MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS HEALTH AND WELFARE FUND

Summary Plan Description

For Full- Time Employees and Their Dependents
and Part-Time Employees

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UPPER MIDWEST LOCAL 1M

Revised as of December 1, 2004

MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS HEALTH AND WELFARE FUND

To All Employees:

The Trustees of your Health and Welfare Fund are pleased to provide you with this new Summary Plan Description (SPD) incorporating all Plan changes adopted through December 1, 2004. In easy-to-understand language, it tells you how to become and remain eligible for benefits, explains the benefits available and their limitations, gives you instructions on how to apply for benefits, and lets you know how to appeal a claim. 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 Eligibility Rules and benefits are maintained at levels in line with Trust Fund income and assets; they are reviewed regularly to provide you with the best protection possible within the Fund's financial means. All Plan provisions are monitored and updated as necessary to comply with legal requirements, such as the Health Insurance Portability and Accountability Act, Privacy Rules, and the Claims Procedure Regulations.

The benefits described in this Summary Plan Description are self-funded with the exception of the Life Insurance and Accidental Death and Dismemberment Benefits insured through Kansas City Life Insurance Company. Benefits payable are limited to Fund assets available for such purposes. This updated Summary incorporates new benefit provisions you were informed of previously by mail in various Participant Notices.

Remember to notify the Fund Office immediately if you have a change of 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. Also, if your marital status changes or there are other changes in your personal life which might affect the name of the person you wish to designate as your beneficiary, you must notify the Fund Office regarding any change in beneficiary you wish to make.

Take time to read the information in this booklet carefully. It is important that you understand your Plan and how it works so you can receive all the benefits to which you are entitled. Familiarize yourself with this SPD now and then keep it in a safe place to refer to when you require health care. If you have any questions at any time regarding the Plan, please feel free to contact the Fund Office. The Fund Office is the best source to provide you with up-to-date, accurate facts about your benefits.

Yours sincerely,

THE BOARD OF TRUSTEES

Union Trustees	**Employer Trustees**
Richard Milbrath	David E. Gerdes
Raymond Sawicky	Edward Kitz
Ronald N. Zwieg	William Seehafer

FUND OFFICE

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

PHONE: (952) 854-0795
FAX: (952) 854-1632

OFFICE HOURS: Monday-Friday 8 a.m. to 5 p.m.

SCHEDULE OF BENEFITS

LIFE INSURANCE BENEFITS

For Full-Time Employees and Dependents and Part-Time Employees

(Insured through Kansas City Life Insurance Company)

Full-time employee	$25,000
Full-time employee's spouse	2,000
Full-time employee's dependent children:	
14 days to one month	400
one month to two months	800
two months to three months	1,200
three months to four months	1,600
four months to 19 years (or 25 years if full-time student and primarily financially dependent upon you)	2,000
Part-time employee	10,000

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

For Part-Time Employees Only

(Insured through Kansas City Life Insurance Company)

Principal sum	$1,000

WEEKLY DISABILITY INCOME BENEFITS

For Full-Time Employees Only

Percentage of average weekly wage	60%
Maximum per week	$300
Maximum number of weeks	26

COMPREHENSIVE MAJOR MEDICAL BENEFITS

For Full-Time Employees and Dependents and Part-Time Employees

Comprehensive Major Medical Benefits cover expenses related to hospital services, physicians' services (including surgeons' and assistant surgeons' fees), x-ray and laboratory services, ambulance, hospice care, routine colonoscopy, and other covered items and services when medically necessary.	
IN-HOSPITAL AND PHYSICIANS' SERVICES AND OUT-OF-HOSPITAL MAJOR MEDICAL SERVICES	
Deductible per calendar year	
Per person	$300
Per family	3 individual deductibles[1]
Plan's copayment	80%
Out-of-pocket maximum per calendar year (including deductible)	
Per person	$2,500
Per family	$5,000
The Plan generally pays 100% of covered expenses in excess of such maximum for remainder of that calendar year.	
Lifetime Maximum	
Per person	
Full-Time	$1,000,000
Part-Time	$ 250,000
The following are specific maximum amounts applicable to certain services and supplies covered under Comprehensive Major Medical Benefits provisions.	
Alcoholism, Chemical Dependency, and Substance Abuse	
Inpatient maximum number of days per person per calendar year	31
Outpatient maximum number of visits per person per calendar year (combined with Mental Illness and Nervous Disorders)	50
Lifetime maximum per person:	
Inpatient	90 days
Outpatient	90 visits
Mental Illness or Nervous Disorders	
Inpatient maximum number of days per person per calendar year	31
Outpatient maximum number of visits per person per calendar year (combined with Alcoholism, Chemical Dependency, and Substance Abuse)	50
Organ Transplants	
Maximum for professional services per transplant	$10,000
Maximum for private nursing care per transplant	$10,000

[1] If your family has only 2 members, then the family deductible is 2 individual deductibles.

COMPREHENSIVE MAJOR MEDICAL BENEFITS (continued)

Skilled Nursing Home Care	
Maximum number of days per person per confinement	30
Chiropractic Care	
Maximum visits per person per calendar year	12[1]
Genetic Testing and Counseling (Other Than Amniocentesis)	
Maximum per lifetime per person	$2,000
Hearing Aid Appliances	
Maximum for each ear per benefit period	$500
Wigs and Toupees	
Maximum per lifetime per person	$300
Diabetic, Cardiac, and Obesity Self-Management Education Programs	
Aggregate maximum per lifetime per person	$300
The deductible and copayment amounts are waived for covered expenses related to the following services. The Plan pays 100% of the usual and customary charges incurred for these services, up to the specified maximum. These benefits are NOT subject to the lifetime maximum.	
Routine Physical Examinations	
Per person per calendar year	
Full-time and part-time employee and full-time employee's dependent spouse	$400
Full-time employee's dependent child(ren)	$200
Routine Immunizations [For full-time employee's dependent child(ren) birth to age two] Per person per calendar year	$300

PRIME THERAPEUTICS PRESCRIPTION DRUG PROGRAM

For Full-Time Employees and Dependents and Part-Time Employees

Plan's copayment	
Prescriptions purchased at a retail pharmacy	80%
Prescriptions purchased through the Preferred Provider Mail Service Pharmacy, for each 90-day supply	80%

[1] Certification of medical necessity by a physician is required for additional chiropractic visits. See page 25.

VISION CARE BENEFITS

For Full-Time Employees and Dependents and Part-Time Employees

Examination	
One per person per calendar year	$ 50
Lenses	
One set per 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)[1]	87
Frames	
One set per person per calendar year	
Maximum payment per set	$ 70

DELTA DENTAL BENEFITS

For Full-Time Employees and Dependents and Part-Time Employees

Deductible per person per calendar year for restorative and prosthetic services, including oral surgery	$25
Plan's copayment	
Diagnostic and preventive services	100%
Restorative services	80%
Prosthetic services	80%
Orthodontic services[2]	50%
Aggregate maximum per person per calendar year for diagnostic and preventive, restorative, and prosthetic services	$1,000
Orthodontic	
Lifetime maximum per person	$1,500

[1] Contact lens benefit is in lieu of all other lens and frame benefits for the calendar year.
[2] Orthodontic services are available only for a full-time employee's dependents ages 8 through 18.

TABLE OF CONTENTS

Page

SCHEDULE OF BENEFITS iii

CLAIMS FILING INSTRUCTIONS 1

CLAIMS REVIEW AND APPEAL PROCEDURES 3

ELIGIBILITY RULES 6

I. Who Is Eligible? 6
II. When Are Employer Contributions First Payable? 6
III. What Is The Effective Date Of My Eligibility? 6
IV. What Is The Effective Date Of Eligibility For My Dependents? 6
V. What Is Required To Remain Eligible? 6
VI. What Coverage Is Provided If I Switch Between Full-Time And Part-Time Employment? 7
VII. May I Make Self-Payments To Maintain Eligibility? 7
VIII. How Can I Reinstate My Coverage? 13
IX. How Are Grace Weeks Applied If My Employment Terminates? 13
X. When Does My Coverage Terminate? 14
    Certificate of Creditable Coverage 14
XI. Are My Dependents Covered If My Spouse And I Divorce? 14
XII. What Happens In The Case Of A Newly Participating Employer? 14
XIII. Is Coverage Provided While I Am On Family And Medical Leave? 15
XIV. Is Coverage Provided When I Enter Military Service? 15

LIFE INSURANCE BENEFITS 17

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS 20

WEEKLY DISABILITY INCOME BENEFITS 21

BLUE CROSS BLUE SHIELD OF MINNESOTA PREFERRED PROVIDER ARRANGEMENT 22

COMPREHENSIVE MAJOR MEDICAL BENEFITS 23

Deductible 23
Copayment 23
Lifetime Maximum 23
Covered Health Services 23
Other Routine Care 28
Comprehensive Major Medical Benefits Limitations 29

PREFERRED PROVIDER PRESCRIPTION DRUG PROGRAM 30

VISION CARE BENEFITS 31

DELTA DENTAL BENEFITS 33

TABLE OF CONTENTS (continued)

Page

GENERAL PROVISIONS 37
General Exclusions 37
Coordination of Benefits (COB) 38
Coordination of Benefits with Automobile Insurance 40
Medicare Provisions 40
Right to Receive or Release Necessary Information 41
Facility of Payment 41
Right of Recovery 41
Effect on Worker's Compensation 42
Subrogation 42
Termination of Plan 44
Records 44
Physical Examination 44
Interpretation by Trustees 44
Privacy Policy 44

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 46

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) 48
Statement of Participant Rights Under ERISA 48
Other ERISA Information 51

GENERAL DEFINITIONS 53

CLAIMS FILING INSTRUCTIONS

Pre-Service Claims: You must obtain: prior authorization for prophylactic mastectomies; certification of medical necessity for chiropractic visits exceeding 12 per person per calendar year; prior approval for the purchase of certain durable medical equipment specified on page 27; and predetermination for certain dental services specified on page 35. 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. All 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 approval of emergency admissions.

Post-Service Claims: Any claim for benefits that is not a pre-service claim is considered a "post-service claim." You must submit all post-service claims in writing within 90 days of the occurrence of the accident or sickness, or as soon thereafter as is reasonably possible. In no event (except in the absence of legal capacity) can you submit a claim later than 15 months from the date of service.

If you use a Blue Cross Blue Shield of Minnesota (BCBSM) provider (see page 22 for details) and present your medical card, they automatically will file your claim for you. All other post-service claims must be sent to: Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund, Fund Office, c/o Wilson-McShane Corporation, 3001 Metro Drive, Suite 500, Bloomington, Minnesota, 55425.

