

**Summary Plan Description
and
Plan Document
for the
MEIJER HEALTH BENEFITS PLAN**

(Restated as of the first day of the 2023 Plan Year)

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INTRODUCTION

Meijer, Inc. (the “Plan Sponsor” or “Company”) adopted the Meijer, Inc. Employee Benefits Plan as of September 1, 1976. The Plan provided health and accident benefits to eligible team members of the Company and the team members’ eligible dependents. The Plan has periodically been amended. One of the amendments changed the name of the Plan to the Meijer Health Benefits Plan.

By this document, the Plan Sponsor is further amending and restating the Plan. The amended and restated Plan will be effective, for each Participant, as of the first day of the Participant’s Plan Year which begins during 2023.

This document also serves as the Summary Plan Description (the “SPD”) and is intended to explain the Plan. Participants should read this document carefully and acquaint their families with its provisions.

The Plan applies to many different groups of the Company’s team members and their eligible dependents. These groups of team members and dependents may be subject to different terms and conditions of the Plan. The provisions of the Plan which apply to a specified group of team members and dependents is called a Sub-Plan.

The initial portion of the Plan, called the Basic Provisions, applies to all Participants. However, attached to the initial portion of the Plan, as Appendices, are the terms and conditions which apply to the different classifications of team members and their eligible dependents. A separate Appendix applies to each group of team members and dependents. For each group of team members and dependents, the Sub-Plan consists of the Basic Provisions and the provisions in the applicable Appendix.

It is intended that the requirements of ERISA be satisfied with regard to the Plan, and that the health and accident benefits provided to Participants be eligible for exclusion from the Participants’ income under Section 105 of the Code.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 107 for details.

For questions, Participants should contact the Meijer Rewards Service Center, toll-free at 1-866-681-6116.

ELIGIBILITY AND PARTICIPATION

Who is an Eligible Team Member?

Each full-time and part-time team member will be eligible to participate in the Plan after completing a period of Service with the Company (for the available benefit options and required period of Service see the applicable Appendix), provided the team member is actively working on the date coverage is scheduled to begin (see the team member Participation subsection below). The required period of Service is described in the Appendix which applies to the team member.

Notwithstanding this general rule, all team members and their eligible dependent children will be eligible for the Health Select with HRA on the first day of the month on or after the completion of 60 days of Service.

Individuals who the Company classifies as independent contractors or leased employees are not eligible for the Plan.

If an eligible team member has a break-in-service (for example, due to termination of employment) during which the team member is not credited with any hours of service for at least 13 weeks, the team member shall be treated as a new hire upon resumption of service. If the break is less than 13 weeks, and the team member was enrolled in medical/prescription drug benefits and returns during the same stability period/plan year, coverage shall be offered as soon as administratively practicable upon resumption of service. Further, such a team member shall be treated as a continuing team member upon resumption of service for purposes of any applicable measurement periods.

Transfers between Full and Part-Time Employment

If a team member transfers from full-time to part-time employment status, his or her spouse or domestic partner may lose Plan eligibility after the transfer occurs. If that occurs, COBRA continuation coverage may be elected for the spouse or domestic partner. For the transferred team member, his or her Company contribution toward the cost of health coverage will be reduced after the switch to part-time status occurs. The Company will keep the team member enrolled in his or her current health coverage. The team member has 30 days to request a change as a result of the new Company contribution level. The change will become effective as of the first day of the month following a requested election change.

If a team member transfers from part-time to full-time employment status, the team member's dependents shall be eligible for health coverage on the first day of the month after the team member requests to add the dependents, provided the team member makes the request within 30 days of the transfer to full-time employment status.

Who is an Eligible Dependent?

Unless provided otherwise in the applicable Appendix, the following dependents of an eligible team member will be eligible to participate in the Plan:

- **Spouse** A person of the same or opposite gender who is “legally married” to the team member and who is residing in the United States. For purposes of this provision, a person is “legally married” to the team member if the marriage is recognized as valid and enforceable in the state or jurisdiction where the couple is married, regardless of the laws of the state or jurisdiction where the couple reside. For purposes of this provision, the term “spouse” does not include:
 - A common-law spouse of the team member; or
 - A spouse who is legally separated or divorced from the team member;
- **Domestic Partner** A person who is the same gender or opposite gender domestic partner of the team member where the team member and domestic partner satisfy all of the following requirements:
 - The team member and domestic partner are each other's sole partner and are not married to or legally separated from any other person nor have either individual had another partner within the prior six months;
 - The team member and domestic partner are both at least age 18 and mentally competent to enter into a contract;

- The team member and domestic partner are not related by blood to a degree of closeness which would prohibit legal marriage in the state where they reside;
- The team member and domestic partner live together at the same residence and have done so for at least the past 12 months;
- The team member and domestic partner are engaged in a committed relationship with mutual caring and support and are jointly responsible for each other's common welfare, financial support and living expenses (and have been for at least the past 12 months), as demonstrated to the Plan Administrator in a declaration of domestic partnership; and
- The team member and domestic partner are not in the relationship solely for the purposes of obtaining Employer-provided benefits.

In order to maintain coverage for a domestic partner the team member must complete and submit to the Company, within 60 days of enrollment, a declaration of domestic partner and an acknowledgment of tax dependent status; and

- **Child** A child who meets one of the following requirements:
 - The team member's natural child or legally adopted child or a child placed with the team member for legal adoption;
 - The team member's step-child (child of current spouse) or a child over whom the team member or spouse or domestic partner has a legal guardianship that remains actively in force;
 - The child (natural, adopted or placed for adoption) of a team member's domestic partner; or
 - The brother, sister, niece, nephew or grandchild of the team member or the team member's current spouse who was enrolled in the Plan prior to July 1, 2010.

The following special eligibility rules also apply with respect to a child:

- The child has not reached the limiting age of 26. A child will cease to be considered a dependent on the last day of the month during which the dependent attains age 26, except as follows:
 - No age limit will apply to a dependent child who is Totally Disabled before age 19. Proof of the Total Disability and that it occurred before age 19 must generally be provided to the Plan Administrator before the child attains age 26, and subsequently at the request of the Plan Administrator. However, if a team member becomes eligible for dependent coverage after the child attains 26 (e.g., in the case of a new hire), then the team member has 60 days

from the date of initial eligibility to provide the required information.

- The brother, sister, niece, nephew or grandchild of the team member or the team member's current spouse who was enrolled in the Plan prior to July 1, 2010 will cease to be considered a dependent on the last day of the month during which he or she attains age 23.
- Notwithstanding the above, a child also includes a child for whom the team member is obligated to provide health care under a qualified medical child support order, as defined by applicable state and federal law.

Note: Generally health coverage under the Plan can be provided on a tax-free basis to spouses and dependent children who are under age 26, such as a natural child, legally adopted child, child placed with the team member for adoption, or step-child. However, tax-free health coverage can only be provided to a domestic partner, domestic partner's child, child over whom the team member has a legal guardianship, child (other than a natural, adopted or step child) who the team member is related to by blood or marriage, or disabled child over age 26 where the individual is the team member's tax dependent under IRS rules. Specifically, the domestic partner or child must be the team member's "qualifying child" or "qualifying relative" in order for health coverage to be tax-free. A qualifying child includes a foster child, sibling, niece, nephew or grandchild who lives with the team member until December 31 of the year he or she attains 18 (or age 23 if a full-time student). A qualifying relative is a relative or member of the team member's household who relies on the team member for the majority of his or her financial support. If the team member enrolls an individual in the Plan who does not qualify under these rules, the individual's coverage will be taxable to the team member and the value of the coverage will be added to the team member's compensation for tax reporting and tax withholding purposes.

Court or State-Initiated Qualified Medical Child Support Orders ("QMCSOs")

If a team member who is eligible for Company-provided dependent health coverage is required to provide medical care to a child pursuant to a qualified medical child support order ("QMCSO") initiated by a court or state administrative agency (as opposed to an individual under a state domestic relations law), the following rules apply:

- The Plan Administrator will permit the child to be enrolled in the Plan without regard to any enrollment season restrictions. Participation will begin on the date specified in the Plan Administrator's QMCSO procedures. Participants can obtain, without charge, a copy of the procedures from the Plan Administrator.
- If the team member-parent is enrolled but fails to make application to obtain coverage for the child, the Plan Administrator will enroll the child in the default benefit option(s) under the Plan Administrator's QMCSO procedures upon application by the Friend of the Court or by the child's other parent through the Friend of the Court.
- The Plan Administrator will not eliminate the child's coverage unless required contributions have not been paid as required by the Plan, the team member is no longer eligible for Company-provided dependent health coverage, or the Plan

Administrator is provided satisfactory written evidence that either the order is no longer in effect or that the child is or will be enrolled in comparable health coverage through another health plan that will not take effect later than the effective date of the termination of the child's Plan coverage.

- The team member must pay any required contributions for the child's coverage in the same amount as if the team member elected dependent coverage for the child under the Plan. If the team member is not eligible or fails to elect to make the necessary pay reduction contributions for the child's coverage on a before-tax basis under the Meijer Pre-Tax Premium Plan, the Company may withhold the required contributions from the team member's paycheck on an after-tax basis.
- If the team member is not the custodial parent, the Plan will provide whatever information is needed to the custodial parent for the child to obtain benefits.
- If the team member is not the custodial parent, the Plan will permit the custodial parent to submit claims on behalf of the child without the approval of the team member.
- If the team member is not the custodial parent, the Plan may make benefit payments to the custodial parent or the state administrative agency initiating the QMCSO, in addition to any other parties to which payment may be made as provided under the Plan.

Obligation to Notify

If at any time a dependent ceases to be eligible for enrollment as described above, the team member must notify the Plan Administrator in writing within 30 days of the date of ineligibility. If the 30-day period has passed, the team member will still be obligated to notify the Plan Administrator of any changes that have caused an enrolled dependent to lose eligibility. If the 30-day period has passed, any premiums paid for coverage after the date of ineligibility may not be refunded.

Social Security Number

In order for an otherwise eligible team member, spouse, domestic partner or child to be eligible for and enroll in the Plan, the person must have a Social Security Number and the Social Security Number must be disclosed to the Meijer Rewards Service Center as part of the enrollment process. In the case of a newborn, immediate enrollment is permitted provided a Social Security Number is promptly applied for and reported to the Meijer Rewards Service Center upon receipt. If a team member has any family members from a foreign country who are unable to obtain a Social Security Number, please contact the Meijer Rewards Service Center.

When Does a Team Member Begin to Participate?

A team member who satisfies the Plan's eligibility and participation requirements will become a Participant in the Plan provided:

- **Request to Enroll** A team member who is eligible to participate as of his or her date of hire will have his or her enrollment effective as of the date of hire provided

the team member makes an election online within the date of hire plus 29 days. For a team member who is eligible to participate in medical coverage on the first day of the month on or after 60 days of Service, the team member's enrollment will be effective as of his or her initial enrollment effective date provided the team member makes an election on or before that date. For team members initially eligible for dental and vision benefits on the first day of a Plan Year, the election must be made during the annual open enrollment period process. Elections generally must be made online or can be made by phone by contacting the Meijer Rewards Service Center.

- **Actively at Work** The team member must be actively at work with the Company on the date he/she is eligible to become a Participant. However, this actively at work requirement will not apply to a team member who is absent from work due to a physical or mental health condition.

If a team member is not actively at work on the date on which the team member would otherwise become a Participant, the team member will become a Participant on the first day of the month following the month the team member is actively at work.

If a team member who meets the Plan's eligibility and participation requirements fails to submit an enrollment request (generally made online or can be made by phone by contacting the Meijer Rewards Service Center) within the applicable time periods described in this section, or as required in the appropriate Appendix, after the team member initially becomes eligible to participate in the Plan, the team member may enroll in the Plan only during a subsequent Open Enrollment Period. However, enrollment may occur earlier in the event of a Special Enrollment Period or in the event of a Change in Status.

When Does a Dependent Begin to Participate?

A dependent who becomes eligible to participate in the Plan will become a Participant in the Plan on the later of the following dates:

- **Team Member Participation** The date the team member becomes a Participant in the Plan, provided the dependent is included in the enrollment request submitted by the team member; or
- **Subsequent Eligibility** The subsequent date on which the dependent first becomes eligible to participate in the Plan (e.g., is born to or acquired by the team member), provided the team member submits a request to enroll the dependent within 30 days after the dependent first becomes eligible to participate in the Plan. Contact the Meijer Rewards Service Center for instructions.

If paternity is established subsequent to the date of a child's birth, the child will be treated as becoming initially eligible as of the date paternity is established and the team member may submit a request to immediately enroll the child provided it is made within 30 days of the date paternity is established. In this situation the child may be enrolled as of the first day of the month following the request date.

If a dependent is not included on a team member's enrollment request or the team member doesn't contact the Plan Administrator within 30 days after the dependent first becomes eligible to participate in the Plan requesting enrollment, the dependent may be enrolled only during a

subsequent Open Enrollment Period. However, enrollment may occur earlier in the event of a Special Enrollment Period or in the event of a Change in Status.

As part of the enrollment process, both for dependents enrolling with the team member and dependents who subsequently become eligible, the team member must provide verification of the dependent's eligibility. Verification must be provided during the 60-day period following the initial eligibility date. If timely verification is not provided, the dependent child's coverage shall be terminated. If a dependent child's coverage is terminated, the team member shall be provided with a 30-day grace period to submit the verification information. If timely provided, coverage may be reinstated as of the first of the month following the date when the verification is furnished.

Open Enrollment Period

Team members may be required to satisfy different eligibility and participation requirements for different options under the Plan. Eligible team members have the following election options for themselves and their eligible dependents: medical and prescription drug benefits under the Plan, dental benefits under the Plan, and/or vision benefits under the Plan. Any benefit options elected during an annual Open Enrollment Period become effective as of the first day of the following Plan Year, provided the team member is actively at work on the first day of the following Plan Year. (Being off work due to vacation, an FMLA leave or during a period described in the "Company-Provided Extensions of Coverage" section below is considered being actively at work for this purpose.) The election will remain in effect for that entire Plan Year (except in the event of a Special Enrollment Period or in the event of a Change in Status).

If a team member is enrolled in a health benefit option during the current Plan Year and fails to timely make an election regarding health coverage for the next Plan Year, the team member's current election shall be automatically renewed and the team member will be considered to have agreed to the appropriate contribution for the next Plan Year for the health coverage. If the health benefit option the team member is currently enrolled in is not being offered in the next Plan Year or the team member is not eligible for that health benefit option for the next Plan Year, and the team member fails to timely make an election, the team member will be deemed to have waived health coverage for the next Plan Year.

Special Enrollment Period

If application for participation is not made within 30 days after an individual meets the eligibility requirements, the individual must wait until the next Open Enrollment Period to become a Participant unless the individual has special enrollment rights to enroll during a Special Enrollment Period. An individual has special enrollment rights to enroll during a Special Enrollment Period in the following circumstances:

- Where the individual (i.e., team member and/or dependent—spouse, domestic partner, child) declined coverage when initially eligible or during a subsequent Open Enrollment Period because the individual had other coverage under another group health plan or health insurance coverage, and the other coverage is lost for one of the following reasons:
 - Where the other coverage is COBRA continuation coverage and it has been exhausted;

- Where the other coverage is involuntarily lost due to the individual's eligibility (i.e., as a result of termination of employment, reduction in hours of employment, or Change in Status);
- Where the other coverage is lost because employer contributions for the coverage have been terminated;
- Where the other coverage was an HMO and the individual no longer lives or works in the service area of the HMO (whether or not within the choice of the individual);
- Where coverage is lost because the other plan no longer offers any benefits to a class of similarly-situated individuals (e.g., part-time employees); or
- Where a benefit package option is terminated unless the individual is provided a current right to enroll in alternative health coverage.

An individual who loses other coverage due to the non-payment of the required contribution or for cause (e.g., filing fraudulent claims) will not have special enrollment rights to enroll during a Special Enrollment Period. An individual who voluntarily terminates other coverage (except during an open enrollment period) will not be considered to have special enrollment rights.

- Where the team member has a new dependent by marriage, birth, adoption or placement for adoption. In this situation, special enrollment rights are available to the team member, the team member's spouse, and any child who becomes a dependent due to the marriage, birth, adoption, or placement for adoption. Establishment of a domestic partner relationship is not marriage for this purpose.
- Where the individual's coverage under Medicaid or a State Children's Health Insurance Program ("CHIP") is terminated as a result of a loss of eligibility or where the individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under this Plan.

