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MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS HEALTH AND WELFARE FUND

IMPORTANT NOTICE

Summary of Material Modifications

TO: Participants and Beneficiaries of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund

FROM: The Board of Trustees

DATE: April 2022

This is a Summary of Material Modifications ("SMM") regarding the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (the "Plan"). The Board of Trustees has amended the Plan Document and Summary Plan Description (amended and restated September 1, 2017) as indicated below.

Amendment No. 18: Surprise Billing Protections & Diabetic Supply Coverage

Effective March 1, 2022 (the first day of the plan year), the Plan was amended to comply with the requirements of the federal No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021. Under the No Surprises Act, the Plan will cover claims for certain "surprise" out-of-network health care costs as if they were in-network expenses. For claims subject to the No Surprises Act, this means that you will not be "balance billed" by the out-of-network provider or health care facility for additional expenses beyond the recognized amount that is covered subject to the Plan's standard cost-sharing rules (copayments, coinsurance, and deductibles).

The No Surprises Act protections will apply to the following three categories of claims:

- Emergency Services provided by an out-of-network provider and/or at an out-of-network health care facility;
- Certain Non-Emergency Services provided by an out-of-network provider at an in-network health care facility; and
- Out-of-network Medically Necessary Air Ambulance Services.

"Emergency Services" are defined as appropriate medical screening examinations and treatment for an Emergency medical condition. Emergency Services also may include services after the patient stabilizes, such as observation and inpatient or outpatient stays in connection with the Emergency.

Non-Emergency Services provided by an out-of-network provider at an in-network health care facility include, but are not limited to, services such as anesthesiology, pathology, radiology, and neonatal care as well as services provided by assistant surgeons, hospitalists, intensivists, and, generally, any out-of-network provider at the facility if there is no in-network provider at the facility who can provide the items or services that provider provides.

In certain cases, however, Emergency Services provided by an out-of-network provider and/or at an out-of-network health care facility and non-Emergency Services provided by an out-of-network provider at an in-network health care facility will not be treated as in-network claims under the No Surprises Act if the provider or facility provides the patient with a notice regarding the out-of-network status of the services or facility and the patient consents to receive those out-of-network services (except for specific circumstances described below).

This notice and consent exception never applies to the following:

- Unforeseen urgent medical needs;
- Pre-stabilization Emergency Services;
- Post-stabilization Emergency Services, unless:
  - The attending provider determines that the patient is able to travel without Emergency medical transportation; and
  - The patient is provided a list of any in-network providers at the facility who are able to furnish the Medically Necessary items or services and is offered a referral to those providers; and
- Certain "ancillary" services provided by an out-of-network provider at an in-network facility, specifically:
  - Anesthesiology, pathology, radiology, and neonatal care;
  - Services provided by an assistant surgeon, hospitalist, or intensivist; and
  - Diagnostic services such as radiology and laboratory services; and
- Items and services provided by an out-of-network provider if there is no in-network provider at the facility who can provide those items and services at the in-network facility.

In other cases where the notice and consent exception is available, the notice must contain specific information required by the No Surprises Act, including a statement of out-of-network status, a good faith estimate of the charges and notice that the estimate is not a binding contract, notice that prior authorization may be required by the Plan, and a clear statement about the option to obtain care from an in-network provider and that obtaining services from an in-network provider would result in no balance billing.

The notice must be provided to you at least 72 hours before an appointment (if the appointment is scheduled at least 72 hours in advance) or at least three hours before an appointment (if the appointment is scheduled fewer than 72 hours in advance).

Consent must be provided voluntarily, and the signed consent must contain a clear statement that the patient understands the consequences of receiving out-of-network services instead of in-network services, such as balance billing. The notice and consent must be made available upon request in the 15 most common non-English languages in the state or geographic region, or for other languages, the services of a qualified interpreter must be provided to help the patient understand the notice and consent. The consent must state the time and date of the patient's receipt of the written notice described above and the time and date of the consent.

Finally, for coverage of out-of-network Air Ambulance Services, the Plan will cover such services as if they were in-network services (i.e., without balance billing but still subject to the Plan's cost sharing rules) but only to the nearest health care facility qualified to provide Medically Necessary treatment for an Emergency or a provider-initiated transfer to another health care facility qualified to provide Medically Necessary treatment. Air ambulance services are only covered if Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would result in a serious adverse impact on the patient's health status.