Post-service claims must be submitted in writing to the Fund Office on forms provided by the Trustees unless otherwise authorized by administrative rule. All applicable questions and information requested on the form must be answered and provided by the eligible person or other provider of service. Claims should be complete. They should contain, at a minimum:

(a) Fund name (Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund);

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

(c) Full name (including "Jr.," if applicable) and 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;

(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.

In order for Weekly Disability Income Benefits to be processed, your physician must complete the "Attending Physician's Statement." Your employer then must complete the "Employer's Statement."

In order for prescription medication claims to be processed, you need a receipt from the pharmacist which contains the following information: patient's name; date the prescription was filled; prescription number; name of drug dispensed; amount of dosage/supply; name and

address of the pharmacy; and cost of the prescription drug. Cash register receipts are not acceptable.

Contact the Fund Office immediately for assistance in filing for Life Insurance Benefits and for part-time employees only in filing for Accidental Death and Dismemberment Benefits.

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. Pre-determined amounts you must pay, such as a prescription drug copayment, 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 Prescription Drug Program), you may submit a formal appeal to the Fund Office in writing within 180 days to have your claim reviewed according to the appeal procedures stated on pages 3 through 5.

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

Generally, benefits automatically are paid directly to the provider. You will be sent a copy of the processed claim payment for your records. Benefits will be paid directly to you only if you submit proof of payment or for dental claims from dentists who are not in the Delta Dental network.

CLAIMS REVIEW AND APPEAL PROCEDURES

When you submit a pre-service claim, the Plan 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.

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 at least 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.

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 you feel that the action taken on your eligibility or claim is incorrect, you immediately should ask the Fund Office to review your claim with you. In some cases, the Fund Office may request additional information from you which might enable the Fund Office to reevaluate its decision.

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, but neither you or your representative will have the right to appear in person before the Board of Trustees.

(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 review opportunities described here. You may, at your own expense, have legal representation at any stage of these review procedures. No legal action for any benefits under the Plan may begin later than two years after the time the claim was required to be filed as specified on page 1. 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.

ELIGIBILITY RULES

I. Who Is Eligible?

You are eligible to receive benefits under the Plan if you are employed by an employer that pays contributions to the Fund on your behalf as required by the collective bargaining agreement or other written agreement.

II. When Are Employer Contributions First Payable?

Your employer is obligated to contribute on your behalf at such time as the Trustees specify by rules and regulations or as may be provided in the applicable collective bargaining agreement.

III. What Is The Effective Date Of My Eligibility?

You become eligible under either Plan 1 (for full-time employees and their dependents) or Plan 2 (for part-time employees only) on the first day of the first month following the month you satisfy the following eligibility requirements.

(a) Plan 1

You will become eligible under Plan 1, which provides coverage for full-time employees and their dependents, during your initial period of employment when you have had eight weeks of full-time contributions made to the Plan on your behalf during a 12-week period. Your coverage will begin on the first day of the first month following the month in which you meet the eligibility requirements of this section.

(b) Plan 2

You will become eligible under Plan 2, which provides coverage for part-time employees only after working 12 months for a contributing employer, during which the employer makes at least one contribution on your behalf in each of the 12 months. Your coverage will begin on the first day of the first month following the month in which you meet the eligibility requirements of this section.

If you are a part-time employee, you will become eligible for Plan 2 even if an occasional full-time contribution is made on your behalf.

IV. What Is The Effective Date Of Eligibility For My Dependents?

Coverage for dependents is provided under Plan 1 only. Your dependents will become eligible on the first day of the first month following the month you satisfy the previously stated eligibility requirements.

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

V. What Is Required To Remain Eligible?

Your continued eligibility is determined weekly. Once you have established eligibility, it continues as long as required employer contributions to the Fund are made on your behalf for each subsequent week. The amount of the employer contribution is based on the number of hours you work per week and the weekly rate specified by the collective bargaining agreement in effect at the time the contributions are earned. The collective bargaining agreement requires employer contributions for Plan 1 or Plan 2 to be paid when you work a specified amount of required hours. The amount contributed determines the Plan under which you are covered.

If, in any week, your employer does not make either the part-time or full-time

contribution, as applicable, on your behalf because you have not worked the required number of hours, you may pay that weekly contribution yourself in order to continue coverage. If the minimum hourly requirements are not satisfied, you will lose eligibility unless you make self-payments as provided in Rule VII.

VI. What Coverage Is Provided If I Switch Between Full-Time And Part-Time Employment?

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

(a) Plan 1

If you, as a full-time employee, only work the number of hours which require part-time contributions to be made on your behalf by your employer, the Plan of benefits under which you are covered will change. In that event, the change in benefits will become effective on the first day following the end of your eight-week grace period (reduced by the number of grace weeks previously used).

If you continue to work part-time under the terms of the collective bargaining agreement with part-time contributions made on your behalf, you will be eligible for part-time employee benefits which provide coverage for the employee only.

(b) Plan 2

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

VII. May I Make Self-Payments To Maintain Eligibility?

When circumstances described in this Rule cause a reduction in or a loss of coverage, some of the coverages in effect at the time can be continued by making self-payments. The following terms include improvements to the Fund's traditional self-payment privileges and incorporate COBRA requirements as amended in all respects, including those changes required by the Omnibus Budget Reconciliation Acts of 1989, 1990, and 1993 and the Health Insurance Portability and Accountability Act of 1996. 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 eligibility and coverage for certain benefits subject to the following conditions.

(a) **Qualifying Events**

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

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

(i) a reduction in hours of covered employment; or

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

(ii) your death;

(iii) divorce or legal separation from you;

(iv) your entitlement to Medicare; or

(v) loss of dependent status.

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 an employee during the employee's period of COBRA continuation coverage will be included within this definition of a Qualified Beneficiary.)

(b) **Notifications and Due Dates**

The Trustees will provide written notice of the continuation coverage provisions of this section to each employee and dependent at the time his coverage under the Plan begins.

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

When the Qualifying Event relates to your divorce or legal separation, or to a dependent losing dependent status under the Plan, the Qualified Beneficiary must notify the Trustees directly in writing of the Qualifying Event so that the Trustees may provide proper notices and explanations to a Qualified Beneficiary about continued eligibility. You may send the notice by written letter to the Trustees at the Fund Office at the address listed on page ii. You must inform the Trustees of the Qualifying Event and when the Event occurred by providing appropriate documentation to support the occurrence of the Event, such as a copy of the divorce or legal separation decree.

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 Divorce or Legal Separation, or to a Change in a Dependent Child's Status

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 Qualifying Events such as a reduction in your hours, your ceasing active work, or your death. The Fund Office, not later than 14 days after receipt of notice of an employee's 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 Beneficiaries' Response

A Qualified Beneficiary has 60 days from the date of coverage termination or the receipt of the Fund Office explanation, whichever is later, to elect whether to continue coverage. The election should be communicated to the Trustees in writing. Each employee, spouse, and dependent child has the right to make an individual election; however, an election by an employee with dependent coverage to continue such coverage or by a parent with custody of minor children to continue coverage will be accepted as the election for both parent and children. Failure to state the election to the Trustees within 60 days terminates rights to continued coverage under this provision. If you decline or waive your right to elect continuation coverage but then change your decision, you must provide the Fund Office with notice of your revised decision within the initial 60-day notice period.

(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. Failure to do so will cause eligibility and coverage to terminate retroactively as of the date of the Qualifying Event.

(6) Due Dates for Subsequent Self-Payments

Subsequent monthly self-payments must be made prior to the month for which coverage is to be extended. The Plan allows a 30-day grace period for making self-payments. 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 last was made.

Checks should be made payable to the Minneapolis Retail Meat Cutters and Food Handlers (MRMC) Health and Welfare Fund and sent to the Fund Office. Failure to make self-payments in the amounts and by the due dates required will cause loss of coverage.

(c) **Coverages and Options**

If a Qualified Beneficiary elects to continue coverage, the following benefit coverage options are available:

(1) Health Care Benefits only;

(2) Health Care Benefits plus Vision Care and Dental Care Benefits;

(3) Health Care Benefits plus Vision Care and Dental Care Benefits, Life Insurance and Accidental Death and Dismemberment; or

(4) Life Insurance Benefits only (see page 17).

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

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 Health, Vision, and Dental 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 the 29th month for those individuals eligible for such disability extension, as explained in the following subsection. The Fund Office initially will notify Qualified Beneficiaries of the self-payment amount and due dates.

(e) **Duration of Continuation Coverage (Maximum Continuation Coverage Period)**

Generally, you may continue coverage for yourself and your dependents for 18 consecutive months in the event your coverage is reduced or lost under the Plan because of your termination of employment or reduction in hours. This 18-month period may be extended for up to 29 months for all Qualified Beneficiaries during the disability of the employee, spouse, or dependent child provided: the Social Security Administration (SSA) determines that any of these 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 the Qualifying Event; and the Qualified Beneficiary notifies the Trustees in writing within 60 days of the SSA determination and before the end of the first 18 months of continuation coverage and provides a copy of the SSA determination of disability. In the event you decline continuation coverage, your spouse and dependent children may continue coverage for up to 18 months from the time coverage ceases. Your dependent spouse and children may continue coverage for 36 consecutive months for all other Qualifying Events. 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 continued for up to 18 months by making self-payments as described in these Rules. However, if you

have been involuntarily reduced from full-time to part-time employment, you may continue Plan 1 coverage through self-payments indefinitely, provided:

(i) you remain continuously employed by the same employer; and

(ii) you are ready, willing, and able to return to full-time employment when it becomes available.

(2) Ceasing Active Work

(i) If you cease active work due to layoff, work stoppage, resignation, or dismissal, you may continue coverage for up to 18 months from the time coverage ceases.

(ii) If you cease active work due to a disability or sick leave:

(A) you may continue coverage to the later of 18 months; or

(B) you (or any other Qualified Beneficiary) may continue coverage for yourself and your dependents for up to 29 months of disability, provided the Social Security Administration (SSA) determines that any of these 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. The Qualified Beneficiary must notify the Trustees in writing within 60 days of the SSA determination and before the end of the first 18 months of continuation coverage; or

(C) when the disability or sick leave prevents working at your regular employment or at any job for compensation, profit, or gain, you may continue coverage longer than the 18 or 29 months stated in (A) and (B); you may continue coverage until the end of your period of disability, subject to medical reports confirming the disability.

(iii) If you cease active work due to a non-medical leave of absence, you may continue coverage by making self-payments for up to 18 consecutive months.

(iv) If you cease active work due to retirement:

(A) Before Age 65

You may continue coverage under Plan 1 or Plan 2 for the first 18 months subject to COBRA. Thereafter, you may continue coverage subject to terms and conditions the Trustees may adopt; no benefits are available for weekly disability income or dental care.

No coverage will be available under the Plan when both you and your spouse attain age 65.

(B) At or After Age 65

You may continue coverage subject to terms and conditions the Trustees may adopt. Currently, coverage under the Plan will end at or after age 65, subject to COBRA.

