HEALTH CARE PLAN
SUMMARY PLAN DESCRIPTION

For members of
United Food and Commercial Workers Union Local 789
and St. Paul Food Employers Health Care Plan

Effective Date: November 1, 2005

PLEASE PRINT COMPLETE AND RETURN **BASIC DATA CARD** PLEASE PRINT

United Food and Commercial Workers Union Local 789 and St. Paul Food Employers Health Care Plan

Full Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP CODE

Social Security No. _____ Date of Birth _____
MONTH DAY YEAR

Employer _____

☐ MALE
☐ FEMALE

No. of Children _____

Spouse's Name _____ Social Security No. _____

Dependent's Name _____ Social Security No. _____

Dependent's Name _____ Social Security No. _____

Full Name & Relationship of

BENEFICIARY _____
LAST FIRST MIDDLE INITIAL RELATIONSHIP

The Above Named Beneficiary Supercedes Any and All Beneficiaries Previously Designated

_____
Date Signed Signature of Employee

Health Care Plan

A Summary Plan Description

For Members of

United Food and Commercial Workers Union Local 789
and St. Paul Food Employers Health Care Plan

Revised as of November 1, 2005

SCHEDULE OF BENEFITS

PLAN 1 AND PLAN 2

For Employees Only

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

For Dependents of Full-Time Employees Only

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

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

COMPREHENSIVE MAJOR MEDICAL BENEFITS	**Plan 1**	**Plan 2**
Comprehensive Major Medical Benefits cover reasonable expenses related to hospital services, physicians' services, x-ray and laboratory services, and other covered items and services when medically necessary.		
Deductible amount per person per calendar year	$ 300	$ 300
Maximum deductible amount per family per calendar year (For Plan 1 only)	$ 900	Not Applicable
Plan's copayment of reasonable expenses (unless otherwise specified)	80%	80%
Annual out-of-pocket maximum for covered expenses per calendar year, including the deductible amount (but NOT including the cost of services for treatment of nervous or mental disorders, abuse of substances, and alcoholism which have not been precertified by TEAM or for infertility treatment)		
Per person	$2,500	$2,500
Per family (For Plan 1 only)	$5,000	Not Applicable
Plan pays 100% of covered expenses in excess of the out-of-pocket maximum for the remainder of that calendar year.		
Lifetime maximum payment per person	$1,000,000	$100,000
Under Plans 1 and 2, the deductible and copayment amounts are waived for covered expenses related to the following services: (a) Pre-admission testing. (b) Hospice care. (c) Home health care, up to a maximum of 40 visits per person per calendar year[1]. For such services, the Plan pays 100% of reasonable expenses incurred, up to the lifetime maximum.		
The following are specific maximum amounts which Plans 1 and 2 pay for certain services and supplies covered under Comprehensive Major Medical Benefits provisions:		
(a) Hospital room and board expense		
: for general and acute care	up to admitting hospital's semi-private room rate	
: for intensive or coronary care	up to twice admitting hospital's semi-private room rate	
(b) Skilled nursing home care		
Maximum confinement per person per period of disability	30 days	30 days

[1] The Trustees may extend this maximum as they deem appropriate on a case-by-case basis.

COMPREHENSIVE MAJOR MEDICAL BENEFITS (continued)	Plan 1	Plan 2
(c) Chiropractic fees		
Maximum per visit	$ 35	$ 35
Maximum per person per calendar year	$ 900	$ 900
(d) Treatment for nervous and mental disorders, abuse of substances, and alcoholism		
Inpatient and Partial Hospitalization		
: If precertified and authorized by TEAM		
Plan's copayment	80%	80%
Maximum aggregate number of days per person per calendar year	31[2,3,4,5]	31[1,2,3,4]
: If NOT precertified by TEAM and/or TEAM's recommendations are NOT followed		
Plan's copayment ***(Eligible person's copayment share will NOT be applied toward out-of-pocket maximum)***	60%	60%
Maximum aggregate number of days per person per calendar year	15[1,2]	15[1,2]
Outpatient Treatment		
: If precertified and authorized by TEAM		
Plan's copayment	80%	80%
Maximum aggregate number of visits per person per calendar year	50[6]	50[5]
: If NOT precertified by TEAM and/or TEAM's recommendations are NOT followed		
Plan's copayment ***(Eligible person's copayment share will NOT be applied toward out-of-pocket maximum)***	60%	60%
Maximum aggregate number of visits per person per calendar year	10[5]	10[5]
(e) Artificial life support		
Limited to first five days after death up to maximum	$ 5,000	$ 5,000
(f) Infertility treatment (For Plan 1 employees and spouses and Plan 2 employees)		
Separate deductible amount per person (once per lifetime)	$ 100	$ 100
Plan's copayment ***(Eligible person's copayment share will NOT be applied toward out-of-pocket maximum)***	80%	80%
Lifetime maximum per person, not to exceed the lesser of the remaining balance under Comprehensive Major Medical Benefits or…	$10,000	$10,000
(g) Genetic testing		
Lifetime maximum per person	$ 2,000	$ 2,000

[2] Each day of partial hospitalization counts as ½ day.
[3] Lifetime maximum number of days per person for alcoholism and substance abuse is 90.
[4] If TEAM deems necessary, the full 90 days may be used in one calendar year.
[5] For nervous and mental disorders, the Trustees may extend this maximum an additional 15 days per person per calendar year (not to exceed three such extensions, up to an additional 45 days, per person per lifetime) as they deem appropriate on a case-by-case basis upon the recommendation of TEAM and verification of medical necessity.
[6] Lifetime maximum number of visits per person for alcoholism and substance abuse is 90.

DENTAL CARE BENEFITS	Plan 1	Plan 2
Percentage payable:		
Diagnostic and preventive services[7]	80%	80%
Basic and special services[1]	80%	80%
Special restorative services	80%	80%
Prosthetics	80%	50%
Maximum per calendar year	$1,000	$800
Orthodontics (for children ages 8 to 18)		
Percentage payable	50%	Not Applicable
Lifetime maximum	$750	Not Applicable

VISION CARE BENEFITS (Plan 1 Only)	Plan 1	Plan 2
Eye examinations, lenses, and frames		
Plan's copayment	80%	Not Applicable
Aggregate maximum per person per calendar year	$300	Not Applicable

PREFERRED PROVIDER PHARMACY PRESCRIPTION DRUG BENEFITS	Plan 1	Plans 2 and 3
Eligible person's copayment per prescription for up to a 34-day supply or 100 units, whichever is greater, at a retail participating pharmacy (or, for maintenance drugs, up to a three-month supply through the Mail Service Pharmacy)	20% with a $10 minimum copayment and a $50 maximum copayment[8]	Plan 2: 20% of the discounted cost[2] Plan 3: 25% of the discounted cost[2]

[7] For Plans 1 and 2: If an eligible person utilizes a dental provider who participates in the DeltaPreferred Option network, benefits are payable as follows:

For diagnostic and preventive services: 100%; and

For basic and special services, including endodontics, periodontics, and oral surgery: 90%.

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

For Retirees and Their Dependents
(Plan 3 - Available Beginning at Age 55)

COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Deductible amount per calendar year	
Per person	$100
Per family	Maximum of 3 individual deductibles
Plan's copayment	75% of first $10,000 of reasonable expenses per person per calendar year; then 100% for remainder of calendar year for such person
Lifetime maximum per person	$250,000
Copayment rates that differ from preceding rates:	
Partial hospitalization for nervous and mental conditions, alcoholism, and substance abuse	80%, up to 20 days per person per calendar year
Outpatient treatment of nervous and mental disorders	80%, up to 8 visits per person per calendar year
Emergency first-aid	100%
Deductible and copayment requirements waived:	
Outpatient surgery	100%
Pre-admission testing	100%
Routine physical examinations (one per calendar year for each employee and each spouse)	100%
Second surgical options	100%
Hospice care	100%
Home health care	100%, up to 40 visits per person per calendar year[9]

[9] The Trustees may extend this maximum as they deem appropriate on a case-by-case basis.

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

Page

UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 789 AND ST. PAUL FOOD EMPLOYERS HEALTH CARE PLAN

To All Active Employees and Retirees:

The Trustees of your Health Care Plan are happy to provide you with this new Summary Plan Description (SPD) effective November 1, 2005. In easy-to-understand language, it tells you how to become and remain eligible for benefits, explains the benefits available, and gives you instructions on how to apply for benefits. If there should be any inconsistencies between this simplified Summary and the more technical legal Plan Document and Trust Agreement, the legal documents will govern. The Trustees have the right to change, add, or to delete benefits, self-payment rates, Eligibility Rules, or any other provisions relating to the operation of the Plan in an effort to best serve all Plan participants.

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

The Eligibility Rules and benefits are maintained at levels in line with Trust Fund income and assets and they are reviewed regularly to provide you with the best protection possible within the Fund's financial means. All Plan provisions are updated as necessary to comply with legal requirements, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its Privacy Rules and Security Regulations and the Claims Procedure Regulations.

Please see page 21 for details of the arrangement the Fund has with Blue Cross Blue Shield of Minnesota, which offers a network of hospitals and physicians that gives the Fund and its members preferred rates. If you or a member of your family must see a doctor or go to the hospital, we strongly urge you to go to a Blue Cross Blue Shield of Minnesota AWARE Network PPO provider. Both you and the Fund will save money. ***Remember: You can use your identification card for all services, including Blue Cross Blue Shield of Minnesota AWARE Network, TEAM, and Caremark Union Retail Network Pharmacies.***

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

Yours sincerely,
The Board of Trustees

Employer Trustees	**Union Trustees**
Dave Gerdes	Howard Kern
David G. Johns, alternate	Caroline Larsen
Edward G. Kitz	Shirley Muelken
Mike Oase	Tom Oswald, alternate
William Seehafer	Don Seaquist

The addresses of the Trustees are found on page 56.

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

ELIGIBILITY RULES

The following Rules I-14 govern eligibility for Plan benefits.

1. Who Is Eligible?

You are eligible to receive benefits from the United Food and Commercial Workers Union Local 789 and St. Paul Food Employers Health Care Plan under Plan 1 or Plan 2 if you are employed by a participating employer and proper contributions are made to the Fund in your behalf as required by the collective bargaining agreement or other written agreement, such as a participation agreement.

2. When Are Employer Contributions First Payable?

Your employer first is obligated to contribute in your behalf according to the current collective bargaining agreement or participation agreement.

3. What Is the Effective Date of My Eligibility?

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

(a) You will become eligible under Plan 1 (full-time employees) provided that you have eight weeks of full-time contributions made in your behalf during a 12-consecutive-week period.

(b) Effective for any part-time employee hired after March 6, 2005, you will become eligible under Plan 2 (part-time employees) after working 12 months for a contributing employer. During that 12-month period, the employer must make at least one contribution to the Health Fund in your behalf in each of the 12 months. A month is defined by the payment calendar.

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

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

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

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

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

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

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

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

5. What Is Required To Remain Eligible?

Your continued eligibility is determined weekly. Once you have established eligibility, it continues so long as employer payments to the Fund are made in your behalf for each subsequent week. The amount of the employer contribution is specified by the collective bargaining agreement or participation agreement in effect at the time the contributions are earned. The amount contributed determines the Plan under which you are covered.

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

In the event you lose eligibility as a part-time employee, the following rules will apply:

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

(b) If you have had more than six months in a row for which no employer health contributions are required, and you are not on an approved leave of absence from your employer, you must begin again the 12-month period of employment.

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

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

In the event a change in the number of hours you (as a full-time employee) work causes a change in the employer contributions in your behalf, your Plan of benefits will change. In that event, the change in benefits will become effective on the day after you have used all grace weeks. If you continue to work part-time under the terms of the collective bargaining agreement or participation agreement, if applicable, with part-time contributions made in your behalf, you will be eligible for part-time employee benefits which provides coverage for the employee only.

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

7. How Are Grace Weeks Used To Continue Coverage?

Each employee who has qualified for health benefits, for either full-time or part-time coverage, will accumulate a total of up to eight weeks of grace. Grace weeks are accumulated during the period in which eligibility is established as described in Rule 3. Once you have become eligible, you may accumulate up to eight grace weeks by purchasing grace weeks at the cost established by the Trustees, but only if you are actively employed by a participating employer on the date the purchase is made. A full-time employee only may purchase full-time grace weeks and a part-time employee only may purchase part-time grace weeks.

The Fund Office will deduct a grace week of health benefits whenever a current weekly contribution is not received for the coverage in effect, provided that coverage has not been extended subject to Rule 10. When all of the grace weeks have been used and there are no current contributions, your coverage will be terminated. However, you still have available the option of continuing coverage by self-payments as described in the following Rule 8 (COBRA).

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

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

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

(a) Qualifying Events

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

(1) For employees eligible because of employer contributions, Qualifying Events occur when coverage is reduced or terminated because of:

(i) a reduction in hours of covered employment for any reason, including disability, sickness, or retirement; or

(ii) voluntary or involuntary termination of covered employment for any reason (except gross misconduct on your part), including disability, sickness, or retirement.