Additionally, the Plan was amended to provide that diabetic supplies are covered under the Plan's prescription drug program.

Amendment No. 19: Over-the-Counter COVID-19 Test Coverage

The United States government is also providing free at home COVID test kits. Please visit www.covidtests.gov to order up to two sets of four free tests per household. The test kits will ship through the USPS and are expected to ship out seven to 12 days after the order date to most residential addresses.

Effective January 15, 2022, the Plan was amended to provide coverage for at-home over-the-counter ("OTC") COVID-19 test kits. The Plan will provide coverage for at-home OTC COVID-19 test kits purchased on and after January 15, 2022 subject to the following provisions. (Please see below for information specific to participants covered under the Plan's Ancillary Benefits package only.)

- ***The Plan will only cover COVID-19 test kits available "over the counter" that have been approved by the FDA for use at home or elsewhere without involvement of a health care provider*** purchased January 15, 2022 through the end of the COVID-19 Public Health Emergency that was declared by the Department of Health and Human Services. Please go to www.fda.gov to learn which tests are currently FDA approved or check the packaging on the test kit before purchasing.

- The Plan will cover 100% of the cost (no Deductible or Copay) for up to eight at-home OTC COVID-19 test kits per Covered Person under the Plan every 30 days.

    - You must purchase the OTC COVID-19 test at the pharmacy counter of a pharmacy in the Express Scripts Choice Plus network and present your Plan Prescription card at the time of purchase. If the in-network pharmacy is set up to process test kits in the same manner as a prescription, you will not pay any amount for the OTC COVID-19 test kits at the time of purchase.

    - Some pharmacies in the Express Scripts Choice Plus network are not set up to process at-home OTC COVID-19 test kits in the same manner as a prescription. You must pay 100% of the cost for at-home OTC COVID-19 test kits you purchase at one of these pharmacies. The Plan will reimburse you for the entire cost of these at-home OTC COVID-19 test kits if you save your receipt of purchase and submit the receipt along with the "*Over-The-Counter (OTC) COVID-19 Test Kit Claim Reimbursement Request*" form to Express Scripts at their address noted on the reimbursement request form. Reimbursement request forms are available at www.express-scripts.com.

- Plan reimbursement for at-home OTC COVID-19 test kits that you do not purchase at an Express Scripts Choice Plus in-network pharmacy will be limited to the cost of the test or

$12, whichever is less. You are responsible for any amount that you pay in excess of $12 for an at-home OTC COVID-19 test kit purchased at a pharmacy that is not in the Express Scripts Choice Plus network, or any other retailer or supplier. The Plan will not count these costs towards your Prescription Drug Benefit Annual Out-of-Pocket Maximum.

  - Save your receipt of purchase and submit the receipt along with the "Over-The-Counter (OTC) COVID-19 Test Kit Claim Reimbursement Request" form to Express Scripts at their address noted on the reimbursement request form. Reimbursement request forms are available at www.express-scripts.com.

- The Plan will cover only OTC COVID-19 test kits for at-home medical use by you or your covered household family members. Tests for employment purposes or resale will not be covered or reimbursed under this program.

- For participants who are only covered under the Plan's Ancillary Benefits package, the Plan will cover 100% of the cost (no Deductible or Copay) for up to eight at-home OTC COVID-19 test kits per covered Eligible Person under the Plan per 30-day period.

  - You must pay 100% of the cost for at-home OTC COVID-19 test kits. The Plan will reimburse you for the entire cost of these at-home OTC COVID-19 test kits if you save your receipt of purchase and submit the receipt along with the *"Over-The-Counter (OTC) COVID-19 Test Kit Claim Reimbursement Request"* form to the Fund Office at its address noted on the reimbursement request form.

  - The Plan will cover only OTC COVID-19 test kits for at-home medical use by you. Tests for employment purposes or resale will not be covered or reimbursed under this program.

The above provisions only apply to at-home OTC COVID-19 test kits and do not affect previous Plan provisions regarding coverage of non-at-home OTC COVID-19 test kits.

Amendment No. 20: Medical Necessity Determinations

Effective April 8, 2022, the Plan was amended to state that whether a covered item or service is Medically Necessary will be determined in accordance with UnitedHealthcare's medical policy.