When you, as a retired full-time employee, and your spouse are not both eligible for Medicare Parts A and B,

you may continue coverage under the Plan until you are both eligible for Medicare, provided the appropriate self-payments are made. The benefits of the person eligible for Medicare will be reduced by the amount payable by Medicare.

Dependent children not eligible for Medicare may continue Plan coverage for up to 36 months from your retirement, provided the appropriate self-payments are made.

The Trustees retain the right in their sole discretion to modify or discontinue, in part or in whole, retiree Eligibility Rules, types and amount of benefits, terms and conditions under which benefits are payable, and self-payment rates.

(3) Death, Divorce, or Legal Separation

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.

(4) Loss of Dependent Status

If a dependent child's coverage ceases because of a change in 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 will be accepted and continued eligibility under this provision will terminate on behalf of all Qualified Beneficiaries (unless specifically stated otherwise) when:

(1) the Plan no longer provides group 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 Fund Office explanation, 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 last day of the month in which eligibility and coverage terminate, unless the self-payments are made within the 30-day grace period;

(6) the person continuing coverage:

    (i) becomes covered under another group health care plan as an employee or dependent after such person's COBRA election date; and

    (ii) waiting periods and/or pre-existing condition limitations, if any, under such other group health care plan have been satisfied with previous coverage credits;

(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; or

(9) a Qualified Beneficiary becomes entitled to Medicare 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. In the case of ESRD, the Fund 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 Fund with COBRA continuation coverage. In the event the Fund's liability as the primary source of coverage ends before the COBRA continuation period expires, the Fund will become secondary to Medicare for the balance of the continuation coverage for such person.

If You Have Questions: Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office as specified on page ii. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

VIII. How Can I Reinstate My Coverage?

For Plan 1, if your coverage terminates, you will be reinstated on the first of the month following the date as of which eight weeks of employer contributions have been paid to the Fund on your behalf during a 12-week period.

For Plan 2, if you lose eligibility, but you do not incur a break in service, you may regain eligibility by completing 12 weeks of employment during which at least 8 weeks of part-time contributions are made to the Plan. A break in service is the longer of a period of six consecutive months during which no employer contributions are made on your behalf or the length of an approved leave of absence. If you lose eligibility after having incurred a break in service, you may regain eligibility by once again satisfying the requirements for initial eligibility. Part-time eligibility credit for months preceding a break in service is forfeited and does not count for purposes of obtaining eligibility.

IX. How Are Grace Weeks Applied If My Employment Terminates?

If your employment is terminated, your eligibility will continue under the Plan for the number of grace weeks you have accrued.

Each eligible employee who has qualified for health care benefits, for either full-time or part-time coverage, accumulates a total of eight weeks of grace. The Fund Office will use one of your grace weeks whenever a current weekly contribution is not received for the coverage in effect. When all of the grace weeks have been used and there are no current contributions, then your coverage, whether full-time or part-time (whichever applies), will be terminated. However, you still have available the other options for continuing coverage.

NOTE: It is not possible for the Fund Office to contact each employee as grace weeks are used. We will assist you in any possible way. BUT, it is each employee's responsibility to keep track of any grace weeks used. Any employee has the option of remitting contributions on his behalf in lieu of using any grace weeks OR may buy back any grace weeks used. Such option, however, must be exercised within 60 days of the date you are notified of either your termination of coverage or your reduction to part-time employee status. If there are any questions regarding this, please call the Fund Office.

X. When Does My Coverage Terminate?

Your coverage and that of your dependents automatically terminates on the earliest of the following dates, subject to the employee's and 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 on your behalf;

(c) the date you enter the armed forces on full-time active duty (according to the provisions of Eligibility Rule XIV); or

(d) the date you cease to be eligible for coverage according to these Eligibility Rules, and all grace weeks are exhausted.

In addition, 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 coverage terminates and COBRA continuation coverage terminates (and also upon request, within 24 months thereafter). The certificate provides information on the period of your coverage under the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund that may be credited on your behalf to satisfy any applicable pre-existing condition limitations of a new health plan in which you enroll.

XI. Are My Dependents Covered If My Spouse And I Divorce?

In the event of divorce, your former spouse is entitled to continue coverage for herself and your dependent children by making required self-payments according to the COBRA continuation coverage provisions specified in Rule VII.

XII. What Happens In The Case Of A Newly Participating Employer?

The following provisions apply only to an employee who was covered under a former policy or plan immediately prior to the effective date of his employer participating under this Plan and who becomes covered under this Plan on that date. Payment of benefits under this Plan may be in lieu of payment under the former policy or plan when coverage under the prior plan is not extended subsequent to policy termination.

(a) If otherwise eligible, your coverage under this Plan will become effective on the date your employer becomes a participating employer.

(b) It is the intent of this provision that you will not lose all coverage solely because your employer becomes a participating

employer and you would not be eligible under this Plan due to an effective date provision. Furthermore, it is not the intent of this provision that you will receive greater benefits than you would have under your former plan. Benefits payable under this Plan will be the lesser of:

(1) the amount of any benefits payable by the former plan had plan termination not occurred, reduced by the amount paid or payable by that plan; or

(2) the amount of benefits provided by this Plan.

(c) If you had applied medical expense toward deductible amount requirements under the former plan for the calendar year during which your employer becomes a participating employer, the deductible amount requirements under this Plan for that calendar year will be reduced by the same amount.

XIII. Is Coverage Provided While I Am On Family And Medical Leave?

If you become eligible for leave under the Family and Medical Leave Act of 1993, your coverage under the Plan may be continued for up to 12 weeks, provided your employer is subject to the FMLA, makes the required contribution (or you do so), and files the appropriate notification and certification forms with the Fund Office.

For additional information regarding your rights under the Family and Medical Leave Act, see page 46.

XIV. Is Coverage Provided When I Enter 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 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 to the Fund Office 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) 18 months from the first date of absence due to military service; 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 re-employment 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 re-employment not later than 90 days after military service is completed.

Such time periods may be extended for injuries or illnesses, 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.

LIFE INSURANCE BENEFITS

For Full-Time and Part-Time Employees Only (Insured through Kansas City Life Insurance Company)

If you die from any cause, on or off the job, your beneficiary will be paid the amount of insurance stated in the Schedule of Benefits. The benefit will be paid in full according to the terms of the policy upon receipt of your claim form, death certificate, and any other required supporting documentation. NOTE: In cases of conflict between this Summary Plan Description and the group policy, the group policy will govern.

Your beneficiary designation and any change in beneficiary must be filed in writing with the Fund Office on a properly completed form. It will become effective on the date the request is signed, provided the Life Insurance Benefit had not been paid already before the request is received. Your beneficiary designation will be made available to you upon request at the Fund Office.

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

(a) spouse;

(b) children;

(c) parents;

(d) brothers and sisters; OR

(e) executors or administrators of your estate.

If you become disabled and subsequently die, and if anyone has paid expenses incurred because of your disability and death, the Plan may reimburse the amount paid, up to $500, from the Life Insurance Benefit. A satisfactory receipt will be proof of expense. The balance of the Life Insurance Benefit will be paid to your beneficiary.

Coverage During Total Disability

If you become totally disabled before age 60 and remain disabled, your Life Insurance Benefits may be continued with no additional cost to you as long as the disability continues. You must provide the Fund Office with written proof of your total disability within one year of the date the disability begins, or as soon as reasonably possible. After the first two years of disability, written proof of disability may be requested annually by physicians chosen by Kansas City Life Insurance Company. Kansas City Life will pay for all such exams. Contact the Fund Office for details and appropriate forms to apply for waiver of premiums.

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

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

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

(a) the date your total disability no longer exists;

(b) the date you fail to submit to the required medical examination; or

(c) the date you fail to submit any required proof of the uninterrupted existence of your total disability.

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

Employee Continuance of Life Insurance

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

To continue life insurance, you must send the Fund Office written notice that you wish to continue life insurance along with the first monthly premium, payable at the Plan's full cost. You must do so within 60 days of written notification from the Fund Office of your right to continue, including the premium amount and due date.

Continued life insurance ends on the earliest of:

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

(b) the day a conversion policy is obtained;

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

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

See the following conversion privilege when continued life insurance ends.

Conversion Privilege

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

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

(a) $5,000 for employees and $2,000 for dependents; or

(b) the amount of your terminated insurance, less any amount of life insurance for which you may be eligible under any other group policy which replaces it within 31 days.

You have 31 days to make application for conversion and pay the required premium following termination of your insurance. If you should die during this 31-day period, the amount of insurance that you would have had under the conversion privilege will be paid to your beneficiary. The premium will be set according to your age and class of risk. No evidence of insurability is required.

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

Life Insurance Benefits for Dependents of Full-Time Employees Only

If, while covered as a full-time employee, one of your eligible dependents dies, Life Insurance Benefits as stated in the Schedule of Benefits will be payable to you as the beneficiary. If you do not survive the insured dependent, payment

will be made to your spouse, if living, otherwise to your estate.

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

(a) termination of your insurance;

(b) modification of the policy to terminate dependents' insurance;

(c) as to any particular dependent, termination of the status of eligible dependent;

(d) the date the group policy terminates;

(e) the date the dependent enters the Armed Forces (does not apply to temporary duty of 30 days or less); or

(f) the end of the period for which the premium has been paid by you or your dependent.

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

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

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

For Part-Time Employees Only (Insured through Kansas City Life Insurance Company)

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

(a) the principal sum for loss of life;

(b) the principal sum for loss of two limbs, sight of both eyes, or one limb and sight of one eye;

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

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

If you suffer more than one loss in an accident, payment will be made only for the one loss for which the larger amount is payable. The Trustees may, at their own expense, require a physical examination while considering your claim or, if you die, an autopsy where law permits. NOTE: In cases of conflict between this Summary Plan Description and the group policy, the group policy will govern.

Limitations

Accidental Death and Dismemberment Benefits do not cover losses from:

(a) intentionally self-inflicted injury or suicide;

(b) insurrection, war or any act of war;

(c) participation in a riot;

(d) commission of an assault or felony; or

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

WEEKLY DISABILITY INCOME BENEFITS

For Full-Time Employees Only

If you become totally disabled after becoming covered under the Plan, you are under a physician's care, and you are unable to work because of a non-occupational injury or illness, you are entitled to Weekly Disability Income Benefits. The Schedule of Benefits reflects how the benefit is calculated, the maximum dollar benefit, and the maximum number of weeks the benefit is payable.

Benefits begin on the first day of an accidental injury or the eighth day of an illness.

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

Once the maximum benefit has been paid and you have returned to work, you will not be eligible for any further Weekly Disability Income Benefits until 12 months from the date you were paid the maximum.

