★★ IMPORTANT NOTICE TO PARTICIPANTS ★★

November 2017

To All Covered Persons:

This Notice is to inform you of important Plan changes. New text is shown in italics.

Routine Care

The coverage for routine care has been revised effective January 1, 2017, to comply with the Affordable Care Act ("ACA"). The routine care section beginning on page 57 of your Summary Plan Description ("SPD") has been changed as follows:

> The following expenses are payable for you or your covered dependent as stated in the Schedule of Benefits, subject to all terms and provisions of the Plan, except the exclusion for services which are not medically necessary, if not confined in a hospital or qualified treatment facility, and if such expenses are not incurred for diagnosis of a specific bodily injury or sickness. Benefits are payable at 100% with no deductible requirement and no calendar year maximum for services obtained at a PPO Provider. For such services obtained at a non-PPO Provider, benefits are payable subject to the Medical Benefits deductible, coinsurance, and out-of-pocket limit as stated in the Schedule of Benefits*. However, if a preventive care service as described in this section is not available from a PPO Provider, the item or service will be payable at 100% with no deductible requirement at a non-PPO Provider.*

Tobacco Cessation Program

The Tobacco Cessation Program on page 84 of your SPD has been expanded as follows effective January 1, 2017, to comply with the ACA:

> The Plan will provide coverage for *100%* of the cost of *FDA-approved* prescription medications, if appropriate, including Chantix and Buproprion (generic Zyban) if you enroll in the Quit For Life Program. Prescription medications may be filled under the Plan's Preferred Provider Pharmacy Program. You must present your Plan ID card to a participating pharmacy along with a physician's written prescription to fill such medications. Please note that these medications only will be payable when it is confirmed that you are enrolled in the Quit For Life Program. A maximum of *two 90-day supplies* will be payable each calendar year.

Retiree Eligibility Update

The retiree eligibility requirements on page 22 of your SPD have been revised as follows effective January 1, 2017:

An employee must provide written notice of his/her retirement to the Fund Office. To continue to receive such benefits, the retiree must pay the current monthly self-payment to the Fund for such benefits, in the manner prescribed by the Trustees; *and the retiree must remain a member in good standing of the Union.*

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Dollar Bank Reimbursement Program

The SPD outlines the Fund's Dollar Bank Reimbursement Program on pages 108-113. Effective January 1, 2017, the Dollar Bank Reimbursement Program is replaced with the following:

DOLLAR BANK REIMBURSEMENT PROGRAM

The Dollar Bank Reimbursement Program is a health reimbursement arrangement available to active Employees and retired Employees who have a sufficient dollar bank balance. For eligible claims, you have the option of requesting reimbursement for certain out-of-pocket medical care expenses for qualifying medical expenses to be paid with "pre-tax" dollars from your dollar bank.

For Class A, your individual account will consist of two subaccounts:

(a) General Reimbursement Account for the reimbursement of qualifying medical expenses and, in certain circumstances, qualifying premium expenses, while an employee.

The first $1,800.00 is your dollar bank and is available solely to purchase monthly Plan eligibility as described on pages 16 and 17 and assets will be transferred monthly from the General Reimbursement Account to the dollar bank to the extent necessary to maintain the $1,800.00 balance in the dollar bank.

Assets in excess of $1,800.00 in your dollar bank will be considered the General Reimbursement Account and it will be designated for the reimbursement of your current out-of-pocket medical care expenses. An employee with a positive balance in his/her General Reimbursement Account may access amounts in the General Reimbursement Account for the reimbursement of qualifying medical expenses while an employee. A retired employee may access amounts in the General Reimbursement Account for the reimbursement of qualifying medical expenses and qualifying premium expenses.

(b) Post-Retirement Reimbursement Account for the reimbursement of qualifying medical expenses and certain qualifying premium expenses while retired.