Please update your Plan Document and Summary Plan Description booklet (dated September 1, 2017) to reflect these changes by inserting the attached replacement and supplemental pages IV, 1, 1A, 3, 3A, 4, 7A, 9, 9A, 10, 11, 14, 16, 17, 20, 20A, 21, 21A, 21B, 21C, 21D, 43, 43A, 44, 44A, 47, 48B, 48C, 49, 51, 51A, 51B, 68, 68A, 69, 70, 71, 73, 73A, 78, 78A, 79, and 98.

If you have any questions about these changes to the Plan, please contact the Plan Administrator at (952) 851-5797 or (844) 468-5917.

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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.

1.0. AIR AMBULANCE SERVICES

"Air Ambulance Services" means medical transport by a rotary wing air ambulance or fixed wing air ambulance for patients.

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

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).

1.8A. EMERGENCY

"Emergency" means:

A. A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain)

such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

2. Serious dysfunction of any bodily organ or part; or

3. Serious impairment of bodily functions; or

B. With respect to a pregnant woman who is having contractions:

1. That there is inadequate time to effect a safe transfer to another Hospital before delivery; or

2. That transfer may pose a threat to the health or safety of the woman or the unborn child.

1.8B. EMERGENCY SERVICES

A. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department and ancillary services routinely available to the emergency department to evaluate such Emergency medical condition; and

B. Such further medical examination and treatment to stabilize the patient as are within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department (regardless of the department of the Hospital in which such further examination or treatment is furnished).

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;

stating that such quarantine is medically necessary or appropriate according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health because the individual has had exposure or suspected exposure to COVID-19.

1.17A. INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT

"Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct and licensed separately from a Hospital under applicable state law and provides any Emergency Services.

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 from this Plan or whose Beneficiaries may be eligible to receive any such benefit.

1.27A. PARTICIPATING HEALTH CARE FACILITY

"Participating Health Care Facility" means any health care facility that has a contractual relationship directly or indirectly with the Plan setting forth the terms and conditions on which a relevant item or service is provided to an Eligible Person under the Plan.

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 28/29.

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 PROVIDER

A "Preferred Provider" means any of the following who alone or as part of a group enter into a contract 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. Effective June 1, 2021, Preferred Providers under the Preferred Provider Prescription Drug Program include Pharmacies in the Express Scripts network.

B. Preferred Provider Comprehensive Major Medical Network. Effective June 1, 2021, the Preferred Provider network for Comprehensive Major Medical Benefits includes only those Hospitals, Physicians, and other health care professionals in the UnitedHealthcare Choice Plus Network.

C. Preferred Provider Dental Care 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, including OTC Preventive Care medications, proton-pump inhibitors, and non-sedating antihistamines upon a Physician's Prescription Order. Prescription Medication also includes insulin and diabetic supplies.

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.

1.43. 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. Effective September 1, 2018, the United Food and Commercial Workers Union District Local 663 and the Food Handlers Division of District Local 663, Section A;

B. Effective September 1, 2018 other Local Union that is or may become a part of the United Food and Commercial Workers Union District Local 663 and the Food Handlers Division of District Local 663, Section A; and

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

SECTION 2 SCHEDULE OF BENEFITS

2.1. COMPREHENSIVE MAJOR MEDICAL BENEFITS

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

PLEASE NOTE: **Out-of-network inpatient non-Emergency Services are excluded from coverage, except that the Plan will cover certain non-Emergency Services furnished to you by a non-Preferred Provider at a Participating Healthcare Facility subject to the conditions described below in Section 3.2.1A.B, the Plan's generally applicable cost-sharing and coordination of benefits provisions, and in accordance with the Consolidated Appropriations Act, 2021.**

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%
Telehealth visits other than through Doctor on Demand	Plan pays 80%, unless the visit is for COVID-19, in which case the Plan pays 100%

2.2. PRESCRIPTION DRUG BENEFITS

Effective June 1, 2021, only Prescription Medication purchased through the Express Scripts network will be covered. Prescription Medication filled at CVS, Walmart, Target, Hy-Vee, Sam's Club, Costco, and Coborn's 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 proton-pump inhibitors and OTC non-sedating antihistamines upon a Physician's written prescription	Plan pays 100%
Prescriptions purchased through the Specialty Drug Program	Plan pays 80%

Certain drugs will be subject to prior authorization and some will also be subject to "Step Therapy," split fills (i.e. a 30-day prescription will be filled in two 15-day increments to determine whether the drug is tolerated by participant to reduce waste) and quantity level limits (dispensing only quantities that will actually be used).