Limitations

Weekly Disability Income Benefits are not payable when:

(a) you are not under the care of a physician;

(b) your disability is due to a self-inflicted injury; or

(c) your injury or illness arises out of and in the course of any occupation or employment for wage or profit.

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

BLUE CROSS BLUE SHIELD OF MINNESOTA PREFERRED PROVIDER ARRANGEMENT

The Trustees have entered into an agreement with Blue Cross Blue Shield of Minnesota (BCBSM) to provide you access to the AWARE network of providers. This network of hospitals, physicians, and other health care professionals provide you quality health services at favorable prices. Your out-of-pocket expenses should be less because your copayment will be applied to reduced charges. AWARE providers also will file your claims for you if you present your identification card and sign the appropriate form(s). AWARE providers are named in a directory provided to you automatically at no cost as a separate document. The participating status of providers in the AWARE network is subject to change as providers enroll or terminate their agreements with BCBSM. A current listing of AWARE network providers will be maintained at the Fund Office and you will be notified of updates periodically. You may use providers that are not a part of BCBSM's AWARE network. However, your out-of-pocket costs generally will be greater and you must file your own claims.

Case Delivery Management, Inc. (CDMI), a wholly-owned subsidiary of Blue Cross Blue Shield, provides case management services. If a catastrophic or other suitable case is referred to them, CDMI will review the case to determine if case management is appropriate. If so, CDMI 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.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

For Full-Time Employees and Dependents and Part-Time Employees

When you or your eligible dependents require covered services or supplies which are medically necessary because of illness or injury, 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 Exclusions for the Plan are on pages 37 and 38.

DEDUCTIBLE

The deductible is the amount of covered charges which you must pay before you are entitled to benefits under this section. The deductible amount per person per calendar year is stated in the Schedule of Benefits. There is a maximum of three individual deductibles required per family per calendar year for full-time employees. The deductible applies only once in any calendar year even though you may have several different injuries and illnesses.

COPAYMENT

After you satisfy the required 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 the charges is payable by you.

Successive confinements will be considered one confinement unless they are due to entirely unrelated causes OR with respect to the:

(a) active employee -- he has returned to active work for at least one full working day before the subsequent confinement begins;

(b) retired employee or dependent -- confinements are separated by three months.

When the out-of-pocket copayment expenses in any one calendar year reach the maximum stated in the Schedule of Benefits, the Plan generally will pay 100% of the balance of covered expenses in excess of such maximum for the remainder of that calendar year. This out-of-pocket maximum includes the deductible amount.

LIFETIME MAXIMUM

The aggregate lifetime maximum for each eligible person under Comprehensive Major Medical Benefits is stated in the Schedule of Benefits.

COVERED HEALTH SERVICES

Benefits are payable for the usual and customary charges incurred by you or an eligible dependent for the following services and supplies which are medically necessary for the treatment of an illness (including pregnancy) or accidental bodily injury.

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.

(a) Hospital inpatient services recommended by the attending physician for:

    (1) Room and board expense, up to the semi-private room rate, and isolation when medically necessary.

Even though part-time employees do not have dependent coverage, benefits are payable for hospital room and board expense for a part-time employee's well newborn dependent child during the period the mother of such child is hospital-confined as a result of giving birth to such child. If the newborn dependent child has a condition (such as illness, injury, congenital defect, or premature birth) which requires treatment, no coverage will be provided for any expenses incurred by such newborn, including charges for hospital confinement.

(2) Confinement in an intensive care unit, including confinement of 24 consecutive hours or more 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.

(3) 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 or while in the outpatient department of the hospital when outpatient surgery is performed. See page 27 for coverage of pre-admission testing.

(4) Services for confinement in a hospital and services provided in an intensive day treatment program that are related to treatment of mental illness or disorders. These services are payable the same as for any other disability, but are limited to the maximum number of days of inpatient care per calendar year as stated in the Schedule of Benefits (including services for self-inflicted injury).

(5) Services provided for treatment during confinement in a hospital or Residential Treatment Program for the treatment of alcoholism, chemical dependency, and substance abuse, payable the same as for any other disability, but limited to the maximum number of days per calendar year as stated in the Schedule of Benefits. Inpatient charges incurred at a detoxification center are not covered unless such center is located within a hospital or Residential Treatment Program and appropriate medical or psychiatric care is being provided. Confinements strictly for custodial care are not covered.

(b) Skilled nursing home care in a licensed skilled nursing home for up to the maximum number of days per confinement as stated in the Schedule of Benefits, provided:

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

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

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

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

(c) Physicians' services for:

(1) Inpatient and outpatient surgery by a physician or surgeon, including charges for:

-- Home deliveries.
-- Circumcision of a full-time eligible newborn dependent.
-- Prophylactic mastectomies when warranted by a history of cancer in the contralateral breast or a “strong family history of breast cancer,” meaning two first degree relatives (sibling or parent) or multiple second degree relatives with breast cancer. Prior authorization is required for such procedures.
-- Following a mastectomy, the following are covered on the same basis as

other surgical procedures covered by the Plan and in a manner determined in consultation with the attending physician and the patient: reconstruction of the breast and nipple of the breast on which the mastectomy has been performed and of the contralateral breast to produce symmetrical appearance; and treatment of physical complications of all stages of mastectomy, including lymphedemas.

-- Organ transplants, up to the maximums stated in the Schedule of Benefits.

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

(2) Services rendered by an assistant surgeon.

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

(4) Medical services rendered during in-hospital, office, and home visits by a physician, including newborn consultations for full-time employees.

(5) Chiropractic care, including acupuncture for pain relief. The Plan will cover the first 12 visits per person per calendar year. After that, certification of medical necessity will be required by a doctor of medicine before coverage will be provided for additional chiropractic care. If the physician so certifies, 12 additional chiropractic visits will be covered. Certification of medical necessity for ongoing care will be required after every 12 visits.

(6) Inpatient services rendered by a licensed psychologist or licensed consulting psychologist that are within the scope of his license and ordered by a physician.

(7) Consultation, diagnosis, and treatment of any mental illness or nervous disorder rendered on an outpatient basis in a licensed mental health facility, hospital, or by a physician, licensed psychologist, licensed consulting psychologist, or clinical social worker certified by the Academy of Certified Social Workers (ACSW). Benefits are payable the same as for any other disability, up to the maximums stated in the Schedule of Benefits.

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

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

(e) Prescription medication prescribed by a physician for treatment of a non-occupational illness or injury. Prescriptions must be dispensed by a pharmacy, physician, or the pharmacy of a hospital. Each time a prescription order is filled, it will be limited to a 90-day supply.

You may elect to purchase prescription drugs through the Preferred Provider Prescription Drug Program described on page 30.

Benefits are not payable under these prescription medication benefits for the following:

(1) oral contraceptive medication (birth control pills), except if determined to be medically necessary for a non-contraceptive use;

(2) supplies or appliances which are not prescription medication even if obtained with a prescription order, such as devices, bandages, heat lamps, braces, splints, artificial appliances, diaphragms, and syringes for use with insulin;

(3) drugs and medications which can be obtained without a prescription order, except insulin;

(4) cost of administering a prescription medication;

(5) cost of prescription medications for use while confined in a hospital;

(6) any prescription medication which is not approved for sale by the United States Government;

(7) cosmetic drugs;

(8) health and beauty aids, cosmetics, and dietary supplements;

(9) state-restricted drugs;

(10) impotence medications; and

(11) injections and injectables. However, insulin when prescribed by a physician, will be covered.

(f) Hospice care for terminally ill eligible persons who otherwise, upon their physician's recommendation, would be required to be hospital-confined. Benefits are payable for home care administered under an approved hospice program or home health care agency at the patient's home, or for care in a hospice unit of a hospital, or in a separate hospice facility.

The following hospice care services are covered during the period in which you otherwise would have to be hospital-confined:

(1) physicians' visits;

(2) care provided by registered nurses (R.N.) and home health care aides;

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

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

(5) drugs and supplies prescribed by a physician.

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

(1) you and/or your dependents suffer from a disease which is known to have a genetic cause;

(2) a strong family history of a disease which is known to have a genetic cause 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 disease which is known to have a genetic cause);

(3) you and/or your dependent spouse has produced a child with mental retardation, a disease which is known to have a genetic cause, 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.

(h) Other covered expenses for:

(1) Maternity and obstetrical services performed by a nurse midwife.

(2) Medically necessary local ambulance services.

(3) Blood and blood plasma.

(4) Health services provided for the treatment of a full-time employee's emotionally handicapped children and furnished by a Residential Treatment Facility (included in the inpatient maximum stated in the Schedule of Benefits on page iv).

(5) Outpatient surgery performed in the outpatient department of a hospital.

(6) Outpatient pre-admission tests and exams, provided that:

-- the surgery for which the tests or exams are furnished is performed within 72 hours of the date on which they were given; and
-- you or your eligible dependent are confined as an inpatient in the hospital immediately following such surgery.

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

-- scheduled diagnostic procedures;
-- follow-up visits for further injections, such as antibiotics;
-- suture removal; and
-- urgent but not life-threatening conditions that are normally treated in a physician's office, such as but not limited to earache, sore throat, upper respiratory infections, flu syndrome, and migraine headaches.

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

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

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

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

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

(13) Outpatient radiation and chemotherapy treatment services.

(14) Oxygen and the rental of equipment for its administration. The purchase of such equipment is covered if the rental would exceed the purchase price; however, the Fund Office must approve the purchase.

(15) Physical therapy provided by a physical therapist and occupational therapy provided by an occupational therapist who is someone other than a person who ordinarily resides in your home or is a member of your immediate family.

(16) Speech therapy provided by a licensed speech therapist under the supervision of a physician when medically necessary for a condition resulting from an injury, illness, or congenital disorder such as a cleft lip or palate. However, benefits are not payable for speech therapy for a condition resulting from developmental or learning disabilities or a personality disorder.

(17) Hearing aid appliances prescribed by a physician, up to the maximum stated in the Schedule of Benefits for each ear per benefit period. Coverage is provided for one hearing aid per ear with replacement every three years. This replacement provision affects any hearing aid appliance received prior to your effective

date of coverage under this Plan. The benefit period begins on the date the hearing aid is received and covered charges include repair and servicing of the hearing aid. Batteries for a hearing aid are not covered.

(18) For eligible persons age 55 and over, immunizations for influenza and pneumonia.

(19) Breast prostheses following a mastectomy.

(20) Wigs and toupees when hair loss is the result of a disease or medical treatment, up to the maximum stated in the Schedule of Benefits per each eligible person's lifetime.

(21) Diabetic, cardiac, and obesity self-management education programs, provided the program is medically necessary and prescribed by a physician. Benefits are payable up to the aggregate maximum stated in the Schedule of Benefits per each eligible person's lifetime for all charges considered for payment for such programs.

(22) Routine colonoscopy.

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

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

(25) Mastectomy bras, up to two per eligible person per calendar year.

