General Mills
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General Mills, Inc.

Retiree Health Reimbursement Arrangement ("Retiree HRA")

User's Guide

Effective January 1, 2024

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Introduction

This Retiree Health Reimbursement Arrangement User's Guide describes the General Mills Retiree Health Reimbursement Arrangement ("Retiree HRA") in which you may be able to participate as an eligible retiree, or an eligible dependent of a retiree, of General Mills, Inc., or any of its affiliates ('Company"). This Retiree HRA User's Guide is a companion to the Plan's underlying Summary Plan Description, which meets the requirements for a Summary Plan Description (SPD) under the Employee Retirement Income Security Act (ERISA) of 1974, as amended (ERISA).

The purpose of the Retiree HRA is to reimburse eligible retirees and their eligible dependents for certain health insurance premiums that are not otherwise reimbursed. The Retiree HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. This Retiree HRA is also intended to be exempt from the Patient Protection and Affordable Care Act ("ACA") as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and IRC Section 9831(a)(2).

Read this User's Guide carefully so you understand the provisions of the Retiree HRA and how you can use the Retiree HRA to your advantage.

This User's Guide describes the current provisions of the Retiree HRA which is designed to comply with applicable legal requirements. The Retiree HRA is subject to federal laws, such as the Internal Revenue Code (IRC), the Employee Retirement Income Security Act (ERISA) and other federal and state laws which may affect your rights. The provisions of the Retiree HRA that is offered through General Mills, Inc. is subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. The Company may also amend or terminate the Retiree HRA. If the provisions of the Plan described in this User's Guide change, you will be notified.

Note that this booklet is only a summary. If there is any difference between the information in this User's Guide and in the official legal Plan document, the official legal Plan document will govern, with one exception. If there is language in the User's Guide regarding a topic the official legal Plan document is silent on, the language in this User's Guide will govern.

Note that terms used in this User's Guide are defined the first time they are used. Please note that "you," "your" and "my" when used in this User's Guide refer to you, the retiree.

How the HRA Works

A Health Reimbursement Arrangement (HRA) is a recordkeeping reimbursement account the Company establishes on your behalf. You do not have to take any action. If eligible, the Company credits a specific dollar amount to your Retiree HRA to help cover the cost of eligible health care expenses for you and your covered dependent(s). Eligible health care expenses include premiums for health care coverage. Out-of-pocket health care expenses are not eligible for reimbursement from your Retiree HRA.

The purpose of the Retiree HRA is to provide a source of funds to reimburse you or your covered dependent(s) for some certain health care premiums. These expenses must be incurred while the Retiree HRA remains in effect, and you are eligible, qualified, and participate in the Retiree HRA.

If you are covering an eligible spouse/domestic partner, the account will be set up as a joint account with separate contributions made for each of you, except for participants in one of the Company's "credit-based plan," where only one contribution will be made to the HRA for the household. Only the Company can contribute to your Retiree HRA. The IRS does not permit you to contribute your own money to an HRA. The Retiree HRA is a bookkeeping account on the Company's records only, with all reimbursements being paid from the Company's general assets or a special trust established for this purpose The account is not funded and cannot earn interest or earnings of any kind.

Your Eligibility

You are eligible to participate in the Retiree HRA if you met all the following requirements:

- You are a former employee of the Company who had met the eligibility requirements for the Company's retiree group health plan,
- You are age 65 or over and eligible for Medicare Parts A & B, and
- You have enrolled in and remain enrolled in a Medicare medical plan through Via Benefits*

**Special enrollment eligibility rules apply to participants covered under the Company's "credit-based plans." Please contact the General Mills Benefits Service Center for more information about these eligibility rules.*

Dependent Eligibility

Your dependents are eligible to participate in the Retiree HRA if they met all the following requirements:

- They are your legal spouse or registered domestic partner, or your dependent disabled child (as defined in Code Section 152(f)(1)),
- They are age 65 or over and eligible for Medicare Parts A & B, and
- They have enrolled in and remain enrolled in a Medicare medical plan through Via Benefits

If your eligible dependent participates in another group health plan sponsored by the Company, they will not be eligible for the Retiree HRA.

Loss of Coverage under the Retiree HRA

You are no longer eligible to participate in the Retiree HRA on the earlier of the date:

- You no longer meet the eligibility requirements for coverage (for example, you do not enroll in a Medicare medical plan through Via Benefits, as required for Retiree HRA funding); or
- You die.