The Step Therapy program is a "step" approach to providing the medications that treat your condition. This means that you may first need to try a more clinically appropriate or cost-effective medication before certain higher-cost medications will be approved. Step Therapy programs can help both you and the Plan save money. A medication meets the Plan's Step Therapy requirements if it is the most cost-effective medication available to treat a disease or condition. This means that if your doctor prescribes you a new medication that is subject to the Plan's Step Therapy program, the Plan will initially only cover the least expensive "step" in that drug class, typically a generic drug. If the first step medication does not safely and effectively treat your condition, the Plan will cover the next "step,", typically a formulary brand medication.

Effective June 1, 2021, if your doctor recommends prescription drugs or quantities that do not comply with the prior authorization and/or Step Therapy protocols, your doctor will need to submit a prior authorization (PA) request that will include the medical reasons supporting that request to Express Scripts. Your doctor can visit www.express-scripts.com to download the PA form. If, as of August 1, 2019, you have started use of a prescription under the Plan's schedule in a manner that does not follow the above rules, you will be grandfathered with regard to that prescription and with regard to the above rules for Step Therapy and prior authorization. To obtain a current list of these prescriptions, please call the Plan Administrator at (952) 851-5797.

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.

Effective June 1, 2021, the Preferred Provider for the Prescription Drug Program is Express Scripts. Only prescriptions that are purchased through the Express Scripts network will be covered.

3.1.1. Payment of Benefits

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

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.

3.1.3. Generic Substitution Requirement

Generic Prescription Medication will be substituted in lieu of any prescribed brand name Prescription Medication if it is commercially available and if such substitution is consistent with the prescription, the dispensing pharmacist’s professional judgement, and applicable law.

3.2. PREFERRED PROVIDER NETWORK

Effective June 1, 2021, the Plan uses the UnitedHealthcare Choice Plus Network as its Preferred Provider network. Although the Plan covers certain services at in-network and out-of-network Hospitals and services provided by Preferred Providers and non-Preferred Providers, you will generally pay less if you use an in-network or Preferred Provider.

Subject to the Plan’s standard cost-sharing requirements (coinsurance, copayments, and deductibles) and coordination of benefits rules, the Plan will cover certain claims for services provided by non-Preferred Providers as if the services were provided by Preferred Providers (i.e., you will not be subject to balance billing). This rule applies to: (i) claims for Emergency Services provided by a non-Preferred Provider and/or at a non-Participating Health Care Facility; (ii) claims for certain non-Emergency Services furnished to you by a non-Preferred

Provider at a Participating Health Care Facility; and (iii) claims for non-Preferred Provider Air Ambulance Services. in accordance with the Consolidated Appropriations Act, 2021. The exact costs payable by you and the Plan for such claims will be determined in accordance with rules and regulations established pursuant to the Consolidated Appropriations Act, 2021.

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. Effective June 1, 2021, the Plan's Preferred Provider network also offers Wellness CARE (a tobacco and nicotine cessation program) and Maternity CARE (a prenatal support program).

For charges incurred with Preferred 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-Preferred Providers, the Plan will pay the Usual and Customary Charge or, if applicable, a separately negotiated amount to the non-Preferred 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-Preferred Provider, except as described below in Section 3.2.1A.

3.2.1A. Certain Non-Preferred Provider Services Treated as Preferred Provider Services

Effective March 1, 2022, subject to the Plan's standard cost-sharing requirements (coinsurance, copayments, and deductibles) and coordination of benefits rules, the Plan will cover certain claims for services provided by non-Preferred Providers as if the services were provided by Preferred Providers (i.e., you will not be subject to balance billing). This rule applies only to: (i) claims for Emergency Services provided by a non-Preferred Provider and/or at a non-Participating Health Care Facility; (ii) claims for certain non-Emergency Services furnished to you by a non-Preferred Provider at a Participating Health Care Facility; and (iii) claims for non-Preferred Provider Air Ambulance Services. The exact costs payable by you and the Plan for such claims will be determined in accordance with rules and regulations established pursuant to the Consolidated Appropriations Act, 2021.

