# U.S. Bank Retiree Medical Program Summary Plan Description

**Effective Jan. 1, 2025**

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## Introduction

### About this document

This is the summary plan description (SPD) for the U.S. Bank Retiree Medical Program ("Program"), a component of the U.S. Bank Comprehensive Welfare Benefits Plan. Read the information carefully and file it with your benefits materials.

U.S. Bank has established the U.S. Bank Comprehensive Welfare Benefits Plan, which provides certain welfare benefits to eligible U.S. Bank employees. For convenience, U.S. Bank has created a separate summary for each welfare benefit program offered under the Plan. This SPD is effective Jan. 1, 2025 and applies only to retirees enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) plan options under the Retiree Medical Program. For a list of the separate SPDs describing the other categories of benefits available to U.S. Bank employees under the U.S. Bank Comprehensive Welfare Benefits Plan, please visit Your Total Rewards.

This document is intended only to provide a summary of the benefits that are available under the Retiree Medical Program. Administration of all claims is handled by UnitedHealthcare, the claims administrator. If there is any discrepancy between this document and the official plan/program documents (for benefits where the summary plan description is not part of the plan document), the official plan/program documents govern. This document does not create any vested right to any benefit under the Retiree Medical Program.

You will receive materials directly from the UnitedHealthcare Group Medicare Advantage (PPO) plan explaining the benefits provided and any requirements or limitations for receiving benefits. When read with the information in this SPD, these materials are the complete summary plan description for the UnitedHealthcare Group Medicare Advantage (PPO) plan.

The materials you receive from the UnitedHealthcare Group Medicare Advantage (PPO) plan will include important information regarding the doctors you may see, the medical services you may receive, any copayments or other out-of-pocket expenses for which you may be responsible, requirements you must satisfy before receiving services (e.g., preadmission notification and prior authorization) and the services and expenses that are excluded under the benefit plan.

### Your responsibilities

- Carefully review this information and keep it for future reference.
- Enroll or request qualifying changes by the deadlines described in this document. If you miss certain deadlines, processing may be delayed or your request may not be processed at all.
- After enrolling or making a change, carefully review your confirmation statement and any other documents.
- Provide documentation as requested to verify eligibility of any dependents you enroll.
- Contact UnitedHealthcare for specific questions about coverage or claims information.

### Eligibility and enrollment

The U.S. Bank Retiree Medical Program is closed to new enrollments for employees that terminated/retired on or after Jan. 1, 2014. You are eligible for the Retiree Medical Program if you were enrolled on or before this date. Newly eligible dependents can be added to coverage if enrolled within 60 days of becoming an eligible dependent, see "Who's eligible," "Enrolling" and "Situations that could affect your coverage."

## Your program options and claims administrators

The health care option available to you is determined by your age (as the U.S. Bank retiree) and Medicare eligibility. For any of the options available to you, there are two coverage levels:

- You Only (the retiree only); or
- Family (you/retiree; and any eligible dependents).

| Plan | Claims administrators |
|---|---|
| **UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs** | **Medical:** UnitedHealthcare® Group Medicare Advantage (PPO)<br>**Pharmacy:** UnitedHealthcare Medicare Part D prescription drug plan administered by Optum Rx |

The UnitedHealthcare Group Medicare Advantage (PPO) plan is available to retirees entitled to Medicare Part A and enrolled in Medicare Part B and their Medicare-eligible dependents (as long as the retiree is also enrolled in this option). This option delivers all of the benefits of Medicare Parts A and B plus additional benefits. (You must be entitled to Medicare Part A and enrolled in Medicare Part B to remain enrolled in the Program. If you are not, your coverage in the Program will be cancelled.)

Under this option, you will generally receive benefits only for covered services you receive from providers that accept the terms of your UnitedHealthcare Group Medicare Advantage (PPO) plan option.

The UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs is offered through an insurance contract with the UnitedHealthcare Group Medicare Advantage (PPO) plan who has the sole authority, discretion and responsibility to interpret and construe the plan and, determine all factual and legal questions under such plan, including but not limited to eligibility, the entitlement of benefits and the amounts of benefits to be paid, and determine all questions arising in the administration of the plan. The UnitedHealthcare Group Medicare Advantage (PPO) plan provides their own materials. If you enroll in the Program, carefully review and refer to these materials. If you have questions about your health care option, Medicare Part D coverage or claims information, contact the UnitedHealthcare Group Medicare Advantage (PPO) plan.