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

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

(ii) your death;

(iii) divorce or legal separation from you;

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

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

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

(b) Notifications and Due Dates

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

When the Qualifying Event relates to your death, divorce or legal separation, or a dependent ceasing to meet the definition of dependent under the Plan, the Qualified Beneficiary must notify the Fund Office directly within 60 days of the Qualifying Event so the Fund Office may provide proper notices and explanations to Qualified Beneficiaries about continued eligibility. When providing notice to the Fund Office, the Qualified Beneficiary must provide documentation to support the occurrence of the Qualifying Event. In case of divorce or legal separation, a copy of the divorce or legal separation decree or similar documentation evidencing the divorce

or legal separation will be required. In the case of a loss of dependent status, documentation indicating the date dependent status was lost will be required.

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

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

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

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

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

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

The Fund Office, not later than 14 days after receipt of notice, will advise the Qualified Beneficiary of the coverages, options, costs, self-payment due dates, and duration of these self-payment privileges.

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

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

The Fund Office, not later than 14 days after receipt of notice of your loss of coverage from the employer or by examining monthly contribution reports, will advise the Qualified Beneficiary of the coverages, options, costs, self-payment due dates, and duration of these self-payment privileges.

(4) Due Date for Qualified Beneficiary's Response

A Qualified Beneficiary has 60 days from the date of coverage termination or the receipt of the COBRA Notice, whichever is later, to elect whether to continue coverage. The election should be communicated to the Fund Office in writing on an Election Form. Each employee, spouse, and dependent child has the right to make their own individual election. However, covered employees may elect to continue coverage on behalf of their spouses, and parents may elect to continue coverage on behalf of their children.

You have 60 days to elect for COBRA continuation coverage. Failure to

properly elect for COBRA continuation coverage by filing the election form with the Fund Office within 60 days will serve to terminate your right to elect for COBRA continuation coverage.

(5) Due Date for Initial Self-Payment

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

(6) Due Dates for Subsequent Self-Payments

Subsequent monthly self-payments must be made by the first day of the month for that month of coverage. The Plan allows a 30-day grace period for making self-payments.

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

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

(c) Coverages and Options

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

(i) Medical Benefits only;

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

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

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

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

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

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

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

(d) Cost of Continuation Coverage

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

Continuation coverage will be purchased on a monthly basis by payment of the predetermined monthly self-payment amount. However, employees and dependents who lose coverage on any day other than the first of a month will be required only to pay a pro rata share of the monthly self-payment to continue coverage until the first day of the next calendar month, at which time full monthly self-payments will be required for continuing coverage.

An employee or dependent who purchases continuation coverage for a period of less than one month, which period is immediately preceded and followed by periods of eligibility attributable to the application of employer contributions and/or grace weeks, will be eligible to pay a pro rata portion of the monthly self-payment amount for coverage during this gap period.

(e) Duration of Continuation Coverage

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

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

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

(2) the Qualified Beneficiary notifies the Fund Office in writing within 60 days of the SSA determination and before the end of the first 18 months of continu-

ation coverage and provides a copy of the SSA determination to the Fund Office.

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

Failure to provide notice of a disability or second Qualifying Event as explained previously in this subsection (e) 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), or a dependent child ceasing to meet the definition of dependent under the Plan, the spouse and eligible dependents may continue coverage for up to 36 months from the date of the Qualifying Event. When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. These general rules are applied to specific circumstances as follows.

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

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

(2) Ceasing Active Work

If you become eligible for leave under the Family and Medical Leave Act of 1993 (FMLA), refer to Rule 14 to determine the effect of the FMLA on the provisions of this section.

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

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

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

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

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

(B) You (or any other Qualified Beneficiary) may continue coverage for yourself and your dependents for up to 29 months of disability or until the end of your period of disability, whichever is longer, provided the Social Security Administration (SSA) determines that any of the Qualified Beneficiaries are disabled under the Social Security Act either: at the time

employment terminated or hours were reduced; or at any time within 60 days of such Qualifying Event, and provided the Qualified Beneficiary notifies Trustees within 60 days of the SSA determination and before the end of the first 18 months of continuation of coverage.

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

Retirees with less than 25 years of service with contributing employers within the Twin City area, including the last five years of participation within the Fund, at retirement will have the option of either choosing COBRA continuation coverage or continuing to pay a nonsubsidized rate based on their age. They will be provided with the Plan 3 retiree benefit level immediately upon retirement, provided they are under age 65.

Retirees with 25 or more years of service at retirement will first be required to elect and pay for COBRA coverage until the earlier of: 18 months after they retire; or attainment of age 65. Their self-payment rate will be based on whether they had 25 through 29 years of service or 30-plus years of service. The COBRA coverage provides the same level of benefits the employee had immediately preceding his retirement (Plan 1 or Plan 2). Following such 18-month period, benefits will be provided at the retiree level of benefits provided under Plan 3, provided the retiree is under age 65.

Coverage for full-time retirees will continue to be offered on a single or family basis; however, full-time retirees must pay the "full-time COBRA" rate regardless of dependent coverage status. Retirees will have the option of choosing Medical Benefits only; or Medical, Dental Care and Vision Care Benefits.

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

Employees Returning to Work After Retirement: If a retiree returns to work on a part-time or temporary basis, employer contributions received by the Fund in their behalf will reduce the amount of the full-time or part-time self-payment otherwise due.

Retiree coverage which continues after exhaustion of continuation coverage rights is subject to change based on Trustee review. The Trustees retain the right in their sole discretion to modify retiree Eligibility Rules, types and amount of benefits, terms and conditions under which benefits are payable, and self-payment rates to the extent allowed by COBRA.

(3) Loss of Dependent Status

(i) If family coverage ceases due to your death, divorce or legal separation, coverage may be continued by your spouse and dependent children for up to 36 months. However, if a retired employee who is covered under Plan 3 dies, his surviving spouse and dependent children who were covered under the Plan at the time of his death may continue Plan coverage by making self-payments. This right terminates if the surviving spouse becomes covered under another health plan with comparable coverage or, in the case of a dependent child, such child ceases to be a dependent as defined on page 59.

(ii) If a dependent child's coverage ceases because of a change in the child's dependent status due to age, marriage, employment, or student enrollment, the former dependent coverage may be continued for the former dependent for up to 36 months.

(f) Multiple Qualifying Events

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

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

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

(1) the Plan no longer provides health care coverage to any eligible employee;

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

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

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

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

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

(7) the maximum continuation coverage period is reached;

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

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

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

9. How Can I Reinstate My Coverage?

If you are terminated from employment (as that process is defined by the collective bargaining agreement or participation agreement), you have exhausted all grace weeks of coverage, and you have not continued coverage with self-payments, you will be required to regain eligibility under the terms of Rules 3 and 5 of this Plan before becoming entitled to participate again.

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

All employees who become eligible to receive Accident and Sickness Benefits from this Fund or Worker's Compensation Benefits will continue coverage for a period extending for the shorter of: 13 weeks from the date eligibility otherwise would cease; or the date eligibility for Accident and Sickness Benefits or Worker's Compensation Benefits ceases.

Employees working under the Retail Meat Contract will be entitled to receive up to an additional 13 weeks of coverage extension for the period they remain eligible for Worker's Compensation Benefits. You must notify the Fund Office when you are receiving Worker's Compensation Benefits in order to receive the extension of coverage. In no case will benefits be extended beyond 13 weeks for a Grocery employee or 26 weeks for a Meat employee.

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

11. When Does My Coverage Terminate?

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

(a) the date the Plan terminates;

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

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

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

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

Certificate of Creditable Coverage: In accordance with the Health Insurance Portability and Accountability Act of 1996

(HIPAA), the Plan will issue a certificate of creditable coverage to you and your dependents when your regular Health Care Benefits Plan coverage or COBRA continuation coverage terminates (and also, upon request, within 24 months thereafter). The certificate provides information on the period of your coverage under the United Food and Commercial Workers Union Local 789 and St. Paul Food Employers Health Care Plan that may be credited on your behalf to satisfy any applicable pre-existing condition limitations of a new health plan in which you enroll.

12. Are My Dependents Covered if My Spouse and I Divorce?

Yes. If you are a full-time employee, coverage for your dependent children who were covered under the Plan on the date of your divorce will remain in force to the same extent as if the divorce had not occurred with no self-payment requirement of or for such dependent children.

Your former spouse is entitled to continue coverage by making required self-payments according to Rule 8. If either of these events occurs, self-payments in the full amount determined by the Trustees will be required for the remainder of the 36 months. This provision does not allow coverage to be extended beyond the period specified in Rule 8.

13. What Happens When an Employee Enters Military Service?

(a) Eligibility Status

(1) You must submit advance written 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). If you submit such notice, your coverage and your dependents' coverage will cease and your eligibility status will be frozen as of the date you enter military service with the uniformed services of the United States, unless you elect to continue coverage as described in the following subsection (b).

(2) If you do not submit such notice, your accumulated grace weeks, if any, will be applied until exhausted to further extend your eligibility. Your coverage will terminate on the date all accumulated grace weeks have been exhausted. If you subsequently submit notice in a reasonable time period, the application of grace weeks will cease.

(3) Your eligibility will be reinstated on the date you return to work for a participating employer (or you are available for work if no such work is available) within the applicable time limits stated in the following subsection (c). If all grace weeks have been exhausted because you failed to submit notification of your military service, you will be treated as a new employee.

(b) Continuation of Coverage

(1) When the Fund Office has been notified that you are entering the military service, you and your eligible dependents will be given the option of continuing coverage under the Plan.

(2) You will have the option of applying accumulated grace weeks, if available, to continue coverage. If grace weeks are not available or you choose not to use them, you are required to make timely self-payments at a rate to be determined by the Trustees from time to time to purchase such coverage.

(3) Your self-payments must be made by the last day of each month in which eligibility and coverage terminate, or within a 30-day grace period.

(4) Failure to make self-payments before the end of the grace period will cause eligibility and coverage to terminate at

the end of the month for which you last made a timely self-payment.

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

(i) the first day of the month for which a timely self-payment has not been received and your grace weeks have been exhausted;

(ii) 24 months from the first date of absence due to military service (or 18 months for any military leave that begins prior to December 10, 2004); or

(iii) the day after the date you fail to apply for reemployment with a participating employer within the applicable time period allowed under the following subsection (c). The right to freeze eligibility and make self-payments under this provision ceases when you provide written notice that you do not intend to return to work for a participating employer after uniformed service.

(c) Status Upon Return from Military Service

If you are eligible for benefits when you enter the military service and you do not exhaust employer-provided coverage by using grace weeks, you and your eligible dependents again will be eligible for benefits on the date of your return to work for a participating employer within the following time periods:

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

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

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

Such time periods may be extended for injuries or sicknesses, as determined by the Secretary of Veteran Affairs, to have been incurred or aggravated during your service in the uniformed services. If you exhaust your grace weeks prior to your return from military service, you will be treated as a new employee.

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

If you become eligible for leave according to the Family and Medical Leave Act of 1993 (FMLA), your coverage under the Plan may be continued for up to 12 weeks, provided your employer is subject to the Act, makes the required contribution (or you do so), and files the appropriate notification and certification forms with the Fund Office. To be subject to the Act, an employer must have at least 50 employees within 75 miles. If your leave is eligible under the FMLA, and you do not return to work after the leave, then for COBRA continuation coverage purposes under Rule 8, the date of the Qualifying Event will be the last day of your FMLA leave. For additional information regarding your rights under the Family and Medical Leave Act, see page 51.

YOUR RESPONSIBILITIES AS A PARTICIPANT UNDER THE PLAN

1. Notify the Fund Office Immediately Regarding Any Change in Address.

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

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

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

2. Notify the Fund Office of a Desired Change in Beneficiary and Any Change in Marital Status.

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

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

For your convenience, you will find a Basic Data Card in the front of this booklet which you may use to notify the Fund Office about an address or beneficiary change. Or just drop a note in the mail with your new address and/or beneficiary designation and send it to the Fund Office.

3. Notify the Fund Office Immediately Regarding Any Change in Dependent Child Status.

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

Also, inform the Fund Office immediately if one of your dependent children becomes ineligible for any reason, such as age, student status, or marriage, so certificates of prior creditable health coverage can be issued in a timely manner. Change of dependent status may trigger COBRA rights.

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

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

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

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

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

6. Notify the Fund Office of Other Group Health Care Coverage.

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

INSTRUCTIONS FOR FILING A CLAIM

Pre-service claims: You must obtain precertification from the Family Assistance Program (FAP) manager for non-emergency inpatient and all outpatient treatment of nervous and mental disorders, substance abuse, and alcoholism for eligible persons covered under Plans 1 and 2. See page 27 for details on how to obtain precertification. Also, you must contact the Fund Office for prior authorization for all organ transplants and certain prescription drugs, such as anorexic drugs and drugs for erectile dysfunction. In addition, the Trustees must approve home health care visit extensions beyond 40 visits per eligible person per calendar year for Plans 1, 2, and 3. Claims such as this are called "pre-service claims," which means any claim which requires approval of the benefit in advance of obtaining medical care. Claims requiring precertification by the FAP may be submitted initially by telephone. All other claims requiring prior authorization must be submitted in writing to the Fund Office.