Enrollment must be requested for an individual with special enrollment rights during a Special Enrollment Period, which is during the first 30 days after the loss of other coverage or marriage, birth, adoption or placement for adoption (whichever is applicable). Further, in the case of the loss of Medicaid or CHIP eligibility or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, the Special Enrollment Period continues until 60 days after the loss or gain of eligibility.

If the team member is already enrolled, a new dependent may be enrolled by contacting the Meijer Rewards Service Center within the applicable deadline. Where the team member is not already enrolled, the team member must complete the required enrollment process with the Meijer Rewards Service Center within the applicable deadline. Provided enrollment is requested and the necessary application is provided to the Plan Administrator within 30 days of the loss of other coverage, enrollment will be effective at the time prescribed by federal tax laws which shall be the first day of the first month after the Meijer Rewards Service Center receives the enrollment request. Provided enrollment is requested and the necessary application is provided to the Plan Administrator within 30 days of the marriage, enrollment will be effective at the time prescribed by federal tax laws which shall be the first day of the first month after the Meijer Rewards Service

Center receives the enrollment request. Provided enrollment is requested and the necessary application is provided to the Plan Administrator within 30 days of the birth, adoption, or placement for adoption, enrollment will be effective at the time prescribed by federal tax laws which shall be as of the date of the birth, adoption or placement for adoption (for all eligible individuals enrolling as a result of the new dependent). Provided enrollment is requested and the necessary application is provided to the Plan Administrator within 60 days of the loss of Medicaid or CHIP eligibility or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, enrollment will be effective at the time prescribed by federal tax laws which shall be the first day of the first month after the Meijer Rewards Service Center receives the enrollment request.

If you experience a special enrollment rights situation or a change in status (see the Flexible Spending Account Program below) and request to add or drop dependents from your group health coverage midyear, you may also request to change the health option(s) you are enrolled in at that time.

If you become ineligible for a premium tax credit to reduce your cost of coverage on the exchange or if you lose health coverage on the exchange due to failure to timely pay your required contributions, neither of these circumstances is a special enrollment rights situation. In other words, neither of these circumstances will cause you to be eligible to enroll in the Plan mid-Plan Year.

Change in Status

A change in status is an exception to the rule prohibiting any change during a Plan Year in your health benefit election. A change in status is limited to situations where your status has changed and this change affects the health benefit election you made earlier.

The following events are changes in status:

- An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation and annulment. A termination of domestic partnership will be considered a change in status for this purpose;
- An event that changes the number of your dependents, including birth, adoption, placement for adoption and death of your dependent;
- An event affecting the employment status of you or your spouse, domestic partner or dependent, including a termination or a commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence (by your spouse or dependent only), a change in work site, and any other change in employment status which affects an individual's eligibility for benefits;
- An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age or any similar circumstance; or
- A change in the place of residence of you or your dependent that affects your previous election.

If you have a change in status, you may change your health benefit election only if the election change is on account of, and corresponds with, the change in status. If the change in status is a transfer from full-time to part-time employment status with the Company, or vice-versa, please see

the “Transfers between Full and Part-Time Employment“ section below. If you seek to decrease or cancel health coverage because you become eligible for coverage under the plan of the employer of your spouse or dependent due to a legal marital or employment status change, the change will only be permitted if coverage is actually obtained. If you have a change in status which causes your number of dependents to increase or decrease, you may change the health benefit option(s) in which you are enrolled, in addition to adjusting the number of your enrolled dependents. Notwithstanding the above, a dependent who is your domestic partner or domestic partner’s child may not enroll in health benefits mid-year. Rather, a domestic partner or domestic partner’s child may only be enrolled upon your initial eligibility or during an Open Enrollment Period.

If you have a change in status, you may request an election change via the Meijer Rewards Service Center within 30 days after the change in status occurs. The election will be effective at the time prescribed by the Plan Administrator which shall generally be the first day of the first month after the Meijer Rewards Service Center receives the request. However, in the case of a change in status due to birth, adoption or placement for adoption the election change will be effective as of the date of the birth, adoption or placement for adoption. Further, for changes in status other than due to birth, adoption or placement for adoption, you must be actively at work on the day as of which the change is to take effect. Being off work due to a vacation, an FMLA leave or during a period described in the “Company-Provided Extensions of Coverage” section below is considered being actively at work for this purpose. If you do not submit a new election request within 30 days after the change in status, you must wait until the next Open Enrollment Period to change your election.

Changes to Coordinate with Health Care Reform

Under Health Care Reform, you may become eligible for Company-provided group health coverage for a period of time and not lose eligibility even if you have a change in employment status where your hours of service will be reasonably expected to be reduced to an average of less than 30 hours of service per week. If this occurs, you can elect to cancel Company-provided group health coverage even if the reduction in hours does not result in you ceasing to be eligible for the coverage. You may revoke coverage in this situation for yourself and any affected family members provided that you enroll in another plan that provides “minimum essential coverage” (as that term is defined under Health Care Reform) which is effective no later than the first day of the second month following the month that includes the date your Company-provided group health coverage is revoked.

Similarly, if you are eligible to enroll in a “qualified health plan” (as that term is defined under Health Care Reform) through the Health Insurance Marketplace (also known as the exchange) during a special enrollment period or annual open enrollment period, you can elect to cancel Company-provided group health coverage. This election is permitted provided that the revocation corresponds to the intended enrollment of you and your family members, if applicable, in a qualified health plan which is effective no later than the day immediately following the date your Company-provided group health coverage is revoked. You must request revocation effective within 30 days of the date of your enrollment in exchange coverage.

Medicare or Medicaid Coverage

If you or one of your dependents becomes entitled to Medicare or Medicaid coverage (other than Medicaid coverage consisting only of pediatric vaccine benefits), you may elect to cancel or reduce Company-provided group health coverage for that individual. Notice must be provided to the Plan Administrator within 60 days of entitlement in order to cancel Company-provided coverage mid-

year. In addition, if you or one of your dependents loses Medicare or Medicaid eligibility, you may elect to begin or increase Company-provided group health coverage for that individual.

Cost and Coverage Changes

If the cost of coverage under the Company's group health plan changes during the plan year, your compensation reductions may be automatically adjusted. However, if the cost increase is significant, you may either agree to the increase, change your election to another comparable benefit option for which you are eligible, or drop coverage if no other comparable benefit option is available. Also, subject to the special enrollment rights rules of HIPAA, if the cost decrease is significant, you may elect the reduced cost option even if you did not previously elect it for the plan year.

If coverage under the Company's group health plan is significantly curtailed or ceases during the plan year, you may elect to receive coverage under another comparable benefit option. If coverage ceases, you may elect to drop coverage if there is no other comparable benefit option. Further, if the Company offers a new or significantly improved benefit or coverage option, you may prospectively elect the new or significantly improved option.

Finally, if you or your spouse, domestic partner or dependent has a change in coverage under another group health plan where the change is as a result of one of the mid-plan year election circumstances described above or where the change is made during the annual open enrollment period of the other plan, you may make a corresponding election change under this Plan.

Coverage at and after Age 65

If a Participant continues to work for the Company after attaining age 65, the Participant has two choices regarding ongoing health coverage:

- The Participant may continue coverage under the Plan as the Participant's primary health coverage with Medicare secondary; or
- The Participant may choose Medicare as his/her sole health coverage. If the Participant elects Medicare as his/her sole health coverage, the Participant will be ineligible for any coverage under the Plan.

If the Participant does not make any election under this section, the Participant will be deemed to have elected coverage under the Plan as primary coverage with Medicare secondary. If a Participant has a dependent spouse who attains age 65, the same rules apply to the dependent spouse.

When Does Coverage Terminate?

Participation in the Plan will generally terminate at midnight on the earliest of the following dates:

- **Team Member** Midnight of the day on which the following occurs:
 - The team member's employment with the Company is terminated, whether voluntarily or involuntarily. Employment is considered terminated for this purpose on the team member's last day of actual work. For third shift team members this is the last day you clock out for work.

However, if the team member retires from the Company, the team member may continue his or her same health coverage under the Plan through the last day of the month in which the retirement occurred. After the last day of the month, COBRA continuation coverage shall be available.

- The team member ceases to be eligible to participate in the Plan for any reason. The benefits available to a team member for a stability period or plan year may depend on whether the team member is credited with an average of a certain minimum number of average hours per week during a measurement period. However, if a team member was determined to be eligible for a stability period or plan year (based on the team member's credited hours during the immediately preceding measurement period) a reduction in hours will generally not cause the team member's participation to terminate until the end of the applicable stability period or plan year. Notwithstanding this general rule, a reduction in hours may cause the spouse or domestic partner's eligibility to end (see the "Transfers between Full and Part-Time Employment" section);
- The team member voluntarily withdraws from the Plan. Voluntary withdrawal can occur for any reason during an Open Enrollment Period. Voluntary withdrawal can occur at other times if all of the following occur:
 - The team member obtains coverage under another employer group health plan due to a Change in Status; and
 - Within 30 days after the team member obtains coverage under another employer group health plan, the team member submits to the Plan Administrator a written request to withdraw from the Plan and also completes and delivers to the Plan Administrator any other forms, agreements and/or information required by the Plan Administrator;
- Any required contribution for the team member's coverage is not paid within the time requirements of the Plan; or
- The team member's participation is terminated for cause by the Plan Administrator. A termination for cause will include a termination for fraud or misrepresentation in the application for participation or in a claim for benefits.
- **Dependent** The day on which the following occurs:
 - The dependent ceases to be included in the definition of the term "dependent" or becomes ineligible. (If the team member is subsequently determined not to be the parent of an enrolled dependent child, the child shall be considered ineligible as of the date the correct paternity is established. If this occurs, the team member should contact the Meijer Rewards Service Center within 30 days of the notification regarding paternity);

- The team member upon whom he/she is dependent ceases to be a Participant;
- The team member upon whom he/she is dependent ceases to be eligible for dependent coverage under the Plan. In the case of a dependent who is no longer eligible (e.g., due to divorce, termination of domestic partnership, child reaches limiting age, etc.) notification of ineligibility must be made within 30 days. Contact the Meijer Rewards Service Center for instructions.
- Any required contribution for the dependent's coverage is not paid within the time requirements of the Plan; or
- The team member upon whom he/she is dependent voluntarily withdraws him/her from the Plan. Voluntary withdrawal can occur for any reason during an Open Enrollment Period. Voluntary withdrawal can occur at other times if all of the following occur:
 - Coverage is obtained for the dependent under another employer group health plan due to a Change in Status; and
 - Within 30 days after coverage is obtained under another employer group health plan, the team member requests the dependent's withdrawal from the Plan and also completes and delivers to the Plan Administrator any other forms, agreements and/or information required by the Plan Administrator.
- **Plan Termination** Notwithstanding the above, participation in the Plan will end on the date the Plan is terminated.

Expenses incurred after the date an individual terminates participation in the Plan are not eligible for Plan coverage unless an extension of participation applies (see below).

Company-Provided Extensions of Coverage for Team Member

A Participant who is a team member on a layoff or leave of absence whose Plan coverage would otherwise terminate will be permitted to pay normal weekly contributions to continue the same benefits for a period of time as follows:

- **Disability Leave of Absence** If a team member is on a disability leave of absence, the team member must pay his/her normal weekly contribution through the end of the sixth month after the month in which the leave begins.
- **Military Leave of Absence** If a team member is on a military leave, coverage ends on the last day of work. However, such a team member with single coverage may continue coverage by paying his/her normal weekly contribution through the end of the month after the month in which the leave begins. Further, if one or more of the team member's dependents continue coverage, the Company-provided extension continues for six months (rather than one month) after the month in which the leave begins. However, notwithstanding any other provision of the Plan,

this extension shall run concurrently with COBRA continuation coverage and USERRA continuation coverage beginning with the first day the team member is absent from work to perform military service.

- **Other Approved Leave of Absence** If the team member is on any other approved leave of absence, the team member must pay his/her normal weekly contribution through the end of the month after the month in which the leave begins.

If a team member terminates employment during a Company-provided extension, the extension shall immediately end and COBRA continuation coverage shall be available.

The team member's health care election and normal weekly contribution amount will begin the first day of the month following his/her return to work (in the case of a disability leave of absence or other approved leave of absence), or on the day he/she returns to work (in the case of a military leave of absence), provided the team member is actively at work on that date. In addition, if coverage is allowed to lapse while on leave as described above, coverage will be reinstated on the first day of the month following the team member's return to work (in the case of a disability leave of absence or other approved leave of absence), or on the day he/she returns to work (in the case of a military leave of absence), provided he/she is actively at work as of that date. If a team member's leave of absence also constitutes an FMLA leave, any time period during which the team member is allowed to pay the normal weekly contribution pursuant to FMLA will run concurrently with the special cost rules described above. (In other words, any time period during which the team member pays the normal weekly contributions pursuant to FMLA will reduce the time period during which the team member may pay a normal weekly contribution pursuant to this paragraph.)

Company-Provided Extension of Coverage for Family Upon Team Member's Death

If the Company is contributing toward the cost of a team member's Plan health coverage and the team member dies, a Company-provided extension of coverage will be provided to the team member's dependents at no cost until the end of the month following the month of death, or from the last date for which health contributions have been paid (whichever is earlier). However, notwithstanding any other provision in the Plan, this extension shall run concurrently with COBRA continuation coverage.

FMLA Extension of Coverage

A team member on a family or medical leave, as defined by FMLA, may continue the same level of benefits under the Plan for himself/herself and his/her dependents as if the team member had continued in active employment continuously for the duration of the leave. Coverage will be available under this Section until the earlier of the last day of the leave or the maximum period provided under FMLA (which is generally 12 weeks, but is 26 weeks if a team member takes an FMLA leave to care for a qualifying military service member injured in the line of active duty).

The team member must pay any required contributions in accordance with the Company's FMLA policy. If the team member fails to pay any required contributions within the time requirements of the Plan, the team member's participation in the Plan may be suspended after receiving 15 days advance written notice in accordance with FMLA, subject to the right of immediate reinstatement of participation upon return to work from the FMLA family or medical leave.

If a team member takes an FMLA family or medical leave and does not return to active employment with the Company at the end of the FMLA family or medical leave, the team member will

experience a Qualifying Event for purposes of COBRA on the last day of the FMLA family or medical leave.

If the Participant fails to return to work from the FMLA family or medical leave for any reason other than the continuation, recurrence, or onset of a “serious health condition” as defined by FMLA or another circumstance considered by the Plan Administrator as beyond the control of the team member, the Company may recover any Company contribution paid to maintain coverage for the Participant during the leave.

Other provisions regarding an FMLA family or medical leave are set forth in FMLA, the accompanying regulations and the Company’s FMLA policy.

COBRA Continuation Coverage

Generally, after a Participant has exhausted any Company-provided extension of coverage and FMLA extension of coverage to which he/she may be entitled, the Participant may be eligible to elect COBRA continuation coverage. However, if specifically indicated elsewhere in the Plan, in certain instances, a Company-provided extension of coverage may run concurrently with COBRA. Continuation coverage is required under the federal law known as COBRA. COBRA continuation coverage allows the team member and/or his/her dependents (including a child for whom the team member is required to provide health insurance coverage pursuant to a QMCSO) an opportunity to temporarily extend health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end. The team member may also have continuation coverage rights with respect to his/her HFSA. (See the Health and Dependent Care Flexible Spending Account Program below.)

The Plan Administrator may delegate some or all of its responsibilities with respect to COBRA to a third-party COBRA administrator. The team member and his or her spouse/domestic partner (if any) will be informed if a COBRA administrator is appointed and which responsibilities the COBRA administrator has assumed, including whether notices required to be provided to the Plan Administrator should be sent to the COBRA administrator.

Eligibility

The team member and/or his/her dependents who are eligible to purchase continuation coverage are “Qualified Beneficiaries.” If a child is born to or adopted by or placed for adoption with the team member during a period of COBRA continuation coverage, the newborn or newly-adopted child will also be a Qualified Beneficiary. However, the newborn or newly-adopted child’s maximum continuation period will be measured from the date of the initial Qualifying Event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle a Qualified Beneficiary to continuation coverage are “Qualifying Events.” The Qualifying Events occur when health coverage is lost, even if the Company pays the cost of continuation coverage for a certain period of time. The Qualifying Events, the Qualified Beneficiaries, and the maximum continuation period are described in the following chart:

<u>Qualifying Event</u>	<u>Qualified Beneficiary</u>	<u>Continuation Period (Months)</u>
Reduced hours ¹ or termination of employment ²	Team member and Dependents	18
Team member's death	Dependents	36
Team member's entitlement to Medicare	Dependents not entitled to Medicare	36
Dependent child becomes ineligible for coverage ³	Ineligible Dependent	36
Team member's divorce/legal separation or termination of domestic partnership ⁴	Dependents	36

Extension of Continuation Coverage

If the team member and/or his/her dependents become entitled to continuation coverage as a result of the team member's termination of employment or reduction in hours, the 18-month continuation period may be extended for the team member and/or his/her dependents in the three circumstances described below ("Extension Events").