Your spouse/domestic partner is no longer eligible to participate in the Retiree HRA on the earlier of the date:

- Your spouse/domestic partner no longer meets the eligibility requirements for coverage (for example, your spouse/domestic partner does not enroll in a Medicare medical plan, as required); or
- You are divorced from your spouse, or your domestic partnership is terminated.

Your dependent disabled child is no longer eligible to participate in the Retiree HRA on the date the disabled child no longer meets requirements for coverage (for example, your dependent disabled child does not enroll in a Medicare medical plan, as required).

If you die, your spouse/domestic partner and dependent disabled child may continue to participate in the Retiree HRA dependent upon the cost-sharing provisions for surviving spouses associated with the Company's pre-65 group plan. For example, if the plan requires surviving spouses to pay full cost for coverage after the retiree passes away, Company contributions to the HRA for the surviving spouse will end as of the date of death of the retiree. If your spouse/domestic partner subsequently remarries or enters a new domestic partnership, he/she will no longer be eligible for HRA funding as of the date of the new marriage/domestic partnership.

When Participation Begins

An Eligible Retiree and Eligible Dependent(s) become a Participant(s) in the Retiree HRA on the later of the Effective Date of the Plan as provided in the Plan Information Appendix or the date that they have satisfied all the following requirements:

- They have become eligible for Medicare Parts A & B,
- They are age 65 or over,
- They have obtained an individual Medicare medical insurance policy through Via Benefits*, and
- They have completed any enrollment forms or procedures required by the Plan Administrator

**Special enrollment eligibility rules apply to participants covered under the Company's "credit-based plans." Please contact the General Mills Benefits Service Center for more information about these eligibility rules.*

Contributions

One joint Retiree HRA* will be established for you and your spouse/domestic partner (and covered dependent disabled child(ren), if applicable). Contributions applicable to each of you will be credited to this joint Retiree HRA.

**If both you and your spouse are retirees from the Company and you each receive Retiree HRA contributions, your Retiree HRAs will be separate individual Retiree HRAs and not jointly connected by your household.*

After qualification, contributions will be credited to the notional Retiree HRA monthly* on the first day of the month following the date you qualified.

**If you are a participant in the Retiree Choice Health Plan who chose the Draw Down credit payout option, one contribution will be credited to the notional Retiree HRA in a single lump sum amount.*

The balance of your Retiree HRA will be reduced from time to time by the amount of any eligible health care premiums for which you are reimbursed under the Retiree HRA. You may receive reimbursement for eligible health care premiums up to the amount in your Retiree HRA.

Unused contributions remaining in your Retiree HRA at the end of a Plan Year roll forward to reimburse you for eligible health care premiums during subsequent Plan Years.

A detailed schedule describing the contribution amounts and how the contributions are determined is available to any Participant or beneficiary free of charge, by contacting the General Mills Benefits Service Center at the address listed in the Plan Information Appendix.

You may opt out of future contributions to the Retiree HRA at least annually. Remaining Retiree HRA contributions cannot be paid in cash or other form of distribution, other than through reimbursement of actual eligible health care premiums incurred while you are eligible for the Retiree HRA.

Eligible and Ineligible Expenses

When you have an eligible expense, you may submit a reimbursement request for reimbursement from your Retiree HRA.

Eligible Expenses

Expenses eligible for reimbursement include **premium expenses** for medical, prescription drug, dental, vision, long-term care (up to the IRS limit as defined in IRS Publication 502) and Medicare Part B incurred while you are eligible for your funding program. You can submit eligible premium expenses for yourself, your covered spouse/domestic partner, or disabled dependent child(ren).

Ineligible Expenses

Ineligible expenses include:

- Out-of-pocket health care expenses,
- Expenses incurred *prior to the date* that you became a Participant in the Retiree HRA,
- Expenses incurred *after the date* that you cease to be a Participant in the Retiree HRA, and
- Premiums that have been reimbursed by another plan or employer.

Health insurance premiums are incurred on the first day of each month of coverage on a pro rata basis, the first day of the period of coverage, or the date the premium is paid, even if the covered individual paid the premium for the coverage prior to the first day of the Plan Year.