Note: If you enroll in an individual Part D prescription drug plan or another Medicare Advantage plan, you will be disenrolled from your U.S. Bank plan. Once your U.S. Bank coverage is cancelled, you will not be allowed to re-enroll in the plan.

### Identification cards

After you enroll, you will receive an ID card mailed to your home address from UnitedHealthcare to be used for your medical and pharmacy services. You must present the ID card when receiving care, so your claim will be handled properly and promptly. If you do not, you may need to pay for services yourself and file a claim for reimbursement. You may request additional or replacement ID cards by contacting UnitedHealthcare.

## Cost of retiree health care coverage

The cost of retiree health care coverage for participants in the Program is based on claims experience and medical expense projections. The cost is generally adjusted on an annual basis and changes on Jan. 1. The cost could, however, be changed more frequently.

### Retiree health care credits

Employees that met age and service requirements were able to accumulate retiree health care credits from Jan. 1, 2002, through Dec. 31, 2013. Effective Jan. 1, 2014, employees can no longer accumulate retiree health care credits. Eligible employees who retired before Jan. 1, 2014, may use their retiree health care credits as described below. Employees who did not retire before Jan. 1, 2014, forfeited any accumulated retiree health care credits.

### Nature of credits and reservation of rights to change credits

As long as U.S. Bank keeps the credits structure in place in its Retiree Medical Program, it will, for bookkeeping purposes, keep a record of any credits you accumulated. Your accumulated credits will be used to offset your cost of Retiree Medical Program coverage for you and any covered dependents. Accumulated credits are not like accounts in a 401(k) or pension plan; no trust holds these credits, and there is no bank account in which the credits are deposited.

If you did not retire by Dec. 31, 2013, or you were not eligible to enroll in retiree health care on or before Dec. 31, 2013, your credits and deemed interest were forfeited under all circumstances. Credits cannot be paid out to you or used for any other purpose than payment toward U.S. Bank retiree health care coverage under the Program.

Additionally, U.S. Bank is not obligated to continue either the Program or the application of retiree health care credits toward the cost of the coverage. U.S. Bank could terminate your coverage altogether or could amend the Program to eliminate or change (including reducing) the credits – including any credits you have already accumulated. This is because retiree health care coverage is not a 'vested' benefit and U.S. Bank has retained its full authority and discretion to amend or terminate the Program.

### Interest on retiree health care credits

Credits are deemed to receive interest payments of 5.5% annually. If you have accumulated retiree health care credits, your remaining credit balance (after deductions from the account toward the cost of coverage) as of each Dec. 31 will be deemed to gain interest at the established interest rate. U.S. Bank has reserved the right to increase or decrease the interest rate.

### Paying for coverage with credits

If your employment ended on or before Dec. 31, 2013, and you enrolled in the U.S. Bank Retiree Medical Program, approximately two-thirds of the annual medical coverage cost will be offset by your accumulated credits, and you will pay the remaining approximately one-third out-of-pocket.

Approximately two-thirds of the medical cost will continue to be deducted from your credit balance until the credits are insufficient to cover two-thirds of the cost. The credit balance will be reviewed Jan. 1 of each year and if the credits will not cover two-thirds of the cost of your premium for the entire year, then the balance will be divided by twelve to determine the amount used to offset your premium payment. If your rate changes during the plan year, the dollar amount used to offset your premium payment will be recalculated. After your health care credit balance is depleted, you can continue to participate in the Program by paying 100% of the cost out-of-pocket.

If you elect coverage for dependents (spouse/domestic partner/children or grandchildren), the annual medical cost includes their coverage. Approximately two-thirds of the total elected coverage will be offset against the accumulated credits to the extent available.

### If you die with accumulated credits

Any remaining credits can be transferred to an eligible spouse or domestic partner if you die while participating in the Program. Your spouse/domestic partner can use the credits for two-thirds of the annual cost of retiree health care coverage. This is the only use for the credits; he or she will not receive any cash payment or be able to use the credits for any other purpose. After the credits are depleted by the spouse/domestic partner, he or she can continue to participate in the Program by paying 100% of the cost.