(26) Jobst stockings, up to two pair per eligible person per calendar year.

(27) Discounted charges from QuickMedX clinics.

OTHER ROUTINE CARE

The deductible and copayment amounts are waived for covered expenses related to the following routine services. The Plan pays 100% of the usual and customary charges incurred for these services, up to the maximums stated in the Schedule of Benefits.

(a) Routine physical examinations including charges for an examination, x-rays, and laboratory tests performed by a physician or surgeon in a hospital, clinic, or physician’s office. Covered expenses include:

   (1) Routine office visits for the ongoing care of a full-time employee’s well baby and also routine well child care, including professional services or supplies related to routine immunizations of a full-time employee’s dependent children ages 2 through age 12. The Plan covers the childhood immunizations recommended by the American Academy of Pediatrics.

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

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

   Benefits are not payable under this routine physical examination benefit for routine immunizations or vaccinations, except as specifically stated, eye or dental examinations, or routine colonoscopy [see “(22)” on this page for coverage of such procedure].

(b) Routine immunizations for a full-time employee's eligible dependent children from birth to age two for related professional services and supplies. The Plan covers the childhood immunizations recommended by

the American Academy of Pediatrics, including but not limited to those to prevent diphtheria, pertussis, tetanus, polio, measles, mumps, and rubella.

COMPREHENSIVE MAJOR MEDICAL BENEFITS LIMITATIONS

In addition to the General Exclusions on pages 37 and 38, Comprehensive Major Medical Benefits do not cover any charges caused by, incurred for, or resulting from:

(a) Services performed on or to the teeth, nerves of the teeth, gingiva or alveolar processes, except to tumors or cysts, or as required because of injury to sound natural teeth, provided the services are performed promptly following the accidental injury and in no event longer than 12 months from the date of such injury.

(b) Cosmetic surgery except to repair a defect caused by an accidental injury, or to repair a congenital anomaly of a full-time employee's eligible dependent child under age 16, or for breast reconstruction due to a documented need for a prophylactic mastectomy as stated on page 24.

(c) Reconstructive surgery except to correct a functional physical defect resulting from a congenital anomaly of a full-time employee's eligible dependent child or that which is incidental to or follows surgery resulting from illness of the involved body part or as specified on pages 24 and 25.

(d) Recreational or educational therapy, all forms of non-medical self-care or self-help, except as specifically stated.

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

(f) Eye refractions, eyeglasses or the fitting of eyeglasses. See page 31 for Vision Care Benefits.

(g) 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; dehumidifiers; allergy-free pillows, blankets, or mattress covers; electric heating units; orthopedic mattresses; exercise equipment; gravity lumbar reduction chairs; vibratory equipment; elevators or stair lifts; stethoscopes; clinical thermometers; scales; blood pressure monitors; or magnetic devices.

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

(i) All expenses associated with personal blood storage.

(j) Health club memberships.

(k) Services of a massage therapist.

(l) Charges in excess of usual and customary for the service.

PREFERRED PROVIDER PRESCRIPTION DRUG PROGRAM

For Full-Time Employees and Dependents and Part-Time Employees

Prime Therapeutics provides full management of the Plan's prescription drug program. Prime Therapeutics is a national pharmacy benefit manager that offers retail and mail-order service, physician education, formulary management, drug utilization review, and health outcomes research. Show your I.D. card at the pharmacy to receive discounts through Prime Therapeutics and then send in your claims to the Fund Office for reimbursement. Benefits are payable at the copayment stated in the Schedule of Benefits. You can locate a participating pharmacy in the retail network by calling toll-free: (800) 509-0545 or visiting: www.myrxhealth.com on the internet.

You or your eligible dependent(s) have the option of purchasing maintenance prescription drugs through the mail-order service. A maintenance drug is a prescription medication expected to be taken on a long-term basis. If prescribed by your physician, you will be able to obtain up to a 90-day supply of medication for each brand name or generic prescription, payable at the copayment stated in the Schedule of Benefits.

If your prescription qualifies as a maintenance drug, you may call PrimeMail toll-free at: (877) 357-7463 with your member and prescription information and they will inform you of the amount of your copayment. Your copayment must be paid before the prescription will be mailed. You either can charge your copayment to a major credit card or you can mail a personal check or money order to Prime Therapeutics. Your prescription will be mailed when the copayment is received. Your prescription will be delivered to your home, postage paid. Please note, when filling a new prescription, you must submit an original prescription to Prime Therapeutics written for a 90-day supply. You may mail your prescription along with an order form and your copayment in the envelopes provided to you or you can give your member ID number to your physician and have him call: (877) 357-7463 for fax instructions.

There are three ways to refill your prescriptions:

(a) On the internet: www.myrxhealth.com;

(b) By phone: (877) 357-7463; or

(c) By mail: Use the refill forms provided with your medication.

The same limitations that apply to the prescription medication benefits on pages 25 and 26 also apply to the Preferred Provider Prescription Drug Program.

VISION CARE BENEFITS

For Full-Time Employees and Dependents and Part-Time Employees

If you or an eligible dependent incur charges of an optician, optometrist, or ophthalmologist for any of the following covered expenses, benefits are payable up to the amounts stated in the Schedule of Benefits.

Eye Examinations

Each eligible person is entitled to one complete eye exam each calendar year. A "complete eye exam" includes, but is not necessarily limited to, the following:

(a) complete case history;

(b) measuring and recording visual acuity, corrected or uncorrected;

(c) examination of fundus, media, crystalline lens, optic disc, and pupil reflex for pathology, anomalies, or injury;

(d) corneal curvature measurements;

(e) retinoscopy;

(f) fusion determination, distance and near;

(g) subjective determination, distance and near;

(h) stereopsis determination, distance and near;

(i) color discrimination;

(j) amplitude or accommodation;

(k) analysis of findings;

(l) determining of prescription, if needed; and

(m) measuring and recording visual acuity, distance and near, with new prescription, if required.

Lenses and Frames

Each eligible person is entitled to one set of lenses and one set of frames each calendar year, if warranted by prescription. Fees for professional services for fitting and adjusting also are covered, including but not limited to, the following:

(a) professional advice on frame selection;

(b) facial measurements and preparation of specifications for optical laboratory;

(c) verifying and fitting of prescription glasses or contact lenses;

(d) reevaluation and progress report two to four weeks after the fitting of a new prescription; and

(e) subsequent servicing.

Contact Lenses

In lieu of conventional lenses and frames, an eligible person will be entitled to one set of contact lenses each calendar year (or disposable contacts up to the contact lenses maximum), including professional fees and materials.

Limitations

In addition to the General Exclusions on pages 37 and 38, Vision Care Benefits do not cover:

(a) sunglasses, plain or prescription;

(b) safety lenses and goggles;

(c) orthoptics, vision training, or aniseikonia;

(d) contact lens care kit and asceptors (heating units);

(e) insurance contracts for contacts, lenses, and frames;

(f) any medical or surgical treatment of the eye; and

(g) such services or supplies which are payable or furnished by any other group policy or prepayment plan (excludes individual policies).

DELTA DENTAL BENEFITS

For Full-Time Employees and Dependents and Part-Time Employees

Under the Delta Dental Plan, you have the choice of receiving care from DeltaPreferred Option Dentists; Participating (DeltaPremier) Dentists; or Non-Participating Dentists. Although you have the freedom to choose your dentists, there are advantages to choosing a dentist who is in the Delta Dental network. These dentists agree to accept Delta Dental's allowable charge as the maximum charge for a procedure. You will not be responsible for any fees in excess of the allowable charge, other than satisfying the deductible and copayment requirements stated in the Schedule of Benefits. Your medical card will alert your dentist that you are entitled to discounts through the Delta Dental network of dentists.

You can find a network dentist by visiting www.deltadental.com/directory on their website, or by calling: (651) 406-5916 or (800) 553-9536.

Dental care coverage has four main parts: preventing dental disease, restoring teeth, furnishing dentures, and straightening teeth (orthodontia).

If you or an eligible dependent incur charges of a dentist or dental hygienist for any of the following covered expenses, benefits are payable after satisfaction of the deductible, if applicable, at the copayment and up to the maximum amounts stated in the Schedule of Benefits. The aggregate maximum amount per calendar year applies to all covered charges incurred for diagnostic and preventive services, basic and extensive restorative services, and prosthetic services.

There also is a separate orthodontic maximum amount which applies to all orthodontic expenses payable for an eligible dependent's lifetime. Orthodontic benefits are available only for full-time employees' dependent children ages 8 through 18.

See page 35 for a description of dental services which require predetermination.

Diagnostic and Preventive Services

Benefits are payable for the following diagnostic and preventive services.

(a) Periodic oral examinations, limited to two in a 12-month period.

Coverage will be provided for two additional oral examinations each 12-month period, provided such services are medically necessary due to a systemic disorder.

(b) X-rays (radiographs), limited to:

(1) two bitewing x-rays twice in a 12-month period;

(2) full mouth x-rays once in a three-year period; and

(3) panagraphic x-rays once in a three-year period unless a special need is indicated.

(c) Topical fluoride treatments for eligible persons through age 18, limited to once in a 12-month period.

Coverage will be provided for two additional topical fluoride treatments each 12-month period for all eligible persons, provided such services are medically necessary due to a systemic disorder.

(d) Dental prophylaxis, limited to two in a 12-month period.

Coverage will be provided for two additional dental prophylaxis each 12-month period, provided such services are medically necessary due to a systemic disorder.

(e) Oral hygiene instruction when prescribed by a dentist, limited to once in a 12-month period.

(f) Sealants, applied to deciduous and permanent teeth with no filling materials present, limited to primary molars for eligible persons through age 18. No charges for dental fillings or reapplication of sealants will be payable within three years after the initial sealant is applied.

Basic and Extensive Restorative Services

Benefits are payable for the following basic and extensive restorative services.

(a) Emergency treatment for the relief of pain.

(b) Space maintainers.

(c) Restorations of amalgam, silicate, synthetic porcelain, acrylic, plastic, resin (white), or composite-type filling material.

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

(e) Recementing of crowns and/or inlays (fillings) when necessary.

(f) Repairs of alveolar processes: Excision of tumors, cysts, neoplasms or bone tissue; and surgical incision for removal of foreign bodies or drainage of abscess.

(g) Endodontic services to include pulpal therapy and root canal therapy.

(h) Routine oral surgery for tooth removal.

(i) General anesthesia for covered oral surgical procedures performed in a dental office.

(j) Periodontics, surgical, and adjunctive services.

(k) Tests and laboratory examinations when necessary.

Prosthetic Services

Benefits are payable for the following prosthetic services.

(a) Complete or partial dentures. Replacement of existing complete or partial dentures is covered only if the denture is five years old or more and cannot be made serviceable.