You may not submit a reimbursement request for a premium expense that was incurred prior to the time the Retiree HRA became effective (typically the first day of the Plan Year or the first day your election for Retiree HRA coverage is effective, if later). In addition, you cannot submit a reimbursement request for any premiums that have been paid in-full through any other plan or employer.

The Company cannot advise you regarding tax or legal considerations relating to the Retiree HRA.

How to Use the Retiree HRA

You must complete a reimbursement request to be reimbursed for covered expenses. You can do so online at myviabenefits.com/generalmills, on the Via Benefits Accounts mobile app, by mail, or by fax to Via Benefits, along with a copy of your insurance premium statement. You can obtain a reimbursement form from Via Benefits.

Mailing Address
Via Benefits
P.O. Box 981156
El Paso, TX 79998-1156

Fax
1-866-886-0878

Mobile App
Search for Via Benefits Accounts where you download apps.

Your reimbursement request is deemed filed when Via Benefits receives it.

If your request for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination.

Via Benefits will determine the method or mode of reimbursement payments, including whether by direct deposit, written check or otherwise.

Via Benefits may establish an automatic premium reimbursement process for the payment of certain health insurance premiums. Automatic premium reimbursements shall not be considered to be reimbursement requests for benefits and shall not be subject to the procedures described in the "Reimbursement Requests and Appeals Procedures" section of this User's Guide. In establishing and operating any automatic premium reimbursement process, Via Benefits may establish a process to remove and/or prevent duplicate reimbursements. Removal of duplicate reimbursements and following procedures to prevent duplicate reimbursements shall also not be considered to be reimbursement requests for benefits and shall not be subject to the procedures described in the "Reimbursement Requests and Appeals Procedures" section of this User's Guide.

Reimbursement Requests and Appeals Procedures

You should submit requests to Via Benefits for reimbursement of eligible premium expenses as soon as possible following the Plan Year in which the expense was incurred. If the plan is terminated, or if you die, you are no longer eligible to participate. Requests for reimbursement of eligible premiums should be submitted within six months following the Plan Year in which the expense is incurred. This also applies to your eligible dependent(s).

Initial Claims Process

If you make a reimbursement request for medical premiums under the Retiree HRA, the following timetable for reimbursement request decisions applies:

Notification of whether the reimbursement request is denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the reimbursement request	15 days
Notification to Participant	15 days
Response by Participant	45 days
Response to reimbursement request	15 days

If a reimbursement request under the Retiree HRA is denied in whole or in part, you will receive electronic or written notification based on your setting. The notification will include:

- The reasons for the denial,
- Reference to the specific provisions of the Retiree HRA on which the denial was based,
- A description of any additional material or information needed to further process the reimbursement request and an explanation of why such material or information is necessary,
- A description of the Plan's internal review procedures and time limits applicable to such procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal,
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the reimbursement request,
- A description of any internal rule, guideline, protocol, or similar criteria used in the decision OR statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol, or other similar criteria will be provided, free of charge, upon request; and
- The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

If you have any questions or concerns about your benefits or a denied reimbursement request, you should first contact Via Benefits at 1-833-414-1448.

Reimbursement Claims Appeal Process

If you disagree with a decision concerning your reimbursement request, you have a right to appeal the reimbursement request decision as described below.

You, your beneficiary, or authorized representative will have 180 days following the receipt of any notification of reimbursement request denial to appeal the decision, making a written request for reconsideration to Via Benefits. Include as much information as possible to identify yourself and provide information to support your appeal. This can include, but is not limited to, your Explanation of Payment. To identify yourself, include your name, covered Participant's name, employers name, last 4 digits of your SSN, date of birth, ID number, phone number, and any additional information that may be relevant to your appeal.

You have the right to:

- Submit written comments, documents, records, and other information relating to the reimbursement claim for benefits,
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your reimbursement request for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your reimbursement request if it:
    - Was relied upon in making the benefit determination,
    - Was submitted, considered, or generated while making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination,
    - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination,
    - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination,
- A review that considers all comments, documents, records, and other information related to the reimbursement request that you submitted, regardless of whether the information was submitted or considered in the initial benefit determination,
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination nor by that person's subordinate.

If sufficient information is available to decide the appeal, Via Benefits will resolve your first level appeal within a reasonable period but not later than 30 business days from receipt of the first level appeal request. If more information is needed to decide on your appeal, Via Benefits shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 30 business days of the appeal request, Via Benefits shall conduct its review based upon the available information. The review shall be completed within a reasonable period but not later than 30 business days from receipt of the appeal request.