Second Qualifying Event

If a second Qualifying Event that is a divorce, legal separation, termination of domestic partnership, the team member's death, or a dependent child's loss of eligibility for health coverage under the Plan occurs during the initial 18-month period (or 29 months, if there is a disability extension), the team member's dependents may be eligible to elect continuation coverage for a period of 36 months, beginning on the date of the team member's termination of employment or reduction in hours. *Notice of this second Qualifying Event must be provided to the Plan Administrator within 60 days of the date of the second Qualifying Event.*

Team Member's Entitlement to Medicare

If the team member becomes entitled to Medicare benefits during the initial 18-month period, his/her dependents may be eligible to elect continuation coverage

¹ A reduction in hours due to a family or medical leave, as defined by the FMLA, will not cause a team member's participation to terminate, to the extent required by the FMLA. Thus, a reduction in hours pursuant to an FMLA leave will not constitute a Qualifying Event. However, if the team member does not return to work at the end of the FMLA leave, a Qualifying Event will occur as of the last day of the FMLA leave.

² Continuation coverage is not available if employment is terminated for gross misconduct.

³ If a team member applied to enroll a dependent but failed to timely provide verification of the dependent's eligibility, the dependent will be deemed to have never been eligible for the Plan and therefore, any loss of coverage will not be a Qualifying Event.

⁴ Elimination of the team member's spouse's or dependent child's health insurance coverage under the Plan in anticipation of a divorce or legal separation or termination of domestic partnership (at open enrollment, for example), is not a Qualifying Event, but

it also does not cause the subsequent divorce or legal separation or termination of domestic partnership to fail to be a Qualifying Event. However, COBRA continuation coverage is not required to be made available between the date coverage under the Plan is eliminated in anticipation of the divorce or legal separation or termination of domestic partnership and the date of the divorce or legal separation or termination of domestic partnership.

for a period of 36 months, if, ignoring the original Qualifying Event, the team member's entitlement to Medicare would have been a Qualifying Event under the Plan. The 36-month continuation period begins on the date of the team member's termination of employment or reduction in hours. *Notice of the team member's entitlement to Medicare in this situation must be provided to the Plan Administrator within 60 days of the date on which the team member became entitled to Medicare.*

A special rule applies if the team member became entitled to Medicare before his/her termination of employment or reduction in hours. In that situation, the maximum continuation period for the team member's dependents may be extended, and may end on the later of: 36 months after the date of the team member's Medicare entitlement or 18 months (or 29 months, if there is a disability extension) after the date of the team member's termination of employment or reduction in hours. *Notice of the team member's entitlement to Medicare in this situation must be provided to the Plan Administrator within 60 days of the team member's termination of employment or reduction in hours.*

Social Security Disability Determination

If it is determined that the team member or one of his/her dependents is entitled to Social Security disability benefits either before the team member's termination of employment or reduction in hours or within 60 days after the team member's termination of employment or reduction in hours, the disabled individual and the Qualified Beneficiaries who are his/her dependents will be entitled to an additional 11 months of continuation coverage (29 months total). *Notice of the Social Security disability determination must be provided to the Plan Administrator within 60 days of the date of the disability determination (or within 60 days of the team member's termination of employment or reduction in hours, if later) and before the end of the 18-month continuation period.*

If there is a final determination that the disabled Qualified Beneficiary is no longer disabled, the disabled Qualified Beneficiary *must notify the Plan Administrator of that determination within 30 days of the date of the final determination.* In this event, continuation coverage for the additional 11-month period will terminate as of the first day of the month beginning more than 30 days after the date of the final determination or on the date continuation coverage would otherwise terminate, if earlier (see the Termination subsection below).

Plan Administrator's Notice Obligations

The Plan Administrator will provide the team member and his/her spouse (if any) with certain information regarding their rights under COBRA in the following situations:

Notice of Eligibility to Elect COBRA

The Plan Administrator will generally notify Qualified Beneficiaries of their eligibility for continuation coverage within 44 days of a Qualifying Event.

However, a special rule applies where the Qualified Beneficiary is required to provide the Plan Administrator with notice of a Qualifying Event in order to trigger

the Qualified Beneficiary's eligibility for continuation coverage (see the Qualified Beneficiary's Notice Obligations subsection below). In that situation, the Plan Administrator will notify the Qualified Beneficiary of his/her eligibility for continuation coverage within 14 days of receiving notice of the Qualifying Event, but only if the notice of the Qualifying Event was timely submitted in accordance with the requirements described in the Notice Procedures subsection.

Notice of Unavailability of Continuation Coverage

The Plan Administrator will provide a notice of the unavailability of continuation coverage in the following situations:

- Where the Plan Administrator determines that continuation coverage is not available after receiving notice of a potential initial Qualifying Event that is a divorce, legal separation, termination of domestic partnership or a dependent child's loss of eligibility for health coverage under the Plan.
- Where the Plan Administrator determines that an extension of the continuation coverage period is not available after receiving notice of a potential Extension Event (i.e., a second Qualifying Event, the team member's entitlement to Medicare, or a Social Security disability determination).

The determination that continuation coverage or an extension of continuation coverage is not available could be made because the Plan Administrator determines that no Qualifying Event or Extension Event occurred, or because the notice of the Qualifying Event or Extension Event was defective. A notice will be defective if it is not provided within the applicable time limit or is not provided in accordance with the requirements of the Notice Procedures subsection.

The Plan Administrator will provide the notice of unavailability of continuation coverage within 14 days of the date the Plan Administrator receives the notice of the potential Qualifying Event or Extension Event, or if later, the deadline for submission of additional information requested by the Plan Administrator to supplement a defective notice. The notice of the unavailability of continuation coverage will be sent to the individual who submitted the notice of the Qualifying Event or Extension Event, and to all individuals for whom continuation coverage or an extension of continuation coverage was being requested.

An individual may appeal the Plan Administrator's determination that continuation coverage or an extension of continuation coverage is not available by following the Appeal of Denial procedures described in the Claims section.

Qualified Beneficiary's Notice Obligations

In some situations, the team member and/or his/her dependents have the obligation to provide notice of a Qualifying Event or Extension Event to the Plan Administrator in order to trigger their eligibility for continuation coverage or an extension of continuation coverage. The team member and/or his/her dependents have this obligation in the following situations:

Notice of Certain Initial Qualifying Events

The team member, one of the team member's dependents, or an individual acting on behalf of the team member and/or the team member's dependents must inform the Plan Administrator of a Qualifying Event that is a divorce, legal separation or termination of domestic partnership, or of a child losing dependent status under the Plan within 60 days after the later of:

- The date of the Qualifying Event; or
- The date the Qualified Beneficiary loses health insurance coverage under the Plan on account of that Qualifying Event.

Notice of an Extension Event

In order to qualify for an extension of the continuation coverage period due to an Extension Event described in the Extension of Continuation Coverage subsection, the team member, one of the team member's dependents, or an individual acting on behalf of the team member and/or the team member's dependent must notify the Plan Administrator of the Extension Event within the time limits that apply to that Extension Event as described in the Extension of Continuation Coverage subsection.

These notices must be provided in accordance with the requirements of the Notice Procedures subsection. If notice is not provided within the applicable time limit or is not provided in accordance with the notice procedures, continuation coverage or an extension of the continuation period will not be available as a result of the Qualifying Event or Extension Event.

Notice Procedures

This subsection describes the procedures a Qualified Beneficiary must follow to notify the Plan Administrator of Qualifying Events and Extension Events.

Notice must be provided to the Plan Administrator electronically or by phone. Once notification is provided, the Plan Administrator reserves the right to require additional information to verify the Qualifying Event or Extension Event, including the following:

- The name and Social Security number of the team member or former team member.
- The name of the individual(s) for whom continuation coverage is being requested (i.e., the Qualified Beneficiary(ies)).
- The current addresses of the individual(s) for whom continuation coverage or an extension of continuation coverage is being requested.
- The date of the Qualifying Event or Extension Event.

- The nature of the Qualifying Event or Extension Event (for example, a divorce).
- If the notice relates to a divorce, a copy of the judgment of divorce.
- If the notice relates to a legal separation, a copy of the judgment of separate maintenance or other relevant court documents establishing the legal separation.
- If the notice relates to a termination of domestic partnership, a termination of domestic partnership form and supporting documentation evidencing the termination.
- If the notice relates to the team member's entitlement to Medicare, a copy of the document(s) establishing the entitlement.
- If the notice relates to a determination that a Qualified Beneficiary is entitled to Social Security disability benefits, a copy of the disability determination.
- If the notice relates to a determination that a Qualified Beneficiary is no longer entitled to Social Security disability benefits, a copy of the determination.

Notice that is not furnished by the applicable deadline and/or does not contain all of the required information is deemed to be defective and may be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential Qualifying Event or Extension Event.

If the Plan Administrator receives notice of a Qualifying Event or Extension Event that is defective because it does not contain all of the required information, the Plan Administrator will request the missing information. If the defective notice was provided by the representative of a Qualified Beneficiary or a potential Qualified Beneficiary, the Plan Administrator will send the request to the representative and each individual who is a Qualified Beneficiary or a potential Qualified Beneficiary. If all of the requested information is not provided, in writing, within 30 days of the date the Plan Administrator requests the additional information, the notice may be rejected. If the notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential Qualifying Event or Extension Event.

The Plan Administrator may also request additional information or documentation that is deemed necessary to determine whether a Qualifying Event or Extension Event has occurred. If the Plan Administrator does not receive the requested information or documentation within 30 days of the date it is requested, continuation coverage or an extension of continuation coverage may not be available.

Qualified Beneficiary's Election of Continuation Coverage

If a Qualified Beneficiary chooses to purchase continuation coverage, the Qualified Beneficiary must notify the Plan Administrator within 60 days after the later of:

- The date the Qualified Beneficiary loses health coverage on account of the Qualifying Event; or
- The date on which the Qualified Beneficiary is sent notice of his/her eligibility for continuation coverage.

Notification is made by timely returning the election form to the Plan Administrator at the address specified in the election notice. If the Qualified Beneficiary does not choose continuation coverage during the 60-day period, his/her participation in the Plan will end as provided in the Termination subsection.

Coverage

If a Qualifying Event occurs, the Qualified Beneficiaries must be offered the opportunity to elect to receive the group health coverage that is provided to similarly-situated non-Qualified Beneficiaries. Generally, this means that if the Qualified Beneficiaries purchase continuation coverage, it will be identical to the health coverage provided to them immediately before the Qualifying Event. Each Qualified Beneficiary has the right to make an independent election to receive continuation coverage. The Qualified Beneficiary may elect to purchase the following alternative coverages:

- All the core health coverages that he/she had before the Qualifying Event. The core health coverages are all health coverages provided under the Plan to the team member other than dental and vision coverage.
- If the Participant could elect only dental and/or vision coverage before the Qualifying Event, the Qualified Beneficiary may elect to purchase only dental coverage and/or only vision coverage.

However, each coverage is initially available only if the Qualified Beneficiary was receiving coverage immediately before the Qualifying Event.

Qualified Beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to the Qualified Beneficiary and his/her dependents. Qualified Beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during the annual Open Enrollment Period just as active team members.

Cost

Generally, the Qualified Beneficiary must pay the total cost of continuation coverage. This cost will be up to 102% of the cost of identical coverage for similarly situated Participants. However, for disabled Qualified Beneficiaries and their dependents who elect an additional 11 months of continuation coverage, the cost will be 150% of the cost of the identical coverage for similarly situated Participants for the additional 11-month period (and for any longer continuation period for which the disabled Qualified Beneficiary is eligible, as permitted by law).

The deadlines for timely paying premiums for COBRA coverage are established in the third-party COBRA administrator's procedures. Generally, the initial premium must be

paid within 45 days after the Qualified Beneficiary elects continuation coverage and subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the Qualified Beneficiary initially elects continuation coverage. Payment is considered made on the date on which it is sent to the Plan (i.e., postmark date).

Termination

Generally, continuation coverage terminates at the end of the initial 18- or 36-month continuation period or at the end of any additional 11- or 18-month continuation period for which the Qualified Beneficiary is entitled to elect continuation coverage. However, continuation coverage may end sooner upon the Qualified Beneficiary's voluntary withdrawal or for any of the following reasons:

Coverage Terminated

The Company no longer offers group health coverage to any of its team members.

Unpaid Premium

The premium for continuation coverage is not timely paid, to the extent payment is required.

Medicare

The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B). However, Medicare entitlement will not cause a qualified beneficiary to become ineligible for continued dental and/or vision coverage under the Plan.

Cause

The date on which a Qualified Beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly-situated non-Qualified Beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits).

The Plan Administrator will notify the Qualified Beneficiary if continuation coverage terminates before the end of the initial 18- or 36-month continuation period or before the end of any additional 11- or 18-month continuation period for which the Qualified Beneficiary has elected continuation coverage. The notification will be provided as soon as practicable following the Plan Administrator's determination that continuation coverage will terminate.

COBRA Continuation and Medicare

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the individual enrollment period for Medicare Part A or B, you have an 8-month special enrollment period to enroll in Medicare Part A or B, beginning the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on your current employment status ends.

If you don't enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide to enroll in Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your COBRA continuation coverage. However, if Medicare Part A or B is effective on or before the date of your COBRA election, COBRA continuation coverage may not be terminated because of your enrollment in Medicare Part A or B, even if you enroll in the other part of Medicare after the date of your election of COBRA continuation coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second (secondary payer). Certain COBRA continuation coverage may pay secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

Other Coverage Options

There may be other coverage options for you and your family. Now that key parts of Health Care Reform have taken effect, you will be able to buy coverage through the Health Insurance Marketplace (also known as the exchange). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, visit www.healthcare.gov. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Questions

Team members and/or their dependents should contact the Plan Administrator at the address or telephone number listed in the Other Basic Information About the Plan section if they have questions regarding COBRA. They may also visit the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

Keep Plan Informed of Address Changes

To protect their rights under COBRA, it is important that the team member and his/her dependents keep the Plan Administrator informed of any changes in address. They should also keep a copy, for their records, of any notices they send to the Plan Administrator.

Continuation of Health Coverage upon Military Leave

If you cease to be eligible for health coverage under the Plan due to service in the U.S. military, you and your eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (“USERRA”). You and your dependents may also be entitled to elect to continue your health coverage under COBRA if you cease to be eligible for health coverage due to your military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

Length of USERRA Continuation Coverage

You may elect to continue health coverage under the Plan for yourself and your eligible dependents for the period that is the lesser of:

- 24 months, beginning after the first 30 days you are absent from work to perform military service; or
- The period beginning on the first day you are absent from work to perform military service and ending with the date you fail to return to employment or apply for reemployment as provided under USERRA.

Electing USERRA Continuation Coverage

If you give the Company advance notice of a period of military service that will be 30 days or less, the plan administrator will treat your notice as an election to continue your health coverage during your military service unless you specifically inform the Company, in writing, that you want to cancel your health coverage during your military leave. You will have to pay the required premiums for your health coverage, but you will not have to complete any additional forms to continue your health coverage during your military service.

If you give the Company advance notice of a period of military service that will be 31 days or longer, the plan administrator will provide you with a notice of your right to elect to continue health coverage pursuant to USERRA and a form for you to elect USERRA continuation coverage for yourself and your eligible dependents. You may elect USERRA continuation coverage for yourself and/or any member of your family who is covered under the Plan when your military service begins. Like COBRA, each person has separate election rights to continue coverage.

If you choose USERRA continuation coverage, you must return the USERRA election form to the plan administrator within 60 days of the date it was provided to you. If you do not timely return the election form, USERRA continuation coverage will not be available to you and your eligible dependents.

A special rule applies if you do not give the Company advance notice of your military service. In that case, you and your eligible dependents will not be provided with USERRA continuation coverage during any portion of your military service, but you can elect to reinstate your coverage (and the coverage of your eligible dependents) retroactive to the first day you were absent from work for military service under the following circumstances:

- You are excused from providing advance notice of your military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for you to provide advance notice or the advance notice was precluded by military necessity);
- You affirmatively elect to reinstate the coverage; and
- You pay all unpaid premiums for the retroactive coverage.

Paying for USERRA Continuation Coverage

For the first 30 days of military service, your required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If your period of military service is more than 30 days, beginning on the 31st day of your military service your required contributions will be 102% of the cost of identical coverage for similarly-situated participants.