A. <u>Emergency Services Provided by a Non-Preferred Provider and/or at a Non-Participating Health Care Facility</u>. Emergency Services provided by a non-Preferred Provider and/or at a non-Participating Health Care Facility will be covered to the same extent as if provided by a Preferred Provider at a Participating Health Care Facility. This may include costs for additional services after the patient stabilizes, such as post-stabilization outpatient observation or inpatient or outpatient stays with respect to the visit for which the Emergency Services were initially furnished. Post-stabilization items and services will not be treated as in-network Emergency Services, however, if both of the following are true:

1. The attending Emergency Physician or treating Provider determines that the individual is able to travel using nonmedical transportation or nonemergency medical transportation to an

available Preferred Provider or Participating Health Care Facility located within a reasonable travel distance, taking into account the individual's medical condition; and

2. Except in cases where unforeseen, urgent medical needs arise, the non-Preferred Provider or non-Participating Health Care Facility furnishing the post-stabilization items or services satisfies the notice and consent criteria described below for non-Emergency Services provided by a non-Preferred Provider at a Participating Health Care Facility, but subject to the following additional conditions:

    (a) If the Hospital or Independent Freestanding Emergency Department is a Participating Health Care Facility, but the Provider is a non-Preferred Provider, the written notice must contain a list of any Preferred Providers at the Participating Health Care Facility who are able to furnish the items and services involved and must notify the patient that he or she may be referred, at his or her option, to such a Preferred Provider; or

    (b) If the Hospital or Independent Freestanding Medical Department is not a Participating Health Care Facility, the written notice must include a good faith estimate of the charges for items or services furnished by the facility or Providers for the visit (and any items or services reasonably expected to be furnished by the facility or non-Preferred Providers in conjunction with those items or services).

B. Non-Emergency Services Provided by a Non-Preferred Provider at a Participating Health Care Facility.

1. When an Eligible Person receives non-Emergency Services at a Participating Health Care Facility, the Plan will cover the following to the same extent as if provided by Preferred Providers (provided that all other criteria for coverage are met, e.g., the services are Medically Necessary):

    (a) Ancillary services, which are:

        i. Items and services related to Emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner;

        ii. Items and services provided by assistant surgeons, hospitalists, and intensivists;

        iii. Diagnostic services, including radiology and laboratory services; and

iv. Items and services provided by a non-Preferred Provider if there is no Preferred Provider who can furnish such item or service at such facility; and

(b) Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-Preferred Provider satisfied the notice and consent criteria described below.

2. Non-Emergency Services provided by a non-Preferred Provider at a Participating Health Care Facility will not be covered to the same extent as if provided by a Preferred Provider if the Provider or the Participating Health Care Facility (on behalf of the Provider) satisfies the following notice and consent criteria by:

(a) Providing the patient a written notice within the time frame noted below, in paper form or, as practicable, electronic form (as selected by the patient), provided separately from other documents and containing the following information:

i. A statement that the Provider is a non-Preferred Provider;

ii. A good faith estimate of the charges for the items and services involved or reasonably expected to be provided;

iii. Notice that the estimate of charges or the patient's consent to be treated by the non-Preferred Provider is not a contract for the estimated charges or a contract to be treated by that Provider or at that facility;

iv. A statement that prior authorization or other care management limitations may be required before receiving further items or services at the facility; and

v. A clear statement that consent to receive items or services from the non-Preferred Provider is optional, that the patient may instead seek care from an available Preferred Provider, and that, in such cases, cost-sharing would be limited to Preferred Provider cost-sharing amounts;

(b) Providing the written notice:

i. Not later than 72 hours before the date on which the individual is furnished the items or services, when the appointment is scheduled at least 72 hours in advance; or

ii. Not later than three hours before the appointment, when the appointment is not scheduled at least 72 hours in advance;