Please note that 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 to your Plan because the Plan does not require prior authorization of emergency admissions.

Post-service claims: Any claim for benefits that is not a pre-service claim is considered a "post-service claim." Post-service claims include those for emergency treatment of nervous and mental disorders, substance abuse, and alcoholism. You must notify the Plan within 48 hours following such an emergency admission. You must submit all other post-service claims in writing within 90 days after you receive the bill for such medical treatment, or as soon thereafter as is reasonably possible. In no event can you submit a claim later than one year from the time proof otherwise is required.

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

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

(a) Fund name (United Food and Commercial Workers Local Union No. 789 and St. Paul Food Employers Health Plan);

(b) Employee's name and Social Security number;

(c) Full name (including "Jr.," if applicable) and date of birth of the eligible person who incurred the covered expense;

(d) Name and address of the service provider;

(e) Federal tax identification number of provider;

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

(g) Procedure or nature of the treatment;

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

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

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

Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address. A general request for an interpretation of Plan provisions will not be considered a claim for benefits. Predetermined amounts you must pay, such as a prescription drug

copayment or amount required because of use of a network or non-network provider, will not be considered a claim for benefits subject to the claims procedures. However, if you feel you have been charged an improper dollar or percentage copayment (for example through the Preferred Provider Pharmacy Program), you may submit a formal appeal to the Fund Office in writing within 180 days to have your claim reviewed according to the claims review and appeal procedures stated on pages 17 through 19.

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

Benefits are paid directly to you, or to the provider if you assign benefits to the provider on a form acceptable to the Trustees.

CLAIMS REVIEW AND APPEAL PROCEDURES (AS REQUIRED BY ERISA)

When you submit a pre-service claim, the Plan (meaning either the FAP or Fund Office, as applicable) will notify you whether or not the claim is approved within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days of the Plan's receipt of the claim. If you fail to follow the Plan's procedures for filing a claim, you will be notified of the failure and the proper procedures as soon as possible, but no later than five days following the failure. We will notify you verbally, unless you request us to notify you in writing. If the FAP denies your pre-service claim, you can contact them directly according to their internal review process which will be stated in the determination letter for reconsideration of your claim. If you are not satisfied with the determination, you can file a formal appeal to the Fund Office in writing, subject to the claims review and appeal procedures which follow.

For post-service claims, the Plan will notify you of an adverse benefit determination within a reasonable period of time, but not later than 30 days of the Plan's receipt of a claim.

For both pre- and post-service claims, 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 15-day extension. The Plan will notify you prior to the expiration of the initial 15- or 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 your failure to submit necessary information to decide the claim, the Plan, in the notice of extension, will specifically describe the required information needed. The time period for making the determination is suspended from the date on which the notice of the necessary information is sent to you until the date you respond. You have 45 days from receipt of the notice to respond to the request for information. Once you respond, the Plan will decide the claim within the 15-day extension period. Your claim will be denied if you do not respond in a timely manner. The Plan may take only one extension for group health claims and may not further extend the time for making its decision unless you agree to a further extension.

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 Plan amendment or termination) before the scheduled end of the treatment. Although this situation almost never arises, we are required by law to tell you that this provision exists. If the Plan reduces or terminates treatment before the end of the course of the treatment, the Plan will notify you far enough in advance of the termination or reduction of treatment to allow you to appeal the adverse benefit determination and obtain a determination on review before the termination or reduction takes effect.

When you submit a claim for benefits to the Fund Office, the Fund Office will determine if you are eligible and calculate the amount of benefit payable, if any.

If your claim for benefits is denied in whole or in part, the Plan will provide you, your dependent, beneficiaries, or authorized or legal representatives, as may be appropriate (hereafter referred to as "you" or "your") with written notice of adverse benefit determinations within the time frames previously stated. Notices will include the following information stated in an easily understandable manner:

(a) The specific reason or reasons for the adverse benefit determination.

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

(c) A description of any additional material or information, if any, necessary for you to perfect

your claim and an explanation of why the material or information is necessary.

(d) A description of the Plan's claims review and appeal procedures and time limits applicable to such appeal procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

(e) 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 you upon request.

(f) If the adverse benefit determination was based on a medical necessity or experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request.

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

If all or part of a claim is denied or if you are otherwise dissatisfied with the determination made by the Plan, or if you have not received the notice of denial of your claim within the applicable time limits after the Plan has received all necessary claim information, you have 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) **You will have 180 days after you receive the notice of an adverse benefit determination to file your appeal in writing to the Fund Office and it must include the specific reasons you feel denial was improper.**

(b) You will be allowed the opportunity to submit written issues and comments, documents, records, and other information relating to the claim for benefits which may have been requested in the notice of denial or which you may consider desirable or necessary.

(c) You or your 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 your claim for benefits.

(d) Your review will take into account all comments, documents, records, and other information submitted by you relating to the claim, 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 professional 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 nor the subordinate of such individual.

(g) If a medical or vocational expert's advice was obtained on behalf of the Plan in connection with your claim, you 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 you of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days of 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 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, but the Plan must notify you of this extension and of the special circumstances and the date as of which the determination will be made prior to the extension time. The Plan will provide you with written notice of an adverse benefit determination as soon as possible but within five days of the decision being made. The notice will include the following information stated in an easily understandable manner:

(1) The specific reason or reasons for the adverse benefit determination.

(2) References to specific Plan provision(s) on which the adverse benefit determination is based.

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

(4) A statement of your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the Plan's claims review and appeal procedures.

(5) 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 determination and that a copy of such criterion will be provided free of charge to you upon request.

(6) If the adverse benefit determination was based on a medical necessity or experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request.

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

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

YOUR FAMILY ASSISTANCE PROGRAM
PLANS 1, 2, AND 3

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

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

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

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

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

How To Use Your Family Assistance Program

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

Some problems can be resolved with a counselor over the phone. Or, you may choose to schedule a meeting with a counselor at any of TEAM's convenient locations throughout the metro area.

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

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

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

BLUE CROSS BLUE SHIELD OF MINNESOTA PREFERRED PROVIDER ARRANGEMENT

The Board of Trustees has entered into a preferred provider arrangement with "Blue Cross Blue Shield of Minnesota AWARE Network (BCBSM)." BCBSM provides a network of hospitals, physicians, and other health care professionals, named in the directory you previously received, who provide high quality medical care while helping you and us to manage costs. You have the option of choosing a BCBSM/PPO provider or a non-PPO provider each time you need medical services. Your current hospital or physician already may be a member of this network. A BCBSM provider list is available upon request, without charge, from the Fund Office. You also may contact BCBSM at 1-800-810-2583 or visit their website at www.bcbs.com.

These hospitals and physicians have agreed to offer you and the Fund "preferred" rates. Your out-of-pocket expenses will be less because your copayment will be applied to reduced charges.

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

BCBSM also provides case management services. If a catastrophic or other suitable case (such as an organ transplant) is referred to them, BCBSM will review the case to determine if case management is appropriate. If so, BCBSM will contact you, your physician, and the Fund Office to discuss treatment options and to identify available community resources. If you and your physician approve, they will coordinate the necessary services. It is often hard to make decisions about ongoing care. Case management allows you to discuss your concerns openly and makes you aware of all your options. Also, both you and the Fund may save money if a less costly setting is appropriate and you choose to use it. But remember, the choice is yours. The case manager will offer you alternatives, but you and your physician have the final decision.

BENEFITS FOR PLAN 1 AND PLAN 2

Life Insurance Benefits

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

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

Your Life Insurance

If you die from any cause, your beneficiary will be paid the amount of insurance specified in the Schedule of Benefits.

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

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

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

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

(d) to your estate.

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

Your beneficiary designation and any change in beneficiary must be filed in writing with the 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. You may not assign the Life Insurance Benefit.

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

Total Disability Benefit

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

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

(b) the date you convert your group insurance.

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

Continuation of Life Insurance

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

To continue Life Insurance Benefits, you must send the 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 60 days after written notification is sent from the Fund Office of your right to continue, including the premium amount and due date.

If you or one of your covered dependents dies within the 60-day election period and before an election whether to continue or not has been made, the insurance company will pay the amount which

could have been continued, less any premium owing at the date of death.

Continued Life Insurance Benefits end on the earliest of:

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

(b) the day a conversion policy is obtained;

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

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

When continued Life Insurance Benefits end, you and your dependents can convert as outlined under "Conversion Privilege."

Conversion Privilege

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

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

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

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

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

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

(a) you;

(b) your spouse;

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

(d) your dependent's estate.

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

If both you and your spouse are eligible as employees, both may enroll for Life Insurance Benefits and Accidental Death and Dismemberment Benefits and then be insured as a dependent for Dependent Life Insurance Benefits.

Conversion Privilege

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

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

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

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

Accidental Death and Dismemberment Benefits

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

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

(a) the principal sum for loss of life;

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

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

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

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

Limitations

In addition to the Plan's General Limitations, which begin on page 41, Accidental Death and Dismemberment Benefits do not cover losses from:

(a) intentionally self-inflicted injury or suicide;

(b) war or any act of war;

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

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

Accident and Sickness Benefits

Plan 1 Only
For Full-Time Employees Only

For each week you are totally disabled and under a physician's care because of injury, sickness, or pregnancy, you will be paid a weekly benefit during any disability equal to the percentage of your weekly earnings and up to the maximum per week and number of weeks specified in the Schedule of Benefits.

The day of disability on which benefits begin is:

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

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

(c) For surgical procedures performed on an outpatient basis: eighth day of disability (however, if the disability extends past the seventh day, benefits are paid retroactively to the first day, provided you submit a physician's written certification of total disability).

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

Comprehensive Major Medical Benefits

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

When you or your dependent require covered services or supplies which are medically necessary because of injury or sickness, benefits are payable as stated in the Schedule of Benefits, provided you have satisfied any required deductible. If there are limitations for a particular benefit, they are

explained with each benefit. General Limitations for the Plan begin on page 41.

Deductible

The deductible is the amount of covered expenses which you pay before you are entitled to benefits. The deductible per person per calendar year and aggregate maximum per family each calendar year for Plan 1 are stated in the Schedule of Benefits. If you use the cost-effective alternatives the Trustees have approved as described on pages 31 and 32, the deductible is waived. Also, there is no deductible required for prescription drugs obtained at a preferred provider pharmacy as described on pages 36 and 37.

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

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

Copayment

After you satisfy the deductible amount, the Plan pays covered expenses at the copayment percentage stated in the Schedule of Benefits, up to the lifetime maximum. The balance of charges is payable by you. If you use the cost-effective alternatives the Trustees have approved as described on pages 31 and 32, the copayment is waived.

When the out-of-pocket covered expenses in a calendar year, including the deductible amount, reach the maximum per person or per family for Plan 1 as stated in the Schedule of Benefits, the Plan pays 100% of the balance of covered expenses for that person or family for the remainder of that calendar year. "Family" means one or more eligible persons within a family unit, consisting of you and your dependents.

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

Covered expenses incurred for the following will not be applied toward your out-of-pocket maximum:

(a) treatment of nervous or mental disorders, abuse of substances, and alcoholism which have not been precertified by TEAM; and

(b) infertility treatment.

Lifetime Maximum

The maximum amount payable with respect to all injuries and sicknesses of any one eligible person during such individual's entire lifetime is stated in the Schedule of Benefits and may be renewed or reinstated as provided in the Plan Document.

All Comprehensive Major Medical Benefits will terminate as to an eligible person on the date the lifetime maximum is paid or becomes payable for all losses due to all injuries and sicknesses covered by the Comprehensive Major Medical Benefits section, subject to the reinstatement provisions.

Covered Expenses

Benefits are payable for reasonable expenses incurred for the following services and supplies which are medically necessary for the treatment of an injury or sickness.

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

  (1) Room and board expense, up to the admitting hospital's semi-private room rate.

  (2) Confinement in an intensive care or coronary care unit, but not to exceed twice the admitting hospital's semi-private room rate.

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

(4) Drugs, medicines, diagnostic x-rays and laboratory tests, and other hospital miscellaneous services and supplies not included in the room charges (including the anesthetist's fee when charged by the hospital), if used while confined in the hospital as a resident patient. See page 31 for coverage of pre-admission testing expenses.

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

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

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

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

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

Successive periods of disability, due to the same or related causes, not separated by return to full-time active work for at least two weeks or, in the case of a dependent, return to normal activities of a person of like age and sex in good health for a period of six months, will be considered as one period of disability unless the subsequent period of disability is due to injury or sickness entirely unrelated to the causes of the previous disability.