USERRA continuation coverage will be cancelled if you do not timely pay any required premiums for that coverage. If your USERRA continuation coverage is cancelled for non-payment of premiums it will not be reinstated.

The initial premium must be paid within 45 days after the date you elect USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after you initially elect USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of your USERRA continuation coverage.

If you comply with USERRA upon returning to active employment after military service, you and your eligible dependents will be automatically reenrolled in the Company-provided health coverage you were receiving at the time you went out on military leave. Reenrollment will occur immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Further, reinstatement will occur without any waiting periods. Return from military service will be treated like other qualifying changes in status. As a result, you have up to 30 days following your return to work to submit a request to drop or change your health coverage option.

PLAN FUNDING

Trust Fund

A trust fund has been established into which contributions are made to pay benefits under the Plan. The Plan and the Trust Agreement which established the trust fund are intended to qualify as a Voluntary Employees' Beneficiary Association ("VEBA") within the meaning of Section 501(c)(9) of the Code.

Company Contributions

The Company will contribute to the trust fund the amount required to fund the present value of the benefit payments expected to be made to Participants amortized over a reasonable period of years, and to establish and accumulate such reserves as the Company deems reasonable and necessary under the Plan. The contribution will be actuarially determined and made on a level basis.

Participant Contributions

Participants may be required to contribute to the cost of coverage under the Plan as periodically determined by the Company and communicated to Participants. Participants may be eligible to pay the required contributions on a pre-tax basis under the Meijer Pre-Tax Premium Plan. It should be noted that pre-tax contributions do not count as wages for Social Security benefit purposes. Participant contributions shall be required to elect the medical benefit option connected to the Health Reimbursement Account. However, any Participant contributions made shall be applied exclusively to coverage under the medical benefit option and shall not be used toward funding of the Health Reimbursement Account. (The Health Reimbursement Account shall be funded exclusively by the Company.)

Participant contributions may vary depending on the team member's job classification, length of employment, average hours, benefit options selected and number of enrolled dependents. In addition, the following will affect the Participant's required contributions:

Spouse/Domestic Partner Surcharge

If an enrolled team member is married or has entered into a domestic partnership and his or her spouse or domestic partner is eligible for medical coverage through the employer of the spouse/domestic partner, the spouse/domestic partner may be enrolled in this Plan. However, in such a case, the participating team member may be required to pay a surcharge for the coverage of the spouse/domestic partner. If the spouse/domestic partner loses medical coverage through his or her employer during the year and promptly notifies Meijer, the surcharge will no longer apply on a prospective basis. The surcharge rule does not apply where both the team member and his or her spouse/domestic partner are employed by the Company. If a team member fails to timely make an election regarding medical coverage for the next Plan Year and is defaulted into his or her current election for the next Plan Year and that election includes the team member's spouse/domestic partner, it will be assumed that the spouse/domestic partner is employed and is eligible for medical coverage through his or her employer. As a result, the surcharge will apply. If the defaulted team member later reports that his or her spouse/domestic partner does not have other employer group health coverage available to them, the surcharge will be removed on a prospective basis.

Tobacco Surcharge

For each Plan Year a Participant's contributions for medical coverage will be increased unless the team member (and the team member's spouse/domestic partner, if applicable) certify that he/she/they do/does not currently use tobacco products and pledge(s) not to use tobacco products that Plan Year. For this purpose, "tobacco products" include, but are not limited to, cigarettes, cigars, pipes, chewing tobacco or tobacco pouches, and e-cigarettes and other electronic vaping products. If the certification/pledge is not made during the open enrollment period for that Plan Year, the team member and his or her spouse/domestic

partner can still avoid the surcharge for the entire Plan Year by completing a qualified tobacco cessation program. In the case of a newly-eligible team member during the Plan Year, if the certification/pledge is not made at the time of initial enrollment, the team member and his or her spouse/domestic partner can still avoid the surcharge for the entire portion of the Plan Year during which he or she/they participate by enrolling in a qualified tobacco cessation program within two months of his or her coverage effective date and completing the qualified tobacco cessation program within six months of his or her coverage effective date. Contact Meijer Rewards at 1-866-681-6116 for more information about the qualified tobacco cessation program. Also, any recommendations of your personal physician regarding the qualified tobacco cessation program or a reasonable alternative to it will be accommodated. Otherwise, if during the course of the Plan Year the team member and/or the team member's spouse/domestic partner complete a tobacco cessation program or other reasonable alternative (after the above deadlines), or successfully quits using tobacco products, the tobacco-free surcharge can be avoided prospectively, at that time (the Participant should contact the Plan Administrator for details). If a team member timely fails to make an election regarding medical coverage for the next Plan Year and is defaulted into his or her current election for the next Plan Year, it will be assumed that the team member (and his or her spouse/domestic partner if applicable) uses tobacco products and as a result, will be subject to the tobacco surcharge. If the defaulted team member later reports he/she/they is/are not a tobacco user, the surcharge can be avoided on a prospective basis for the balance of the Plan Year.

Wellness Non-Compliance Surcharge and Wellness Points

Each team member enrolled in medical coverage for a Plan Year shall begin the year based on his or her current participation in the Be Healthy at Meijer wellness program. In other words, if, immediately before the Plan Year begins the team member and his or her spouse/domestic partner (if enrolled) had avoided the wellness non-compliance surcharge (increase in the required participant contribution for medical coverage), the team member will be eligible to continue to avoid the surcharge at the beginning of the Plan Year. In order to continue to avoid the wellness non-compliance surcharge for the Plan Year, the enrolling team member and his or her spouse/domestic partner (if enrolled) must participate in the first component of the wellness program by the applicable deadline. Similarly, a new enrollee will be eligible to avoid the surcharge but in order to continue doing so for the Plan Year, the newly enrolling team member and his or her spouse/domestic partner (if enrolled) must participate in the first component of the wellness program by the applicable deadline. If the team member is not a new enrollee and the team member and/or his or her spouse/domestic partner (if enrolled) were subject to the wellness non-compliance surcharge at the beginning of the Plan Year (i.e., they were non-compliant), the surcharge will be discontinued following the individual(s)' participation in the first component of the wellness program by the applicable deadline. The two components of the wellness program are as follows:

- **Health Screening ("HS")** Under the first component, enrolled team members and their covered spouses/domestic partners must undergo a health screening ("HS") upon initial eligibility and every other year thereafter. The testing for the HS can be conducted at a Meijer pharmacy at no cost to a Participant or can be conducted by your primary care physician. Participants will be notified of the procedures and deadline following enrollment. Even though team members and their covered spouses/domestic partners are only required to complete the HS every

other year, these individuals are eligible for an annual HS from a Meijer pharmacy at no cost. Results of the HS are kept confidential and the results will not be shared with the Company (other than in a summary de-identified form). This is a participation-based wellness requirement with a non-compliance surcharge and if it is completed by the deadline established by the Plan Administrator, the surcharge will be avoided for the current and immediately following Plan Year. The Plan Administrator will inform individuals of the deadline to complete the HS to avoid the non-compliance surcharge.

- **Points Toward Rewards** Under the second component, enrolled team members and their covered spouses/domestic partners may complete various wellness activities and earn points.

The wellness activities include completing the HS (which also qualifies you for a premium discount under the first component of the wellness incentive), having health screening measures of BMI, blood pressure, cholesterol and glucose within the normal range, completing a health assessment and/or online health questionnaire, engaging in tracking activities to monitor your steps, food and sleep, engaging in step challenges, taking advantage of the telemedicine and/or Blue Cross Blue Shield of Michigan transparency health care shopping tool features under the medical plan options, or participating in a health improvement program based on your specific health status (such as the diabetes case management programs administered by Livongo and Virta, or the musculoskeletal management program administered by Hinge Health).

You can redeem your points for mTeam points. Contact Meijer Rewards at 1-866-681-6116. Please note that the mTeam points are taxable. Also, please note that points do not carry over to a later calendar year. You must use your points during the current calendar year. If you do not, the unused points will be forfeited.

For any of the wellness activities such as the step challenge, if it is unreasonably difficult due to a medical condition for a team member or a spouse/domestic partner to complete the activity or it is medically inadvisable for the team member or spouse/domestic partner to do so, the individual should contact Meijer Rewards at 1-866-681-6116 to find an alternative to qualify for the points. Any recommendations of the physician for the team member or the spouse/domestic partner regarding the wellness program or a reasonable alternative to it will be accommodated.

Team members and their spouses/domestic partners (if enrolled) will be provided with additional information concerning the wellness program, including an explanation of their rights under federal law with respect to the wellness program.

MEDICAL AND DENTAL BENEFITS

The Plan provides medical and dental benefits on a self-funded basis. The medical benefit options are administered by Blue Cross Blue Shield of Michigan and the rules concerning the medical benefit options

are set forth in one or more separate health care handbooks or benefit documents. Participants will be provided with a copy of the applicable handbook/document for the medical option in which he or she is enrolled. The handbooks and documents are hereby incorporated into and made part of the Meijer Health Benefits Plan.

The two medical options are Health Select with HRA and Advantages Health with HSA. (Team members in some locations may have the option to select a High Performance Network under either the Health Select with HRA or Advantages Health with HSA medical options. Under the High Performance Network, there are fewer in-network providers, but team members who select the High Performance Network under either medical option will generally be eligible for a lower participant contribution towards the cost of the team member's selected medical option.)

The dental benefit is administered by Delta Dental of Michigan and the rules concerning the dental benefit are set forth in a separate dental care certificate. Participants will be provided with a copy of the certificate. The certificate is hereby incorporated into and made part of the Meijer Health Benefits Plan.

Note: Upon becoming eligible for Medicare (e.g., attaining age 65), individuals must either enroll in Medicare Part D (prescription drug coverage) or creditable coverage under an employer plan. Otherwise, the individual may be required to pay a permanently higher premium upon later enrolling in Medicare Part D. The Meijer-provided medical options are creditable coverage for this purpose.

Note: Benefits for maternity services incurred by a team member's dependent child are excluded, except as otherwise required by Health Care Reform (e.g., coverage for preventive care benefits or when a pregnancy results in an "emergency medical condition"). See the "HEALTH CARE REFORM" section for more information.

Note: The Health Select with HRA medical benefit option includes a Health Reimbursement Account. The Health Reimbursement Account is part of the Plan and details are provided below. Team members who are enrolled in the Advantages Health with HSA medical option may also maintain a Health Savings Account. Unlike the Health Reimbursement Account, the Health Savings Account is not technically considered part of the Plan. However, details concerning the Health Savings Account are included below, for informational purposes.

HEALTH REIMBURSEMENT ACCOUNT

A Health Reimbursement Account (HRA) will be established for each eligible team member who enrolls in the Health Select with HRA medical option. The Health Reimbursement Account is a health reimbursement arrangement as defined in IRS Notice 2002-45 and is intended to reimburse Participants for certain Qualifying Expenses not covered by the Health Select medical option. The terms and conditions of the Health Reimbursement Account are described below.

Eligibility and Participation

Each team member who is eligible for the Health Select with HRA medical option shall also be eligible for a Health Reimbursement Account. Participation will begin on the date the team member enrolls in the option under the Plan. The medical option and the Health Reimbursement Account operate on a Plan Year beginning each January 1 and ending on the following December 31.

Establishing and Crediting of Health Reimbursement Account

Employer will establish a Health Reimbursement Account in each participating team member's name and credit an amount to the Health Reimbursement Account. The amount is a "basic" credit for all enrolled team members.

The amount of the **basic credit** for team members eligible as of the first day of the Plan Year (January 1) is as follows:

<u>Medical Benefit Option</u>	<u>Basic credit for team members enrolled in single coverage</u>	<u>Basic credit for team members enrolled in team member plus one or more dependent(s) coverage</u>
Health Select with HRA	\$150	\$300

The basic credit will be allocated to the team member's Health Reimbursement Account as of January 1.

If a team member enrolls in medical coverage after the first day of the Plan Year, the Health Reimbursement Account basic credit will be prorated and will equal $\frac{1}{12}$ of the annual credit multiplied by the months during the year in which the team member is a Participant. For example, if a single team member enrolls in Health Select medical coverage on April 15, the team member will be a Participant during nine months of the Plan Year so the Health Reimbursement Account basic credit as of April 15 will equal $\frac{9}{12}$ of \$150 (\$112.50).

The Health Reimbursement Account will consist solely of the Employer basic and wellness credits. By law, individual Participants may not make contributions to their Health Reimbursement Account.

Mid-Year Changes in Participation/Effect on Personal Health Bank Credit

If a team member has a drop or increase in the number of his or her dependents during a Plan Year, it will have the following effect on the team member's Health Reimbursement Account credit:

Drop in the Number of Dependents

If a team member experiences a mid-year change in status which causes a drop in the number of the team member's dependents enrolled in medical coverage, it will have no effect on the team member's Health Reimbursement Account credit for the Plan Year.

Increase in the Number of Dependents

If a team member enrolls in single, team member only coverage and experiences a mid-year change in status which causes the team member to enroll one or more dependents in medical coverage, Employer will credit an additional basic credit amount to the team member's Health Reimbursement Account equal to $\frac{1}{12}$ of the annual basic credit for each month during the plan year the team member has enrolled dependents. For example, if a single team member enrolled in the Health Select medical option adds a dependent on July 12, the team member will have dependent coverage during six months of the Plan

Year, so an additional basic credit of $\frac{6}{12}$ of \$150 (\$75) will be added to the team member's Health Reimbursement Account as of July 12. Any other increases in dependent coverage during the plan year (for example, going from one enrolled dependent to two or more enrolled dependents) will have no effect on the team member's Health Reimbursement Account basic credit.

Reimbursement of Qualifying Expenses

A Participant may obtain reimbursement from the amount credited to the team member's Health Reimbursement Account for Qualifying Expenses.

"Qualifying Expenses" means expenses incurred by a participating team member or one of the participating team member's dependents who is the team member's tax dependent and who is enrolled in medical coverage to satisfy deductibles, coinsurance and copays (including prescription drug copays), as well as uninsured dental and vision expenses. Qualifying Expenses must also satisfy the following requirements:

- The expenses must be incurred while the applicable individual was enrolled in the Health Select medical option and covered by the Health Reimbursement Account; and
- The expenses must not be eligible for payment under the medical option in which the Participant is enrolled nor be paid or reimbursed by any other plan or insurance, or any other source.
- **Note:** If you are also enrolled in the health FSA, you will be issued a single debit card for that benefit and your Health Reimbursement Account. When you use the debit card, the charges will first be deducted from your health FSA. (The reason is that the health FSA has a use-it-or-lose-it forfeiture rule and it is important to exhaust that account before accessing the Health Reimbursement Account which has a rollover feature.) After your health FSA benefit is exhausted, any remaining debit charges will be deducted from your Health Reimbursement Account. If you submit a written claim for benefits with respect to a charge which is eligible for reimbursement from both your Health Reimbursement Account and your health FSA, you may choose on an expense-by-expense basis, to be reimbursed under the health FSA before payment under the Health Reimbursement Account, or vice versa as long as you are not reimbursed from both accounts for the same charge.

The entire amount of Employer's credit to a Participant's Health Reimbursement Account for a Plan Year will be available to the Participant for reimbursement of Qualifying Expenses as of the effective date it is made. In other words, for team members enrolled in medical coverage as of the first day of a Plan Year, the full annual employer basic credit will be entirely available as of January 1 of the Plan Year. If a team member becomes a Participant in medical coverage during the Plan Year, the prorated amount of the Health Reimbursement Account credit will be entirely available as of the effective date the team member enrolls. Similarly, if the team member's employer basic credit is increased during the Plan Year because the team member enrolls in dependent coverage, the increased basic credit will be available as of the date the new dependent(s) is/are enrolled.

Any unused amounts credited to the Participant's Health Reimbursement Account may not be paid to the Participant in cash, as additional compensation, or be reimbursed to the Participant for any

purpose (other than for the reimbursement of qualifying expenses). For each Plan Year, Participants may apply for the reimbursement of Qualifying Expenses to the extent of the Employer's credit for the Plan Year plus any rollover amount of unused credits from prior Plan Years.

Rollovers

At the end of the Plan Year, if a Participant has any unused amounts credited to his or her Health Reimbursement Account, the entire balance will be rolled over for use in the subsequent Plan Year provided the Participant is enrolled in the Health Select medical option for the subsequent Plan Year. Participants can go online to check their rollover amount or can call the Claims Administrator. Please contact Meijer Rewards for details. The rollover amount will not accumulate interest.