(b) Denture refining and rebasing. Rebasing is considered a new denture and the same limitations apply as stated in the prior subsection (a).

(c) Denture adjustments when necessary.

(d) Bridges, bridge abutment crowns, bridge pontics, and retainers. Replacement of such appliances is covered only if the current prosthetic appliance is five years old or more and cannot be made serviceable.

(e) Repairs to crowns, bridges, and dentures.

(f) Temporomandibular joint (TMJ) appliances when necessary.

Orthodontic Services

Benefits are payable for the following orthodontic services when incurred by a full-time employee's eligible dependent children ages 8 through 18.

Covered charges must be incurred as the result of the installation of orthodontic appliances and will include orthodontic treatment rendered by a dentist as follows:

(a) Placement of the appliance (banding).

(b) Follow-up monthly visits, including services and supplies needed during the course of such treatment. These charges are payable following a six-month period of time since placement of the appliance, provided the dependent remains covered by the Plan.

Predetermination of Benefits

A request for predetermination of benefits for procedures requiring predetermination must be submitted to the Fund Office prior to the procedure being initiated.

A treatment plan from the eligible person's dentist along with substantiative material, such as radiographs (x-rays), study models, and photographs must be submitted with the request. Any amount predetermined by the Fund will be subject to adjustments by the Fund at the time of payment as may be necessary to correct any mathematical errors and to comply with the eligible person's coverage in effect at the time of service.

If predetermination is not requested, the Fund retains the right to pay a claim on the basis of the amount of benefits which would have been paid had predetermination been requested.

The following procedures require predetermination:

(a) Diagnostic and Preventive Services:

(1) two additional oral examinations each 12-month period when medically necessary due to a systemic disorder;

(2) two additional topical fluoride treatments each 12-month period when medically necessary due to a systemic disorder; and

(3) two additional dental prophylaxis each 12-month period when medically necessary due to a systemic disorder.

(b) Restorative Procedures:

(1) gold foil or inlay restorations and onlays;

(2) porcelain restorations;

(3) crowns, all single restorations;

(4) skin grafts; and

(5) miscellaneous repair procedures:

-- injection of trigeminal nerve branches for destruction;
-- avulsion of trigeminal nerve branches;
-- osteoplasty for orthognathic deformities; and
-- osseous, osteoperiosteal, periosteal, or cartilage graft of the mandible, autogenous or nonautogenous.

(c) Periodontic Procedures:

(1) gingivectomy or gingivoplasty;

(2) gingival curettage and root planing;

(3) mucogingival procedure;

(4) osseous surgery;

(5) osseous graft;

(6) pedicle soft tissue grafts; and

(7) free soft tissue grafts.

(d) Prosthetic Procedures:

(1) complete or partial dentures;

(2) denture rebasing;

(3) bridge abutment crowns;

(4) bridge pontics;

(5) retainers; and

(6) temporomandibular joint (TMJ) appliances.

Limitations

Recognizing that many dental problems can be solved in more than one way, the Plan will pay an amount equal to that applicable for the generally accepted treatment method which, in its own judgment, will provide adequate dental care at the lowest cost to you. In determining its liability, the Plan will be guided by nationally established standards of the dental profession.

In addition to the General Exclusions on pages 37 and 38, Dental Care Benefits do not cover:

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

(b) Charges for failure to keep a scheduled dental visit.

(c) Charges for the completion of any insurance forms.

(d) Prescription drugs.

(e) Services or supplies which do not meet accepted standards of dental practice, including charges for services and supplies which are experimental in nature.

(f) Upgrading of serviceable dentistry.

(g) Services performed before the effective date of the eligible person's coverage under this Plan.

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

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

(j) Charges for any dental procedures performed solely because the eligible person has changed dentists.

(k) Charges for infection control of the doctor, including Occupational Safety and Health Act barriers.

(l) Orthodontic services other than for eligible dependent children ages 8 through 18 of full-time employees.

(m) Restorations for identification purposes.

(n) Repair or replacement of a retainer, even if lost or stolen.

(o) Replacement of lost or stolen dentures, bridges, or other prosthetic appliances.

GENERAL PROVISIONS

GENERAL EXCLUSIONS

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

(a) Accidental bodily injury or illness which arises out of and in the course of any occupation or employment for wage or profit, or which may be payable in whole or in part under any Worker's Compensation Law, Employer's Liability Law, Occupational Disease Law, or similar law. However, the Fund will consider advancing medical expenses, payable in whole or in part under the Worker's Compensation Law, provided the eligible employee signs a subrogation agreement with the Plan.

(b) Any loss caused by war or any act of war (declared or undeclared), including armed aggression.

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

(d) Further expenses furnished within any facility of, or provided by, the United States Veterans Administration or Department of Defense incurred for non-service-connected conditions for which there has not been furnished to the Fund Office required details and supporting papers.

(e) Experimental medical or surgical procedures or treatments (as defined on page 54), except as may be specifically stated or those that may be authorized by the Board of Trustees pursuant to advice provided by a competent medical authority retained by the Trustees as medical consultant.

(f) Any services or supplies which are not medically necessary, as determined by a physician.

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

(h) Surrogate maternity services.

(i) Services for which the eligible person is not required to pay.

(j) Transportation, except local ambulance services.

(k) Abortions.

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

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

(n) Services of the clergy during normal duty when a charge usually would not be made.

(o) All treatment for and related to sex transformations.

(p) Any diagnostic hospital admission which can be performed on an outpatient basis.

(q) Illness for which any benefits are received or could be received if claims were made under any no-fault automobile insurance policy to the extent that such policy provides benefits for charges covered under this Plan.

(r) Costs associated with the removal of organs from a transplant donor who is a living eligible person or who was an eligible person prior to his death.

(s) Charges incurred for obtaining additional medical records.

(t) Claims submitted later than 15 months from the date incurred.

(u) Services privately contracted with a provider that otherwise would be covered by Medicare which are incurred by an eligible person for whom Medicare is the primary source of coverage.

(v) Any expense relating to an accidental bodily injury or illness for which you or an eligible dependent, whether or not a minor, has a right to receive payment from a third party, has collected from a third party without notifying the Trustees or their representatives, or has not submitted all charges related to the bodily injury or illness before the claim is resolved.

(w) A third party (such as the driver of a car that caused an accident for which medical expenses were incurred) was responsible for paying the incurred medical expenses, and you or your dependent, whether or not a minor, did not comply with the subrogation provisions of this Plan as described on pages 42 and 43.

(x) Charges incurred for any special education rendered to any eligible person, regardless of the type of education, except as otherwise specifically stated.

(y) Charges for telephone conversations and/or telephone consultations.

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

(aa) 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.

(bb) 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 or reimbursement or otherwise failed to cooperate with the Plan as specified.

(cc) Radial keratotomy or Lasik surgery.

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

(ee) Drugs or medicines prescribed by a physician which are available as over-the-counter purchases, including but not limited to, aspirin, cough medicine, vitamin supplements, etc.

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

(gg) Charges incurred for smoking cessation programs.

(hh) Charges incurred for gambling addiction in a residential treatment program.

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

COORDINATION OF BENEFITS (COB)

If you or an eligible dependent 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 medical expenses incurred. 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.

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 be primary and 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.

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

(c) When parents are divorced or separated, the order of benefit determination is:

(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 Qualified Medical Child Support Order 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 first. There is one exception to this rule: A plan that covers a person as an active 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) 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.

(f) For active eligible employees age 65 and over performing covered employment, this Plan is the primary payer and Medicare is the secondary payer. However, such active employee or dependent spouse has the right to reject this Plan and retain Medicare as their primary source of coverage. In such case, the Plan is legally prohibited from supplementing Medicare coverage.

(g) Credits: Whenever this Plan is considered the secondary plan and a claim payment is reduced because of this coordination of benefits provision, the amount of reduction will be carried for the balance of the calendar year as a credit for the person for whom the claim was made. This amount may be used for other claims, due to any cause, in the same calendar year if the person has an out-of-pocket allowable expense after the normal benefits under both plans have been paid. A claim record with credit is maintained only for a calendar year. Each January 1st a new record begins for each eligible person.

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.

COORDINATION OF BENEFITS WITH AUTOMOBILE INSURANCE

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

(a) Benefits payable under the Plan are not in lieu of those that would be payable under no-fault automobile insurance and do not affect any legal requirement that an individual maintain the minimum no-fault automobile insurance coverage within the jurisdiction in which that individual resides.

(b) For any expenses arising from the maintenance or use of a motor vehicle, no-fault automobile insurance will calculate and pay its benefits first and this Plan will calculate and pay benefits second. The amount of benefits payable by this Plan will be coordinated so that the total amount paid will not exceed 100% of the expenses incurred.

(c) Benefits that otherwise might be payable under no-fault automobile insurance will not be payable by the Plan merely because no claim for no-fault benefits was filed. If you or an eligible dependent fails to maintain the legally required amount of no-fault automobile insurance within the jurisdiction where you or your dependent resides, Plan benefits will not be payable for amounts which the legally required no-fault insurance otherwise would have paid.

(d) An individual injured in an automobile accident which is or should be covered by no-fault automobile insurance must arbitrate any notice of discontinuance of no-fault insurance or benefits for those injuries will not be payable under this Plan.

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. Also, the combined amounts payable under Part A and Part B of Medicare and the Plan will not exceed the eligible expenses incurred by the eligible person as the result of any one accidental bodily injury or illness. Benefits payable by Part A and 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-serviced-connected disabilities will be reduced by the amount that would have been payable by Medicare had the services been rendered by a Medicare-approved facility.

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

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

When an eligible person for whom Medicare is the primary source of coverage incurs services otherwise covered by Medicare through a private contract with a provider, no benefits are payable under this Plan.

Neither you nor the Plan is 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.

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 under the Plan 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), benefits payable under this Plan will be reduced by the amount of benefits paid or payable under Part A or Part B of Medicare.

If such person subsequently becomes entitled to Medicare due to ESRD, Medicare will continue to pay primary.

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 active employees and their dependent spouses who are eligible under the Plan through employer contributions even though they also may become initially entitled to Part A or Part B of Medicare due to attained age or a qualifying disability (other than ESRD).

If such person subsequently becomes entitled to Medicare due to ESRD, the Plan will continue to pay primary to Medicare for the full 30-month coordination period specified in the following subsection.

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

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 are provided subject to the following terms. The same terms apply if 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.

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

(b) 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 TO RECEIVE OR RELEASE NECESSARY INFORMATION

The Trustees may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or persons any information with respect to any person which the Trustees deem to be necessary to determine the applicability of and to implement the provisions of the Plan. Any person claiming benefits under this Plan must furnish to the Trustees any information they deem necessary.

FACILITY OF PAYMENT

Whenever payments have been made under any other plan which should have been made under this Plan, the Fund will have the right to pay to such a plan the amounts it determines to be warranted. These amounts so paid will be considered benefits paid under this Plan to the extent that they are applied toward covered services and the Fund will be fully discharged from liability under this Plan.

