan (including formulary development and administration, development or improvement of methods of payment or coverage policies); and

F. Management and general administrative activities of the Plan, including but not limited to:

1. Managing activities related to implementing and complying with the Privacy Regulations;

2. Resolving claim appeals and other internal grievances;

3. Merging or consolidating the Plan with another plan, including related due diligence; and

4. As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.

10.2.4. Other uses and Disclosures of PHI

The Privacy Regulations permit certain other uses and disclosures of PHI. These include, for example, releasing PHI to personal representatives of deceased Eligible Persons, releasing PHI for public health activities, releasing PHI for court proceedings, and releasing PHI for law enforcement and similar purposes. If the Plan releases PHI in any

of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

The Privacy Regulations also permit the Plan to release PHI if it receives a valid authorization from the person who is the subject of the PHI. If the Plan receives a valid authorization, the Plan will disclose PHI to the person or organization authorized to receive the information. This may include, for example, releasing information to a Spouse, the pension plan, other retirement plans, the vacation plan, or another similar plan for the purposes related to administering those plans.

10.2.5. Release of PHI to the Board of Trustees

The Plan will disclose PHI to the Board of Trustees, which is considered the Plan Sponsor under the Privacy Regulations. The Plan has received a certificate from the Board of Trustees that the Plan Document and Summary Plan Description has been amended to incorporate the following provisions:

The Board of Trustees will receive and use PHI only for the Plan administration functions that the Trustees perform for the Plan. In addition, the Trustees will:

A. Not use or further disclose PHI other than as permitted or required by the Plan Document and Summary Plan Description, or as required by law;

B. Ensure that any agents, including subcontractors, to whom the Board of Trustees provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such PHI;

C. Not use or disclose PHI for employment-related actions and decisions unless authorized by the person who is the subject of the PHI;

D. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the person who is the subject of the PHI;

E. Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;

F. Make PHI available to a person who is the subject of the information according to the Privacy Regulations requirements;

G. Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;

H. Make available the PHI required to provide an accounting of disclosures;

I. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Regulations; and

J. If feasible, return or destroy all PHI received from the Plan that the Trustees maintain in any form and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

10.2.6. Trustee Access to PHI for Plan Administration Functions

As required under the Privacy Regulations, the Plan will give access to PHI only to the Board of Trustees (including alternate Trustees). The Plan will release PHI to the Trustees, and the Trustees will be able to use PHI for purposes of hearing and determining claim appeals; making other determinations concerning claim payments; Plan benefit design; amending, modifying, and terminating the Plan; and Plan management issues. Any such disclosures of electronic PHI to the Trustees will be supported by reasonable and appropriate security measures.

10.2.7. Noncompliance Issues

If the persons previously described in this Section 10.2 do not comply with this Plan Document and Summary Plan Description, the Board of Trustees will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

10.2.8. Coordination of Plan Participation

As a condition of Plan participation, the Board of Trustees requires that the privacy rights of an Eligible Person be governed only by HIPAA and the laws of the State of Minnesota (but only to the extent such laws are not preempted by the Employee Retirement Income Security Act of 1974) without regard to whether HIPAA or Minnesota law incorporates privacy rights granted under the laws of other states.

10.2.9. Plan's Privacy Officer and Contact Person

As required by the Privacy Regulations, the Plan has named a Privacy Officer to oversee the Plan's compliance with the Privacy Regulations. The Plan also has named a Contact Person to help answer questions concerning the Privacy Regulations and PHI. An Eligible Person can call the Contact Person regarding complaints concerning the use or disclosure of PHI. For questions or complaints concerning PHI, an Eligible Person should contact the Plan Administrator and ask to speak with the Plan's Contact Person.

10.3. 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, 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.

10.4. GENETIC INFORMATION NONDISCRIMINATION ACT

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