Your spouse/domestic partner is the only dependent eligible for transferred credits; no non-spousal dependents receive transferred credits. However, if there are additional eligible dependents (such as a dependent child) receiving coverage at the time of your death, your spouse would continue to receive family coverage and the health care credits would continue to pay two-thirds of the cost until the credits are insufficient to cover two-thirds of the cost. Special payment rules apply in the year when the credits become insufficient to cover two-thirds of the cost. After your health care credit balance is depleted, your spouse/domestic partner and your covered dependents can continue to participate in the Program by paying 100% of the cost.

## Plan highlights

Call UnitedHealthcare Group and request the Medicare Advantage (PPO) Plan with Prescription Drugs Plan Guide.

## Who's eligible

### Retirees

The U.S. Bank Retiree Medical Program is closed to new enrollments for employees that terminated/retired on or after Jan. 1, 2014. You are eligible for the Retiree Medical Program if you were enrolled on or before this date.

### Dependents

#### Eligible dependents

If you are enrolled in the Program, your eligible dependent may be eligible for coverage under the Program if:

- Your eligible dependent is and continues to be:
  - Your opposite-sex or same-sex spouse/domestic partner. A common-law spouse may be covered only if you reside in a state that recognizes common-law marriage and you meet the common-law requirements at the time you enroll the dependent in coverage. See the definition of domestic partnership in the Glossary.
  - Your or your spouse/domestic partner's children/grandchildren under age 26 who are:
    - your or your domestic partner's biological children;
    - your stepchildren;
    - your or your spouse/domestic partner's foster children;
    - children/grandchildren for whom you or your spouse/domestic partner have legal guardianship;
    - children/grandchildren legally adopted by you or your spouse/domestic partner or placed with you or your spouse/domestic partner for adoption; or
    - grandchildren who are eligible to be claimed as an exemption on your or your spouse/domestic partner's federal income tax return.
- Disabled children age 26 and older who otherwise meet the dependent children definition as long as ALL the following requirements are met:
  - the child is severely disabled by prolonged physical or mental incapacity;
  - the child became disabled prior to reaching age 26;
  - the child was covered by the Program prior to reaching age 26, or, if older than age 26, loses coverage under a parent's/guardian's plan. In the event of loss of coverage, proof of prior coverage must be provided;
  - the child is unmarried and you or your spouse/domestic partner provide more than 50% of his or her support because he or she is unable to earn a living; and
  - disabled dependent status is approved by a medical claims administrator for U.S. Bank.

If, however, one of your current dependents later gains eligibility due to a change in the eligibility requirements, you will not be able to enroll that dependent in the Program.

#### Ineligible dependents

Ineligible dependents include, but are not limited to:

- Dependents on active military duty in the uniformed services or armed forces of any country.
- Parents of a retiree or a retiree's spouse/domestic partner.
- A spouse from whom you are legally separated or divorced (even if the divorce decree stipulates you will continue coverage for your ex-spouse), or a domestic partner or domestic partner's dependents if your domestic partnership has ended.
- Spouses or domestic partners of your dependent adult children or grandchildren.
- Children who become disabled after age 26.

## Enrolling

### How to enroll

To enroll a newly eligible dependent, call U.S. Bank Employee Services and speak to a representative. U.S. Bank Employee Services will send you an enrollment packet. You must complete an application from your claims administrator and return the application to U.S. Bank Employee Services. Coverage generally takes effect the first day of the month after your application is received and processed, or the first of the month following the date you experience a qualifying new dependent enrollment event and contact U.S. Bank Employee Services to make your election, whichever is later.

### U.S. Bank retirees/employees related to each other

If you and your spouse/domestic partner are both eligible retirees of U.S. Bank, or if your dependent is employed by U.S. Bank, you must choose a coverage level that will cover you and any eligible dependents only once. Since the plan integrates coverage for medical services and does not coordinate coverage for pharmacy, there is no benefit to being covered twice under the U.S. Bank plan.

### Dependent SSN requirement

As a result of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) which took effect Jan. 1, 2009, U.S. Bank is required to report Social Security numbers (SSNs) of covered dependents who are U.S. citizens age three months and older. The Centers for Medicare and Medicaid Services (CMS) and health plans use this information to properly coordinate payment of benefits.

To cover your dependent(s) in a U.S. Bank medical plan, you must provide your dependent's SSN(s) during or after enrollment or take one of the following actions:

- Complete a form indicating your dependent is not a Medicare beneficiary or that you refuse to comply with this request. You must complete this form annually until the SSN is provided or the dependent is no longer covered. Obtain this form on Your Total Rewards at usbank.com/benefitsandrewards or request it by calling U.S. Bank Employee Services; or
- Notify U.S Bank if your covered dependent doesn't have an SSN because he/she is not a U.S. citizen by calling U.S. Bank Employee Services. Tax Identification number is not a valid substitute for SSN.