If you are not satisfied with the decision made on the first level appeal, you may request in writing, within 90 days of receipt of the notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative. To initiate a second level appeal, you can provide all information from the first level of appeal and additional information or statements that you feel are

relevant. You have the same rights with the second level appeal as you do with the first level appeal, and all responses will follow the same timetable.

The first and second levels of appeal will not take more than 60 days combined to resolve, from the receipt of each written appeal to the notice of decision for each appeal.

Notice of an adverse benefit determination on appeals will contain all the following information:

- The specific reasons for the denial,
- Information sufficient to identify the reimbursement request involved, including the dates of coverage and the reimbursement request amount (if applicable),
- The specific Retiree HRA provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the plan's standard, if any, used in denying the reimbursement request, and in the case of a final adverse determination, a discussion of the decision,
- A description of any additional material or information necessary for the reimbursement request to be completed and an explanation of why such material or information is necessary,
- A description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, OR a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request, free of charge, and
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

Via Benefits and General Mills decisions are conclusive and binding.

No action at law or in equity shall be brought to recover on the Retiree HRA until 90 days after a proof of reimbursement request has been provided. Once you have exhausted all your administrative appeal rights, if you decide to file a court action on your reimbursement request, the court action must be filed within 24 months following the date the cause of action arose.

You and the Retiree HRA may also have the right to other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

Overpayments

If it is later determined that you and/or your covered eligible dependent(s) received an overpayment or a payment was made in error, you (or your covered eligible dependents) will be required to refund the overpayment or erroneous reimbursement to the Retiree HRA. An example of an overpayment is being reimbursed for an expense under the Retiree HRA that is later determined to be ineligible or paid for by some other plan or employer.

If you do not refund the overpayment or erroneous payment, the Retiree HRA reserves the right to offset future reimbursements from the Retiree HRA equal to the overpayment or erroneous payment. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may include the amount on IRS Form 1099 as income. In addition, if the Plan Administrator determines that you have submitted a fraudulent reimbursement request, the Plan Administrator may terminate your coverage under the Retiree HRA.

Unclaimed payments

Any Retiree HRA payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) will automatically forfeit 18 months from the date set forth on the check or from the date the payment was otherwise approved.

If the Participant or other authorized person does not contact Via Benefits prior to the 18-month forfeiture time frame, the unclaimed reimbursement will be voided, and the amount of the voided check will be a contribution as of such date and shall be credited to the Participant's Retiree HRA as of such date. This means that such contribution may be used to reimburse eligible health care premiums incurred from and after the date of such contribution, in accordance with the terms of the Retiree HRA on such date. If the Participant's Retiree HRA has been closed as of the date such contribution would otherwise be made, the contribution will not be made, but rather will be forfeited.

If the Participant or other authorized person contacts Via Benefits within 6 months, Via Benefits may cancel and void the original check or payment and re-issue a new check, or as otherwise determined by Via Benefits.

If the Participant or other authorized person contacts Via Benefits after six months, Via Benefits will cancel and void the original check or payment and shall re-issue the payment by direct deposit, or as otherwise determined by Via Benefits.

Continuation of Coverage under COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your covered spouse and disabled dependent children, and what you need to do to protect the right to receive it.**

Domestic partners are not "qualified beneficiaries" under COBRA. However, subject to applicable regulations, under the Company-sponsored group health plans, General Mills will extend COBRA-like coverage to domestic partners in the same manner as COBRA continuation coverage is provided to spouses.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose coverage under the Plan. It can also become available to your spouse and dependent children who are covered under the Plan when they would otherwise lose such coverage.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Retiree HRA coverage when you would otherwise lose such coverage because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You and your covered spouse could become qualified beneficiaries if covered under the Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Under the Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described in the "Paying for COBRA Continuation Coverage" section.

COBRA Qualifying Events

If you are a covered retiree, you will become a qualified beneficiary if you lose coverage under the Retiree HRA because the following qualifying event happens:

- The Company files for Chapter 11 bankruptcy and coverage under the Retiree HRA is substantially eliminated within one year before or after the filing.