Here is an example:

Assume a team member is enrolled in single, team member only coverage under the Health Select medical option in 2023. Such a team member would receive a \$150 annual Employer basic credit for 2023 (assuming he participated during all 12 months of the year). If the Participant incurred and submitted \$50 in Qualifying Expenses during 2023, at the end of the Plan Year, the Participant would have an unused account balance of \$100. The entire \$100 will be rolled over for use in 2024 provided the team member continues to be eligible for and enrolled in the Health Select medical option for 2024. Assume the Employer Health Reimbursement Account basic credit for 2024 is \$150 for team members enrolled in single coverage under the Health Select medical option. As a result, at the beginning of 2024 if the Participant participates in the Health Select medical option for 2024, he will have a \$100 rollover amount plus will receive another \$150 in basic credits (\$250 total).

This rollover provision continues for all subsequent Plan Years in which the team member is enrolled in the Health Select medical option. As a result, it creates a compounding effect in the Health Reimbursement Account so team members may build a balance for the reimbursement of expenses incurred in future years.

Health Reimbursement Account Claim and Appeal Procedures

Employer will reimburse Qualifying Expenses incurred on or after the date the individual becomes a Participant in the Health Reimbursement Account. An enrolled team member will be issued a debit card for use in connection with the Health Reimbursement Account. An enrolled team member may obtain reimbursement either by using the debit card with a provider eligible to accept the debit card at the point of service or alternatively, may submit a claim for reimbursement with the Claims Administrator. For non-debit card reimbursements, checks will be made payable to the Participant. The Plan will not recognize an assignment of Health Reimbursement Account benefits.

If a team member terminates participation on or before the last day of a Plan Year claims for reimbursement must be filed with the Claims Administrator within 90 days after the end of the Plan Year.

Claims for reimbursement of Qualifying Expenses will be treated as post-service claims and will be subject to the claim and appeal procedures provisions, including the time limits, of the Claims section of the Health Benefits Plan. However, the claim and appeal procedure for the Health

Reimbursement Account will be administered by the Company's third-party administrator, as the Claims Administrator, and Employer, as the Plan Administrator, versus any other Claims Administrator identified in the Health Benefits Plan.

Effect of Ineligibility Due to Leave of Absence, Layoff, Reduction in Hours, Etc.

If a team member becomes ineligible for the medical coverage due to a job change, leave of absence, layoff or other status change that affects eligibility, the team member's Health Reimbursement Account will be suspended (following any Company-provided extension of participation). As a result, the team member will not be eligible to be reimbursed from the Health Reimbursement Account for claims incurred on or after the date of medical benefit suspension. However, the Health Reimbursement Account may be reactivated if the team member reenrolls in HRA-eligible medical coverage within 12 months after the date of suspension. If the team member does not reenroll in the HRA-eligible medical coverage within the 12-month period, any amount remaining in the team member's Health Reimbursement Account will be forfeited. The rules in the paragraph also apply in the event a team member becomes ineligible due to a reduction in hours. However, in this latter circumstance ineligibility generally only occurs at the end of a Plan Year (and not during the Plan Year).

Effect of Non-Reenrollment

If, during the annual Open Enrollment Period, a team member does not elect to enroll in HRA-eligible medical coverage for a subsequent Plan Year, his or her Health Reimbursement Account will be suspended and will not be accessible for the reimbursement of claims incurred on or after the last day of the Plan Year in which the team member was last enrolled in HRA-eligible medical coverage. If the team member enrolls in HRA-eligible medical coverage within 12 months, the Health Reimbursement Account will be reactivated. Otherwise, any amount remaining in the Health Reimbursement Account will be forfeited at the end of the 12-month period.

Effect of Termination of Employment and Retirement

Termination of Employment and COBRA

If a team member terminates employment, the team member will only be eligible to be reimbursed for Qualifying Expenses incurred prior to termination. Expenses incurred after termination will be ineligible for reimbursement. Any amounts remaining in the participant's Health Reimbursement Account will be forfeited.

Notwithstanding the above, in the event a team member terminates employment or experiences another COBRA qualifying event, the team member may continue to have access to the Health Reimbursement Account for the payment of Qualifying Expenses by electing COBRA continuation coverage. The Health Reimbursement Account will be considered part of the Health Select medical option in which the individual was enrolled upon termination for purposes of electing COBRA.

Retirement

Notwithstanding the above, if a team member retires under Employer's policies, consistent with the definition of retirement for purposes of its qualified retirement plans (that is, retiring after attaining at least age 55 and completing at least ten years of vested service as defined for Meijer pension purposes), the retiree will have the option to elect COBRA

continuation coverage (see above), or elect to “spend down” his or her Health Reimbursement Account. If the retiree elects the “spend down” approach, the team member will be allowed to spend down any balance in his or her Health Reimbursement Account as of his or her retirement date, subject to the following:

- The definition of Qualifying Expenses will be expanded to allow reimbursement of any expense which constitutes a deductible medical expense under Section 213(d) of the Internal Revenue Code (see IRS Publication 502 for details). Further, expenses may be incurred on behalf of the retired team member as well as any other tax dependent of the team member, even if not previously or currently enrolled in the Employer-provided medical coverage connected to the Health Reimbursement Account.
- Generally, there is no time table to exhaust the Health Reimbursement Account balance. However, once the balance falls below \$250, if the retired team member does not seek reimbursement of expenses to spend the entire balance in the following 12 months, any amounts remaining shall be forfeited.
- No monthly premiums for coverage under the Health Select medical option or the Health Reimbursement Account will be required under the “spend down” approach following retirement. The team member isn’t required to enroll in the Health Select medical option in order to spend down the balance in his or her Health Reimbursement Account.

Health Care Reform

Pursuant to IRS Notices 2013-54 and 2015-87, the Health Reimbursement Account shall be an “integrated” health reimbursement arrangement under the “minimum value required” method. As a result, the market reforms of Health Care Reform shall not apply to the Health Reimbursement Account. Accordingly, the Health Reimbursement shall maintain the following rules:

- Employer shall offer a group health plan to the Participant that provides minimum value pursuant to Section 36B(c)(2)(C)(ii) of the Code;
- The Participant must be enrolled in a group health plan that provides minimum value (the Health Select medical option provides minimum value);
- Only team members who are enrolled in the Health Select medical option may participate in the Health Reimbursement Account;
- The Participant may permanently opt out of and waive future reimbursements once each Plan Year. Similarly, upon termination of employment, the Participant may permanently opt out of and waive future reimbursements; and
- In order for a claim for reimbursement to be a Qualifying Expense, if the claim is for expenses regarding a team member’s dependent, the dependent must be enrolled in Employer medical coverage connected to the Health Reimbursement

Account (i.e., the Health Select medical option), along with the team member (but this requirement doesn't apply for retired team members – see above).

HEALTH SAVINGS ACCOUNT

What is a Health Savings Account?

A health savings account (HSA) is a tax-favored IRA-type of account established for an eligible individual covered under a qualified high deductible health plan. Contributions are fully vested when made and earnings on the account grow tax-free. Distributions from the HSA are tax-free if they are used to pay qualified health care expenses. Unused benefits can be carried forward and used in future years.

Who is an Eligible Individual?

To be an eligible individual who may contribute to an HSA for a month, a person must be enrolled in a qualified high deductible health plan, such as Meijer's Advantages Health with HSA medical option as of the first day of that month. So if you enroll in the Advantages Health with HSA medical option mid-month, you are not an eligible individual until the first day of the following month. In addition, you must satisfy the following additional requirements:

- You cannot be covered by a non-high deductible health plan, such as through your spouse's employer. The Meijer Health flexible spending account (FSA) is a non-high deductible health plan for this purpose. So you will not be an HSA eligible individual if you participate in the Health FSA. However this restriction does not apply to specific injury insurance, accident insurance, short or long-term disability insurance, dental insurance, vision insurance or long-term care insurance.
- You cannot be enrolled in Medicare or be a dependent on another person's tax return.

How Does an HSA Work?

If you are enrolled in the Advantages Health with HSA medical option, you may make an annual pledge to the HSA to fund it. The pledge will be deducted from your pay on a pre-tax basis. Then, each payroll period your pre-tax contribution will be deposited in your HSA account. The money in your account may be used for out-of-pocket expenses before your deductible is met. You can also use the dollars to pay for uninsured health expenses not covered by the Advantages Health with HSA medical option. Amounts not used during the plan year will roll over and may be used in future years.

In Addition to My Pre-Tax Contributions, Does the Company Contribute to My HSA?

The Plan will contribute a "basic" contribution of \$300 for team member only coverage and \$600 for team member plus one or more dependents coverage. This is an annual basic contribution amount and is prorated for team members not participating in the Advantages Health with HSA medical option for the entire year.

The Company basic contribution will be made for actively-working team members enrolled in the Advantages Health with HSA medical option as well as team members enrolled in the Advantages Health with HSA medical option during a Company-provided extension of coverage (e.g., a leave

of absence) or an FMLA extension of coverage, or team members who are enrolled in the Advantages Health medical option pursuant to COBRA (e.g., a team member who has had a reduction in hours). However, no Company contribution will be made for a former team member or other individual (e.g., a dependent) during the time period the individual is enrolled in the Advantages Health medical option pursuant to COBRA.

Is There a Limit on HSA Contributions?

The IRS limits the HSA contributions a team member may make each calendar year. The maximum amount depends on whether you are enrolled in team member only coverage or team member plus one or more dependents coverage. For 2023, the maximum annual contribution to the HSA if you are enrolled in team member only coverage under the Advantages Health with HSA medical option is \$3,850. If you are enrolled in team member plus one or more dependents coverage under the Advantages Health with HSA medical option, the maximum annual HSA contribution is \$7,750 for 2023. For purposes of the maximum, both the team member's contributions and the Plan's contributions on the team member's behalf for the calendar year are considered. These maximums are adjusted each year for changes in the cost of living.

If you will be at least age 55 by December 31, 2023, the maximum annual HSA contribution limit for that calendar year will be increased under a special catch-up rule. For 2023, the additional catch-up contribution amount is \$1,000 regardless of whether you are enrolled in team member only coverage or team member plus one or more dependents coverage. This amount may be adjusted in future years for changes in the cost of living. For example, if you are enrolled in team member only coverage under the Advantages Health with HSA medical option for 2023 and will be at least age 55 by December 31, 2023, the maximum annual HSA contribution (both the sum of your contributions and the Plan's contributions for 2023) will be \$4,850 ($\$3,850 + \$1,000 = \$4,850$).

Is the HSA Similar to the Health FSA?

There are similarities and there are differences. For example, under a health FSA, you may access the account for the full amount of your annual election at the beginning of the year even though contributions have not yet been made to cover the requested reimbursement. With respect to an HSA, reimbursement can only be made to the extent of your actual account balance consisting of contributions and any earnings. On the other hand, there are definite advantages to an HSA over a health FSA. For example, you may change your HSA contribution amount at any time during the plan year on a prospective basis in accordance with the procedures established by the Company. In contrast, by law your contribution to a health FSA may only be changed during the year in the event of a qualifying change in status. Also, any unused amounts from your health FSA are forfeited at year end while unused amounts held in your HSA may be rolled over and used in future years.

Who Administers the HSA?

The Company uses a third party to administer the HSA, which may periodically change. The Company will inform you of the current third party that administers the HSA, as well as any changes to that third-party administrator. In addition, the HSA must be held by a trustee or custodian (such as a bank). You will be informed of which trustee or custodian Employer has selected for the HSA. However, this arrangement will not prohibit you from subsequently transferring your HSA to another qualified trustee or custodian. If you elect to contribute to an HSA, Employer will forward your contributions to the trustee or custodian.

How Can I Access My HSA?

Once you establish an HSA, you will be issued an HSA debit card. Your HSA may then be accessed by either using the debit card or by submitting a written reimbursement request form to the administrator. In certain circumstances the written reimbursement request form must be used.

Amounts in your HSA can be distributed on a tax-free basis to cover your deductibles and other eligible health care expenses of you and your spouse (of the same or opposite gender). However, amounts can only be reimbursed on a tax-free basis to cover deductible and eligible health care expenses of your domestic partner, your children and other dependents where they are your qualifying child or qualifying relative (see the “Health FSA” subsection under the “HEALTH AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PROGRAM” section). In other words, if you have a domestic partner or an older child (for example, age 25) who is covered under the HDHP as a result of the new definition of older dependent child required by Health Care Reform, his or her out-of-pocket expenses will not be eligible to be reimbursed under the HSA on a tax-free basis unless the domestic partner or child is otherwise your tax dependent (i.e., qualifying child or qualifying relative).

You can also request a distribution for other purposes. For expenses other than eligible health care expenses, the amount distributed is taxable income and is also subject to a 20% penalty tax. But in certain circumstances the 20% penalty tax may be waived (such as for individuals who are disabled or at least age 65).

What if I Change Jobs?

HSAs are permanent and portable. You can take your HSA with you to your next job. You can continue to grow the dollars in your account through investment or use the monies for eligible health care expenses. However, in order to actively continue to contribute to an HSA, you must be covered under a qualified high deductible health plan either through your new employer or an individual policy. HSAs can be rolled over in to a similar HSA at a different bank or investment provider.

What Happens to the HSA after I Turn 65?

After you reach age 65, your HSA can be used to pay eligible health care expenses and certain insurance premiums like Medicare Parts A and B. Monies cannot be used to purchase a Medigap policy. Distributions for eligible health care expenses are tax-free. Distributions for other expenses are taxable.

SURGERY CARE BENEFIT

Team members, spouses, domestic partners, and dependent children who are enrolled in one of the medical options (either the Health Select with HRA or the Advantages Health with HSA) are eligible for a surgery care benefit administered by Transcarent. (The Surgery Care Benefit is in addition to the surgery benefits provided under the medical options administered by Blue Cross Blue Shield of Michigan). The Surgery Care Benefit includes the following benefits:

- Pre-operation surgeon appointment.
- Travel, meals, and incidental benefits for the Participant and a travel companion.

- Facility, anesthesia, surgeon, and surgical staff.
- Inpatient services.
- Post-operation surgeon appointment.

If you need a non-emergency or a pre-planned surgery, you should contact Transcarent. If you are eligible for the Surgery Care Benefit, your coinsurance requirement will be waived if you are enrolled in the Advantages Health with HSA medical option (but the deductible will still apply), and your deductible and coinsurance requirement will be waived if you are enrolled in the Health Select with HRA medical option. If you are not eligible for the Surgery Care Benefit (e.g., your surgery is not covered), you will be referred back to Blue Cross Blue Shield of Michigan.

CANCER SUPPORT PROGRAM

Team members, spouses, domestic partners, and dependent children who are enrolled in one of the medical options (either the Health Select with HRA or the Advantages Health with HSA) are eligible for a Cancer Support Program administered by AccessHope. The Cancer Support Program includes the following benefits:

- A Cancer Support Team. You will have access to a team, including compassionate oncology nurses, that will provide you with information, empowerment, and support.
- Expert Advisory Review. Experts are available to review all cancer diagnoses, and provide the most effective path forward in collaboration with your local oncologist.
- Ongoing Expert Collaboration with Your Local Physician.

You do not need to sign up for the Cancer Support Program. AccessHope will work with Blue Cross Blue Shield of Michigan to identify Participants who are eligible for the Cancer Support Program.

DIABETES CASE MANAGEMENT

Team members, spouses, domestic partners, and dependent children who are enrolled in one of the medical options (either the Health Select with HRA or the Advantages Health with HSA) who have been diagnosed with diabetes are eligible for a diabetes case management program administered by either Livongo or Virta. These case management programs provide advice, counseling, and other services and supplies to help individuals effectively manage diabetes, and in some cases a prediabetes or diabetes reversal.

HEALTH CARE REFORM

The medical and prescription drug benefits under the Plan have been amended to comply, and will continue to comply, with the patient protections of the Patient Protection and Affordable Care Act (PPACA), and the Health Care and Education Reconciliation Act (HCERA), and the Consolidated Appropriations Act, 2021 (CAA). Collectively, the PPACA, HCERA, and CAA are known as Health Care Reform. The required changes include the following:

- Dependent children must be eligible to participate in the medical and prescription drug benefits under the Plan until at least the child's 26th birthday. However, the Company

voluntarily extends coverage under these benefits until the end of the month of the child's 26th birthday. Further, the dental and vision benefits are "excepted benefits" that are not subject to Health Care Reform. But the Company voluntarily extends coverage under the dental and vision benefits until the end of the month of the child's 26th birthday.