If your dependent is a newborn, apply for and enter his/her SSN before he/she is three months old. You may receive monthly reminders until the SSN is entered.

## Situations that could affect your coverage (including becoming Medicare-eligible)

### If you spend time in another part of the country

Call U.S. Bank Employee Services and make sure you have both a permanent address and an alternate address on file. As your location changes, call back and designate the appropriate address as your mailing address. This ensures you receive all retiree health care mailings. Call UnitedHealthcare to change your address.

*Example: John's permanent address is Minnesota, but he lives in Arizona (his alternate address) from December through April. Just before John leaves for Arizona in December, he contacts U.S. Bank Employee Services and designates his Arizona address as his preferred mailing address. Just before John returns to Minnesota in April, he contacts U.S. Bank Employee Services and designates his Minnesota address as his preferred mailing address.*

You will also need to refer to your plan materials to determine the provisions and requirements of these benefit options while traveling. Call UnitedHealthcare for more information.

### If your address changes

Call U.S. Bank Employee Services to report a change to your permanent address as soon as possible. U.S. Bank Employee Services will send you a letter confirming this change. Call UnitedHealthcare to change your address.

### If your dependent turns age 65 or becomes Medicare-eligible before age 65

Your covered dependent must enroll in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs at the time they turn age 65 or when they become Medicare-eligible if before age 65. Enrollment information will be provided to your covered dependent about 90 days prior to turning age 65. Your dependent must enroll by the deadline on the enrollment materials, or your dependent will no longer be enrolled in the Program. The effective date of coverage into the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs will be the first of the month in which your dependent turns age 65 (as long as their UnitedHealthcare Enrollment Request form has been processed). If your dependent's birthday is on the first day of the month, then their coverage under the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs will be effective on the first of the prior month (as long as their UnitedHealthcare Enrollment Request form has been processed).

To enroll in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs, your Medicare-eligible dependent must be entitled to Medicare Part A and enrolled in Medicare Part B. If your dependent is not, they will not be eligible to continue coverage in the Program.

When your dependent turns age 65 or becomes Medicare-eligible before age 65, your dependent will enroll in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs. Your coverage cost also will change when a covered dependent turns age 65 or becomes Medicare-eligible before age 65. However, for that dependent, Medicare Parts A (for inpatient services) and B (for physician services, outpatient services, and supplies and equipment) will be considered the primary insurer, effective the first of the month in which the dependent turns age 65 (or the first of the prior month if the dependent's birthday is on the first of the month). The Program will assume that your dependent has enrolled in Medicare Parts A and B and UnitedHealthcare will process your

dependent's claims as if your dependent had Medicare Part A and Part B, whether or not that is actually the case. If your dependent doesn't have Medicare Part A, your dependent must pay the portion that Medicare would have paid. The Program only pays benefits when the benefit amount payable under the Program exceeds the Medicare payment.

**Qualified Medical Child Support Orders**
A Qualified Medical Child Support Order (QMCSO) is any judgment, decree or order (including approval of a settlement agreement) for one parent to provide a child or children with healthcare coverage. If U.S. Bank receives a QMCSO for your child or children, we will contact you concerning the procedures for such an order. You also may request a free copy of the QMCSO procedures from U.S. Bank Employee Services any time.

Generally, coverage for the child who is the subject of the QMCSO will become effective on the date specified in the QMCSO or at a later date as specified in the QMCSO procedures of U.S. Bank. In addition, U.S. Bank will increase your deduction or bill you for appropriate charges beginning on the date the QMCSO becomes effective. If the request for coverage is not made within 31 days of the date of the QMCSO, coverage for the child will be subject to all of the terms of the Retiree Medical Program, as applicable.

For more information on QMCSOs and National Medical Support Notices (NMSNs) visit the Qualified Order website at QOCenter.com.

### If you return to work after retirement
You may either continue your coverage under the U.S. Bank Retiree Medical Program or enroll in an active employee medical plan. If you remain enrolled in the Retiree Medical Program, any remaining accumulated retiree health care credits will continue to earn interest during your period of re-employment. If you enroll in an active employee medical plan, you will not be able to re-enroll in the Retiree Medical Program at any time in the future and will forfeit any remaining health care credit balance. These rules are also subject to the generally reserved right of U.S. Bank to amend or terminate coverage under the Program (see "Amendment or termination of the plans"). Some general rules are stated below.

