United Food & Commercial Workers Local Union #1189 and St. Paul Food Employers Health Care Plan

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IMPORTANT NOTICE

Summary of Material Modifications

TO: Participants and Beneficiaries of the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan

FROM: The Board of Trustees

DATE: February 2020

This is a Summary of Material Modifications (SMM) regarding the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan (Plan). The Board of Trustees has amended the Summary Plan Description and Plan Document (amended and restated April 1, 2018) as indicated below.

Amendment No. 3: Ancillary Benefits On-Year of Service Rule

Effective January 1, 2020, the Plan has been amended to grant Eligible Employees certain ancillary benefits following the completion of one year of service to their Employer.

Amendment No. 4: Remove the Pharmacy Exclusion for Walgreens

Effective January 1, 2020, the Plan has been amended to remove the pharmacy exclusion for Walgreens.

Please update your Summary Plan Description and Plan Document booklet (dated April 1, 2018) to reflect these changes by inserting replacement pages 1, 6, and 44 into your booklet to replace existing pages.

If you have any questions about these changes to the Plan, please contact the Plan Administrator at (952) 854-0795 or 1-800-535-6373.

GRANDFATHERED STATUS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Trustees believe this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that already was in effect when that law was enacted. Being a grandfathered health plan means that your Plan is not required to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of Lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at: United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan, 3001 Metro Drive, Suite 500, Bloomington, MN 55425, (952) 854-0795 or 1-800-535-6373. You also may contact the Employee Benefits Security Administration, U.S. Department of Labor at: 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

ELIGIBILITY RULES

The following Rules 1-17 govern eligibility for Plan benefits.

1. Who Is Eligible?

You are eligible to receive benefits from the United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan under Plan 1 or Plan 2 if you are employed by a Participating Employer and proper Contributions are made to the Plan on your behalf as required by the Collective Bargaining Agreement or other written agreement, such as a Participation Agreement.

2. When Are Employer Contributions First Payable?

Your Employer first is obligated to contribute on your behalf according to the current Collective Bargaining Agreement or Participation Agreement.

3. What Is the Effective Date of My Eligibility?

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

(a) You will become eligible under Plan 1 (Full-Time Employees) provided that you have eight weeks of full-time Contributions made to the Plan on your behalf during a 12-consecutive-week period.

(b) Effective for any Part-Time Employee hired after March 5, 2005, you will become eligible under Plan 2 (Part-Time Employees) after working 12 months for a Participating Employer. During that 12-month period, the Employer must make at least one Contribution to the Plan on your behalf in each of the 12 months. A month is defined by the payment calendar.

If the Employer is not required to make a Contribution to the Plan on your behalf for six months in a row, then you must begin again the 12-month period of employment with Employer Contributions to the Plan.

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

If a prime part-time or part-time courtesy Employee hired on or before March 5, 2005, is promoted to a Covered Position, the Employee will become eligible for Plan coverage under the rules in effect prior to March 6, 2005 (26 weeks to be eligible for coverage the first of the following month). A Covered Position is one that requires Employer Contributions to the Plan.

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

(c) Effective on and after January 1, 2020, an Eligible Employee who is not eligible for coverage under Plan 1 or Plan 2 will be eligible for Life, Accidental Death and Dismemberment, and the Employee Assistance Program under Plan 2 ("ancillary benefits") after completing one year of employment if, in the month following the Eligible Employee's one-year employment anniversary and every month thereafter, the Employer makes either ancillary-benefit-only Contributions to the Plan under the Collective Bargaining Agreement, or any Contributions to the Plan for the Eligible Employee, whether or not the Eligible Employee is eligible for other benefits under Plan 1 or Plan 2. Eligibility will begin on the first day of the month after the Eligible Employee has completed one year of employment with the Participating Employer and will terminate on the earlier of the last day of the month in which employment ends or the last day of the month for which an Employer is required to make Contributions on behalf of the Eligible Employee.

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

See also "Special Enrollment Events" on page 2.

The Plan allows a 30-day grace period for making Self-Payments.

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

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

Checks should be made payable to the UFCW 1189 Health Care Plan and sent to the Plan Administrator.

(c) Coverages and Options

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

(i) Medical Benefits only;

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

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

(iv) Life Benefits only.

Employees continuing coverage are not eligible for Accident and Sickness Benefits; Employees continuing coverage under Plan 2 are not eligible for Vision Care Benefits; Employees receiving only Plan 2's Life, Accidental Death and Dismemberment, and Employee Assistance Program Benefits are not eligible to continue Accidental Death and Dismemberment and Employee Assistance Program Benefits; and Retirees are not eligible to continue Life or Accidental Death and Dismemberment Benefits.

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

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

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

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

(d) Cost of Continuation Coverage

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

(f) OTC and legend diabetic supplies/insulin needles, syringes;

(g) androgenic agents;

(h) drugs to treat impotency;

(i) contraceptives requiring a written prescription executed by a Physician and dispensed by a licensed pharmacist;

(j) daily low dose erectile dysfunction drugs (other erectile dysfunction medications limited to 10 pills per month);

(k) multivitamins with fluoride and prenatal vitamins;

(l) injectables;

(m) growth hormones;

(n) migraine therapy medications;

(o) hormone replacement therapy; and

(p) acne-related products such as Retin-A, Accutane, and Azelex.

Prior authorization is required for certain medications.

You can find a participating network pharmacy by calling: Prime Therapeutics or visiting: www.myprime.com.

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

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

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

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

If your prescription is being obtained from an out-of-network retail pharmacy (including for maintenance drugs in a 90-day supply), then you must pay the pharmacist for the entire discounted cost of the prescription at the time of purchase and submit a claim for reimbursement to the Plan. You will be reimbursed for 100% of the discounted prescription price, less your Copayment, provided the prescription is for an Eligible Person. Out-of-network pharmacies include Walmart, Sam's Club, CVS/Target, and Econo Foods.

Dispensing Limitations

At a retail pharmacy, you are entitled to the amount of prescription legend drugs or insulin usually prescribed by the attending Physician or Dentist, but not to exceed a 31-day supply.

Maintenance drugs may be purchased in a 90-day supply at a retail pharmacy that participates in the Prime Extended Supply Network.

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

Certain medications are included in the Drug Quantity Management program and have a dispensing limit so you receive the right amount of medication that is considered safe and effective according to FDA guidelines.

The Step Therapy program is for people who take prescription drugs regularly to treat an ongoing medical condition, such as arthritis, asthma, or high blood pressure. In step therapy, prescription drugs are grouped in categories (front-line and back-up drugs) based on several factors. Front-line drugs are the first step and are lower cost drugs that are proven safe, effective, and affordable. These medications should be tried first because they can provide the same health benefit as more expensive medications. Back-up drugs (step 2 and step 3 drugs) are brand name drugs such as those you may see advertised on TV, and likely cost more than front-line drugs. If you receive a prescription for a new medication that requires step therapy, as with prior authorizations, your pharmacist will work with your Physician to ensure you receive the right medication.