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.

EFFECT ON WORKER'S COMPENSATION

This Plan is not in lieu of and does not affect any requirements for coverage by Worker's Compensation Law, Occupational Disease Law, or similar law. Benefits that otherwise would be payable under the provisions of these laws will not be paid by the Plan merely because you did not file a claim for benefits under the rules of these laws.

The Fund will use its "right to recover" if an eligible person is provided services or is paid benefits under this Plan due to injury or illness for which he is or may become entitled to benefits under the applicable Worker's Compensation Law, Occupational Disease Law, or similar law. The person who receives services or benefits from this Plan under these circumstances must sign and deliver all related papers or forms to the Fund and must do whatever else is necessary to help the Fund administer this recovery provision. Such person must not do anything or sign anything after the loss for which the Fund provided services or paid benefits to impair the Fund's right to recover for the services provided or benefits paid.

SUBROGATION

The Plan has the right to recover all benefits paid or payable to or on behalf of a participant or beneficiary. Upon paying benefits, the Plan automatically is subrogated on a first priority basis to the rights of the recipient of Plan benefits (recipient includes an individual on whose behalf the Plan has paid or will pay benefits to another person or entity) against any person, insurer, or entity which is, as the result of such injuries, illness or death, legally liable for the recipient's injuries, illness or death, or is, or may be legally liable or responsible for paying benefits or damages or may be to the extent of payments made by the Plan. The following rules apply:

(a) The Plan's right of recovery extends to any and all individuals, insurers, or entities which are or may be responsible in tort or in contract including, but not limited to, insurers providing liability, medical expense or medical payment coverage, wage loss, uninsured motorist or underinsured motorist coverage, whether or not the policy of insurance is owned by the recipient.

(b) The Plan's right of recovery through subrogation will be a first priority claim. The Plan will be reimbursed to the extent of its payment from the proceeds of recovery without deduction for attorney's fees or costs. Any amount remaining may be applied to reimburse the recipient.

(c) The Plan's first priority subrogation rights apply whether or not the recipient has been fully compensated for damages arising from the illness or death.

(d) The Plan's first priority subrogation rights include all portions of the recipient's cause of action notwithstanding any settlement allocation or apportionment that purports to dispose of any portion of the cause of action not subject to subrogation. Benefits will not be paid for charges for any injury or condition that is the result of the actions of a third party to the extent an eligible individual is awarded future medical costs or general compensatory damages in a lawsuit or settles a claim which includes payments covering future medical expenses or "pain and suffering" damages.

(e) The Plan's first priority subrogation rights extend to all types of claims and actions, including wrongful death actions, and actions brought by minors.

(f) The recipient must cooperate fully with the Plan, do nothing to prejudice the Plan's subrogation rights, and promptly advise the Plan Administrator, in writing, of any claim being made against anyone who may be liable for the illness or death.

(g) The recipient agrees to sign a subrogation agreement acknowledging the Plan's subrogation rights and rights of recovery and as a condition to payment of benefits by the Plan. Failure or refusal to execute the subrogation agreement will result in non-processing of claims by the Plan Administrator where there is the possibility of liability on the part of a third party or the possibility of a subrogation recovery. The acceptance of any benefits or payments will constitute an assignment to the Plan of its subrogation rights and recognition by the recipient that the Plan has first priority subrogation rights. The failure or refusal of any individual to execute documents at the Plan's request will not defeat the Plan's right of recovery.

(h) The Plan may sue in the name of the recipient to recover the payments made by it. The recipient will actively cooperate with the Plan in pursuit of the Plan's subrogation rights.

(i) This subrogation provision applies to claims of dependents covered by the Plan regardless of whether or not such dependents are legally responsible for expenses of treatment.

(j) This subrogation provision applies to all categories of benefits paid by the Plan, but only to the extent of such payments by the Plan.

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

(l) Monies made available to settle or pay a claim made against a third party first will be applied to reimburse the Plan in full for benefits paid. Thereafter, the remaining balance, if any, may be paid to the eligible individual. Such proceeds from a third-party recovery will be allocated in the preceding order of priority:

    (1) regardless of whether or not the monies are sufficient to fully compensate the injured party; and

    (2) notwithstanding any settlement allocation or apportionment that purports to dispose of any portion of the cause of action not subject to subrogation.

    This order of allocation also will apply whether or not the individual on whose behalf benefits were paid is legally responsible for the expenses of medical treatment.

(m) This Plan will not be responsible for any attorney's fees or costs incurred by the recipient in any legal proceeding or claim for recovery, unless prior to incurring such fees or costs, the Plan, in the exercise of its sole discretion, agrees in writing to pay all or some portion of said fees or costs.

(n) 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 the recipient 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 recipient's attorney from the Plan's recovery, the recipient will reimburse the Plan for any such amounts.

(o) The Trustees of the Plan will have the right to adjust, amend, and interpret these provisions regarding subrogation. It is their intent that these rules will be construed in such manner as will most completely protect the Plan's interest in these matters.

The Trustees believe that subrogation will allow the Fund to allocate its assets to the greater good of all eligible persons because the cost of medical treatment and other expenses will be the responsibility of the third parties who are legally responsible for them (or their insurance companies).

TERMINATION OF PLAN

This Plan may be terminated:

(a) As to participants (and their dependents) in the collective bargaining unit, by agreement of the Union(s) and Employer Association (or individual employers, where applicable) which negotiate the labor agreements covering such collective bargaining unit; or

(b) When the Trustees determine that the Trust Fund is inadequate to carry out the intent and purpose of the Trust Agreement or is inadequate to meet the payments due or to become due 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.

RECORDS

Each eligible person authorizes and directs any provider that has attended, examined, or treated him to furnish the Fund, at any time upon its request, any and all information and records or copies of records relating to such services. The Fund agrees that such information and records will be considered confidential.

PHYSICAL EXAMINATION

The Fund, at its own expense, has the right and opportunity to examine any eligible person whose illness is the basis of claim when and as often as it may reasonably require during the pendency of a claim under the Plan.

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.

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 insurance.

Generally, protected 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.

Please be advised that the Plan will provide eligibility and "basic" claims payment information to members of your family and to those who are involved in your health care unless you request otherwise.

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.

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

The federal 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.

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 the 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.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

STATEMENT OF PARTICIPANT 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 welfare plans. The law also spells out certain rights and protections to which you are entitled as a participant.

The Trustees of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund want you to be fully aware of your rights, and in accordance with federal law, a statement of your rights follows.

As a Participant in the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund:

(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, and copies of all documents filed by the Plan with the Department of Labor or the Internal Revenue Service, such as the latest annual report (Form 5500 Series) and Plan descriptions.

Such documents may be examined at the Fund Office (or at other specified locations such as worksites or Union halls) during normal business hours.

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; and

(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 your 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 welfare 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 3 through 5 of this booklet. Basically, they provide that:

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

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

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.

(j) In addition to creating rights for Plan participants, ERISA also defines the obligations of people responsible in operating employee benefit plans. These persons are known as "fiduciaries." They have the duty to operate your Plan prudently and with reasonable care and to look out for your best interests as a participant under the Plan and the best interests of other 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 a copy of Plan documents or the latest annual report 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:

-- the request actually was received;

-- the material was mailed to the right address; or

-- 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
Minneapolis Retail Meat Cutters
and Food Handlers
Health and Welfare Fund
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Phone: (952) 854-0795
Fax: (952) 854-1632

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 at U.S. Department of Labor, EBSA, Chicago Regional Office, 200 West Adams Street, Suite 1600, Chicago, IL 60606, (312) 353-0900. Or, you may contact the 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 1-866-444-3272; sending electronic inquiries to* www.askebsa.dol.gov; *or visiting the website of the EBSA at* www.dol.gov/ebsa/.

OTHER ERISA INFORMATION

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

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

3. **Employer Identification Number (EIN):** 41-0905139.

4. **Plan Number (PN):** 501.

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

6. **Type of Administration:** This Plan is administered by a Joint Board of Trustees and through the Fund's administrative office ("Fund Office"). Benefits are provided directly from Trust Fund assets, except Life Insurance and Accidental Death and Dismemberment Benefits as described on pages 17 through 20 are provided through an insurance contract with Kansas City Life Insurance Company, Broadway at Armour, Box 419139, Kansas City, MO 64141-6139. Benefits eligible under the life insurance and accidental death and dismemberment policy are submitted to and paid by Kansas City Life.

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

7. **Collective Bargaining Agreements:** The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries at the Fund Office.

8. **Eligibility Requirements, and Circumstances Which May Cause Disqualification, Ineligibility or Denial, Loss, Forfeiture or Suspension of Benefits:** These matters are discussed in detail in the Eligibility Rules on pages 6 through 16.

9. **Source of Contributions:** Contributions to the Plan are made by participating employers on behalf of their employees according to their respective collective bargaining agreements. Under certain circumstances, employees may make contributions on their own behalf.

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

11. **Claim Procedure:** The procedures for filing for benefits are described on pages 1 and 2.

    If you wish to appeal a denial of a claim, in whole or in part, certain procedures for this purpose are found on pages 3 through 5.

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

Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, Minnesota 55425
Phone: (952) 854-0795
Fax: (952) 854-1632

13. Agent for Service of Legal Process: Legal process may be served upon the Plan Administrator, attention Pamela Hoppe, or upon any Trustee of the Plan.

14. Names and Addresses of Each Trustee:

Union Trustees	**Employer Trustees**
Richard Milbrath	David E. Gerdes
UFCW Local 653	Jerry's Foods
505 North Highway 169	5101 Vernon Avenue
Suite 755	South
Plymouth, MN 55441	Edina, MN 55436
Raymond Sawicky	Edward Kitz
UFCW Local 653	Roundy's, Inc.
505 North Highway 169	M.S.-2040
Suite 755	P.O. Box 473
Plymouth, MN 55441	Milwaukee, WI 53201
Ronald N. Zwieg	William Seehafer
UFCW Local 653	SuperValu
505 North Highway 169	11840 Valley View Road
Suite 755	Eden Prairie, MN 55344
Plymouth, MN 55441	

15. Amendment and Termination: The Trustees may modify or amend the Plan from time to time at their sole discretion. Amendments or modifications which affect participants will be communicated to them as required by law. Although it is the intention that this Plan be ongoing, it may be terminated at any time. Upon termination, the rights of the Plan participants to benefits are limited to claims incurred and due up to the date of termination subject to the availability of Plan assets to pay these claims. Any termination of the Plan will be communicated to participants.

GENERAL DEFINITIONS

Average Weekly Wage means the average weekly amount you earned as an eligible employee during the last four weeks before you became totally disabled. Such wage does not include overtime or bonuses.