### If you die
Under the current terms of the Program, if you die and your family is covered by the U.S. Bank Retiree Medical Program, your spouse/domestic partner can continue retiree health care coverage as long as the Program continues to be available and subject to any changes made to the Program. In addition, your children can stay covered for as long as they are eligible under the Program. However, your spouse/domestic partner may not add any dependents to the Program at any time.

## When coverage ends
Your coverage under the Program will end when one of the following events first occurs.

For you:
- You die;
- You no longer satisfy the eligibility requirements for participation;
- You fail to pay any required premiums in full by the required due date;

- You request that coverage be terminated; or
- The Program is discontinued or amended so that you lose eligibility.

In addition to the events listed above, coverage for your dependents will end on the last day of the month when one of the following events first occurs:

- Divorce, legal separation or termination of domestic partnership (if you terminate your domestic partnership, coverage for your partner and any covered dependent(s) of your partner will end);
- The dependent no longer satisfying the dependent criteria for participation in a plan or Program;
- A decision by you to terminate coverage; or
- You fail to provide requested documentation that proves your dependent's eligibility for coverage or the documentation you provide does not verify your dependent's eligibility for coverage.

If one of the events listed earlier occurs, coverage will be cancelled as soon as administratively feasible.

If you commit an act, practice or omission that constituted fraud, or an intentional misrepresentation of a material fact, U.S. Bank reserves the right to terminate coverage retroactively with proper notice.

### If you don't notify U.S. Bank of dependent ineligibility

If you do not call U.S. Bank Employee Services within 60 days of the date your dependent became ineligible, your dependent's coverage will be canceled as soon as administratively feasible.

### Coverage cancellation

You can cancel coverage for yourself and/or your dependents at any time by calling U.S. Bank Employee Services. If you cancel or lose retiree health care coverage under the Program for any reason (including non-payment of premiums), you will not be able to re-enroll in the Program. If you cancel or lose retiree health care coverage, any covered dependents will also lose coverage. Similarly, if you cancel coverage for an eligible dependent for any reason, that dependent will not be able to re-enroll in the Program.

Coverage will end the first of the month following the date that U.S. Bank Employee Services receives a written request to cancel coverage for you and/or your dependents. This request must be signed and dated by each member that wants to cancel coverage under the UnitedHealthcare Group Medicare Advantage (PPO) Plan.

## Appeals and disputes

The UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs is fully insured. The insurer has the sole authority, discretion and responsibility to interpret and construe the terms of the benefit plan it insures, and determine all factual and legal questions under such benefit plan, including but not limited to eligibility to participate, the entitlement of benefits and the amount of benefits to be paid, if any. U.S. Bank has no authority to make determinations with respect to the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs. Your only source of recovery is from the applicable insurer.

The Plan's claims procedures are furnished automatically, without charge, as a separate document. Please review your Evidence of Coverage for more details.

### Exhaustion of administrative remedies

The exhaustion of the claim-and-review procedure (with the exception of the external claim review process) is mandatory for resolving every claim and dispute arising under this Program prior to initiating legal action (except if the internal claim and appeal process is deemed exhausted. If any legal action brought after you have exhausted the administrative remedies, all determinations made by the claims administrator, U.S. Bank or other fiduciary, shall be afforded the maximum deference permitted by law.

### Time limitations for commencing a claim

You must submit your claim for benefits within one year after whichever is earliest – the date on which you were denied benefits or received benefits at a different level than you believed the Program provides, or the date you knew or reasonably should have known of the principal facts on which your claim is based. After you file your claim, you must complete the entire claim-and-review procedure (with the exception of the external claim process) before you can sue over your claim. It is important that you include all the facts and arguments that you want considered during the claim-and-review procedure.

### Time limitations for commencing a legal action

You must commence any lawsuit within the earlier of:

- Two years after you knew or reasonably should have known of the facts behind your claim; or
- Six months after the claim-and-review procedure is completed (including completion of external review if you pursue it).

### Venue for legal action

Any legal action filed with respect to the Program must be filed in the federal court for Minnesota located in Hennepin County.