If you are the covered spouse of a retiree, you will become a qualified beneficiary if you lose coverage under the Retiree HRA because any of the following qualifying events happens:

- Your spouse dies,
- You become divorced or legally separated from your spouse; or
- The Company files for Chapter 11 bankruptcy and coverage under the Retiree HRA is substantially eliminated within one year before or after the filing.

If you are the covered dependent child of a retiree, you will become a qualified beneficiary if you lose coverage under the Retiree HRA because any of the following qualifying events happens:

- Your retiree parent dies,
- Your retiree parent becomes divorced or legally separated from his or her spouse,
- You no longer meet the definition of dependent child under the Retiree HRA; or
- The Company files for Chapter 11 bankruptcy and coverage under the Retiree HRA is substantially eliminated within one year before or after the filing.

For this purpose, "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event.

Giving Notice that a COBRA Qualifying Event Has Occurred

The Retiree HRA will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the retiree's death or the employer's bankruptcy filing, the employer must notify the Plan Administrator of the qualifying events.

For all other qualifying events (divorce or legal separation), you are responsible for notifying the Plan Administrator in writing within 60 days after the later of: (1) the date of the qualifying event, or (2) the date the qualified beneficiary loses (or would lose) coverage under the Plan because of the qualifying event. You must provide this notice in writing to:

WillisTowersWatson | COBRA
National Benefit Services
COBRA Department
PO Box 670
West Jordan, UT 84084
1-833-996-1054

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a "COBRA Continuation Coverage Election Notice") to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered retirees may elect COBRA continuation on behalf of their

covered spouses or covered dependent children but covered retirees cannot reject COBRA continuation on behalf of their covered spouses or covered dependent children.

If coverage under the Retiree HRA is changed for retirees, the same changes will apply to individuals receiving COBRA continuation coverage.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of HRA coverage.

When the qualifying event is the death of the retiree or divorce, COBRA continuation coverage for the retiree's covered spouse or covered dependent child(ren) (but not the retiree) under the Retiree HRA lasts for up to a total of 36 months from the date of the qualifying event.

When the qualifying event is the bankruptcy of the Company, retiree health coverage under the Retiree HRA for you and your covered spouse and/or covered dependent children may be continued for the rest of your (the retiree's) life. After your death (including if you have already died when the bankruptcy proceeding begins), your surviving covered spouse and/or surviving covered dependent children may continue Retiree HRA coverage for an additional 36 months after your death. Please note that under the Retiree HRA, spouses may continue coverage. Please see Loss of Retiree Coverage under the HRA.

The table below provides a summary of the COBRA provisions outlined in this section.

	Maximum Continuation Period	
Qualifying Events That Result in Loss of Coverage	**Employee**	**Spouse/dependent**
Retiree dies	N/A	36 months
Retiree and spouse or divorce	N/A	36 months
The Company commences bankruptcy proceedings under Title 11 of the United States Code	Death	36 months[1]

[3] 36-month period is counted from the date of retiree's death.

Electing COBRA Continuation Coverage

You, your covered spouse, or your covered dependent child(ren) must choose to continue coverage under the Retiree HRA within 60 days after the later of the following dates:

- The date you, your covered spouse or covered dependent child would lose coverage under the Retiree HRA because of the qualifying event; or
- The date the Company notifies you and/or your covered spouse and/or covered dependent child (through a "COBRA Continuation Coverage Election Notice") of your right to choose to continue coverage because of the qualifying event.

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the cost of Retiree HRA coverage.

Premium Due Dates: If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all contributions due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA Election Notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Retiree HRA. Payment is considered made on the date it is sent to the Retiree HRA Plan Administrator.

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The contribution due date and exact amount due each coverage period for each qualified beneficiary will be shown in the COBRA Election Notice you receive. Although periodic payments are due on the dates shown in the COBRA Election Notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period if payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment 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, your coverage under the Retiree HRA 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. This means that any reimbursement request you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you elect COBRA continuation coverage but then fail to make an initial or periodic payment before the end of the 45- or 30-day grace period — respectively — for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any qualified beneficiary will end when the first of the following occurs:

- The applicable 36-month COBRA continuation coverage period ends,
- Any required premium is not paid on time,
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as a retiree or otherwise) under another group health Plan (not offered by the Company),
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes entitled to (that is, enrolled in) Medicare benefits (under Part A, Part B, or both). This does not apply to other qualified beneficiaries who are not entitled to Medicare and does not apply at all to end retiree COBRA continuation coverage if bankruptcy is the qualifying event, and
- The date the Company ceases to provide any group health plan for its employees and retirees.