(c) Obtaining from the patient (or Participant, Beneficiary, or other authorized representative) a signed consent that is current (i.e., has not been revoked), that was obtained voluntarily (i.e., the individual must be able to consent freely, without undue influence, fraud, or duress), and that is in a form specified by the Department of Health and Human Services. The consent must:

i. Acknowledge in clear and understandable language that the patient (or Participant or Beneficiary) has been provided the written notice described above in the form (mail or email) he or she selected and informed that the payment of non-Preferred Provider charges might not count toward a deductible, out-of-pocket maximum, or other cost-sharing limitation;

ii. State that by signing the consent, the individual agrees to be treated by the non-Preferred Provider and understands that he or she may be billed for the balance and subject to cost-sharing requirements that apply to services furnished by a non-Preferred Provider; and

iii. Document the time and date of receipt of the written notice described above and the time and date of the signed consent;

(d) Providing the patient with a copy of the signed written notice and consent in person, by mail, or by email; and

(e) Making the notice and consent available upon request in any of the 15 most common languages in the state or geographic region and, for other languages, if the individual does not understand the notice and consent, obtaining the services of a qualified interpreter to assist the individual with understanding the notice and consent.

C. Non-Preferred Provider Air Ambulance Services. Air Ambulance Services provided by a non-Preferred Provider may be treated as Preferred Provider expenses as described below in Section 5.1.I.2.

3.2.2. UMR Maternity Management Service

Effective June 1, 2021, Employees and Eligible Dependents have access to UMR's maternity management service, UMR Maternity CARE. Enrolling in this program can help

you learn how healthy lifestyle choices and proper medical care before and during your pregnancy can boost your odds of having a healthy, full-term baby.

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 maternity management service 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 UMR at 888-438-8105 or visit www.umr.com 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.

PLEASE NOTE: **Out-of-network inpatient non-Emergency Services are excluded from coverage, except that the Plan will cover non-Emergency Services furnished to you by a non-Preferred Provider at a Participating Healthcare Facility subject to the conditions described above in Section 3.2.1A.B, the Plan's generally applicable cost-sharing and coordination of benefits provisions, and in accordance with the Consolidated Appropriations Act, 2021.**

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). Whether a covered item or service is Medically Necessary will be determined in accordance with UnitedHealthcare’s medical policy.

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 and out-of-network inpatient non-Emergency Services are excluded from coverage, except that the Plan will cover inpatient non-Emergency Services furnished to you by a non-Preferred Provider at a Participating Healthcare Facility subject to the conditions described above in Section 3.2.1A.B, the Plan's generally applicable cost-sharing and coordination of benefits provisions, and in accordance with the Consolidated Appropriations Act, 2021.

Coverage for Emergency Services will be provided without the need for any prior authorization. The Plan will not impose any administrative requirement or limitation to coverage for Emergency Services from out-of-network Providers that is more restrictive than for Emergency Services from Preferred Providers.

The Plan will cover out-of-network Emergency Services, non-Emergency Services furnished to you by a non-Preferred Provider at a Participating

Healthcare Facility, and out-of-network Air Ambulance Services in accordance with the Consolidated Appropriations Act, 2021, as more fully described above in Section 3.2.1A. Your cost-sharing requirements for these specific out-of-network services will be no greater than would apply if the services were provided by Preferred Providers.

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

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, and diaphragms, except for diabetic supplies;
2. Drugs and medications that can be obtained without a Prescription Order, except insulin, OTC Preventive Care medications, OTC proton-pump inhibitors, and OTC non-sedating antihistamines 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. Cosmetic drugs;
7. Health and beauty aids, cosmetics, and dietary supplements;
8. State restricted drugs;
9. Impotence medications; and
10. Injections and injectables, except insulin when prescribed by a Physician and Prescription Medications 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;

(e) In the absence of a medical contraindication, complete twelve (12) months of continuous hormone therapy appropriate to the Eligible Employee's and/or the Employee's Dependent's gender goals and complete twelve (12) months of living in a congruent gender role;

(f) Obtain treatment from a Provider and facility with appropriate experience in the provision of the requested services; and

(g) Obtain precertification prior to surgical procedure.

6. Hormone therapy is covered for an Eligible Employees and/or Employee's Dependent under the Prescription Drug Benefit under the following conditions:

(a) Completion of evaluations as outlined and have a diagnosis of Gender Dysphoria with no contraindications to treatment;

(b) Treatment must be ordered and supervised by a Provider experienced in the treatment of individuals with Gender Dysphoria;

(c) The Eligible Employee and/or the Employee's Dependent must obtain precertification prior to beginning therapy; and

(d) The Eligible Employee and/or the Employee's Dependent must be age 18 or over.