## Required legal information

This section includes some information you may need to know about the U.S. Bank Comprehensive Welfare Benefits Plan.

| Official plan name | Plan type | Plan number |
|---|---|---|
| U.S. Bank Comprehensive Welfare Benefits Plan | Welfare plan | 518 |

Reports on the plans are identified and filed with the federal government using an Employer Identification Number (EIN) assigned by the Internal Revenue Service. The EIN for U.S. Bank is 41-0255900. The address of the Plan Sponsor is:

U.S. Bancorp Center
800 Nicollet Mall
Minneapolis, MN 55402

### Amendment or termination of the plans

U.S. Bank has reserved the right to amend the Plan, including any program or option offered under the Plan, by written action of the Benefits Administration Committee of U.S. Bank at any time, for any

reason and in any respect at its sole discretion. The right of U.S. Bank to amend or terminate the Plan includes, but is not limited to, changes in the eligibility requirements, premiums or other payments charged, benefits provided and termination of all or a portion of the coverage provided under the plans, programs or options offered under the Plan. If a plan is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination, and your rights will be reduced, terminated, altered or increased accordingly, as of the effective date of the amendment or termination. You do not have ongoing rights to any plan benefit, other than payment of any covered health services you incurred or benefits to which you become otherwise entitled prior to the plan amendment or termination.

If the welfare plans are terminated and replaced by new plans, you can enroll in the new plans if you meet eligibility requirements.

**Insured plans, programs or options**
The insurance company has the sole authority, discretion and responsibility to interpret and apply the terms of the plan, program or option insured by the company and to determine all factual and legal questions under the plan, program or option insured by the company, including entitlement to benefits and the amount of benefit to be paid under the insurance contract, if any.

The insurance company is responsible for the payment of all benefits offered under the plan that it insures. In no event will U.S. Bank provide a benefit under an insured plan, program or option except through the payment of the relevant insurance premium. No covered employee, dependent or other person shall have any claim or cause of action against U.S. Bank as to the payment of benefits under any insurance policy or contract. Each covered person or other claimant entitled to the payment of benefits under an insured plan shall look solely to the applicable insurance policy or contract, and not to U.S. Bank for payment of such insured benefits.

## Claims administrator information

The plans and Programs listed below are administered through contracts with insurance companies or third-party administrators:

| Plan, program or option | Administration | Funding |
|---|---|---|
| General benefit administration and customer service | U.S. Bank Employee Services | U.S. Bank has a contract with Alight Solutions to provide these services. |
| UnitedHealthcare® Group Medicare Advantage PPO Retiree Plan with Prescription Drugs Medicare-eligible retirees and their Medicare-eligible dependents | UnitedHealthcare<br>P.O. Box 29650<br>Hot Springs, AR 71903-9973 | This is an insured option, funded by employer contributions and retiree contributions. U.S. Bank has a contract with UnitedHealthcare® Group Medicare Advantage PPO Plan with Prescription Drugs to administer and pay all eligible claims incurred under the terms of the plan. Benefits are paid from the general assets of U.S. Bank. |

## Agent for service of legal process

If for any reason you want to seek legal action against a plan, you can serve legal process on the administrator of the plan and/or the agent for this process. The agent for legal process is:

General Counsel of U.S. Bank
U.S. Bancorp Center
800 Nicollet Mall
Minneapolis, MN 55402

## Plan year

The plan year for all plans is the calendar year (Jan. 1 through Dec. 31).

## Questions about plans

If you have questions regarding specific coverage or claims status, contact your claims administrator. If you have general questions about your benefit plans (such as eligibility or deadlines), contact U.S. Bank Employee Services.

## Employment rights not implied

Participating in the benefit plans does not assure you continued employment or rights to benefits except as outlined by each plan.

## Assignment of benefits

Except as permitted by this Summary Plan Description or by applicable Department of Labor Regulations:

- You shall not have the right to transfer any interest or claim you may have under this Plan, including claims for benefits, for breach of fiduciary duty, to receive documents or information, or any other claim or right you may have under this Plan to any party. Nor shall you have the power to anticipate, alienate, assign, sell, transfer, pledge or encumber the same;
- Nor shall the Plan recognize an assignment therefore, either in whole or in part (except as discussed in this section);
- Nor shall any benefit be subject to attachment, garnishment, execution following judgment or other legal process.

Except as may be required by law, your benefits and rights under the Plan are not subject to the claims of your creditors.