- Lifetime limits on the dollar value of essential health benefits under the Plan no longer apply.
- No annual limits on the dollar value of essential health benefits under the Plan apply.
- Coverage may not be retroactively rescinded except as permitted by law, for example, in cases of fraud, intentional misrepresentation or failure to timely pay required premiums for coverage (including required COBRA premiums). Thirty days advance notice may be required before coverage may be retroactively terminated.
- Pre-existing condition limitations or exclusions no longer apply.
- Certain medical options under the Plan may require or allow a Participant to designate a primary care physician (PCP). Participants have the right to designate any PCP, including a pediatrician, who participates in the network for the medical option in which the Participant is enrolled and who is available to accept the Participant. If the medical option in which the Participant is enrolled designates a PCP automatically, this designation will apply until you change the designation.
- Participants do not need prior authorization from the Plan or from any person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the network for the medical option in which the Participant is enrolled and who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including: obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology in the various medical options, contact the Plan Administrator or Blue Cross Blue Shield of Michigan.
- This Plan is not a grandfathered plan under the PPACA or HCERA. Accordingly, the following patient protections under the PPACA or HCERA apply:
 - The Plan must provide certain preventive care items and services without required Participant cost-sharing.
 - The out-of-pocket limits for medical and prescription drug benefits are subject to annual maximums.
 - Certain routine patient costs associated with clinical trials are covered.
 - Participant must be afforded additional rights with respect to internal appeals under the Plan and must be provided with the opportunity to undergo an external review procedure.

- The Plan complies with the applicable nondiscrimination requirements of Section 1557 of Health Care Reform.
- The following patient protections apply with respect to emergency services:
 - The Plan must cover emergency services without requiring you to get approval for emergency services in advance (prior authorization).
 - The Plan must cover emergency services by out-of-network providers.
 - The Plan must base what you owe the provider or facility (your cost-sharing) on the amount that you would pay an in-network provider or facility, and show that amount on your explanation of benefits.
 - The Plan must count any amount you pay for emergency services toward your in-network deductible and in-network out-of-pocket limit.
 - The out-of-network provider or facility is not permitted to “balance bill” you for emergency services (see the “NO SURPRISES ACT” section for more information).

“Emergency services” generally means: (1) an appropriate medical screening that is within the capabilities of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate an “emergency medical condition;” and (2) further medical examination and treatment that is within the capabilities of the staff and facilities available at the hospital or independent freestanding emergency department, as applicable, to stabilize you (regardless of the department of the hospital in which such further examination or treatment is furnished).

An “emergency medical condition” generally means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to: (1) place the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) result in serious impairment to bodily functions; or (3) result in serious dysfunction of any bodily organ or part.

- If you receive non-emergency services at an in-network hospital or ambulatory surgery center and you are treated by an out-of-network provider, the following patient protections apply (unless you waive these protections):
 - Your cost-sharing requirement for items or services provided by the out-of-network provider may not be greater than the cost-sharing requirement that would apply if the items or services were provided by an in-network provider. Additionally, the Plan generally must base the cost-sharing amount on the lesser of: (1) the amount billed by the out-of-network provider; and (2) the median of the Plan’s (or the claim administrator’s)

contracted rates with in-network providers for the items or services in the same geographic region.

- The Plan must count any amount you pay for the items or services provided by the out-of-network provider toward your in-network deductible and in-network out-of-pocket limit.
- The out-of-network provider is not permitted to “balance bill” you for these items or services, unless you waive these patient protections (see the “NO SURPRISES ACT” section for more information).

NOTE: Providers of ancillary services are not permitted to ask you to waive these patient protections. Ancillary services currently include the following: (1) emergency medicine, anesthesiology, pathology, radiology, or neonatology (whether provided by a physician or non-physician practitioner); (2) assistant surgeons, hospitalists, and intensivists; (3) diagnostic services (including radiology and laboratory services); and (4) items and services provided by an out-of-network provider when there is no in-network provider available to furnish the items or services.

- If you receive air ambulance services (either by airplane or helicopter) from an out-of-network air ambulance provider, the following patient protections apply:
 - Your cost-sharing requirement for items or services provided by the out-of-network air ambulance provider may not be greater than the cost-sharing requirement that would apply if the items or services were provided by an in-network air ambulance provider. Additionally, the Plan generally must base the cost-sharing amount on the lesser of: (1) the amount billed by the out-of-network air ambulance provider; and (2) the median of the Plan’s (or the claim administrator’s) contracted rates with in-network air ambulance providers for the items or services in the same geographic region.
 - The Plan must count any amount you pay for the items or services provided by the out-of-network air ambulance provider toward your in-network deductible and in-network out-of-pocket limit.
 - The out-of-network air ambulance provider is not permitted to “balance bill” you for its services (see the “NO SURPRISES ACT” section for more information).
- If you are a “continuing care patient,” you will receive a notice from the Plan that you may elect “transitional care” if an in-network provider or facility that is providing you care leaves the Plan’s network for reasons other than the provider’s or facility’s failure to meet applicable quality standards, or for fraud. If you timely notify the Plan (through the claim administrator) of your need for “transitional care,” charges from the provider or facility that moved out-of-network will continue to be paid on an in-network basis, and will be subject to the same terms and conditions that apply in-network for a period of 90 days or, if shorter, the date

that you are no longer a “continuing care patient.” This 90-day period begins on the date that you receive the notice from the Plan regarding the transitional care.

You are a “continuing care patient” if you: (1) are undergoing a course of treatment for a “serious and complex” condition; (2) are undergoing a course of institutional care or inpatient care; (3) are scheduled to undergo non-elective surgery, including receipt of postoperative care with respect to the non-elective surgery; (4) are pregnant and undergoing a course of treatment for the pregnancy; or (5) were determined to be “terminally ill” and are receiving treatment for the terminal illness.

- If you receive items or services from an out-of-network provider or at an out-of-network facility on the belief that the provider or facility was in-network after consulting the Plan’s (or claim administrator’s) provider directory (which includes a telephone or electronic, web-based, or internet-based response protocol), the following patient protections apply:
 - The Plan is required to limit your cost-sharing to an amount that is no greater than the cost-sharing that would apply under the Plan if the items or services were provided by an in-network provider or at an in-network facility.
 - The Plan must count any amount you pay for the items or services provided by the out-of-network provider or at an out-of-network facility toward your in-network deductible and in-network out-of-pocket limit.

For more information concerning Health Care Reform or any of these required changes, please contact the Plan Administrator.

NO SURPRISES ACT

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn’t be charged more than the Plan’s copayments, coinsurance, and/or deductible.

What is “Balance Billing” (Sometimes Called “Surprise Billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in the Plan’s network.

“Out-of-network” means providers and facilities that haven’t signed a contract with the Plan (through the Plan’s claim administrator) to provide services. Out-of-network providers may be allowed to bill you for the difference between what the Plan pays and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward the Plan’s deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are Protected from Balance Billing for the Following Services:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is the Plan’s in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can’t** be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is the Plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balanced billed.

If you get other types of services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get out-of-network care. You can choose a provider or facility in the Plan’s network.

When Balance Billing Isn’t Allowed

When balance billing isn’t allowed, you also have these protections:

- You’re only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). The Plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, the Plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as “**prior authorization**”).
 - Cover emergency services by out-of-network providers.

- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the Department of Health and **Human** Services at <https://www.cms.gov/nosurprises/consumers> or 1-800-985-3059. The Department of Health and Human Services will route your complaint to the Department of Labor's Employee Benefits Security Administration.

Visit dol.gov/agencies/ebsa for more information about your rights under federal law.

PRESCRIPTION DRUG BENEFIT

THIS SECTION ONLY APPLIES IF A PARTICIPANT IS ENROLLED IN ONE OF THE MEIJER SELF-FUNDED MEDICAL OPTIONS MADE AVAILABLE BY THE COMPANY.

General Rules

Eligible Participants will receive the Prescription Drug Benefit as provided in this Article. Generally, the Plan pays a portion of the cost of Prescription Drugs, as defined below. However, the payment of Prescription Drug benefits is subject to certain limitations and exclusions.

Except with respect to the Advantages Health Plan (with an HSA) the Prescription Drug Benefit is a separate benefit from the medical benefit. As a result, expenses covered by the Prescription Drug Benefit are generally not considered or integrated with the medical benefit for purposes of applying the applicable deductible or out-of-pocket maximum under the medical benefit (except with respect to the Advantages Health Plan (with an HSA) – see Special Rules Regarding the Advantages Health Plan below).

Eligible Expenses

A Participant will be eligible for the Prescription Drug Benefit if all the following requirements are satisfied in respect to a prescription:

- The prescription is ordered in writing by a Physician (except in the case of certain vaccinations under the Pharmacy Vaccination Program);
- The prescription is intended to treat the Participant's injury or illness, or to prevent illness;
- The prescription is recognized as being appropriate treatment of the Participant's illness or injury; and
- The prescription is for a Prescription Drug, as defined below.

Amount of Benefits

Prescription Copayment Amount	Advantages Health (with HSA)⁵	Health Select with HRA
Preventive and contraceptive drugs and devices as required by Health Care Reform (including smoking cessation drugs and drugs for women at increased risk for breast cancer)	No charge	No charge
Other Generic – 30 day supply	\$5	\$5
Generic – 90 day supply	\$10	\$10
Brand Name Formulary	25% copay, subject to a \$35 minimum (30 day fill) or \$70 minimum (90 day fill) and a \$125 maximum (30 day fill) or \$300 maximum (90 day fill)	
Brand Name Non-Formulary	50% copay, subject to a \$60 minimum (30 day fill) or \$125 (90 day fill) and no maximum	
Value Based Design Generic – 30 day supply	\$2	\$2
Value Based Design Generic – 90 day supply	\$2	\$3.50
Value Based Design Brand Name Formulary	12.5%, subject to a \$15 minimum and a \$30 maximum	
Maximum Annual Benefit	None	None
Maximum Out-of-Pocket	Combined with medical benefit	\$1,600 single, \$3,200 coverage with one or more dependents

If the prescription qualifies as an Eligible Expense, the Plan will pay the cost of the Prescription Drug, after the Participant pays the applicable copayment amount (see above). There is a special copayment rule if the Participant requests a brand-name Prescription Drug be dispensed when an equivalent generic Prescription Drug is available. In this case, the Participant must pay the difference in cost between the brand-name Prescription Drug ordered and the generic equivalent Prescription Drug, in addition to the generic Prescription Drug copayment amount. This special copayment rule applies in all cases—even if the Physician’s order specifies a brand-name Prescription Drug (i.e., is dispense as written or “DAW”).

However, “lifestyle drugs” including infertility Prescription Drugs, weight loss Prescription Drugs, and Prescription Drugs to treat sexual dysfunction, such as Viagra, are subject to a higher 50% copayment (rather than the lower copayment described above).

⁵ All prescription drug expenses (other than preventive and contraceptive) are first subject to the deductible under the medical benefit.

Value Based Design Benefit

The Prescription Drug Benefit offers a value based design benefit. The value based design benefit provides a reduced prescription copayment amount for medications to treat certain medical conditions. The goal of the value based design benefit is to encourage Participants to take the medications necessary to properly treat their medical conditions. Specifically, the Prescription Drug claims administrator has established a list of eligible Prescription Drugs to treat diabetes and cardiovascular disease. (Please note that all of these drugs are considered preventive for purposes of the Advantages Health with HSA medical option as discussed below.) If you are a Participant in one of the medical plans with a value based design benefit and you seek to fill a generic or brand-name formulary Prescription Drug which is on the list, you will be eligible for the reduced prescription copayment amount described above. However, in order to qualify for this program, you will need to participate in the Plan's wellness program and maintain eligibility at the time the Prescription Drug order is processed.

Special Rules Regarding the Advantages Health with HSA

In order for you to be eligible to make HSA contributions, the Advantages Health with HSA medical option must satisfy certain legal requirements. One of those requirements is that your Prescription Drug coverage must be integrated with the Advantages Health with HSA medical option and be subject to the deductible under the Advantages Health with HSA medical option before the Plan may pay Prescription Drug Benefits. Once you have satisfied the deductible, your Prescription Drug Benefit will be reactivated and coverage will be provided for Prescription Drugs in accordance with the Prescription Drug copayment amount schedule described above.

However, preventive drugs are not subject to this deductible integration rule and are provided after paying the Prescription Drug copayment amount described above. As a result, the Prescription Drug copayment amount for preventive drugs does not count towards satisfying the deductible under the Advantages Health with HSA medical option. Regarding preventive drugs, in addition to the preventive and contraceptive drugs and contraceptive devices required to be covered on a first dollar basis by Health Care Reform, the Prescription Drug claims administrator has developed a list of Prescription Drugs which are considered to be preventive within IRS guidelines for the Advantages Health with HSA medical option. You can obtain a current list from the Prescription Drug claims administrator.

Also, certain other expenses such as generic/brand ancillary charges, unapproved Prescription Drug charges and non-covered Prescription Drug charges are not considered in satisfying the deductible under the Advantages Health with HSA medical option.

Both your Prescription Drug expenses applied toward the deductible and your Prescription Drug copayment amounts (for preventive drugs and post-deductible generic, brand name formulary, brand name non-formulary and lifestyle drugs) are included in reaching your out-of-pocket maximum limit under the Advantages Health with HSA medical option. The Plan's payment of a Participant's Prescription Drug expenses after a Participant has paid the Prescription Drug copayment amount for preventive drugs and post-deductible generic, brand name formulary, brand name non-formulary and lifestyle drugs will be considered in applying the Plan Year and lifetime maximum benefits under the Advantages Health with HSA medical option.

Quantity

The Plan will pay for a 30-day supply, unless the drug is a maintenance drug. The Plan will pay for a 90-day supply of a maintenance drug. For purposes of this provision, “maintenance drug” means a drug which is considered a maintenance drug under a list which is maintained by the prescription drug claims administrator, pursuant to industry standards. Some Prescription Drugs have special dispensing limitations.

Drug Quantity Management Program

For certain medications, such as drugs that come in several strengths, Participants can receive an amount to last a certain number of days. This provides Participants with the right amount to take the daily dose considered to be safe and effective according to the recommendations of the U.S. Food and Drug Administration and/or the prescription drug manufacturer. The prescription drug claims administrator maintains a list of prescription drugs that are included in the drug quantity management program.

Prior Authorization

If a Participant is prescribed a certain medicine, it may require prior authorization. Typically, prior authorization must be renewed annually. The purpose of the prior authorization program is to ensure that Participants are receiving a cost effective drug that is well suited to treat the Participant’s health condition. In this program, the Participant’s physician is consulted. The prescription drug claims administrator maintains a list of prescriptions drugs requiring prior authorization.

Step Therapy

This program is designed for Participants who take medications regularly to treat an ongoing medical condition such as arthritis, asthma or blood pressure. In step therapy, the covered drugs a Participant takes are organized in a series of “steps,” with the Participant’s physician approving in writing the prescriptions. The program usually starts with generic drugs as the first step. The first step allows the Participant to begin or continue treatment with a safe and effective Prescription Drug that is also the most affordable. If needed, more expensive brand name drugs are usually covered in the second step.

Specialty Drugs

Specialty drugs are injectable and non-injectable medications that have one or more of the following characteristics: frequent dosing adjustments, intensive patient training, intensive clinical monitoring, limited product availability, specialized product handling or administrative requirements, and a significantly higher cost than other medications (usually in excess of \$500 for a 30-day supply). A component has been added to the step therapy program described above applicable to certain specialty drugs. In addition, the Plan is establishing Meijer Pharmacy and Accredo as the preferred pharmacy network for the dispensing of specialty drugs. When specialty drugs are obtained at a Meijer pharmacy or through Accredo the drug will be subject to the brand-name formulary co-pay. However, when specialty drugs are obtained outside of this preferred network, the brand name non-formulary co-pay will apply.

SaveonSP

Participants may participate in the SaveonSP program. The SaveonSP program is designed to help Participants save money on certain special drugs. The program utilizes the copay assistance funding available from prescription drug manufacturers to lower the cost of certain specialty drugs for Participants. Specialty drugs that are part of the SaveonSP program will be offered free of charge to the Participant. In other words, the SaveonSP program will pay the prescription copayment amount on the Participant's behalf. The prescription copayment amount paid by the program's copay assistance will not apply toward the Participant's deductible or maximum out-of-pocket amount under the Plan. If a Participant chooses not to participate in the SaveonSP program with respect to an eligible specialty drug, the Plan's full prescription copayment amount will apply. To obtain a list of the current specialty drugs under the SaveonSP program, please call 1-800-683-1074.

Voluntary Therapeutic Equivalent Outreach Program

This is a voluntary program designed for Participants to enable them to qualify for a temporary lower copay or no copay. This program is available where a Participant is using a brand name prescription drug and there may be a less costly brand name or generic prescription drug which is a therapeutic equivalent. If the Participant, in consultation with the Participant's Physician, considers using the lesser cost brand name or generic prescription drug, a temporary lower copay or no copay may be offered for a trial period.