Only retirees may obtain reimbursement for qualifying medical expenses and qualifying premium expenses from the Post-Retirement Account and only after exhausting amounts in the General Reimbursement Account. The Post-

Retirement Reimbursement Account will be funded with employer contributions specified in the collective bargaining agreement as a post-retirement contribution.

An employee's or retiree's dependents will have access to funds accumulated in these accounts upon the employee's or retiree's death to reimburse out-of-pocket expenses incurred for qualifying medical expenses and qualifying premium expenses until the earliest of: when the employee's or retiree's accounts balance is zero; the accounts are forfeited under the Plan's rules; or the Plan ends.

Eligible Medical Expenses

The Dollar Bank Reimbursement Program may reimburse qualifying medical expenses and qualifying premium expenses. Generally, an expense that is considered "medical care" under Section 213(d) of the Internal Revenue Code is eligible for reimbursement, unless it is specifically listed as excluded by the Dollar Bank Reimbursement Program. "Medical care" means amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. You cannot be reimbursed for any medical expenses that you incurred before the Dollar Bank Reimbursement Program was established or before you became a participant in the Dollar Bank Reimbursement Program.

Qualifying medical expenses eligible for reimbursement include, but are not limited to, the following:

(a) medical and prescription drug expenses that are covered by other provisions of the Plan, but which were applied to your deductible and coinsurance;

(b) over-the-counter drugs and medicines that are for treatment of a medical condition (not only for general well-being) upon a physician's written prescription (except insulin does not require a prescription);

(c) dental expenses, including orthodontics;

(d) eye examinations, glasses, or contact lenses;

(e) LASIK eye surgery;

(f) hearing examinations and hearing aids;

(g) vaccinations;

(h) acupuncture; and

(i) wheelchairs.

Ineligible medical expenses include, but are not limited to: teeth whitening; cosmetic surgery; long-term care; and vitamins, fitness programs, weight loss programs, and exercise equipment, unless prescribed by a physician as medically necessary.

Qualifying premium expenses include self-payment contributions; COBRA continuation coverage under the Plan or a spouse's plan; retiree coverage; and substantiated premium payments for qualified dental insurance and vision insurance. They also include Medicare Parts B and D, Medicare Supplement policies, group Medicare Advantage premiums, and group health plan premiums for retirees and dependents of deceased employees and retirees (unless the premium is paid or could have been paid pre-tax from another source). Premium expenses do not otherwise include premiums for accident or health insurance as defined in Code Section 213(d), fixed indemnity, cancer, or hospital indemnity insurance; premiums for disability insurance; premiums paid by an employer; or premiums that are or could be deducted pre-tax through a Section 125 cafeteria plan (including a spouse's plan).

Please refer to IRS Publication 502 (www.irs.gov/pub/irs-pdf/p502.pdf) for additional details on what the IRS considers medical care while keeping in mind the specific exclusions under the Dollar Bank Reimbursement Program.

Amounts eligible for reimbursement only will be those amounts: which you or your dependent are required to pay; which are not payable under the regular medical benefits provided by this Plan or by any other insurance or group health benefits available to you or your dependent; for which you or your dependent have not previously taken a tax deduction; and are not expenses for long-term care services. For example, if your spouse has health benefit coverage, the amount paid by your spouse's coverage is not eligible for reimbursement. You will be required to submit the Explanation of Benefits (EOB) from your spouse's health plan, so be sure to save the EOBs for charges incurred. The total combined reimbursement for all benefit/insurance plans when added to the amount of the dollar bank reimbursement cannot exceed 100% of the billed amount. If your spouse has a health flexible spending account or a health reimbursement arrangement through his or her employer which also reimburses uninsured medical expenses, you cannot, under IRS rules, be reimbursed for the same expense from both your and your spouse's account. Also, you first should submit the expense for reimbursement to the Dollar Bank Reimbursement Program before submitting it to your spouse's health flexible spending account. If you misuse the policy and, as a result, receive reimbursement for more than 100% of the billed amount, you will be solely responsible for any tax or other regulatory penalty assessed as a result of your action.