In-hospital benefits are not payable for hospitalizations starting on weekends for treatment or surgery scheduled to begin the following Monday or later, unless scheduled to begin before 6:00 a.m. Monday morning.

See page 27 for coverage of hospital confinements, partial hospitalization, and care in a residential treatment facility related to treatment of nervous and mental disorders, abuse of substances, and alcoholism.

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

(1) you are transferred to the nursing home within 24 hours of hospital discharge;

(2) you were hospitalized for at least five days immediately before transfer to the nursing home;

(3) the attending physician certifies this care is medically necessary and recertification is made every seven days;

(4) further hospitalization would be necessary if not for skilled nursing home confinement; and

(5) the daily room rate does not exceed that established by the Minnesota Department of

Health and Social Services or by a similar agency if in another state.

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

(1) Surgery by a physician, including charges for outpatient surgery, home deliveries, circumcision of an eligible newborn dependent child of a Plan 1 eligible person, and the surgical removal of impacted wisdom teeth. For organ transplant surgery and related items, see pages 29 and 30.

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

(3) Medical services rendered during in-hospital, outpatient, office, and home visits, including examination of an eligible newborn dependent child of a Plan 1 eligible person when the examination is performed within 48 hours of birth by a physician, and a simple office visit related to a pap test.

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

See the following section for coverage of physicians' services for outpatient treatment for nervous and mental disorders, abuse of substances, and alcoholism. See page 31 for coverage of physicians' services for routine physical examinations.

(d) **Inpatient and Outpatient Expenses Related to Treatment for Nervous and Mental Disorders, Abuse of Substances, and Alcoholism,** up to the aggregate maximums stated in the Schedule of Benefits.

The number of inpatient days will be calculated as follows:

(1) Each day of confinement in a hospital or residential treatment facility will count as one full day.

(2) Each day of partial hospitalization at an approved hospital, clinic, and/or non-medical residential treatment facility will count as one-half day.

Outpatient treatment must be rendered in a hospital, approved outpatient psychiatric facility, or a facility licensed by the state of Minnesota to provide these services (or a similar agency if in another state), except that a physician can render such treatment at any location. Outpatient treatment includes collateral interviews with your family when you are present, medical evaluations, and psychological testing.

To receive the maximum benefits possible, you must call TEAM, the Family Assistance Program (FAP) manager, before you begin any treatment related to these specified conditions. In addition, TEAM must authorize your treatment program and will provide ongoing case management of your treatment. Any treatment beyond what is initially authorized must be approved by TEAM. **Both inpatient and outpatient benefits for these conditions will be payable at 80% if precertified and authorized by TEAM. If you do not precertify and/or follow TEAM's recommendations, benefits payable will be reduced to 60% of reasonable expenses and your copayment share will not be applied toward your out-of-pocket maximum.**

For example, let's say you were in the hospital for five days at a cost of $800 per day, for a total bill of $4,000. If you precertify with TEAM, the Plan will pay 80% of those charges, or $3,200. If you do not precertify and follow TEAM's recommendations, the Plan only will pay 60%, or $2,400. You will be responsible to pay $800 more out of your own pocket. Also, the entire 40% you pay will not apply toward your out-of-pocket maximum.

REMEMBER: You must call TEAM at (651) 642-0182 or 1-800-634-7710 to receive precertification <u>before</u> you incur <u>any</u> expenses in order to receive the higher copayment.

However, we realize that in emergency situations you are not always able to call ahead

of time. In the event of an emergency requiring immediate hospitalization or admission to a treatment center, you must notify TEAM within 48 hours following the emergency admission.

(e) **Diagnostic X-Ray and Laboratory Services,** including the pap test regardless of the purpose for which it is performed and for amniocentesis. Genetic testing, other than amniocentesis, is payable only under specific parameters described under subsection (i) on page 30. Expenses for dental x-rays [unless rendered for dental treatment of temporomandibular joint disorder (TMJ) or a fractured jaw or injury to natural teeth within six months after an accident] or allergy tests are excluded.

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

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

(2) Services of a qualified physiotherapist, occupational therapist, speech therapist, registered nurse (R.N.), or licensed practical nurse (L.P.N.). Benefits are payable for services of a licensed speech therapist under the supervision of a physician for a condition resulting from an injury, sickness, or congenital disorder such as cleft lip or palate. However, benefits are not payable for speech therapy for a condition resulting from developmental or learning disabilities or a personality disorder.

(3) Local professional ground ambulance service to the nearest hospital and if the injury or sickness requires special and unique hospital treatment, transfer to the nearest hospital equipped to furnish such treatment, provided you obtain prior documentation of medical necessity.

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

(4) Charges for the following additional services and supplies: oxygen and the rental of equipment for its administration; x-ray, radium, or cobalt treatment, including the services of a radiologist and the rental (but not purchase) of such radioactive materials, provided that treatment is rendered in the radiologist's office or in the outpatient department of the hospital making the charge; blood and blood plasma (if not replaced) and its administration; surgical dressings, casts, splints, braces (except dental braces), trusses, and crutches; rental of hospital-type bed, wheelchair, or iron lung (or the purchase of such device if the rental would exceed the purchase price); initial artificial limbs and eyes replacing natural limbs and eyes, provided such replacement occurs promptly following the loss and in no event later than six months from the date of the loss; dental services (excluding dental implants) rendered by a physician, dentist, or dental surgeon for treatment of a fractured jaw or injury to natural teeth, including replacement of such teeth within six months after the date of the accident; the first set of lenses following cataract surgery; contraceptive devices which require the written prescription of a physician, and contraceptive injections and surgical procedures when administered or performed by a physician (voluntary sterilizations are covered for employees and dependent spouses); initial pair of podiatric orthotic appliances when prescribed by a physician and medically necessary replacement; custom-made stockings, such as Jobst stockings, up to two pair per eligible person per calendar year; medically necessary durable medical equipment; and following a mastectomy for which benefits are payable under the Plan (including a covered prophylactic mastectomy), coverage will be provided for the following in a manner determined in consultation with the attending physician and the patient: reconstruction of the breast and nipple or surgical implant of a prosthesis on the breast on which the mastectomy has been performed and of the contralateral breast to produce symmetrical appearance; treatment of physical complications at all stages of mastectomy, including lymphedemas; breast prostheses; and two mastectomy bras per eligible person per calendar year.

A prophylactic mastectomy will be covered when an eligible person has:

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

A prophylactic oophorectomy will be covered when an eligible person has:

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

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

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

Benefits for prescription drugs payable under the Preferred Provider Pharmacy Benefits are described on pages 36 and 37.

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

See pages 31 and 32 for coverage of routine immunizations, hospice care, and home health care.

(g) **Organ and Tissue Transplant Surgery** and related covered costs including human organ or tissue transplants during the transplant benefit period to a recipient who is an eligible person, not to exceed, in the aggregate, the Comprehensive Major Medical lifetime maximum stated in the Schedule of Benefits. A transplant benefit period consists of five days before and eighteen months after the date of a transplant. If the transplant decision has been approved as specified later in this section, but the eligible transplant procedure has to be delayed for reasons such as the recipient's medical condition or the unavailability of an organ, the transplant benefit period may be extended to include more than five days prior to the transplant.

Organ transplant benefits are payable provided each of the following conditions is satisfied:

(1) You or your dependent must have been eligible under the Plan for at least 24 consecutive months immediately prior to incurring covered expenses. Newborn dependent children covered under Plan 1 will be eligible for organ transplant benefits provided the parent who is an employee has been a full-time participant for at least 24 months immediately prior to the newborn organ transplant.

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

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

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

(5) You must contact the Fund Office for prior approval for all organ transplants.

Transplants of the following human organs or tissues are covered when transplanted to an eligible person:

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

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

All other covered services for the recipient will be payable under the Plan the same as for any other injury or sickness.

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

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

No organ transplant benefits are payable for:

(1) services not ordered by a physician;

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

(3) animal or mechanical organs for transplantation;

(4) investigational drugs;

(5) any items specified in the Plan's General Limitations which begin on page 41;

(6) purchase of the organ or tissue;

(7) the use of experimental mechanical equipment;

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

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

(h) **Infertility Treatment** for 80% of reasonable expenses incurred by employees and dependent spouses in Plan 1 and employees in Plan 2. These benefits are subject to a separate $100 deductible which must be satisfied once per lifetime before any benefits are payable under this subsection. This deductible is in addition to any other deductible(s) required under the Plan. Also, your copayment share of covered expenses for infertility treatment will not be applied toward satisfaction of your annual out-of-pocket maximum required under Comprehensive Major Medical Benefits.

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

The aggregate maximum amount payable for infertility treatment will not exceed the lesser of:

(1) $10,000 per lifetime; or

(2) the balance remaining of the overall Comprehensive Major Medical Benefits lifetime maximum stated in the Schedule of Benefits.

Benefits payable for infertility treatment are considered as part of the overall Comprehensive Major Medical Benefits lifetime maximum.

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

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

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

(3) You and/or your dependent spouse has produced a child with mental retardation, a hereditary disease, or a birth defect; or

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

Genetic testing, other than amniocentesis, will be subject to the separate lifetime maximum for such services as stated in the Schedule of Benefits.

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

(k) **Well Baby/Well Child Care** for Plan 1 eligible dependent children from birth to age 24 months. Eligible expenses include routine examinations and related x-ray and laboratory charges.

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

Alternative Ways of Obtaining Care

Deductibles and copayments are waived for the following benefits available under Comprehensive Major Medical Benefits to encourage you and your physician to consider their use. If you and your physician use these less costly systems and facilities for appropriate treatment, you will help keep your own and Plan costs under control. These benefits are subject to all other provisions of the Plan unless otherwise specified.

Pre-Admission Testing

Laboratory tests and x-rays sometimes are needed by your physician before treatment begins or surgery takes place. Sometimes these tests and x-rays may be performed without being hospital-confined. Whether they are performed before or after hospitalization begins is a decision for you and your physician to make.

When you or your dependent incur expenses for pre-admission testing, the Plan will pay 100% of the reasonable expenses incurred for diagnostic laboratory tests and x-rays performed in a hospital outpatient department, physician's office, or clinic which are required for medically necessary treatment you are scheduled to receive upon hospital admission, provided:

(a) you are scheduled for hospital admission and the scheduled admission occurs;

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

(c) hospital benefits are payable for the treatment or surgery.

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

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

(b) a hospital bed is not available; or

(c) the tests showed that admission is not medically necessary or that treatment or surgery is required to be deferred beyond seven days of the testing.

Hospice Care

When it is medically determined that an eligible person is terminally ill, the eligible person (or his authorized representative, such as a family member) and the physician may prefer hospice care as opposed to hospital confinement. Benefits are payable for 100% of reasonable expenses incurred for covered hospice services during the period in which the eligible person otherwise, upon recommendation of his physician, would have to be hospital-confined. Such benefits are payable for

home care administered under an approved hospice program or home health care agency at the patient's home, or for care in a hospice unit of a hospital or a separate hospice facility. Covered hospice services include:

(a) physicians' visits;

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

(c) assessment visit by a hospice program staff member;

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

(e) drugs and supplies prescribed by a physician.

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

Home Health Care

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

(a) hospitalization or confinement in a skilled nursing home would be required in the absence of home health care;

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

(c) home health care services are coordinated by a state-licensed or Medicare-certified home health care agency or certified rehabilitation agency.

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

Reasonable expenses are payable for up to 40 visits per person each calendar year. Benefits are payable for additional visits exceeding the 40-visit maximum, provided the Trustees determine such visits to be medically necessary, cost-effective, and the most appropriate course of treatment based upon recommendations of the case manager.

Covered home health care services include:

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

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

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

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

(e) nutritional counseling by a registered dietitian when medically necessary; and

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

Limitations: Home health care benefits are not provided for:

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

(b) custodial care;

(c) services or supplies not included in the home health care plan established for the patient;

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

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

Comprehensive Major Medical Benefits Limitations

In addition to the Plan's General Limitations which begin on page 41 and other limits that apply to specific benefit provisions as described in those sections, Comprehensive Major Medical Benefits do not cover:

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

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

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

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

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

(f) any loss caused by or resulting from mental deficiency, mental retardation, developmental deficiencies, or any treatment for learning disabilities;

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

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

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

(j) routine care for dependent children (except well baby/well child care is covered for eligible dependent children from birth to age 24 months who are covered under Plan 1).

Dental Care Benefits

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

Delta Dental Plan has been selected to provide your dental coverage. The Group Dental Contract issued to the Fund is the complete document of coverage and governs all claims processing. You can find a participating network dentist by calling: 1-800-448-3815 or visiting: www.deltadentalmn.org.

The Plan stresses the concept of "preventive care," encouraging you and your dependents to receive regular dental care to avoid the acute and expensive problems that many times arise from neglected dental care.

You are free to go to the dentist of your choice. When your dentist is a Delta Dental Plan of Minnesota (DDPM) Participating Dentist, benefits are payable at the applicable percentage of negotiated charges as stated in the Schedule of Benefits. You will not be billed for charges that exceed the negotiated amount.