COBRA continuation coverage may also be terminated for any reason the Retiree HRA would terminate coverage of a Participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

Continuing Your Health Reimbursement Arrangement under COBRA

If you elect to continue your Retiree HRA under COBRA, the Retiree HRA will provide for continuation of the maximum reimbursement available at the time of the qualifying event reduced by any reimbursement requests reimbursed during the period of coverage.

Marketplace Coverage as an Alternative to COBRA

As explained above, when you lose your coverage under the Retiree HRA by reason of a COBRA qualifying event (e.g., your employment termination), you temporarily can elect to continue that coverage under the applicable health plan at your own expense at group rates (known as COBRA coverage). You also may have special enrollment rights to enroll under another group health plan (such as your spouse's employer plan). You also have viable purchasing options for individual health insurance policies through the Health Insurance Marketplace ("Public Marketplace") or through other commercial insurance issuers outside of the Public Marketplace. The Public Marketplace may offer you less expensive premiums and out-of-pocket costs than any other health care coverage options, including COBRA coverage, especially in the event that you qualify for governmental subsidies (i.e., tax credits) that help you pay for your coverage purchased from the Public Marketplace.

You should carefully and timely review all your coverage options before making a final decision. If you decide to purchase other health coverage (e.g., through your spouse or through the Public Marketplace or other commercial insurance) and do not elect COBRA within the 60-day election period, you will no longer have the right to elect COBRA coverage under the health plans.

If you decide to elect COBRA coverage, you also should be aware that you are restricted in when you can enroll in an individual health insurance policy. For example, if you enroll in COBRA medical coverage under the plan but decide mid-year that you want to drop that coverage because it is not affordable to you, most insurance carriers will not permit you to enroll in an individual health insurance policy until the next open enrollment period. This restriction applies even though COBRA is no longer affordable to you (e.g., when your financial situation changes or a COBRA subsidy, if any, from General Mills or another source ends).

More information regarding COBRA coverage is included above and in the COBRA Notices available from the Plan Administrator. Additional information regarding Public Marketplace coverage is available by visiting www.healthcare.gov and also in the health plans' COBRA Notices.

If You Have Questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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.)

Additional Information

Keep Your Plan Informed of Address and Contact Changes

To protect your rights, as well as the rights of your spouse/domestic partner and dependent children, you should keep the General Mills Benefits Service Center and Via Benefits informed of any changes in the addresses of your spouse/domestic partner and/or dependent children. You should also keep a copy for your records of any notices you send to the Service Center.

Plan Accounting

Via Benefits will periodically furnish you with a statement of your HRA balance and reimbursements so you can track your account balance during the year. This will also help you budget for premium expense reimbursement needs in future years. You may also submit a written request to the Plan Administrator to receive a copy of your account information at any time.

Your Rights

As a Participant in the Retiree HRA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as work sites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration,
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies; and
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue group health coverage for yourself, your spouse, or your dependents if there is 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 User's Guide for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your reimbursement request for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. 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 a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a reimbursement request for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court but only after you have exhausted the Plan's reimbursement requests and appeals procedure as described in this User's Guide. 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 a federal court. Any action at law or in equity must begin within 24 months after the denial of any appeal from an initial adverse benefit determination, regardless of any state or federal statutes establishing procedures relating to limitations of actions.

If plan fiduciaries misuse the plan's money, or if you are discriminated against 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 fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your reimbursement request is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-EBSA (1-866-444-3272), logging on to www.dol.gov or contacting the EBSA field office nearest you.

Qualified Medical Child Support Order

The Retiree HRA will comply with all the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order or judgment from a court or administrative body that directs the plan to cover a child of a Participant under a health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected Participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedure for determining if the order is valid. Coverage under the plan pursuant to a medical child support order will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact:

Qualified Order Center
P.O. Box 1542
Lincolnshire, IL 60069-1542
www.QOcenter.com
Telephone Number: 1-877-430-4015

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Retiree HRA is intended to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). The Company is required to provide notice of the ways that Protected Health Information (PHI) may be used in accordance with HIPAA. A copy of the HIPAA notice of privacy practices can be obtained by contacting the

General Mills, Inc. Benefits Department M03-13
Attn: Privacy Officer
Number One General Mills Boulevard
Minneapolis, MN 55426-1348