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

Dental Hygienist means a person who is currently licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene, and who works under the supervision and direction of a dentist.

Dentist means a doctor of dental surgery or doctor of dental medicine who is currently and duly licensed to practice dentistry under the laws of the state wherein he practices and who is acting within the usual scope of such practice.

Dependent means your spouse and unmarried child or children who meet the requirements of this section. (Dependent coverage applies only to full-time eligible employees.)

The term "child" or "children" includes the following:

(a) Children under 19 years of age.

(b) Students under 25 years of age, while attending school and during summer vacations and between semesters (or the equivalent of such), provided their primary occupation and activity is that of a full-time student and they remain primarily financially dependent upon the full-time employee. To qualify as a full-time student, the child must attend an accredited college, university, or trade school on a full-time basis as defined by the educational institute. A student dependent who is unable to carry 100% of the full-time course load due to illness, injury, or physical or mental disability documented by a physician will remain eligible if the student dependent carries at least 60% of the full-time course load. Eligibility will terminate upon graduation.

(c) Children legally adopted by you and children placed for adoption with you for the purpose of legal adoption. Placement for adoption means the assumption and retention by you of a legal obligation for total or partial support of a child in anticipation of your legal adoption of such child. Placement for adoption terminates upon the termination of such legal obligation.

(d) Stepchildren includes any child of the spouse of an eligible employee, born to the spouse or legally adopted by the spouse. Coverage is provided for any stepchild of an eligible employee, provided that:

(1) the stepchild is living in the eligible employee's household;

(2) the stepchild's non-custodial natural parent does not have group health benefits available through the non-custodial parent's place of employment; and

(3) the stepchild's non-custodial parent is not obligated by any court decree to be responsible for and provide health care for such child.

Benefits will be considered to be "available" to the non-custodial parent even if the non-custodial parent must pay a premium or contribution to obtain benefits either for himself or for the child as a dependent and whether or not the non-custodial parent actually makes the required payments.

In order to have coverage for the stepchild, the eligible employee or his spouse must provide to the Plan, periodically at the Plan's request, the following:

(1) a copy of the divorce decree showing which natural parent has the primary

obligation to provide health care coverage for the stepchild;

(2) a copy of the stepchild's birth certificate or adoption decree showing the stepchild is the child of the eligible employee's spouse; and

(3) evidence of the non-custodial parent's employment status and inability to obtain health benefits for the stepchild.

The eligible employee and his spouse must cooperate fully with the Plan in obtaining these documents, including but not limited to, having the non-custodial parent of the stepchild authorize in writing the release of information requested by the Plan and cooperating with the Plan in obtaining this information.

(e) Foster children if the eligible employee has taken full parental responsibility and control for a foster child and is raising the child as his own. A foster child will not be considered an eligible dependent if the child is temporarily living in the eligible employee's home, is placed with the eligible employee by a social service agency which retains control of the child, or whose natural parent is in a position to exercise or share parental responsibility and control.

(f) Children who are incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapable prior to attainment of the termination age stated previously and who are primarily financially dependent upon you, provided you furnish due proof of such incapacity to the Trustees within 31 days after: attainment of such age; or your receipt of notification of such dependent child's incapability.

You must furnish proof of the continued existence of such incapability and dependency to the Trustees from time to time at their request.

(g) Grandchildren of an eligible employee or spouse if the parent of the grandchild is an eligible dependent or when legal guardianship of the grandchild has been awarded to the eligible employee or spouse. Both the parent and the grandchild must be primarily financially dependent upon and reside with the eligible employee.

(h) An unmarried child who is named in a Qualified Medical Child Support Order (QMCSO) with which you and the Fund are obligated to comply.

For dependent Life Insurance Benefits only, dependent includes your spouse and each unmarried child from 14 days to 19 years of age, or up to age 25 if the dependent is a full-time student and primarily financially dependent upon you.

Parents or other relatives are not eligible for dependent coverage even though supported by you.

Eligible Employee means any employee, former employee, or retiree of an employer as defined in the Trust Agreement, who is eligible for benefits according to the Eligibility Rules of the Fund as adopted by the Trustees from time to time.

Eligible Person means either the part-time or full-time eligible employee or the eligible dependent of a full-time employee.

Experimental means any procedure that is investigative and limited to research rather than applied to accepted, general clinical practice. It also means any technique that is restricted to use at those centers which are capable of carrying out disciplined clinical efforts and scientific studies. Any procedure that has a lack of objective evidence which suggests therapeutic benefit and proven value, or whose efficacy is medically questionable, also is considered experimental.

Family Unit means you, as a full-time eligible employee, and your dependents.

Health Service means any service, supply, drug, or equipment provided to an eligible person for diagnosis, relief, or treatment of an illness or injury. It also includes services and supplies for reconstructive surgery which is

incidental to or follows surgery resulting from illness of the involved body part.

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

Hospice Program means programs which:

(a) have received necessary authorization from the Health Systems Agency to initiate hospice care in a given area;

(b) are eligible to satisfy accreditation requirements as developed by the National Hospice Organization and the Joint Commission on the Accreditation of Hospitals; and

(c) meet the following criteria:

   (1) the patient and family are seen as the unit of care;

   (2) an integrated, centralized administrative structure ensures continuity of care for home care and inpatient care;

   (3) direct provision of care is provided by an interdisciplinary team consisting of physicians, nurses, social workers, chaplains, and volunteers;

   (4) volunteers are used to assist paid staff members; and

   (5) 24-hour-per-day, seven-day-per-week service is available.

Hospital means an institution which meets all of the following requirements:

(a) holds a license as a hospital (if licensing is required in the state);

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

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

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

(e) provides organized facilities for diagnostic and major surgical procedures; and

(f) is not primarily a clinic, nursing, rest, or convalescent home or similar establishment.

For the purpose of this Plan, the term "hospital" includes a Residential Treatment Facility licensed by the Commission of Public Welfare for the state in which it is located for the treatment of emotionally handicapped dependent children under age 18 as defined by the rules of the Commissioner.

"Hospital" also includes the following:

(a) free-standing ambulatory surgical center which is approved as such by the applicable state; and

(b) free-standing ambulatory medical center which is staffed to provide 24-hour-per-day, seven-day-per-week care which is approved as such by the applicable state.

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

Injury means accidental bodily damage which requires treatment by a physician and which results in loss independent of illness and other causes.

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

(a) personal care by specialized registered nurses and other nursing care on a 24-hour-a-day basis;

(b) special equipment and supplies which are immediately available on a standby basis; and

(c) care required but not rendered in the general surgical or medical nursing units of the hospital.

The term "intensive care unit" also will include an area of the hospital designated and operated exclusively as a coronary care unit, cardiac care unit, or neonatal intensive care unit.

Licensed Psychologist and **Licensed Consulting Psychologist** and **Licensed Social Worker** means a person who is duly licensed as a licensed psychologist or licensed consulting psychologist or licensed social worker by and qualified under the laws of the state in which eligible health services are personally rendered by such person.

Medically Necessary means a service or supply which:

(a) is appropriate and consistent with the diagnosis of an illness or injury according to accepted standards of community practice; and

(b) could not have been omitted without adversely affecting the person's condition or the quality of medical care.

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

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

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

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

Optician, Optometrist, and **Ophthalmologist** means any person who is qualified and currently licensed to practice each such profession by the appropriate governmental authority having jurisdiction over the licensure and practice of such profession, and who is acting within the usual scope of such practice.

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.

Pharmacy means a facility licensed by the state in which it is located to dispense prescription medication by licensed pharmacists.

Physician means any individual who is licensed to practice medicine by the governmental authority having jurisdiction over such licensure, and who is acting within the usual scope of such practice. "Physician" will be interpreted to include, but will not be limited to, a doctor of medicine, chiropractor, osteopath, podiatrist, optometrist, doctor of dental surgery, nurse anesthetist for anesthesia services such person renders, and nurse midwife for obstetrical services such person renders. The physician must be duly licensed and qualified under the laws of the state in which eligible health services are performed.

Plan Year means the 12 months beginning any March 1st and ending the following February 28th.

Predetermination means the pretreatment review to determine the eligibility of the individual and the coverage for services according to the Schedule of Benefits.

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 agreeing 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 Prescription Drug Program" means the pharmacy which is party to a contract with the Trustees, currently Prime Therapeutics.

(b) "Preferred Provider Network" means any of the hospitals, physicians, and other health care professionals which contract with the Trustees through Blue Cross Blue Shield of Minnesota. The network of hospitals and physicians are named in a directory given to eligible persons.

Prescription Medication means a drug or biological obtained or dispensed only by a prescription order of a physician, except for insulin.

Prescription Order means the physician's written order for dispensing a prescription medication.

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

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 of a participant 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 alternate 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 you, as a full-time eligible employee; and

(d) includes the name and last known mailing address (if any) of the participant from whom such child's status as an alternate recipient under this Plan is derived and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of state or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient, a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient or the manner in which the type of coverage is determined, and 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 by the Plan Administrator 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.

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

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.

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

Skilled Nursing Home means an institution which meets every one of the following requirements:

(a) is regularly engaged in providing skilled nursing care for ill and injured persons at the patient's expense;

(b) requires that patients be regularly attended by a physician and that medications be given only on the order of that 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 facility 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.

Total Disability means any physical condition commencing after the eligible person becomes covered under the Plan and which results from injury or disease and which wholly and continuously prevents the eligible employee from engaging in his regular or customary occupation or, in the case of a dependent, prevents the dependent from engaging in substantially all of the normal activities of a person of like age and sex and in good health.

Treatment Plan means a written report showing the recommended treatment of any dental disease, defect, or injury prepared by a dentist as a result of any examination made by him of an eligible person.

Usual and Customary Charge means the normal charge of the provider of a service or supply, but not more than the prevailing charge in the area for a like service or supply. A **like service** is of the same nature and duration, requires the same skill, and is performed by a provider of similar training and experience. A **like supply** is one which is identical or substantially equivalent. **Area** means the municipality (or, in the case of a large city, the subdivision thereof) in which the service or supply is actually provided, or such greater area, as determined by the Fund, that is necessary to obtain a representative cross section of charges

for a like service or supply. The fee schedule used to determine “prevailing charges” is the 90th percentile of ADP Context.

The terms, **"Association,"** **"Beneficiary,"** **"Employee,"** **"Employer,"** **"Participant,"** **"Trust Agreement,"** **"Trust Fund,"** **"Trustees,"** and **"Union"** mean the same in this Summary as they do in the Restated Trust Agreement effective February 7, 1966, and are incorporated by reference.

ADMINISTRATOR
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ATTORNEY
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PREFERRED PRESCRIPTION DRUG PROVIDER
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Eagan, MN 55121

PREFERRED DENTAL PROVIDER
Delta Dental Plan of Minnesota
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Eagan, MN 55122

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