If you utilize a dental provider who participates in the DeltaPreferred Option network, benefits for regular diagnostic and preventive services, and basic and special services are payable at a higher percentage as stated in the Schedule of Benefits.

When you are treated by a non-participating dentist, benefits are payable at the applicable percentage of reasonable expenses as stated in the Schedule of Benefits. You may be billed for charges that exceed reasonable expenses.

What Do Your Dental Care Benefits Cover?

Benefits are payable for the following dental procedures performed, up to the maximum and at the applicable percentages specified in the Schedule of Benefits.

Regular Diagnostic and Preventive Services

Regular diagnostic and preventive services include:

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

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

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

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

(e) oral hygiene instruction as prescribed by the dentist, but not more than once per lifetime of an eligible person; and

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

Basic and Special Restorative Services

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

Basic services include:

(a) emergency treatment for relief of pain;

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

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

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

(e) sealants: coverage limited to once per lifetime of permanent molars of eligible dependent children up to their 16th birthday.

Special services include:

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

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

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

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

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

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

Special restorative services include:

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

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

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

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

(d) Filled composite resin restorations for posterior teeth.

Limitations:

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

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

Prosthetics (Removable and Fixed)

Prosthetics includes coverage for:

(a) repairs and adjustments to prosthetic appliances; and

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

Replacement Benefits

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

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

Orthodontics (For Dependents of Full-Time Employees Only)

Benefits are payable under this section for eligible dependents from eight to eighteen years of age.

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

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

Dental Care Benefits Limitations

In addition to the Plan's General Limitations which begin on page 41, Dental Care Benefits are not payable for:

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

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

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

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

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

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

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

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

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

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

Alternative Treatment Plans

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

Reconstructive Surgery

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

Vision Care Benefits

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

If you or your dependent incur physicians' charges for any of the following covered expenses, benefits are payable at the copayment and up to the aggregate maximum amount per person per calendar year specified in the Schedule of Benefits.

Eye Examinations

Each eligible person is entitled to one exam each calendar year.

Lenses and Frames

Each eligible person is entitled to one set of lenses and one set of frames each calendar year. Fees for professional services for fitting and adjusting also are covered.

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

Limitations

In addition to the Plan's General Limitations which begin on page 41, Vision Care Benefits are not payable for:

(a) sunglasses;

(b) safety lenses and goggles;

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

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

Preferred Provider Pharmacy Prescription Drug Benefits

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

When you incur expense for prescription drugs at a Preferred Provider Pharmacy (including Cub, Snyder, and Rainbow Pharmacies), benefits will be payable for federal legend drugs, insulin and insulin syringes, and contraceptives requiring a written prescription executed by a physician or dentist and dispensed by a licensed pharmacist.

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

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

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

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

If you use the identification card to obtain a prescription which is not covered under the Plan, you will be responsible for reimbursing the Fund for the full amount less your copayment. For further information regarding non-covered prescriptions, see the Limitations section on page 37.

If the prescription is being obtained from a participating Caremark National Retail Network Pharmacy, then you must pay the pharmacist for the entire discounted cost of the prescription at the time of purchase and submit a claim for reimbursement to Caremark. You will be reimbursed for 100% of the discounted prescription price, less your copayment, provided the prescription is for an eligible person.

Dispensing Limitations

At a retail pharmacy, you are entitled to the amount of prescription legend drugs or insulin usually prescribed by the attending physician or dentist, but not to exceed a 34-day supply or 100 units, whichever is greater.

Maintenance drugs may be purchased through the Mail Service Pharmacy in a three-month supply.

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

Limitations

In addition to the Plan's General Limitations which begin on page 41, Preferred Provider Pharmacy Prescription Drug Benefits are not payable under this section for:

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

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

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

(d) refilling of a prescription in excess of the number specified by a physician or dentist;

(e) medication dispensed during hospital confinement including confinement in a rest home, sanitarium, extended care facility, skilled nursing home, convalescent hospital, or similar institution which operates on its premises a facility for dispensing pharmaceuticals;

(f) drugs prescribed for treatment of infertility (see page 30 for coverage of such prescription drugs);

(g) cosmetics and dietary aids, except where classified as "prescription legend drugs"; or

(h) emergency contraceptive kits; drugs whose sole purpose is to promote or stimulate hair growth (such as Rogaine and Propecia); Renova; Retin-A (except covered for acne); alcohol wipes for diabetics; smoking cessation gums, inhalers, and sprays; and anorexic drugs. Anorexic drugs (meaning weight loss drugs and appetite suppressants) are excluded, unless the eligible person has been diagnosed as morbidly obese and such prescriptions are preauthorized by the Fund Office. Prior authorization also is required for erectile dysfunction prescriptions.

BENEFITS FOR PLAN 3

Comprehensive Major Medical Benefits
Plan 3
For Retirees and Their Dependents

Comprehensive Major Medical Benefits include substantial coverage for the catastrophic or disaster type injury or sickness which involves hospital, surgical, and medical expenses.

Deductible

The deductible is the amount of covered expenses which you pay before you are entitled to Comprehensive Major Medical Benefits. It is $100 per person per calendar year.

The deductible amount applies separately to you and each of your dependents, except that no more than three individual deductibles will be charged against your family's total Comprehensive Major Medical Benefits during any calendar year.

The deductible amount is applicable each calendar year. Any covered expense incurred and applied toward the deductible during the last three months of any calendar year also is applied to the deductible requirements for the following year.

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

Copayment

After satisfaction of the deductible amount, the Plan will pay 75% of the first $10,000 of covered expenses per person per calendar year; then the Plan will pay 100% of covered expenses for the remainder of that calendar year for such person, up to the lifetime maximum. Covered expenses incurred during the last three months of the preceding calendar year which you had to pay are counted toward your $2,500 out-of-pocket copayment limit for the following calendar year.

Lifetime Maximum

The lifetime maximum is specified in the Schedule of Benefits. It applies separately to you and each of your dependents. This lifetime maximum is effective with your change in status to Plan 3.

If you or your dependent has received Comprehensive Major Medical Benefits, a portion of the lifetime maximum will be reinstated automatically on the first of each calendar year. The maximum will be increased by the lesser of the amount of benefits paid or $1,000. In no event will the maximum exceed the initial amount specified in the Schedule of Benefits.

Further, at any time you or your dependent has received Comprehensive Major Medical Benefits, the lifetime maximum may be reinstated to the full amount on the date evidence of good health is approved as being satisfactory. The required evidence must be submitted by you or your dependent at your own expense.

Description of Benefits

Benefits are payable at the rate and up to the limits specified in the Schedule of Benefits for covered expenses which include reasonable expenses for the following services and supplies which are medically necessary for the treatment of an injury or sickness:

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

The Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a hospital length of stay not in

excess of these periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable.

NOTE: The copayment is waived for emergency treatment of injuries incurred within 24 hours after the injury is sustained.

(b) Partial hospitalization expenses at an approved hospital for treatment of nervous and mental conditions, alcoholism, and substance abuse, payable at 80% up to 20 days per person per calendar year.

(c) Care in a residential treatment facility in lieu of full hospitalization for treatment of nervous and mental conditions, alcoholism, and substance abuse, up to 31 days per person per calendar year.

(d) Physicians' services for:

(1) in-hospital physician visits (limit one visit per day) and office visits;

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

(3) in-hospital consultation when requested by attending physician;

(4) anesthesia;

(5) emergency treatment of injury or sickness;

(6) outpatient treatment of nervous and mental disorders, including consultation, diagnosis, and treatment if services are furnished by a hospital, community mental health center, or mental health clinic approved or licensed by the commissioner of public welfare or other authorized state agency, psychiatrist, or licensed consulting psychologist. Benefits are payable at 80%, up to eight visits per person per calendar year for such outpatient treatment; and

(7) outpatient treatment of alcoholism and substance abuse, up to 130 hours per person per calendar year, provided such treatment is rendered by a physician or is furnished at a hospital or licensed treatment facility.

(e) Services of a licensed chiropractor acting within the usual scope of chiropractic practice, up to $35 per visit and $900 per person per calendar year.

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

(g) Non-genetic diagnostic x-rays and laboratory tests (excluding allergy tests) and amniocentesis, provided such testing and x-rays are medically necessary, authorized by a physician, and performed while you or your dependent are not confined within a hospital as a resident patient.

(h) Ambulance service.

(i) Additional services and supplies, including anesthetics and oxygen; rental of iron lung and other equipment for therapeutic treatment (or the purchase of such device if the rental would exceed the purchase price); initial artificial limbs or eyes replacing natural limbs and eyes, provided such replacement occurs promptly following the loss and in no event later than six months from the date of the loss; initial pair of podiatric orthotic appliances when prescribed by a physician and medically necessary replacements; custom-made stockings, such as Jobst stockings, up to two pair per eligible person per calendar year; and following a mastectomy for which benefits are payable under the Plan (including a covered prophylactic mastectomy), coverage will be provided for the following in a manner determined in consultation with the attending physician and the patient: reconstruction of the breast and nipple or surgical implant of a prosthesis on the breast on which the mastectomy has been performed and of the contralateral breast to produce symmetrical appearance; treatment of physical complications at all stages of mastectomy, including

lymphedemas; breast prostheses; and two mastectomy bras per eligible person per calendar year.

A prophylactic mastectomy will be covered when an eligible person has:

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

A prophylactic oophorectomy will be covered when an eligible person has:

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

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

(j) Dental services rendered by a physician, dentist, or dental surgeon within six months of an injury to the jaw or natural teeth, including their initial replacement and any dental x-rays.

(k) Drugs and medicines legally obtained from a licensed pharmacist only upon a physician's prescription which are obtained at a pharmacy which does not participate in the Preferred Provider Pharmacy network. Benefits for prescriptions drugs payable under the Preferred Provider Pharmacy Benefits are described on pages 36 and 37. Those drugs or other forms of medication which may be obtained without a prescription, even though they may be so prescribed, are excluded. Drugs prescribed for treatment of infertility are specifically excluded under this section (see page 30 for coverage of such prescription drugs).

The following reasonable charges also are covered expenses which are included in the lifetime maximum, but which have the deductible and copayment requirements waived as specified in the Schedule of Benefits:

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

(b) pre-admission testing;

(c) routine physical examinations (one exam per calendar year for each employee and each spouse);

(d) second surgical opinions;

(e) hospice care for terminally ill eligible persons during the time they otherwise would have to be hospital-confined; and

(f) home health care in lieu of confinement in a hospital or skilled nursing home, up to 40 visits per person per calendar year. Benefits are payable for additional visits exceeding the 40-visit maximum provided the Trustees determine such visits to be medically necessary, cost-effective, and the most appropriate course of treatment based upon recommendations of the case manager.

GENERAL PROVISIONS

General Limitations

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

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

(a) Injury or sickness for which the eligible person is not under the care of a physician.

(b) Disability covered by any Worker's Compensation or Occupational Disease Law.

(c) Injury or sickness arising from or sustained in the course of any gainful occupation or employment.

(d) Services or supplies:

(1) for which no charge is made;

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

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

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

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

(6) for artificial life support after legal or clinical death, except as provided on page 29; or

(7) which are not medically necessary, as defined on page 62.

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

(f) Cosmetic surgery unless:

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

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

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

Benefits are payable for: reconstructive surgery following a covered mastectomy, including reconstruction of the contralateral breast to produce symmetrical appearance; and for a prophylactic mastectomy or prophylactic oophorectomy as provided on pages 28, 29 and 40.

(g) Accidental bodily injury or sickness caused by war or any act of war (declared or undeclared), participation in a riot, or commission of a felony by the eligible person.

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

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

(j) Application of podiatric orthotic appliances.

(k) Artificial insemination, including related services and supplies, and invitro-fertilization, except as provided on page 30.

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

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

(n) Charges incurred while an eligible person is confined for purposes of custodial care in an institution which is primarily a place of rest, a place for the aged, or a nursing home.

(o) Charges incurred for any type of custodial care (care that is designed primarily to assist an eligible person in meeting the activities of daily living), regardless of what the care is called.

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

(q) Charges incurred for all enternal feedings and other nutritional and electrolyte supplements or formula whether or not prescribed by a physician.

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

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

(t) Charges incurred for services or supplies received from a physician who does not meet this Plan's definition of a physician or from a hospital which does not meet this Plan's definition of a hospital.

(u) Charges incurred for services, treatment, supplies, or procedures which are not rendered for the treatment or correction of, or in connection with, a specified non-occupational injury or sickness unless such charges are specifically identified as being covered expenses under the Plan.

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

(w) Charges incurred for speech therapy, except when it is medically necessary because of physical impairment caused by injury or sickness.

(x) Charges incurred for any special education rendered to any eligible person, regardless of the type of education, the purpose of the education, except for a single nutritional consultation session recommended by the attending physician.

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

(z) Charges incurred for travel, whether or not recommended by a physician, except if specified as a covered expense under the Plan.