Pharmacy Vaccination Program

Many diseases are preventable through the use of vaccinations. To help Participants stay healthy, Participants can now receive vaccines administered at the Meijer pharmacy through the Prescription Drug Benefit. Vaccines administered at Meijer pharmacy typically do not require an appointment and are the same effective medications as in a physician's office. Best of all, most of the vaccinations listed below are considered preventive, which means they will be covered in full (no co-pay).

Along with protection from the flu, the Prescription Drug Benefit covers several other vaccines, which are available at many retail pharmacies. The table below lists the vaccines covered by the Prescription Drug Benefit.

Call or visit the Meijer pharmacy or mBenefitsConnect in advance to inquire about vaccine availability, age restrictions, and current vaccination schedules.

Disease State	Group
Seasonal Influenza	Flu
Hepatitis A Virus Hepatitis B Virus	Hepatitis
Pneumococcal	Pneumonia
Zoster (Shingles)	Zoster

Human Papillomavirus	HPV
Measles Mumps Rubella Varicella Haemophilus influenzae Poliomyelitis Rotavirus	Childhood Vaccines: Measles, Mumps, Rubella, Varicella, Poliomyelitis, Rotavirus
Meningococcal	Meningococcal
Rabies, Human Diploid Rabies, PF Chick-EMB Cell	Rabies
Tetanus, Diphtheria, Pertussis Tetanus Booster	Tetanus and Diphtheria
Japanese Encephalitis Typhoid Yellow Fever Smallpox (Vaccinia) vaccine Anthrax	Travel Vaccines and Bioterrorism

NOTE: Every state has specific regulations regarding age restrictions and what vaccines can be administered by a pharmacist. Check with the Meijer pharmacy for further clarification.

Method of Payment

In the states where the Company operates stores, a Participant may use his/her prescription drug card if the Prescription Drug is obtained from one of the Company's pharmacies. If the Prescription Drug is obtained from any other source, the Participant must pay the entire cost and apply to the Plan for reimbursement. However, where the Prescription Drug is obtained from another source, the Plan will only pay what it would have paid, less the applicable prescription copayment amount, if the Prescription Drug had been obtained from one of the Company's pharmacies. There will be an exception to this rule where the Prescription Drug is obtained from another source in an emergency situation or during a time period where the Company stores are closed for business and it is Medically Necessary for the Participant to obtain the Prescription Drug immediately. In this exception situation the claim should be submitted to Meijer Rewards Service Center along with a

note from the Participant's Physician explaining why it was Medically Necessary to obtain the Prescription Drug immediately. The Plan will then consider the submitted charge, less the applicable prescription copayment amount.

If a Participant seeks to obtain a Prescription Drug outside of the states where the Company operates stores (for example, the Participant is traveling), the Participant may use his/her prescription drug card if the Prescription Drug is obtained from a pharmacy in the prescription drug claims administrator's network for the Plan (which shall not include any Wal-Mart or Sam's Club pharmacy). If the Prescription Drug is obtained from any other source, the Participant must pay the entire cost and apply to the Plan for reimbursement. However, where the Prescription Drug is obtained from another source, the Plan will only pay what it would have paid, less the applicable prescription copayment amount, if the Prescription Drug had been obtained from one of the Company's pharmacies.

Definition

For purposes of the Prescription Drug Benefit, "Prescription Drug" means:

- **Prescription Legend Drug** Drugs which under federal law are required to bear the legend "Caution: Federal Law prohibits dispensing without prescription";
- **State Law** Drugs which under applicable state law may only be dispensed upon the prescription of a Physician;
- **Compound** A compound medication which contains at least one ingredient which is a prescription legend drug or a drug requiring a prescription under state law;
- **Insulin** Injectable insulin, including syringes and needles. (The insulin and the syringes or needles are each subject to a separate copayment amount, even if purchased as part of the same prescription.);
- **Diabetic Supplies** Glucometers, test strips and other diabetic supplies;
- **Anti-rejection Drugs** Prescription drugs dispensed and consumed to prevent the rejection of a transplanted organ;
- **AIDS Drugs** Prescription drugs dispensed and consumed as part of the treatment of Acquired Immune Deficiency Syndrome (AIDS);
- **Oral Infertility Drugs** Prescription drugs dispensed by a Pharmacy as part of an infertility treatment program;
- **Injectable Infertility Drugs** Prescription drugs dispensed by a pharmacy as part of an infertility treatment program;
- **Contraceptives**
 - **Oral Medication** Prescription drugs dispensed by a pharmacy for contraceptive and/or therapeutic purposes;

- **Injectables** Prescription drugs dispensed by a pharmacy for contraceptive and/or therapeutic purposes;
- **Devices** Contraceptive devices which are self-inserted or self-administered by the participant for contraceptive purposes (for example, NuvaRing), approved self-placed diaphragms and approved contraceptive devices inserted by a Physician;
- **Breast Cancer Drugs** Drugs such as tamoxifen and raloxifene for certain women at increased risk for breast cancer;
- **Sexual Dysfunction** Drugs to treat sexual dysfunction including, but not limited to, Viagra. However, coverage will be limited to no more than six pills per month;
- **Smoking Cessation Drugs** If a smoking cessation drug for a Participant who is age 18 or older, up to a 180 day supply per 365 day period is provided at no charge as a preventive care drug under Health Care Reform; or
- **Weight Loss Medications** Weight loss medications which are Medically Necessary.

Exclusions

The Plan will not pay for the following drugs or drug-related items:

- **Minimal** A Prescription Drug for which the Reasonable and Available Charge is equal to or less than the Prescription copayment amount.
- **Consumed** Any Prescription Drug which is consumed at the time and place the prescription is filled.
- **Substance** Immunization agents, biological sera, blood, or blood plasma.
- **Investigational** Any drug labeled “Caution: Limited by Federal Law to Investigational Use” or experimental drugs, even though a charge is made.
- **Administration** The administration of drugs or insulin.
- **Quantity** A quantity of a drug in excess of the amount normally prescribed by Physicians. Notwithstanding the previous sentence, the Plan will not pay for quantities beyond the limitations described above.
- **Confinement** Medication taken or administered while the Participant is confined to a Hospital, nursing home, rest home, sanitarium, Skilled Nursing Facility, convalescent hospital, or similar institution which has a facility for dispensing pharmaceuticals on its premises. However, these expenses may be covered by the Medical Expense Benefit.

- **Therapeutic Devices** Any therapeutic device or appliance, including, without limitation, hypodermic needles, syringes, support garments, and other non-medicinal substances. However, this exclusion does not apply to insulin syringes.
- **No Charge** Medication for which no charge is made to the Participant.
- **Refill Limits** A refill in excess of the number specified in the prescription, or any refill dispensed more than one year after the date of the prescription.
- **Not a Prescription Drug** A drug or medication which is not within the Plan's definition of a Prescription Drug, even if dispensed on a written prescription from a Physician.
- **Cosmetic** Drugs for cosmetic purposes.
- **Over-the-Counter Equivalent** A Prescription Drug which is available on an over-the-counter basis provided that the over-the-counter drug is equivalent to the Prescription Drug in terms of strength per dosage.
- **Loss or Theft** Replacement of lost or stolen Prescription Drugs.

THE LIMITATIONS AND EXCLUSIONS LISTED IN THE LIMITATIONS AND EXCLUSIONS SECTION ALSO APPLY TO THE PRESCRIPTION DRUG BENEFIT.

VISION BENEFIT

In-Network/Out-of-Network

The Plan has entered into an agreement with EyeMed Vision Care ("EyeMed") for the Vision Benefit. EyeMed provides access to a network of vision care providers that have agreed to provide services and supplies to Participants at a pre-negotiated rate. The Eligible Expenses under the Vision Benefit depend upon whether the vision care provider is in the network ("in-network") or out of the network ("out-of-network"). If an in-network provider is used, the Participant is responsible for the payment of the Participant's share of expenses described below at the time services or supplies are provided. However, no claim forms are needed in order for the Plan to provide its share of the benefit. On the other hand, if an out-of-network provider is used, the Participant must pay for the entire amount of the services and supplies at the time provided and then submit a claim for reimbursement for any Eligible Expenses.

Eligible Expenses

Subject to the agreement between the Plan Sponsor and the claims administrator for the Vision Benefit, the Plan shall pay the following expenses incurred by a Participant.

Examinations

- **In-Network**
 - The Plan pays 100% of the cost of a comprehensive spectacle eye examination per Participant, including dilation, as necessary.
 - The Plan provides a discount for the cost of a contact lens fitting and two follow-up examinations per Participant, once a comprehensive eye examination has been completed.
 - Standard contact lenses – under the discount the Participant pays up to \$40 of the usual and customary charge for a standard contact lens fitting and follow-up (for spherical clear contact lenses in conventional wear and planned replacement).
 - Premium contact lenses – the Participant is eligible for a 10% discount off of the usual and customary charge for a premium contact lens fitting and follow-up (premium contact lenses are all lens designs, materials and specialty fittings other than standard contact lenses).
- **Out-of-Network**
 - The Plan reimburses the cost of a comprehensive spectacle eye examination per Participant, including dilation, up to a maximum allowance of \$150.
 - The Plan reimburses up to \$150 of the cost of a contact lens fitting and two follow-up visits per Participant, once a comprehensive eye examination has been completed. Note: This \$150 maximum allowance includes both the initial examination and the contact lens fitting and follow-up visits and materials (see below).
- **Benefit Frequency** Examination benefits are available to a Participant once every Plan Year.
- **Contact Lenses (Materials)**
 - **In-Network** In lieu of eyeglass lenses, a Participant is eligible for non-disposable, disposable or Medically Necessary contact lenses obtained through an in-network provider. The Plan pays the following benefits and the Participant is responsible for the balance:
 - **Non-Disposable** The Plan pays up to \$100 of the cost of non-disposable contact lenses per Participant and the Participant is responsible for 85% of the cost above \$100.

- **Disposable** The Plan pays up to \$100 of the cost of disposable contact lenses per Participant and the Participant is responsible for 100% of the balance over \$100.
- **Medically Necessary** The Plan pays 100% of the usual and customary charge for Medically Necessary contact lenses.
- **Out-of-Network** In lieu of eyeglass lenses, a Participant is eligible for reimbursement of 50% of the cost of non-disposable, disposable or Medically Necessary contact lenses obtained through an out-of-network provider, up to a maximum allowance of \$150. The maximum allowance includes all materials as well as the eye exam, contact lens fitting and follow-up visits (see above).
- **Benefit Frequency** Contact lens benefits (or frames and eyeglass lens benefits) are available to a Participant once every Plan Year.
- **Frames**
 - **In-Network** The Plan pays up to \$125 of the cost of frames with the purchase of prescription lenses per Participant and the Participant is responsible for 80% of the cost above \$125.
 - **Out-of-Network** The Plan reimburses 50% of the cost of frames per Participant, up to a maximum allowance of \$150. The maximum allowance includes all materials as well as the eye exam, contact lens fitting and follow-up visits (see above).
 - **Benefit Frequency** Frames benefits are available to a Participant once every Plan Year.
- **Eyeglass Lenses**
 - **In-Network** The Plan pays 100% of the cost of single vision, bifocal or trifocal lenses after a \$20 copay and subject to the following additional costs for lens options:

<u>Additional Options</u>	<u>Additional Participant Cost</u>
Ultraviolet coating	\$15
Tint (solid and gradient)	\$15
Standard scratch resistant	\$15
Standard polycarbonate	\$40
Standard progressives (add-on to bifocals)	\$65
Standard anti-reflective	\$45
Other add-ons	Participant eligible for 20% discount

- **Out-of-Network** The Plan reimburses 50% of the cost single vision lenses, bifocal lenses, or trifocal lenses per Participant, up to a maximum allowance of \$150. The maximum allowance includes all materials as well as the eye exam, contact lens fitting and follow-up visits (see above).
- **Benefit Frequency** Eyeglass lens benefits are available to a Participant once every Plan Year.
- **Laser Vision** The Plan provides a 15% discount or a 5% discount on promotional pricing to Participants for LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, the discount is not available for any pre- and/or post-operative care the Participant elects to obtain from a provider outside of the network. The Participant should contact the claims administrator for the Vision Benefit for more information on obtaining the laser vision discount.
- **Additional Purchases and Out-of-Pocket Discounts** The Plan provides a 20% discount to Participants on any remaining balances for vision expenses at an in-network provider beyond the coverage described above. However, this discount may not be combined with any other discounts or promotional offers and does not apply to an in-network provider's professional service charges, disposable contact lens fees, or laser vision provider service charges. A Participant may also be eligible for an additional discount on eyewear purchases. Once the initial benefits described above have been utilized, Participants are eligible for 40% off the retail price for purchase of a complete pair of eyeglasses and a 15% discount off the retail price for purchase of conventional contact lenses.

Exclusions

The Plan shall not pay for the following vision services and supplies:

- **Duplicative Discounts** Any discounts described above shall not apply for benefits provided by any other group benefit plan.
- **Balance on Allowance** In-network allowances are one-time use benefits and any remaining unused balance cannot be carried forward except for the contact lens allowance which has a declining balance. Out-of-network allowances are provided on a declining balance and will be applied on a combined basis to the examination, fit and follow-up benefit, and the eyeglass lenses/frames or contact lenses benefit.
- **Lost or Broken Materials** are not covered during a Plan Year if the Plan has already paid for eyeglass lenses/frames or contact lenses during the Plan Year.
- **Orthoptic or Vision Training**
- **Subnormal Vision Aids** and any associated supplemental testing.
- **Medical and/or Surgical Treatment** of the eye, eyes, or supporting structures except as described above regarding LASIK and PRK surgery.

- **Work-Related** Corrective eyewear required by an employer as a condition of employment and safety eyewear, unless specifically covered under the Plan.
- **Workers' Compensation** Services provided as a result of any workers' compensation law.
- **Non-Prescription** Plan non-prescription lenses and non-prescription sunglasses, except for the 20% discount described above.
- **Substitute for Bifocals** Two pairs of glasses in lieu of bifocals.
- **Eyeglass or Contact Lenses** Contact lenses are only available in lieu of eyeglass lenses.

VOLUNTARY BENEFITS

The Company also provides fully-insured voluntary critical illness, hospital indemnity and accident benefits to eligible team members. The rules concerning eligibility, benefits, claims and appeals, are determined and administered by the insurer. Team members have the option to elect one or more of the voluntary benefits. Team members must pay the full premium cost. Payment is made on a post-tax payroll deduction basis. The voluntary benefits are subject to ERISA and are included in this Plan for annual Form 5500 filing purposes.

CLAIMS

Claim and Appeal Procedures for Medical and Dental Benefits

The claim and appeal procedures for the self-funded medical benefit(s) administered by Blue Cross Blue Shield of Michigan are set forth in the applicable health care handbooks and benefit documents. The claim and appeal procedures for the self-funded dental benefit administered by Delta Dental of Michigan are set forth in the dental care handbook. Regardless of any provisions to the contrary in the handbooks maintained by Blue Cross Blue Shield of Michigan or Delta Dental of Michigan, any appeal of an adverse benefit determination of a self-funded benefit under the Plan must be submitted within 180 days following the denial of the claim.

Claim and Appeal Procedures for Other Self-Funded Benefits

There are usually no claim forms for Prescription Drugs to submit because Participants receive Prescription Drug Benefits when presenting their card at a Meijer retail pharmacy. However, there are some instances where the Participant may obtain a Prescription Drug from a non-Meijer pharmacy. In states where the Company operates stores, if the Participant obtains the Prescription Drug from a non-Meijer pharmacy, the Participant must pay the entire cost and apply to the Plan for reimbursement. If the Participant seeks to obtain a Prescription Drug outside of the states where the Company operates stores (for example, the Participant is traveling), the Participant may use his/her Prescription Drug card if the Prescription Drug is obtained from a pharmacy in the Prescription Drug claim administrator's network for the Plan (which shall not include any Wal-Mart or Sam's Club pharmacy). If the Prescription Drug is obtained from any other source, the Participant must pay the entire cost and apply to the Plan for reimbursement. In cases where the

Participant must apply to the Plan for reimbursement, an application must be made by furnishing a written claim for benefits to the Prescription Drug claims administrator within one year after the Eligible Expense was incurred. Failure to timely submit a claim will result in the claim being ineligible for payment. However, this time limit will not apply where the reason for the delay was due to the Participant's legal incapacitation.