Requesting Reimbursement

You must submit your reimbursement request to the Fund Office with a properly completed request form. You can obtain the form by contacting the Fund Office. You also must include a copy of the itemized bill when applicable. Any reimbursement request for a covered person with other health care coverage, regardless of whether the

other coverage is primary or secondary, must be accompanied by an Explanation of Benefits (EOB) from the other health care plan. For over-the-counter medications, your physician's prescription (except for insulin) must be included when you submit your reimbursement request form. "Prescription" for over-the-counter medications means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state where the medical expense is incurred and is written by an individual who is legally authorized to issue a prescription in that state.

You have the option of authorizing automatic reimbursement of deductibles and coinsurance amounts from your General Reimbursement Account when the Fund Office possesses sufficient substantiation for the expense. You may request an election form from the Fund Office if you wish to use the automatic reimbursement option.

If there is any question as to whether an expense for which you are requesting reimbursement is allowable, or if medical necessity or any other documentation is required, you are solely responsible for obtaining the necessary substantiation or documentation, including any expense associated with obtaining such substantiation or documentation.

You may request reimbursement for expenses eligible under the Dollar Bank Reimbursement Program on a monthly basis (or more frequently as may be permitted by the Trustees), according to a schedule of which you are notified by separate Notice. Expenses must be submitted so that they are received by the Fund Office *within two calendar years* following the calendar year in which the expenses are incurred.

Upon receipt of a properly completed reimbursement request, the Plan will issue you a reimbursement check and will deduct the amount of the reimbursement from your accounts. If there is an insufficient amount in your accounts to cover the reimbursement request, it is your responsibility to resubmit the balance during the next quarter if you then have a sufficient balance in your accounts.

If a claim for reimbursement is denied, you will be notified of the denial and your right to appeal the denial within certain time limits under the claims procedures for the Plan. If you become ineligible for coverage under the Plan, you will be notified of your COBRA continuation rights for the Dollar Bank Reimbursement Program.

<u>Forfeiture of Accounts</u>

The accounts are subject to the following forfeiture rules:

(a) If you die, the entire balance of your General Reimbursement Account and your Post-Retirement Reimbursement Account immediately becomes available to your spouse and/or other dependents for the reimbursement of qualifying medical expenses or qualifying premium expenses. In no event will the amounts in the Post-Retirement Reimbursement Account be paid in cash to any person for other than reimbursement of an eligible expense. For example, there are no lump sum

distributions of your account balance as a death or termination benefit. The balance will be forfeited if you have no spouse or other dependents.

(b) Your General Reimbursement and Post-Retirement Reimbursement Account are subject to the forfeiture provisions of the dollar bank previously stated on pages 17 and 18.

Opt Out of Dollar Bank Reimbursement Program

To comply with guidance from the Internal Revenue Service under the Affordable Care Act, you will be given the opportunity to opt out of the Dollar Bank Reimbursement Program and waive future reimbursements. Contributions under the Program are not available in cash upon opt out.

The Plan will offer an opt-out opportunity to the extent required by the ACA at the following times:

(a) Annually while you remain covered under the Plan.

If you elect to opt out of the Dollar Bank Reimbursement Program, any amounts remaining in your dollar bank will be forfeited and will not be reinstated if you subsequently choose to reenroll in the Dollar Bank Reimbursement Program.

Effective June 1, 2017, if you elect to opt-out, amounts in your accounts will be suspended and will not be available for reimbursement of qualifying medical or premium expenses for the period of the opt-out. However, amounts in your General Reimbursement Account will remain available for eligibility purposes and the Plan will continue to credit and debit the General Reimbursement Account as described previously and on pages 16 and 17. Your suspended accounts will be reinstated the earlier of the January 1 following the Plan's receipt of a written request to reinstate your accounts; the occurrence of a special enrollment event; or upon your death. The accounts will not be subject to the Plan's 5 year forfeiture rule described on page 17 for the period of the opt-out.

(b) Upon loss of Plan eligibility.