(aa) Charges incurred for physical, occupational, and speech therapy for treatment of an eligible person diagnosed as developmentally delayed.

(bb) Any amount of an incurred charge that is determined to be in excess of reasonable expenses.

(cc) Charges incurred for the rental or purchase of any durable medical equipment or other equipment that is not used solely for the therapeutic treatment of an eligible person's injury or sickness.

(dd) Charges incurred for any of the following list of items, regardless of intended use, including but not limited to: air conditioners; air purifiers;

whirlpools; swimming pools; humidifiers; de-humidifiers; allergy-free pillows, blankets, or mattress covers; electric heating units; orthopedic mattresses; exercise equipment; gravity lumbar reduction chairs; vibratory equipment; elevators or stair lifts; stethoscopes; clinical thermometers; scales; blood pressure monitors; and magnetic devices.

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

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

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

(hh) Charges incurred in connection with acupuncture unless performed by a Medical Doctor (M.D.).

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

(jj) Charges incurred for the treatment of compulsive gambling.

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

(ll) Charges for special home construction to accommodate a disabled eligible person.

(mm) Charges for telephone conversations/telephone consultations.

(nn) Charges incurred for hypnosis.

(oo) Charges incurred for any operation or treatment in connection with sex transformations.

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

(qq) Charges incurred by dependent children for vasectomies or other sterilization procedures unless recommended by a physician for therapeutic purposes of the patient.

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

(ss) Shipping and handling for charges incurred on covered expenses.

(tt) Radial Keratotomy or Lasik surgery.

(uu) Services of a massage therapist.

(vv) All expenses associated with personal blood storage.

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

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

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

(2) the Plan determines it likely that recovery will be received. At the discretion of the Trustees, losses, expenses and charges

excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement.

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

(zz) Homeopatic providers, services, and supplies.

(aaa) Any loss, expense, or charge incurred as the result of any injury, occurrence, condition, or circumstance for which an eligible person:

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

(2) has recovered from a third party; or

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

Coordination of Benefits

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

If the other group plan does not contain a coordination of benefits or similar provision, then that plan always will calculate and pay its benefits first. When duplicate coverage arises and both plans contain a coordination of benefits or similar provision, this Plan has established the following rules to decide which group plan will calculate and pay its benefits first:

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

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

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

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

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

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

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

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

laid-off or retired employee, or a dependent of such person.

(e) Coordination of Benefits with Automobile Insurance

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

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

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

(f) Right to Receive and Release Necessary Information

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

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

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

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

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 Stage Renal Disease (ESRD).

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 one injury or sickness. Benefits payable under Part A or Part B of Medicare include those which 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, the benefits payable under this Plan for services otherwise covered by Medicare, but which are privately contracted with a provider, will be limited to the amount that would have been payable by the Plan had the services been payable by Medicare.

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

Neither you 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 that physicians can bill Medicare patients above the Medicare allowance for a particular procedure or service, unless services are privately contracted.

(a) **Persons Initially Entitled to Medicare by Reason of Attained Age or Qualifying Disability (other than ESRD) and Eligible Under the Plan Through Self-Payments.** In the event a person eligible in Plans 1, 2, or 3 solely because of self-payments becomes initially entitled to Part A or Part B of Medicare due to attained age or a qualifying disability (other than ESRD), no benefits are payable under this Plan.

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

(b) **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 are not reduced for persons who are eligible in Plans 1 or 2 through employer contributions even though they also may become initially entitled to Part A or Part B of Medicare due to attained age or a qualifying disability (other than ESRD). In the event such person subsequently becomes entitled to Medicare due to ESRD, the Plan will continue to be the primary source of coverage for the full 30-month coordination period specified in the following subsection.

(c) **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. 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.

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

(2) Benefits payable under the Plan beginning with the 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.

Right of Subrogation and Reimbursement

If medical, dental, or disability benefits are provided by the Plan to or on behalf of an eligible person which are the result of or related to an injury, occurrence, condition, or circumstance for which the eligible person has a right of redress against any third party or insurer, the Plan will have a first priority subrogation interest in and have an independent right of reimbursement to any cause of action, right of recovery or recovery in the amount of benefits paid to or on behalf of the eligible person. The rights of subrogation and reimbursement are incorporated into this Plan for the benefit of each participant in recognition of the fact that the value of the benefits provided to each participant will be maintained and enhanced by enforcement of these rights. Therefore, each participant or other eligible person in this Plan has the right to enforce this section of the Plan as against any other participant or eligible person who fails to abide by the terms of this section. The Trustees, any participant, and any other eligible person are entitled to bring an action to enforce the rights of subrogation and reimbursement under the terms of this Plan. The following rules apply:

(a) The purpose of the subrogation and reimbursement provisions are to ensure that the Plan is reimbursed for benefits it pays which are in any way the responsibility of or otherwise compensated by a third party or insurer. This provision will prevent the unjust enrichment of any eligible person at the Plan's expense, and at the expense of every other eligible person, as a result of a recovery arising from the same injury, occurrence, condition, or circumstance that gave rise to the provision of benefits by the Plan.

(b) The Plan or any participant or other eligible person is entitled to bring an action for specific performance, injunction, or such other legal or equitable action as it deems advisable to protect its rights in the cause of action, right of recovery, or recovery by an eligible person. The Plan does not have an adequate remedy at law to protect it from dissipation of its rights. The Plan specifically reserves its rights to commence any action it deems appropriate against an eligible person, an attorney, or any third party to protect its rights under this Plan.

(c) The Plans' rights of subrogation and reimbursement extend to the eligible person's cause of action, recovery, or right of recovery from any third party who is or may be in any way legally obligated to reimburse, compensate, or pay for the eligible person's losses, damages, injuries, or claims relating in any way to the injury, occurrence, conditions, or circumstances giving rise to the Plan's provision of medical, dental, or disability benefits. If the third party is an insurance company, this right exists regardless of whether or not the policy of insurance is owned by the eligible person.

(d) Notwithstanding whether claims against or payments from a third party are characterized as covered medical, dental, or disability expenses or for some other loss relating in any way to the injury, occurrence, condition, or circumstance giving rise to the payment of covered medical, dental, or disability expenses, the Plan's subrogation and reimbursement rights will be a first priority claim against any such claims against or payments by a third party, and the amounts expended or reimbursed by the Plan to or on behalf of the eligible person will be paid by or from said third party before the payment of any amounts due from that third party to the eligible person. Amounts recovered or recoverable by the eligible person or on the eligible person's behalf will first be paid to the Plan to the full extent of its rights of subrogation and reimbursement, and the balance, if any, to the eligible person. If, for any reason, the Plan's subrogation rights are not fully satisfied directly by a third party, the Plan's right to reimbursement may be enforced to the full extent of any recovery that the eligible person may have received or may be entitled to receive from the third party.

(e) The Plan's first priority subrogation and reimbursement rights include all portions of the eligible person's claims, notwithstanding any allocation or appointment that purports to dispose of any portion of the claims not otherwise subject to subrogation, including, but not limited to, any apportionment to a spouse for loss of consortium.

(f) The eligible person will cooperate fully with the Plan, will do nothing to prejudice or adversely affect the Plan's subrogation and reimbursement rights, and will promptly advise the Plan administrator, in writing, of any claim being made against any person or entity who may be obligated in any way to pay the eligible person for the injuries, sickness, or death.

(g) Prior to the commencement of benefit payments, the eligible person agrees to sign a subrogation and reimbursement agreement acknowledging the Plan's rights as a condition of payment of benefits by the Plan. Failure to sign such agreement will be cause for the denial of benefits. The eligible person's failure or refusal to execute documents at the Plan's request will not defeat the Plan's first priority right of subrogation and reimbursement.

(h) The Plan may sue in the eligible person's name to recover the payments made by it on their behalf. The eligible person agrees that he will actively cooperate with the Plan in pursuit of the Plan's subrogation rights.

(i) This subrogation and reimbursement provision applies to claims of eligible dependents covered by the Plan regardless of whether or not such

dependent is legally obligated for expenses of treatment.

(j) This subrogation and reimbursement provision applies to all categories of benefits paid by the Plan.

(k) The Plan will not be responsible for any attorney's fees or costs incurred by an eligible person in any legal proceeding or claim for recovery, unless prior to incurring such fees or costs, the Trustees, in the exercise of their sole discretion, agree in writing to pay all or some portion of said fees or costs.

(l) If the Plan has paid medical, dental, or disability benefits for any injury which is or may be compensable under any Worker's Compensation law, the Plan's right of subrogation and reimbursement will apply to all awards or settlements received by an eligible person regardless of how the award or settlement is characterized and regardless of whether the Plan has intervened in the action. In the event any attorney's fees are awarded to an eligible person's attorney from the Plan's recovery, an eligible person will reimburse the Plan for any such amounts.

(m) The Plan's first priority subrogation and reimbursement rights apply whether or not the eligible person has been fully compensated for damages arising from the injury, sickness, or death.

(n) In the event it is determined to the sole satisfaction of the Plan administrator that there is no, or can be no, recovery against a third party, the injury or sickness then may be treated as any other sickness under the Plan. The Plan administrator further will have the authority to compromise claims of subrogation as circumstances may warrant.

(o) The Plan administrator may appoint a third party to manage any necessary non-litigated subrogation proceeding up to a point when it is determined that an attorney must be hired. The Plan administrator retains the right to hire and the financial responsibility for an attorney.

Right of Recovery

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

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

(b) any insurance companies; or

(c) any other organizations.

Termination of Plan

This Plan may be terminated:

(a) as to participants (and their dependents) in a particular collective bargaining unit, by agreement of the union and employer association (or individual employers, where applicable) which negotiate the labor agreements covering such collective bargaining units;

(b) for a particular employer and his non-bargaining unit persons, the Trustees determine that an employer, signatory to a participation agreement to cover non-bargaining unit persons, no longer meets the requirements of such participation agreement and related policies; or

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

In the event of termination, the Trustees will:

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

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

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

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

Interpretation by Trustees

Benefits under this Plan will be paid only if the Board of Trustees (or its Plan Administrator) decides in its discretion that the applicant is entitled to them. The Plan will be interpreted and applied in the sole discretion of the Board of Trustees (or its delegate, including but not limited to, its Plan Administrator). Such decision will be final and binding on all persons covered by the Plan who are claiming any benefits under the Plan.

Prohibition Against Assignment to Providers

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

(a) receive benefits;

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

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

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

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

(f) any and all other rights afforded an eligible person, participant, or beneficiary under the Plan, Restated Trust Agreement, federal law, and state law.

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

Privacy Policy

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan is required to protect the confidentiality of your protected health information, including electronic protected health information. Generally, health information means any information, whether oral or recorded in any form or medium, that is created or received by a covered entity such as the Plan, and relates to your past, present, or future physical or mental health condition, the provision of health care to you, or your past, present, or future payment for the provision of health care. By law, you have a right to adequate notice of the uses and disclosures of your protected health information that may be made by the Plan, and of your rights and the Plan's legal duties with respect to your protected health information. The Plan's Privacy Notice sets forth your rights under HIPAA's privacy rules and regulations and the Plan's privacy policies and procedures. You may obtain a copy of the Plan's Privacy Notice by contacting the Fund Office.

As a condition of Plan participation, the Board of Trustees require that the privacy rights of you, your spouse, and dependents be governed only by the Health Insurance Portability and Accountability Act of 1996 ("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 or "ERISA"), without regard to whether HIPAA or Minnesota law incorporates privacy rights granted under the laws of other states.

HIPAA Security Regulations

The Plan has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity,

and availability of protected health information in electronic form that it creates, receives, maintains, or transmits on behalf of the Plan. The Trustees will report to the Plan any security incident of which they become aware. The Plan's agreements with its business associates will require that the electronic, physical, and technical security of electronic protected health information be maintained. Any disclosures of electronic protected health information to the Trustees are supported by reasonable and appropriate security measures.

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act of 1993 (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for the same covered employer for at least one year, and for 1,250 hours over the previous 12 months. See page 12 for an explanation of what constitutes a "covered" employer.

Reasons for Taking Leave

Unpaid leave must be granted for **any** of the following reasons:

(a) to care for the employee's child after birth, or placement for adoption or foster care;

(b) to care for the employee's spouse, son or daughter, or parent who has a serious health condition; or

(c) for a serious health condition that makes the employee unable to perform his job.

At the employee's or employer's option, certain kinds of **paid** leave may be substituted for unpaid leave.

Advance Notice and Medical Certification

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

(a) The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."

(b) An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection

(a) For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."

(b) Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

(c) The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

(a) interfere with, restrain, or deny the exercise of any right provided under FMLA; or

(b) discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

(a) The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.

(b) An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights. Certain states, including Minnesota, have laws providing additional rights concerning parental leave.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under "U.S. Government, Department of Labor." For information on the Minnesota parental leave law, contact the Minnesota Department of Labor and Industry.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Statement of Participants' Rights Under ERISA

In 1974, Congress passed and the President signed the Employee Retirement Income Security Act, commonly referred to as ERISA.