I. Other covered expenses for:

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

2. Local ground ambulance services to the nearest health care facility qualified to provide Medically Necessary treatment for an Emergency or acute Illness, or a Provider-initiated inter-health care facility transfer to the nearest health care facility qualified to provide the Medically Necessary treatment.

Subject to the Plan's generally applicable cost-sharing and coordination of benefits provisions, the Plan also covers Medically Necessary Air Ambulance Services to the nearest health care facility qualified to provide Medically Necessary treatment for an Emergency. The Plan also will cover, subject to the Plan's generally applicable cost-sharing and coordination of benefits provisions, a Provider-initiated inter-health care facility transfer to the nearest health care facility qualified to provide the Medically Necessary treatment. Charges are payable for Medically Necessary Air Ambulance Services subject to the Plan's deductible and coinsurance and the reimbursement terms available to the Plan

through the Preferred Provider's contract. Air Ambulance Services will be provided only as Medically Necessary: (i) due to inaccessibility by ground transport; and/or (ii) if the use of ground transport would result in a serious adverse impact on the Eligible Person's health status.

Out-of-network Air Ambulance Services will be covered, subject to the Plan's generally applicable cost-sharing and coordination of benefits provisions, in accordance with the Consolidated Appropriations Act, 2021. The cost-sharing requirements will be the same as Air Ambulance Services provided by a Preferred Provider.

Expenses incurred for transportation and/or ambulance services, including Air Ambulance Services, are not covered if such services are incurred for the convenience of the Eligible Person, the Eligible Person's health care Provider, or the Eligible Person's family or another individual involved in the Eligible Person's care. Expenses for any transportation and/or ambulance services are not covered if the Plan determines that the transportation and/or ambulance services are not Medically Necessary.

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 in-network Hospital immediately following the surgery.

7. Emergency room treatment for accidental Injury or an Emergency.

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

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.

27. For the duration of the national emergency concerning COVID-19, the Plan will cover at 100% (no member cost share) claims for COVID-19 diagnostic testing and diagnosis as well as the related office (urgent care, emergency room) visit during which the treating health care provider determined such testing was Medically Necessary and appropriate according to the accepted guidelines of the Federal Food and Drug Administration ("FDA") and/or the respective state Department of Health.

28. Effective March 1, 2020, the Plan will pay claims for a medical or dental procedure for a Participant or Participant's Dependent(s) that was scheduled to occur prior to the declaration of the national emergency concerning COVID-19 on March 13, 2020 ("National Emergency") and was canceled by the health care or service provider due to the National Emergency, and who subsequently had his or her coverage terminated under the Plan before the procedure could be completed. To be eligible for coverage for such procedure, Participants and/or Dependent(s) must provide documentation to the Fund Office demonstrating that (1) the procedure was originally scheduled prior to the National Emergency for a date after such declaration; (2) the procedure was canceled by the health care or service provider after the commencement of the National Emergency; and (3) and the procedure was rescheduled and performed no later than December 31, 2020.

29. Effective January 15, 2022, and for the duration of the public health emergency concerning COVID-19, the Plan will provide coverage for at-home over-the-counter ("OTC") COVID-19 test kits subject to the following provisions. The Plan will only cover COVID-19 test kits available "over-the-counter" that have been approved by the FDA for use at home or elsewhere without involvement of a health care provider. The Plan will provide coverage for up to eight at-home OTC COVID-19 test kits per Eligible Person covered under the Plan every 30 days.

    For Eligible Persons other than those covered under the Plan's Ancillary Benefits package, the Plan will cover 100% of the cost of an at-home OTC COVID-19 test kit purchased at a Preferred Provider Pharmacy. Plan reimbursement for at-home OTC COVID-19 test kits that are not purchased at a Preferred Provider Pharmacy will be limited to the cost of the test or $12, whichever is

less. The Eligible Person is responsible for any amount in excess of $12 for an at-home OTC COVID-19 test kit purchased a non-Preferred Provider Pharmacy or any other retailer or supplier. The Plan will not count these costs towards the Prescription Drug Program annual out-of-pocket maximum.

For Eligible Persons covered only under the Plan's Ancillary Benefits package, the Plan will cover 100% of the cost of an at-home OTC COVID-19 test kit purchased at any Pharmacy or other retailer or supplier.