If you elect to opt out of the Dollar Bank Reimbursement Program, any amounts remaining in your dollar bank will be forfeited and will not be reinstated if you subsequently choose to reenroll in the Dollar Bank Reimbursement Program.

Effective June 1, 2017 if you elect to opt-out, amounts in your accounts will be suspended and will not be available for reimbursement of qualifying medical or premium expenses for the period of the opt-out. Your suspended accounts will be reinstated if you regain Plan and Dollar Bank Reimbursement Program eligibility. The accounts will remain subject to the Plan's forfeiture rules described on page 17.

(c) Upon becoming eligible for retiree coverage.

If you elect to opt out of the Dollar Bank Reimbursement Program, any amounts remaining in your dollar bank will be forfeited and will not be reinstated if you subsequently choose to reenroll in the Dollar Bank Reimbursement Program.

Effective June 1, 2017, if you elect to opt-out, amounts in your accounts will be suspended and will not be available for reimbursement of qualifying medical or premium expenses for the period of the opt-out. Your suspended accounts will be reinstated the earlier of the January 1 following the Plan's receipt of a written request to reinstate your accounts; loss of other group health plan coverage, following the Plan's receipt of a written notice of the loss of coverage; or upon your death. The accounts will not be subject to the Plan's 5 year forfeiture rule described on page 17 for the period of the opt-out.

(d) Upon your death, your dependent(s) will be given the opportunity to opt-out.

If your dependent(s) elect to opt out of the Dollar Bank Reimbursement Program, any amounts remaining in your dollar bank will be forfeited.

Effective June 1, 2017, if your dependent(s) elect to opt-out, amounts in your accounts will be suspended and will not be available for reimbursement of qualifying medical or premium expenses for the period of the opt-out. Your suspended accounts will be reinstated on the January 1 following the Plan's receipt of a written request from the dependent(s) to reinstate the accounts. Any amounts remaining in the account(s) will forfeit to the Plan upon the dependent's death. In addition, the account(s) will remain subject to the Plan's forfeiture rules described on page 17.

Tax Implications

The Dollar Bank Reimbursement Program is intended to meet certain requirements of federal tax law under which the reimbursements you receive from your dollar bank generally are not taxable to you. However, the Plan cannot guarantee the tax treatment to any given participant since individual circumstances may produce a different tax result. You should consult a tax advisor if you have any questions about the possible taxation of any benefits.

Preferred Provider Pharmacy Program

Preferred Provider Pharmacy Program coverage has been revised effective June 1, 2017, to comply with the ACA. The following excerpt, beginning on page 87 of your SPD, has been changed as follows:

The Plan covers drugs and supplements at a $0 copayment through both retail network pharmacies and the mail service pharmacy, upon a physician's written prescription, in their generic formulation (or if no generic formulation is available, brand name formulation), as required by the Affordable Care Act preventive care rules. Such drugs and supplements include, but are not limited to, the following:

(a) over-the-counter (OTC) aspirin up to 325 mg once per day to prevent cardiovascular disease and colorectal cancer , to the extent recommended by the U.S. Preventive Services Task Force;

(b) federal legend fluoride for dependent children age five and younger to prevent dental cavities;

(c) OTC folic acid for doses of 0.4mg-0.8mg once per day for women age 55 and younger who are planning or capable of pregnancy;

(d) OTC iron supplements for dependent children up to one year old to treat/prevent anemia; and

(e) Women's contraceptives..

In addition, shingles vaccinations obtained at a retail network pharmacy will be covered at 100% for Covered Persons age 60 and over.

Please keep this Notice with your Summary Plan Description (SPD) booklet for future reference. If you have any questions, please call the Fund Office at (952) 854-0795 or toll-free at: 1-800-535-6373.

Yours very truly,

THE BOARD OF TRUSTEES

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This Notice, which serves as a Summary of Material Modifications (SMM), contains only highlights of certain features of the Local 434 Health and Welfare Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or discontinue all or part of the Plan at any time.