Plan Information Appendix

Details About Plan Administration	
Plan Sponsor/Plan Administrator	General Mills, Inc. Number One General Mills Boulevard Minneapolis, MN 55426
COBRA Administrator	WillisTowersWatson|COBRA National Benefit Services COBRA Department PO Box 670 West Jordan, UT 84084 1-833-996-1054
Employer Identification Number	41-0274440
Official Plan Names and Numbers	The General Mills Retiree Health Plan Plan 505 (Non-union retirees) The General Mills Retiree Health Plan for Union Employees (65+) Plan 509 (Union retirees)
Plan Year	January 1 through December 31
Type of Plan	Welfare benefit plan providing health care reimbursements under ERISA.
Agent for Service of Legal Process	Corporate Secretary General Mills, Inc Number One General Mills Boulevard Minneapolis, MN 55426 1-763-764-7600
Third Party Administrator	Via Benefits 10975 South Sterling View Drive South Jordan, UT 84905 my.viabenefits.com/generalmills 1-833-414-1448
Reimbursement Requests Submission Information	Name: Via Benefits Mobile App: Search for Via Benefits Accounts where you download apps URL VIAbenefits.com my.viabenefits.com/generalmills Via Benefits P.O. Box 981156 El Paso, TX 79998-1156 Fax: 1-866-886-0878

Plan Funding	The Company contributes contributions to the Participants' Retiree HRAs as described in this User's Guide. The Retiree HRAs are notional accounts and reimbursements of eligible health care expenses are made from the Company's general assets or a special trust established for this purpose.

Plan Administrator's Discretionary Authority to Interpret the Plan

The administration of the Retiree HRA will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretionary authority to determine all matters relating to the Retiree HRA, including eligibility, coverage, and benefits.

The Plan Administrator will also have the exclusive discretionary authority to determine all matters relating to interpretation and operation of the Retiree HRA. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegation of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. Decisions by the Plan Administrator, or any authorized delegate, will be conclusive and legally binding on all parties.

Requirement to File an Appeal Before Filing a Lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it begins within three years of the Retiree HRA Plan Administrator's final decision on the reimbursement request or other request for benefits. If the Plan Administrator decides an appeal is untimely, the Plan Administrator's latest decision on the merits of the underlying reimbursement request or benefit request is the final decision date. You must exhaust the Plan Administrator's internal Appeals Procedure, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

Plan Document

This User's Guide is intended to help you understand the main features of the Retiree HRA. It should not be considered a substitute for the official legal Plan document that governs the operation of the Plan. That document sets forth the Plan provisions and is subject to amendment. If any questions arise that are not covered in this User's Guide or if this User's Guide appears to conflict with the official legal Plan document, the text of the official legal Plan document will determine how questions will be resolved, with one exception: If this User's Guide contains provisions regarding an issue on which the official legal Plan document is silent, this User's Guide will determine how that issue will be resolved. To request a copy of the Plan document, contact the General Mills Benefits Service Center at DEPT 00186, PO Box 64116, The Woodlands, TX 77387-4116. Toll-free phone: 1-877-430-4015.

The Company's Right to Amend or Terminate the Plan

It is the Company's intent that the Retiree HRA will continue in the future. However, the Company reserves the right to amend, modify, suspend, or terminate the Retiree HRA, in whole or in part, by action of the Company. Any such action would be taken in writing and maintained with the records of the Retiree HRA Plan Administrator. Plan amendments, modifications, suspension, or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction of or elimination of benefits or other features of the Retiree HRA to the extent permitted by law and to the extent permitted under the applicable collective bargaining agreement.

The Company's rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, third-party administrators, etc., at any time, and the right to revise the amount of Company contributions. Participants will be notified of any material modification to the Retiree HRA.

If the Retiree HRA is terminated, there will not be any plan assets that would need to be distributed.

Limitation on Assignment

Your rights under the Retiree HRA cannot be assigned, sold, or transferred to your creditors or anyone else. However, you may assign any benefit payments you may be entitled to the insurance provider who provided the individual insurance policy.

Your Employment

This User's Guide provides a detailed summary of the Company's Retiree HRA and how it works. This User's Guide does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under the Retiree HRA should not be interpreted as an implied or express contract or guarantee of employment. The Company's employment decisions are made without regard to benefits to which you are entitled upon employment.