The above provisions only apply to at-home COVID-19 test kits and do not affect the Plan provisions regarding coverage at non-at-home OTC COVID-19 test kits described in Paragraph (27) above.

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.

I. Surrogate maternity services.

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

K. Transportation, except ambulance services, including Air Ambulance Services, as described in Section 5.1.2.I.2.

L. Abortions.

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

N. Any services and supplies for, or related to, artificial insemination, in vitro-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. Reversal of genital surgery; hair replacement or removal; voice therapy or lessons; liposuction; rhinoplasty; breast augmentation; lip reduction; lip augmentation; laryngeal or thyroid cartilage shaving or contouring; abdominoplasty; chest wall contouring; body contouring; facial contouring; skin resurfacing; collagen injections; reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or Gender Dysphoria surgery; cryopreservation of fertilized embryos; oocyte preservation; surrogate parenting; donor eggs; donor sperm and host uterus; or any other service considered to be cosmetic or not Medically Necessary under the Plan.

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 special home construction to accommodate a disabled Eligible Person.

Z. 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.

AA. 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.

BB. Radial keratotomy or Lasik surgery.

CC. 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.

DD. 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 Prescription Drug Program for OTC proton-pump inhibitors and OTC non-sedating antihistamines), unless the prescription qualifies as Preventive Care.

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

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

GG. 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.

HH. 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.

II. 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.

JJ. 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.

KK. 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.

LL. Charges for PCSK9 drugs and drugs containing bulk powders unless the Eligible Person receives preauthorization by the Plan for such drugs.

MM. Charges for out-of-network inpatient services except in the case of an Emergency and as provided in Section 3.2.1A.B.

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,” but, by definition, these provisions do not apply because the Plan does not require prior authorization of urgent care or Emergency Services.

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.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing a post-service claim.

Starting on March 1, 2020, the deadline to file a post-service claim was suspended during a “Tolling Period,” which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the “Outbreak Period”); or

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 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 a Preferred Provider; and (ii) the Fund Office accepts a request to pay the claims directly to the Provider. 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 Provider directly, or the charges were incurred with a non-Preferred Provider, benefits will be paid directly to the Eligible Person upon proper submission of the claim and proof of payment.

Notwithstanding the previous paragraph, the Fund Office will make payments directly to non-Preferred Providers and non-Participating Health Care Facilities for Emergency Services, certain non-Preferred Providers for non-Emergency Services performed at Participating Health Care Facilities, and non-Preferred Provider Air Ambulance Services in accordance with the Consolidated Appropriations Act, 2021 and Section 5.1.2.I.2 above.

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.

7.4. EXTERNAL REVIEW

The Plan will permit external review of adverse benefit determinations in accordance with Section 2719 of the Public Health Service Act and its implementing regulations. If the Plan denies your claim (including a claim involving consideration of whether the Plan is complying with the surprise billing prohibitions of Sections 716 and 717 of ERISA and the regulations issued thereunder, as provided by the Consolidated Appropriations Act, 2021) or if your coverage is rescinded, and your appeal of that adverse benefit determination is denied, 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 of the initial adverse benefit determination. For more information on external review, contact the Fund Office.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing a request for an external review.

Starting on March 1, 2020, the deadline to file a request for an external review was suspended during a “Tolling Period,” which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the “Outbreak Period”); or

One (1) year from the date the claimant was first eligible for relief from the deadline related to filing a request for an external review. The earliest date that a claimant was first eligible for relief from a deadline related to filing a request for an external review was either:

1. March 1, 2020 for claim appeal denials occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. The date of a claim appeal denial after March 1, 2020, but before March 1, 2021.

The calculation of a claimant’s Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each claimant. The Tolling Period may not exceed one (1) year. If the claim appeal denial was provided to the claimant prior to March 1, 2020, the number of days by which the claimant is required to take action after the Tolling Period is shortened by the number of days between the date that the claim appeal denial was provided and March 1, 2020.

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 UnitedHealthcare 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.

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.

10.5. CONSOLIDATED APPROPRATIONS ACT, 2021

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Consolidated Appropriations Act, 2021 ("CAA"). The Plan has been amended to comply with the requirements of the CAA as of the effective date of Amendment No. 18: March 1, 2022.