ERISA sets forth certain minimum standards for the design and operation of privately-sponsored health care plans. The law also spells out certain rights and protections to which you are entitled as a participant.

The Trustees of the United Food and Commercial Workers Union Local 789 and St. Paul Food Employers Health Care Plan want you to be fully aware of your rights, and for this reason a statement of your rights follows.

As a participant in the United Food and Commercial Workers Union Local 789 and St. Paul Food Employers Health Care Plan:

(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.

Federal regulations under HIPAA require that participants and beneficiaries receive a summary of material modifications of any modification or change that is a material reduction in covered services or benefits under a group health plan within 60 days after the adoption of the modification or change, unless the Plan sponsor regularly sends out summaries of the modifications or changes at regular intervals of 90 or fewer days.

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

(d) You may examine, without charge, all documents relating to the operation of this Plan. These documents include: the legal Plan Document, insurance contracts, collective bargaining agreements, participation agreements, and copies of all documents filed by the Plan with the Department of Labor or the Internal Revenue Service, such as annual reports (Form 5500 Series) and Plan descriptions.

Such documents may be examined by request at the Fund Office (or at other required locations such as worksites or union halls) during normal business hours.

In order to ensure that your request is handled promptly and that you are given the information you want, the Trustees have adopted certain procedures which you should follow:

(1) Your request should be in writing.

(2) It should specify what materials you wish to look at.

(3) It should be received at the Fund Office at least three 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 50 or more participants report to work. Allow 10 days for delivery.

(e) You may obtain copies of any Plan document governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary 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.

(f) You have the right to continue health care coverage for yourself, your spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

(g) You are entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

(h) No one including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way or take any action which would prevent you from obtaining a benefit to which you may be entitled or from exercising any of your rights under ERISA.

(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 on pages 17 through 19 of this booklet. These procedures are designed to give you a full and fair review and to provide maximum opportunity for all the pertinent facts to be presented in your behalf.

(1) If your claim for a health care benefit is denied, in whole or in part, you have a right to know why this was done, you will receive a written explanation of the reason(s) for the denial, and you have a right to obtain copies of documents relating to the decision without charge.

(2) Then, if you still are not satisfied with the action on your claim, you have the right to have the Plan review and reconsider your claim in accordance with the Plan's claims review and appeal procedures.

(j) In addition to creating rights for Plan participants, ERISA also defines the obligations of people involved in operating employee benefit plans. These persons are known as “fiduciaries.” They have the duty to operate your Plan with reasonable care and look out for your best interests as a participant under the Plan and the best interests of other Plan participants and beneficiaries under the Plan. The duties of a fiduciary are complex and are constantly changing as new laws and regulations are adopted applicable to employee benefit plans. Be assured that the Trustees of this Plan will do their best to know what is required of them as “fiduciaries” and to take whatever actions are necessary to ensure full compliance with all state and federal laws.

(k) Under ERISA, you may take certain actions to enforce the rights previously listed.

(1) For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court.

Of course, before taking such action, you will no doubt want to check again with the Fund Office to make sure that:

(i) the request actually was received;

(ii) the material was mailed to the right address; or

(iii) the failure to send the material was not due to circumstances beyond the Trustees’ control.

If you still are not able to get the information you want, you may wish to take legal action. The court may require the Trustees to provide the materials promptly or pay you a fine of up to $110 for each day’s delay until you actually receive the materials (unless the delay was caused by reasons beyond the Trustees’ control).

(2) Although the Trustees will make every effort to settle any disputed claims with participants fairly and promptly, there always is the possibility that differences cannot be resolved satisfactorily.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court if you feel that you have been improperly denied a benefit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

However, before exercising this right, you must take advantage of all the claims review and appeal procedures provided under the Plan at no cost. If you still are not satisfied, then you may wish to seek legal advice.

(3) If it should happen that Plan fiduciaries misuse the Plan's money or discriminate against you for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you are not successful, the court may order you to pay these costs and fees. For example, if the court finds your claim is frivolous, you may be expected to pay legal costs and fees.

If you have any questions about your Plan, you should contact the Trustees by writing to:

The Board of Trustees
c/o Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Or phone: (952) 854-0795
Call toll-free: 1-800-535-6373

Or, if you have questions about this statement or your rights under ERISA or if you need assistance in obtaining documents from the Trustees, you may contact the nearest office of the Employee Benefits Security Administration (EBSA) at U.S. Department of Labor listed in your telephone directory or at: Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You also may find answers to your Plan questions, your rights and responsibilities under ERISA, and a list of EBSA field offices by contacting the EBSA by: calling (866) 444-3272; sending electronic inquiries to www.askebsa.dol.gov; or visiting the website of the EBSA at www.dol.gov/ebsa/.

Other Erisa Information

1. Names and Addresses of the Trustees

Employer Trustees

Dave Gerdes
Jerry's Foods
5125 Vernon Avenue South
Minneapolis, MN 55436

David G. Johns, alternate
SuperValu, Inc.
11840 Valley View Road
Eden Prairie, MN 55344

Edward G. Kitz, CPA, CCM
Roundy's, Inc.
MS-2040 P.O. Box 473
Milwaukee, WI 53201

Mike Oase
Kowalski's
8505 Valley Creek Road
Woodbury, MN 55125

William Seehafer
SuperValu, Inc.
11840 Valley View Road
Eden Prairie, MN 55344

Union Trustees

Howard Kern
UFCW Union Local 789
266 Hardman Avenue
South St. Paul, MN 55075

Caroline Larsen
UFCW Union Local 789
266 Hardman Avenue
South St. Paul, MN 55075

Shirley Muelken
UFCW Union Local 789
266 Hardman Avenue
South St. Paul, MN 55075

Tom Oswald, alternate
UFCW Union Local 789
266 Hardman Avenue
South St. Paul, MN 55075

Don Seaquist
UFCW Union Local 789
266 Hardman Avenue
South St. Paul, MN 55075

2. Names and Address of Plan Administrator

The Plan is administered and maintained by the Board of Trustees. The Fund Office is located at:

United Food and Commercial Workers
Union Local 789 and St. Paul Food Employers Health Care Plan
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Phone: (952) 854-0795
Toll-Free: 1-800-535-6373

3. Type of Plan

This Plan is a group health plan. It is maintained for the exclusive benefit of the employees and provides death, accidental death and dismemberment, and accident and sickness benefits for employees and health care, vision, and dental benefits for employees and dependents. This Plan is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

4. Plan Sponsor

The Plan Sponsor is the Board of Trustees of United Food and Commercial Workers Union Local 789 and St. Paul Food Employers Health Care Plan. This Fund 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.

5. Type of Plan Administration

The Trustees have selected a professional employee benefits administration firm, Wilson-McShane Corporation, as the Administrative Manager of the Plan. The Administrative Manager is responsible for carrying out Trustees' policy decisions, recordkeeping, accounting, and paying benefits subject to the Plan Document.

Plan benefits are provided under the terms of the Plan Document. Additionally, life insurance is a fully-insured benefit provided via a master insurance policy with United of Omaha Life Insurance Company. For life insurance, should any conflict arise between the provisions of this document and the Master Insurance Policy, the Master Insurance Policy will govern.

6. Parties to the Collective Bargaining Agreement

United Food and Commercial Workers
Union Local 789
266 Hardman Avenue
South St. Paul, MN 55075

And those employers which execute an individual collective bargaining agreement or participation agreement with the participating Local Union. Participants and beneficiaries may obtain, upon written request to the Administrative Manager, information as to the address of a particular employer and whether that employer is required to pay contributions to the Plan.

7. Internal Revenue Service Employer and Plan Identification Numbers

The Employer Identification Number (EIN) issued to the Board of Trustees is 36-2871230 and the Plan Number (PN) is 501.

8. Name and Address of the Person Designated as Agent for Service of Legal Process:

Matt Winkel
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Service of legal process also may be made upon any Plan Trustee.

9. Eligibility Requirements

The Plan's requirements with respect to eligibility for benefits are shown in the Eligibility Rules on pages 1 through 12. Circumstances which may cause the participant to lose eligibility also are explained in the Eligibility Rules.

10. Sources of Trust Fund Income

Sources of Trust Fund income include employer contributions, self-payments, and investment earnings.

All employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining agreements between the Union and employers and participation agreements between employers and Trustees. The labor agreements specify the amount of contribution, due date of employer contributions, type of work for which contributions are payable, and the geographic area covered by the labor contract.

Employee self-payments are permitted by the Trustees under certain conditions.

Contributions to the Fund are held in trust and invested by the Trustees in a way that sets a reasonable balance between safety and return while providing enough liquidity to pay benefits when due.

11. Method of Funding Benefits

All Plan benefits except Life Insurance Benefits for Plans 1 and 2 and Accidental Death and Dismemberment Benefits for Plan 1 are self-funded from accumulated assets and are provided directly from the Trust Fund. A portion of Fund assets is allocated for reserves to carry out the objectives of the Plan. Self-funded benefits payable are limited to Fund assets available for such purposes. All assets of the Fund are held by a custodian (bank) selected by the Trustees. US Bank Trust is currently the custodian of Fund assets. Assets not needed for the immediate payment of benefits and other

Fund expenses are invested by an investment manager hired by the Trustees in accordance with guidelines established and monitored by the Trustees. The current Investment Manager is Voyager Asset Management.

Benefits for Life Insurance for Plans 1 and 2 as described on pages 22 through 24 and Accidental Death and Dismemberment Benefits for Plan 1 as described on page 24, are provided subject to Master Insurance Policy No. GLUG-PJ60 through United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175. Benefits eligible under the Life Insurance and Accidental Death and Dismemberment policy are submitted to the Fund Office and paid by United of Omaha directly to you, if living, otherwise to your beneficiary.

12. Fiscal Year of the Plan

The Plan's fiscal year begins March 1 and ends February 28.

13. Procedures To Be Followed in Presenting Claims for Benefits Under the Plan

The procedures for filing for benefits are described on page 15.

If a participant wishes to appeal a denial of a claim in whole or in part, certain procedures for this purpose are found on pages 17 through 19.

GENERAL DEFINITIONS

Wherever used in this Summary Plan Description, the following definitions apply.

Any One Sickness means all sickness arising from the same cause or causes, including complications. If no treatment is received within three months for that sickness, it will be treated as a new sickness.

Bargaining Unit Employee means any employee represented by the Union and working for an employer (as defined in the Trust Agreement) who is required to make contributions to the Trust Fund.

Beneficiary means a person designated by a participant or by the terms of the Plan established pursuant to the Trust Agreement who is or may become entitled to a benefit hereunder.

Calendar Month means any one of the 12 named months of the calendar year, beginning with the first day of that month.

Calendar Year means the period of 12 consecutive months commencing on January 1.

Dentist means a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the license and practice of dentistry.

Dependent means the eligible employee's legal spouse (or former spouses as provided for under Eligibility Rule 12) and unmarried child or children.

If both husband and wife are eligible under the Plan as employees, each will be covered under the Plan as an employee and also will be eligible for coverage as a dependent of their respective spouse. Children may be covered as dependents of both the husband and wife, subject to coordination of benefits provisions on pages 44 and 45.

A dependent child is the eligible employee's:

(a) Unmarried natural blood-related child or legally adopted child (or child placed for adoption) whose age is less than the limiting age, who is dependent on the employee for more than half of his annual financial support and who has the same principal residence of the employee for more than half the calendar year except for temporary absences.[10] An individual who satisfies the limiting age because he is a full-time student may qualify as a dependent child despite the preceding residency requirement if he receives more than half of his annual financial support from the employee and is not considered a "qualifying child" of another taxpayer under IRS rules.[11] Adopted children and children placed for adoption are subject to all terms and provisions of the Plan.

    The limiting age for each dependent child is age 19, or up to age 23 if the child meets the requirements for full-time student status as follows: Dependent must be unmarried with his primary activity being that of a full-time student attending an accredited college or university carrying at least 12 credits per semester. Verification of full-time student status must be submitted to the Fund Office each semester.

(b) Stepchildren who meet the requirements of subsection (a) and the following provisions. The Plan's obligation to provide benefits will be secondary to any obligation of either or both of the natural parents created by court order or judgment of divorce or of legal separation. The stepparent must promptly provide a copy of any such court order or judgment and, in the event there is imposed such obligation on the natural parent or parents, the stepchildren first will seek payment or provision of benefits pursuant to the

[10] A temporary absence can be due to special circumstances such as sickness or education. Children who are away at school are considered to share your principal residence, as long as it is reasonable to assume that they return to your home when school is not in session.

