SECTION 2 SCHEDULE OF BENEFITS - JANUARY 1, 2026

2.1. COMPREHENSIVE MAJOR MEDICAL BENEFITS

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

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

Deductible amount per Calendar Year	
Per Eligible Person	$500
Per Family	$1,500
Copayment	$25 per office visit $50 per specialist visit $250 per emergency room visit
Plan's Coinsurance (including In-Hospital and Physician's Services and Out-of-Hospital Major Medical Services)	Plan pays 80%
Out-of-pocket maximum per Calendar Year (including the deductible)	
Per Eligible Person	$2,500
Per Family	$5,000
The Plan generally pays 100% of covered expenses in excess of the out-of-pocket maximum for remainder of that Calendar Year	
Preventive Care (including routine immunizations that are Preventive Care)	Plan pays 100%
Routine Physical Examinations that are not Preventive Care per Eligible Person per Calendar Year	Plan pays 100%
Teladoc	Plan pays 100%
Telehealth visits other than through Teladoc	Plan pays 80%, unless the visit is for COVID-19, in which case the Plan pays 100%

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

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

2.2. PRESCRIPTION DRUG BENEFITS

Effective June 1, 2021, only Prescription Medication purchased through the Express Scripts network will be covered. Prescription Medication filled at CVS, Walmart, Target, Hy-Vee, Sam's Club, Costco, and Coborn's will not be covered or reimbursed. Below is the schedule of benefits for "Prescription Drug Benefits."

Out-of-pocket maximum per Calendar Year	
Per Eligible Person	$3,600
Per Family	$7,200
Prescription	**Plan's Coinsurance**
Prescriptions purchased at a retail pharmacy, except as otherwise specifically stated	Plan pays 80%
OTC proton-pump inhibitors and OTC non-sedating antihistamines upon a Physician's written prescription	Plan pays 100%
Prescriptions purchased through the Specialty Drug Program	Plan pays 80%

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

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

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

2.3. VISION CARE BENEFITS

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

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

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

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

2.4. DENTAL CARE BENEFITS

"Dental Care Benefits" are payable for full-time Eligible Employees and their Eligible Dependents and part-time Eligible Employees (and their Dependent Children, if applicable). The maximum annual dollar limit of $1,250 described below in this Section does not apply to the following Dental Care Benefits for Eligible Employees or Eligible Dependents under age nineteen (19):

A. Routine dental examinations;

B. Sealants;

C. Dental prophylaxis;

D. Topical fluoride treatments; and

E. X-rays.

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

Deductible amount per Eligible Person per Calendar Year for restorative and prosthetic services, including oral surgery	$25
Plan's Coinsurance Diagnostic and Preventive Services Restorative Services Prosthetic Services	 Plan pays 100% Plan pays 80% Plan pays 80%
Calendar Year maximum aggregate amount payable per Eligible Person for diagnostic and preventive, restorative, and prosthetic services	$2,000
Orthodontics Deductible Amount Plan's Coinsurance Orthodontic Lifetime maximum amount payable per Eligible Person Orthodontics services are available only for Eligible Dependents who are ages 8 through 18.	 No Deductible Plan pays 50% $1,500

2.5. WEEKLY DISABILITY INCOME BENEFITS

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

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

2.6. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

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

Principal sum	$1,000

2.7. LIFE INSURANCE BENEFITS

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

Full-time Eligible Employee	$25,000
Full-time Eligible Employee's Spouse	$2,000
Full-time Eligible Employee's Dependent Children:	
Fifteen (15) days to nineteen (19) years or twenty-five (25) years if full-time student	$2,000
Part-time Eligible Employee	$10,000

Employee Assistance Program

The Employee Assistance Program ("EAP") and Work/Life Program provided by TEAM provide confidential assessment, short term counseling, and referral services for all Eligible Persons to help resolve personal problems that may affect life at work and at home. Skilled counselors are available to talk with an Eligible Person about personal issues in confidence.
The EAP can help with a variety of situations, such as:

A. Stress;
B. Relationship or family problems;
C. Grief;
D. Workplace concerns; or
E. Alcohol or substance abuse.

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

TEAM can be contacted via phone at 651-642-0182 or 800-634-7710 or online at www.startwithteam.com

QUESTIONS
For questions regarding any of these benefits, please call the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund Office at: 952-851-5797. Or you can find additional benefit information on the Fund website: www.663benefits.com