You may not assign any of your rights under the Plan to a provider, however the Plan will make direct payment of benefits to an in-network provider. This does not, however, constitute a waiver of this anti-assignment provision. Any other attempt to assign any rights under this Plan will be void. The Plan is not required to reimburse anyone other than you for covered expenses when you use nonparticipating providers. It is your responsibility to arrange for the payment of those expenses and then get reimbursed from the Plan. Providers are not third-party beneficiaries under the Plan. You may appoint an “authorized representative” to act on your behalf solely with respect to any administrative claim for benefits you may have under Department of Labor regulations. The designation of an authorized representative, however, does not constitute an assignment of any right

under this Plan and does not provide the authorized representative with the authority to file a lawsuit on his, her or your behalf.

This anti-assignment clause can only be waived in writing by a Vice President of Employee Benefits or Benefits Design. No other conduct shall be deemed a waiver of this anti-assignment clause.

## ERISA – Your rights as a member of the plans

As a participant in the Retiree Medical Program offered through U.S. Bank and described in this document, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This section summarizes the rights you have as a participant in the Retiree Medical Program – rights that ERISA guarantees.

### Plan documents

You can examine, without charge, any of the plan documents – which are in the Plan Administrator's office in Minneapolis, MN – during normal work hours. You may also make a written request to examine, without charge, any of the plan documents at your worksite. The documents will be sent to you within 10 business days after the date of your request. If you want to examine a document, send your written request to:

U.S. Bancorp Center
BC-MN-4BEN
800 Nicollet Mall
Minneapolis, MN 55402-7020
Fax: 833-691-7958

These documents include insurance contracts, annual financial reports and the plan documents descriptions. You may get copies of these by sending a written request to the address noted above.

The Plan Administrator may make a reasonable charge for the copies ($5 per document as of the printing of this document).

### Summary Annual Report

You'll receive a summary of the Plan's annual financial report, as applicable, once a year.

### Request for information

If you make a written request for material that U.S. Bank is required to provide to you, you should receive the material within 30 days of your request. However, because of matters beyond the Plan Administrator's control (for example, if your request is lost in the mail), the requested material may reach you more than 30 days after your request. If you do not receive the material you requested within 30 days, call U.S. Bank Employee Services and it will be sent to you again.

**Note:** The U.S. Bank Retiree Medical Program does not impose a pre-existing condition limitation.

### Plan fiduciaries

The plan fiduciaries are responsible for the proper operation of the plan. They have a duty to act prudently and in the sole interest of plan participants and beneficiaries.

**Benefits claims and legal actions**
If you have any questions or problems concerning any of your plan benefits or about applying for benefits, call UnitedHealthcare. If you have a claim for benefits that is denied in whole or in part, you should receive a written explanation of the reason for denial. You have the right to have UnitedHealthcare review and reconsider your claim, call 888-556-6648.

If you have completed the appeals process, your claim for benefits is denied and you believe you are entitled to the benefits you claimed, you can take your case to federal or state court. If you discover that a plan fiduciary is misusing the plan's money or if you are discriminated against for exercising your rights under ERISA, you can file suit in a federal court or ask the U.S. Department of Labor for help. If you make a written request for material and do not receive the material within 30 days after your request, you can bring suit if there is no valid reason for the delay. In this situation, the court can require the Plan Administrator to provide the material and pay you up to $110 a day until you receive the materials.

If you bring suit in federal or state court to protect any of the ERISA rights discussed in this section, the court will decide who will pay court costs and legal fees. If you win your case, the court may ask that the losing party pay these costs and fees. If you lose your case – for example, if the court finds your claim is frivolous, the court may ask you to pay these costs and fees.

**Exercising your ERISA rights**
The law provides that you will not be fired or discriminated against in any way for the sole purpose of preventing you from getting plan benefits or from exercising the rights you have as a plan member under ERISA. If you have any questions 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 (formerly known as Pension and Welfare Benefits Administration), 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 Ave. NW, 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.

## HIPAA privacy notice
It is the Plan’s policy to protect your medical information to the extent required by any applicable law, including Health Insurance Portability and Accountability Act (HIPAA).

However, the Plan may share your medical information with U.S. Bank, other U.S. Bank group health plans; and with others for the purposes of treatment, payment and healthcare operations and for certain other legally permitted purposes. To the extent required by law, U.S. Bank will not use any medical information about you to make employment-related decisions.