[11] For instance, if your child does not live with you or the child's other parent, but instead lives with another relative, the child could be the "qualifying child" of that relative even though you provide more than half of your child's financial support. **Please contact a tax advisor if you have questions on whether you can receive tax-exempt benefits under the Plan due to the new IRS rules for dependents.**

obligation of the natural parent(s). If collection under, or enforcement of, that obligation is impossible or impracticable in the Trustees' judgment, this Plan will provide benefits the same as for legally adopted children in accordance with the terms and conditions of the Plan Document, provided that, as a condition precedent to such provision of benefits, the participant assigns to the Fund in writing the right to enforce such obligation so as to entitle the Fund to obtain reimbursement from the responsible parent or parents, or from their insurer, for benefits provided.

(c) Child who is entitled to coverage under the Plan because of a Qualified Medical Child Support Order. The Plan has detailed procedures regarding Qualified Medical Child Support Orders which are available upon request from the Fund Office.

(d) A covered dependent under the preceding subsection (a) who attains the limiting age while covered under the Plan may remain eligible under the Plan if all of the following conditions exist for this child at the same time:

(1) is mentally retarded or physically handicapped;

(2) is incapable of self-sustaining employment;

(3) is dependent on the employee for more than half of his annual financial support and maintenance;

(4) has the same principal residence as the employee for more than half the calendar year except for temporary absences. If the dependent does not reside with the employee as described, but satisfies all other requirements of this paragraph, he still may be considered a dependent as long as he is not considered a "qualifying child" of another taxpayer under IRS rules; and

(5) is unmarried.

You must furnish satisfactory proof to the Fund Office that the preceding conditions continuously exist on and after the date the limiting age is reached. The Fund Office may not request such proof more than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the Fund Office, the child's coverage will cease on the date such proof is due.

(e) A dependent child described in this definition of an employee must be a citizen or national of the United States or a resident of the United States, Canada, or Mexico. This does not exclude an adopted child who does not meet the citizenship criteria if the child has the same principal residence as the employee, is a member of the employee's household, and the employee is a citizen or national of the United States.

During any Disability means, as it applies to an eligible employee, all periods of disability arising from the same cause including any and all complications, except that if you completely recover or return to active full-time employment for two weeks, any subsequent period of disability from the same cause will be considered a new disability.

As it applies to your dependents, the term means all periods of disability arising from the same cause including complications, except that if the dependent recovers and resumes normal activities of a person of like age and sex for a period of six months, any subsequent period of disability from the same cause will be considered a new disability.

Eligible Employee means any employee or former employee of an employer who is eligible for benefits in accordance with the Eligibility Rules of the Fund as adopted by the Trustees from time to time.

The term "employee" will include bargaining unit employees and, provided the employer is party to an approved participation agreement, the term also will include certain non-bargaining unit employees.

Eligible Person means either the eligible employee or an eligible dependent.

Experimental or **Investigative** means the use of any diagnostic procedure or treatment (which includes use of any treatment, procedure, facility, drug, equipment, device, or supply) which is not yet generally recognized as accepted medical practice, or its use requires federal or other governmental agency approval and the approval has not been

granted at the time the service or supply is provided, or its use is not supported by the reliable evidence (as defined in the Plan Document) which shows that, as applied to a particular condition, it:

(a) is generally recognized as a safe and effective diagnostic procedure or treatment of the condition by those practicing the appropriate medical specialty;

(b) has a definite positive effect on health outcomes;

(c) over time leads to improvement in health outcomes under standard conditions of medical practice outside clinical investigatory settings (i.e., the beneficial effects outweigh the harmful effects); and

(d) is at least as effective as standard means of treatment in improving health outcomes, or is usable in appropriate clinical contexts in which standard treatment is not employable.

The Trustees will have the final determination as to whether the use of a treatment is experimental or investigative.

Full-Time Employee means a bargaining unit employee who works for a participating employer an average of 32 or more hours per week (excluding Sunday and holiday hours). If an employee is on a four-days-per-week, ten-hours-per-day regular schedule, he will be considered a full-time employee if he works 30 or more hours per week. If an employee is covered by the Retail Meat Contract and was hired prior to March 1, 1992, he will be considered a full-time employee if he works 24 or more hours per week (excluding Sunday and holiday hours).

Home Health Care Agency means a public or private organization which is primarily engaged in providing skilled nursing and therapeutic services (but not custodial care) in the home where the patient is residing. 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.

Hospice Program means a program which has received a certificate of need from the state or locality in which it operates to initiate hospice care in a given area; is eligible to satisfy accreditation requirements as developed by Medicare and/or the Joint Commission on the Accreditation of Health Care Organizations; and meets all of the following criteria:

(a) The patient and family are seen as the unit of care.

(b) An integrated, centralized administrative structure ensures continuity for home care and inpatient care.

(c) There is direct provision of care by an interdisciplinary team consisting of physicians, nurses, social workers, chaplains, and volunteers.

(d) Volunteers are used to assist paid staff members.

(e) Twenty-four-hour-per-day, seven-day-per-week service is available.

Hospital means an establishment which meets each of the following requirements:

(a) is operating lawfully in the jurisdiction where it is located;

(b) operates primarily for the reception, care, and treatment of injured or sick persons as inpatients;

(c) provides 24-hour-per-day nursing service by registered nurses;

(d) has a staff of one or more licensed physicians available at all times; and

(e) provides organized facilities for diagnostic, therapeutic, and surgical services.

“Hospital” also will include:

(a) a residential primary treatment program licensed by the Minnesota Department of Health for the treatment of alcoholics or substance addicts;

(b) a residential treatment facility licensed by the Minnesota Commissioner of Public Welfare for

the treatment of emotionally handicapped children;

(c) a community health center or mental health clinic approved or licensed by the Commissioner of Public Welfare or other authorized state agency; and

(d) a free-standing ambulatory surgical center or other facility offering ambulatory medical services 24 hours per day, seven days per week, which is not part of a hospital but has been reviewed and approved by the State Board of Health to provide specified health care treatments or services.

"Hospital" will not include an institution operated primarily as a clinic, nursing, rest, or convalescent home or similar establishment.

Injury means bodily harm caused by external means due to an accident which requires treatment by a physician and which results in loss independently of sickness and other causes.

Lifetime, with reference to benefit maximums and limitations, means aggregate covered expenses incurred while an eligible person is both alive and covered under the Plan.

Medically Necessary means those services, treatment, or supplies provided by a hospital, physician, or other qualified provider of medical services or supplies that are required to identify or treat an eligible person's injury or sickness and which:

(a) are consistent with the symptoms or diagnosis and treatment of the eligible person's condition, disease, ailment, or injury;

(b) are appropriate according to professional standards of medical practice;

(c) are not solely for the convenience of the eligible person (including his family or caregiver), physician, or hospital;

(d) are the most appropriate which can be provided safely to the eligible person;

(e) are not deemed to be experimental or investigative; and

(f) are not furnished in connection with medical or other research.

The Trustees will make the final determination regarding questions of medical necessity.

Non-Bargaining Unit Employee means an employer's employees who perform work which is not covered by a labor contract requiring contributions to this Fund and who are, therefore, not represented by a labor organization.

Outpatient Psychiatric Facility means a hospital, community mental health center, day care center, or night care center associated with a hospital and licensed as required by applicable law. It does not include institutions or facilities primarily engaged in providing services which are custodial, recreational, social, or educational in nature. An approved outpatient psychiatric facility will be recognized only if there is either a psychiatric physician or a licensed psychologist present in the facility on a regularly scheduled basis who assumes the overall responsibility for coordinating the care of all patients. Services must be available through the professional staff of the facility, as needed, from a psychiatric physician, licensed psychologist, registered nurse, and psychiatric social worker. Emergency medical care must be accessible through formal agreement with a hospital.

Part-Time Employee means a bargaining unit employee (other than bagger/carryout/part-time maintenance employees) who works less than 32 hours per week (excluding Sunday and holiday hours) for a participating employer.

Participant means any employee or former employee of an employer who is eligible to receive any benefit from this Fund in accordance with the Eligibility Rules or other regulations that the Trustees may establish from time to time.

Participating Employer means any employer which:

(a) is bound by the Trust Agreement establishing the United Food and Commercial Workers Union Local 789 and St. Paul Food Employers Health Care Plan; and

(b) is required by the terms of a collective bargaining agreement or other written agreement to make contributions to the Fund.

Personal Pronoun Usage. Words used in this SPD in the masculine or feminine gender will be considered as the feminine gender or masculine gender respectively, where appropriate. Words used in the singular or plural will be considered as the plural or singular, respectively, where appropriate.

Physician and **Surgeon** means any individual, other than you or your dependent, licensed to practice medicine by the governmental authority having jurisdiction over such licensure in his state and who is acting within the usual scope of such practice. Physician will include, but will not be limited to, Medical Doctor, M.D.; Osteopath, D.O.; Podiatrist, D.P.M.; Doctor of Dental Surgery, D.D.S.; Chiropractor, D.C.; Optometrist, O.D.; and licensed midwives to the extent they perform the same services as a physician.

Plan means the document adopted by the Trustees, as amended form time to time, which incorporates the provisions, terms, and conditions under which benefits are paid and the schedule of benefits which is in effect.

Plan Year means the 12 months beginning March 1st and ending February 28th.

Preferred Provider means a:

(a) physician, dentist, registered nurse, physical therapist, or other licensed health care provider;

(b) hospital;

(c) alcohol and substance abuse treatment facility;

(d) hospice;

(e) laboratory;

(f) outpatient surgical facility;

(g) pharmacy;

(h) business establishment selling or renting durable medical equipment; or

(i) any other source for services or supplies covered under this Plan;

who/which alone, or as part of a group, enter into a contract with the Trustees and who/which agree to be compensated for their services and supplies as are covered under this Plan according to the terms of the contract. Such parties are preferred providers while such contract is in effect.

Current types of preferred providers include the following:

(a) "Preferred Provider Hospital" or "Contract Hospital" or "Preferred Provider Physician" means any of the hospitals or physicians which contract with the Trustees through their agent from time to time. This preferred provider arrangement is provided through Blue Cross Blue Shield of Minnesota. The network of hospitals and physicians are named in a directory given to eligible persons.

(b) "Family Assistance Program (FAP) Manager" means the organization which contracts with the Trustees to provide specified family assistance services. The current FAP manager is Total Employee Assistance Management, Inc. (TEAM).

(c) "Preferred Provider Pharmacy (PPRx)" means the pharmacy which is party to contract with the Trustees. Currently, Caremark is the PPRx.

Qualified Medical Child Support Order (QMCSO) means any court judgment, decree, or order, including a court's approval of a domestic relations settlement agreement, or any judgment, decree, or order issued through an administrative process established under state law which has the force and effect of law under applicable state law, that:

(a) provides for child support payments related to health benefits with respect to a child or requires health benefit coverage of such child by the Plan, and is ordered under state domestic relations law; or

(b) enforces a state law relating to medical child support payments with respect to the Plan; and

(c) creates or recognizes the right of a child as an alternative recipient who is recognized under

the order as having a right to be enrolled under the Plan to receive benefits derived from such child's relationship to an eligible employee who is a participant in the Plan; and

(d) includes the name and last known address of the participant from whom such child's status as an alternate recipient under this Plan is derived and of each alternate recipient, a reasonable description of the type of coverage to be provided by the Plan, and the period for which coverage must be provided; and

(e) does not require or purport to require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act; and

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

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

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

Sickness means a disease, disorder, or condition (including pregnancy and childbirth and any related conditions) which requires treatment by a physician.

Skilled Nursing Home means an institution which fully meets each of the following requirements:

(a) is regularly engaged in providing skilled nursing care for injured and sick persons at the patient's expense;

(b) requires that patients regularly be attended by a physician and that medications be given only on the order of the physician;

(c) maintains a daily medical record of each patient;

(d) continuously provides nursing care under 24-hour-per-day supervision by a registered nurse;

(e) is not, except incidentally, a place for the aged, a rest home, or the like;

(f) is not, except incidentally, a place for treatment of substance addiction, alcoholism, or mental illness;

(g) is currently licensed as a skilled nursing home, if licensing is required in the area where it is located, and is classified as a skilled nursing home under Medicare;

(h) has permanent facilities for the care of six or more resident patients; and

(i) requires a physician's certification that confinement is medically necessary.

Trust Agreement means the "Agreement and Declaration of Trust" including all restatements, amendments, and modifications as may from time to time be made.

Trust Fund or **Fund** means the entire trust estate of the United Food and Commercial Workers Union Local 789 and St. Paul Food Employers Health

Care Plan as it may from time to time be constituted, including but not limited to policies of insurance, investments, and the income from any and all investments, employers' contributions, and any and all other assets, property, or money received by or held by the Trustees for the uses and purpose of this Trust.

Trustees means the Trustees of the United Food and Commercial Workers Union Local 789 and St. Paul Food Employers Health Care Plan equally representing the union and the employer.

Weekly Earnings means an average of the five weeks in which the highest wages or salary were received from a participating employer during the eight-week period immediately prior to the date the disability began, exclusive of commissions, bonuses, overtime, or any other additional remunerations.

The terms **"Employee," "Employer,"** and **"Union"** mean the same in this Summary as they do in the Trust Agreement effective July 1, 1983, and are incorporated by reference.

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