The Plan will make reasonable efforts to use, share or request only the minimum amount of information necessary to accomplish the intended purpose. You also have certain privacy-related rights, including the right to access, request restrictions on and request amendments to your health

records. Details about the Plan's privacy policies, including your privacy rights, are found in the HIPAA Privacy Notice available through Your Total Rewards site.

## Glossary

**Benefit subsidy:** the U.S. Bank contribution to the total cost if you elect medical coverage

**Domestic partnership:** an ongoing and committed spouse-like relationship between adults of the same or opposite gender. If you are in a qualified domestic partnership, your domestic partner is eligible for this benefit.

A domestic partnership is **qualified** if the partners are registered with any state or local governmental domestic partner registry, or all of the criteria below are met:

- The partners have an ongoing and committed spouse-like relationship.
- The partners intend to continue their relationship indefinitely.
- The partners are:
  – both 18 years of age or older and competent to enter into a contract;
  – not legally married to each other;
  – not legally married to, nor the domestic partner of, anyone else; and
  – not related by blood closer than permitted by marriage law in their state of residence.
- The partners share a principal residence and intend to do so indefinitely.
- The partners are responsible for the direction and financial management of their household and are jointly responsible for each other's financial obligations.

Domestic partnerships are not subject to any requirements for proof of relationship or waiting periods that are not also applied to marriages. A domestic partner registry certificates or the U.S. Bank Domestic Partner Affidavit are accepted as fully equivalent to marriage certificates.

**HIPAA:** the Health Insurance Portability and Accountability Act, a federal law passed in 1996 that provides for portability of healthcare in certain situations — such as by limiting pre-existing condition exclusions and providing for special enrollment rights in group health plans — and protection of the privacy of patient medical records

**Member:** a covered individual; can be the retiree or a covered dependent

**Newborns' and Mothers' Health Protection Act of 1996:** Under the Newborns' and Mothers' Health Protection Act of 1996, benefits may not be restricted for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following Cesarean section delivery.

You cannot be required to obtain prior authorization from your plan for your 48-hour or 96-hour stay to be covered. However, authorization is recommended from your plan beyond the applicable 48-hour or 96-hour stay.

The law allows you and your baby to be released earlier than these time periods only if the attending provider decides, after consulting with you, that you and your baby can be discharged earlier. In any

case, the attending provider cannot receive incentives or disincentives to discharge you or your baby earlier than 48 hours (or 96 hours).

**Plan year:** Jan. 1 through Dec. 31

**Premium:** the fixed cost you pay each month for participating; you pay this amount whether you use/receive services under the plan or not

**Prescription drugs:** medications, including insulin, that are required by state or federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe it

**Provider:** an individual, institution or agency that provides health services to healthcare consumers

**Summary plan description (SPD):** a document that provides comprehensive information about a given plan or Program, including eligibility provisions, coverage options and details, and claims procedures

**U.S. Bank Employee Services:** the U.S. Bank contact center for benefits and HR questions and transactions; see "Whom to contact" for details

**Women's Health and Cancer Rights Act of 1998:** In accordance with this act – which requires group health plans that cover mastectomies to also cover certain mastectomy-related benefits or services, this plan covers the following with the same deductibles and coinsurance as any other illness:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance; and
- Prostheses and approved treatment of physical complications (including lymphedemas) at all stages of the mastectomy.

**Your Total Rewards (YTR):** website that contains personalized data about your total rewards at the bank and links to view and manage your benefits; see "Whom to contact" for details

## Whom to contact

| Resource | Whom to contact | Contact information |
|---|---|---|
| **U.S. Bank Employee Services** Personalized information on your benefits via phone; representatives available 8 a.m. to 7 p.m. CT Monday through Friday (except holidays) | Questions about rate renewal, dependent eligibility, address updates, general assistance | 800-806-7009 |
| **Your Total Rewards (YTR)** | Detailed information about benefits. | usbank.com/benefitsandrewards |
| **UnitedHealthcare® Group Medicare Advantage PPO Plan with Prescription Drugs** | To find a provider or for specific questions about medical coverage or claims, order replacement ID cards | **Pre-enrollment information:** 877-714-0178 TTY 711 |

| Resource | Whom to contact | Contact information |
|---|---|---|
| Group numbers:<br>Plan 1 – 13481<br>Plan 2 – 13482 | | 8 a.m. to 8 p.m. local time, Monday-Friday<br><br>**Customer service department:**<br>888-556-6648<br>TTY 711<br>8 a.m. to 8 p.m. local time, Monday-Friday |