Similarly, there are usually no claim forms for vision benefits to submit when using an in-network provider because Participants receive vision benefits when presenting their card at the point of service. However, a claim form will be required where the Participant obtains vision care services or supplies from an out-of-network provider. In these circumstances the Participant must pay the entire cost and apply to the Plan for reimbursement. Where the Participant must apply to the Plan for reimbursement an application must be made by furnishing a claim for benefits to the vision benefit claims administrator within one year after the Eligible Expense was incurred. Failure to timely submit a claim will result in the claim being ineligible for payment. However, this time limit will not apply for the reason the delay was due to the Participant's legal incapacitation.

The remaining provisions of the Claims section shall apply to the prescription drug, vision, surgical care, cancer support program, and diabetes case management benefits. It should be noted that all services and supplies eligible under the Plan are considered to be post-service claims.

Initial Decision

The Plan Administrator will notify a claimant of the Plan's benefit determination as follows:

- **Urgent Care Claims** An urgent care claim is a pre-service claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Plan Administrator shall notify the claimant of the Plan's benefit determination regarding an urgent care claim as soon as possible, consistent with the medical exigencies (i.e., urgencies) involved, but not later than 72 hours after the Plan's receipt of the claim unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant within 24 hours after the Plan's receipt of the claim of the information necessary to complete the claim. The claimant shall then be granted 48 hours to provide the information. The Plan Administrator shall notify the claimant of the Plan's benefit determination within 48 hours after the earlier of the Plan's receipt of the information or the end of the period granted the claimant to provide the information.
- **Pre-Service Claims** A pre-service claim is a claim for a benefit which is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining medical care. The Plan Administrator shall notify the claimant of the Plan's benefit determination regarding a pre-service claim within 15 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the

circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of the extension shall describe the required information and the claimant shall be granted 45 days from receipt of the notice within which to provide the information. The Plan Administrator will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan Administrator may issue a denial of the claim within 15 days after the expiration of the 45-day period.

- **Post-Service Claims** A post-service claim is a claim for a benefit which is not a pre-service claim or an urgent care claim. If the Plan Administrator denies a post-service claim, in whole or in part, it shall notify the claimant of the adverse determination within 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall describe the required information and the claimant will be granted 45 days from the receipt of the notice within which to provide the information. The Plan Administrator will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan Administrator may issue a denial of the claim within 15 days after the expiration of the 45-day period.
- **Concurrent Care Claims** If the Plan has approved an ongoing course of treatment to be provided over a period of time or over a number of treatments, any reduction or termination by the Plan of that course of treatment (other than by Plan amendment or termination), shall constitute an adverse benefit determination. The Plan Administrator will provide notice in accordance with the Benefit Determination Notice section below. Notice shall be given at least 30 days before the course of treatment is reduced or terminated in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. Any request to extend a course of treatment for urgent care shall be decided as soon as possible and the Plan Administrator will notify the claimant of its determination within 24 hours, provided the claim is made to the Plan at least 24 hours before the expiration of the prescribed course of treatment for urgent care.

Benefit Determination Notice

The Plan Administrator will provide the claimant with a written or electronic notification of any adverse benefit determination. The notice will set forth the reason or reasons for the adverse determination, contain other information which may be required by law, and describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. The notice will also describe the Plan's review

procedures and related time limits and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

If the adverse benefit determination was based upon an internal rule, guideline, protocol or other similar criterion, a statement will be included that such a rule, guideline, protocol or other similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request. If the adverse benefit determination was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, the notice will contain a statement that such an explanation will be provided free of charge to the claimant upon request.

Appeal of Denial

The claimant may request a review of an adverse benefit determination by submitting a written application to the Plan Administrator within 180 days following the denial of the claim. An adverse benefit determination includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In addition, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under the Plan. The claimant may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted or considered in the initial benefit determination.

In filing the appeal, the claimant will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claimant's claim for benefits. For this purpose, a document, record or other information will be considered relevant if it was relied upon in making the benefit determination, was submitted, considered or generated in the course of making the benefit determination, or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit. In connection with the appeal of an adverse benefit determination, the claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim, as well as any new or additional rationale for the adverse benefit determination. Further, the claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.

The appeal procedure will provide for a review that does not rely on the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor is a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment including a determination with regard to whether a particular treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involving the judgment. The health care professional engaged for purposes of reviewing the appeal will be an individual who is neither an individual who is consulted in connection with the initial adverse benefit determination nor a subordinate of such an individual. The Plan Administrator shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination without regard to whether the advice was relied upon. The Plan shall not base decisions regarding the hiring, compensation, termination or promotion of a claims adjudicator, medical expert or similar individual upon the likelihood that the individual will support the Plan's denial of benefits.

In the case of an appeal of an adverse benefit determination regarding an urgent care claim, a request for an expedited appeal may be made orally or in writing and all necessary information

including the Plan's determination on review may be transmitted between the Plan and the claimant by telephone, facsimile or any other available similarly expeditious method.

Final Decision

The Plan Administrator shall make a decision regarding a request for review as follows:

- **Urgent Care Claims** The Plan Administrator shall notify the claimant of the Plan's determination on review regarding an urgent care claim within 72 hours after the Plan's receipt of the claimant's request for a review of an adverse benefit determination.
- **Pre-Service Claims** There shall be two levels of appeal for pre-service claims. Both levels of appeal will be administered by the third party claims administrator and the third party claims administrator shall be a Plan fiduciary for this purpose. The third party claims administrator shall notify the claimant of the Plan's determination regarding a first level appeal within 15 days after the Plan's receipt of the claimant's request for a review of an adverse benefit determination. The claimant may submit a second level appeal within 45 days of receiving written notice of the Plan's determination regarding the first level appeal. If the claimant submits a second appeal, the third party claims administrator shall notify the claimant of the Plan's determination regarding a second level appeal within 15 days after the Plan's receipt of the claimant's request of a second level review of an adverse benefit determination.
- **Post-Service Claims** There shall be two levels of appeal for post-service claims. Both levels of appeal will be administered by the third party claims administrator and the third party claims administrator shall be a Plan fiduciary for this purpose. The third party claims administrator shall notify the claimant of the Plan's determination regarding a first level appeal within 30 days after the Plan's receipt of the claimant's request for a review of an adverse benefit determination. The claimant may submit a second level appeal within 45 days of receiving written notice of the Plan's determination regarding the first level appeal. If the claimant submits a second appeal, the third party claims administrator shall notify the claimant of the Plan's determination regarding a second level appeal within 30 days after the Plan's receipt of the claimant's request of a second level review of an adverse benefit determination.

The Plan Administrator shall provide a claimant with written or electronic notification of the Plan's determination on review. The notice shall include the same information which must be included in the notification of the initial adverse benefit determination. The decision of the Plan Administrator on appeal shall be final and binding.

For the prescription drug, surgical care, cancer support program, and diabetes management benefits (but not the vision benefit), if the claimant has exhausted the above internal appeal procedure and if the Plan issues an adverse benefit determination under the final internal appeal described above, the claimant may submit a request for an external review. Also, if you believe the Plan has violated the No Surprises Act (see the "NO SURPRISES ACT" section), that potential violation may also be eligible for external review.

External Review – Prescription Drug, Surgical Care, Cancer Support Program, and Diabetes Care Management Benefits

The primary type of external review is a standard external review. A claimant must file a request for a standard external review within four months after the date of receipt of a notice of adverse benefit determination or final internal adverse benefit determination.

Within five business days following the date of receipt of the external review request, the Plan must complete a preliminary review of the request to determine whether:

- The claimant had coverage under the Plan at the time the service or supply was provided;
- Whether the claimant has exhausted the Plan's internal appeal process unless not required to do so as described above; and
- Whether the claimant has provided all information and forms necessary to process the external review.

Within one business day after completing the preliminary review, the Plan will issue a written notification to the claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. In such case, the Plan will allow the claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If the Plan determines that an adverse benefit determination or final internal adverse benefit determination is eligible for external review, the Plan shall assign the external review to an independent review organization ("IRO") that is accredited by URAC or by a similar nationally recognized accrediting organization. The Plan shall take action against bias and to ensure independence. The Plan shall have contracts in place with at least three IROs. External reviews shall be rotated among the IROs. In addition, an IRO shall not be eligible for any financial incentive based on the likelihood that the IRO will support the denial of benefits.

- The assigned IRO will notify the claimant in writing of the request's eligibility and acceptance for external review. In order to be eligible for external review, the adverse benefit determination or final internal adverse benefit determination must involve a medical judgment or rescission of coverage. The IRO shall make this determination when considering the request's eligibility for external review. If accepted, the notice will include a statement that the claimant may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information for the IRO to consider when conducting the external review.
- Within five business days after the date of the assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse

the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

- Upon any receipt of any information submitted by the claimant, the IRO must, within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination. The external review may be terminated as a result of the reconsideration only if the Plan reverses its adverse benefit determination or final internal adverse benefit determination and provides coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO shall terminate the external review upon receipt of the notice from the Plan.
- The IRO will review all the information and documents timely received. In reaching a decision the assigned IRO will review the claim “de novo” (i.e., anew) and will not be bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process. The IRO may also consider additional documents and information in conducting the external review including the claimant’s medical records, the attending health care professional’s recommendation, reports from appropriate health care professionals and other documents submitted by the Plan, claimant or claimant’s treating provider, the terms of the Plan, appropriate practice guidelines (including applicable evidence-based standards), any applicable clinical review criteria developed and used by the Plan, unless inconsistent with the terms of the Plan or applicable law, and the opinion of the IROs clinical reviewer(s).
- The IRO must provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of its final external review decision to the claimant and the Plan.
- The IRO’s decision notice will contain a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date(s) of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial), the date the IRO received the assignment to conduct the external review and date of the IRO decision, references to the evidence or documentation considered in reaching its decision, a discussion of the principal reason(s) for its decision, a statement that the determination is binding except to the extent that other remedies may be available under state or federal law, a statement that judicial review may be available, and current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.
- After a final external review, the IRO must maintain records of all claims and notices associated with the external review for six years. The IRO must make such records available for examination by the claimant, Plan or state or federal oversight

agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of final external review reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment in connection with the claim.

The second type of external review is an expedited external review. The Plan must allow a claimant to make a request for an expedited external review in two situations. First, an expedited external review is available where the claimant has received an adverse benefit determination and it involves a medical condition of the claimant for which the time frame for completing an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited external appeal. Second, an expedited external review is available where the claimant has received a final internal adverse benefit determination and the claimant has a medical condition where the time frame for completing a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged for a facility.

- Immediately upon the receipt of a request for an expedited external review, the Plan must determine whether the request meets the review ability requirements set forth above for a standard external review. The Plan must immediately send a written notice that meet the requirements set forth above for a standard external review to the claimant regarding its eligibility determination.
- Upon a determination that the request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for a standard external review. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents under the same procedures for a standard external review. In reaching a decision, the IRO must review the claim "de novo" (i.e., anew) and is not bound by any decisions or conclusions reached during the Plan's internal claim and appeals process.
- The IRO shall provide notice of its decision in the same manner as a standard external review and shall do so as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

Claim Denials Based on Disabled Status

If a claim for Plan benefits with respect to an adult dependent child is denied because it is determined that the child does not satisfy all of the requirements to be considered Totally Disabled

for purposes of the Plan, the claimant will have certain appeal rights as required by the U.S. Department of Labor regulations issued pursuant to ERISA. In the event a child's claim for Plan benefits is denied for this reason, the claimant that will be furnished with a written description of the additional Plan provisions which apply.

GENERAL BENEFIT PAYMENT RULES

The rules set forth in this section apply to all Plan benefits.

Legal Actions

No legal action may be brought to recover any benefits under the Plan until:

- A claim for benefits has been submitted in accordance with the Plan;
- The Plan Administrator has provided the Participant with a written notice denying the claim, in whole or in part;
- The Participant has exhausted the claim review procedure set forth above; and
- The Participant has exhausted all other appeals and remedies available under the Plan. However, if the Plan fails to strictly adhere to the internal claim and appeal procedures prescribed by Health Care Reform with respect to a denied medical or prescription drug benefit claim, the claimant will be deemed to have exhausted the internal claim and appeal procedures and as a result, may initiate an external review and/or file a legal proceeding. However, this rule shall not apply to minor, de minimis violations.

No legal action may be brought after the expiration of one year after the Plan Administrator has provided the Participant with a written notice denying the final level of Plan appeal concerning a claim and must be brought in the Federal District Court for the Western District of Michigan.

Facility of Payment

Whenever a Participant or provider to whom benefits are directed to be paid will be mentally, physically, or legally incapable of receiving or acknowledging receipt of a payment, the Company will not be under any obligation to have a legal representative appointed or to make payments to a legal representative, if appointed. Payments may be made in any one or more of the following ways, at the Plan Administrator's sole discretion:

- **Direct** Directly to the Participant or provider.
- **Legal Representative** To the legal representative of the Participant or provider, including a custodial parent pursuant to a qualified medical child support order.
- **Relative** To a spouse, child, or other relative, by blood or marriage, of the Participant or provider.
- **Resident** To a person with whom the Participant or provider resides.

- **Benefit** By expending the amount directly for the exclusive benefit of the Participant or provider.

A determination of payment made in good faith will be conclusive on all persons. The Plan Administrator, Claims Administrator and the Company will not be liable to any person as the result of a payment made, and will be fully discharged from all future liability with respect to a payment made pursuant to this Section.

Incorrect Payments

Whenever another plan pays benefits which should have been paid by the Plan, the Plan Administrator may pay the necessary amounts to the entities which are entitled to them. These amounts will be treated as benefits paid by the Plan for purposes of the benefit maximums.

If the Plan pays benefits which should not have been paid under any provision of the Plan, the Plan may recover the excess payments from the Participant, any provider, any persons to whom the payments were made, or any insurance company or other organization, in the Plan Administrator's discretion. Errors in payment will not be considered to give a Participant a Plan benefit to which the Participant is not otherwise entitled.

If another plan provides benefits in the form of services rather than cash, the reasonable cash value of each service rendered will be treated as a benefit paid to the Participant.

No Interest

The Plan shall not be required to pay interest on any claim for Plan benefits regardless of when paid.

No Escheat or Unclaimed Property Laws

If a check for the payment of Plan benefits is not negotiated within one year after the date it is issued, the check shall be dishonored. State escheat and unclaimed property laws will not apply to the ERISA benefits under the Plan which are not insured.

LIMITATIONS AND EXCLUSIONS

Exclusion for Motor Vehicle Injuries for Michigan Residents

For any Participant who is a Michigan resident, benefits are not payable under this Plan for the first \$250,000 in health expenses for Injuries received in an accident involving a motor vehicle. The term "motor vehicle" means an automobile, truck, motor driven trailer, or other vehicle with at least four wheels which is the type of vehicle normally intended for use on paved roads and highways. Motor vehicle does not include a motorcycle or other two-wheel vehicle. Motor vehicle also does not include a snowmobile, motor boat, all-terrain vehicle, or similar type of motor driven vehicle which is not intended for use on paved roads and highways.

For any health expenses in excess of \$250,000 for Injuries received in an accident involving a motor vehicle, this Plan will pay on a secondary basis to any motor vehicle insurance which provides health benefits. The primary plan will pay all benefits due under that plan. Subject to the non-duplication of benefits basis rule (see the first paragraph of the Plans Which Coordinate subsection

of the Coordination of Benefits section below), the secondary plan will pay any benefits in excess of the first \$250,000 in health expenses per accident which would not be paid by the primary plan but which are covered by the secondary plan. This Section applies to Michigan residents only.

However, this rule will not apply to a Participant who is a Michigan resident, who is injured in a motor vehicle accident where no-fault motor vehicle benefits are not legally payable, such as an accident involving a motor vehicle where the accident occurs outside of North America.

Excluded Services and Supplies

The Plan will not pay for the following services and supplies:

- **Physician's Care** Any Illness or Injury unless the Participant is under the care of a Physician, except as otherwise provided in the Plan.
- **Occupational** Services or supplies received as a result of an Injury arising out of, or in the course of, any employment for wage or profit; or services or supplies received as a result of an Injury or Illness covered by any workers' compensation law, occupational disease law, or similar legislation under which the Participant is, or is eligible to be, covered. A Participant will be considered eligible to be covered even if the Participant failed to apply for coverage.
- **Governmental** Services or supplies furnished by or for the United States government or any other government, unless payment is required by law; or services or supplies to the extent provided under any governmental program or law under which the Participant is, or is eligible to be, covered. A Participant will be considered eligible to be covered even if the Participant failed to apply for coverage.
- **Armed Services** or supplies furnished to a Participant while in the armed services.
- **War** Services or supplies received as a result of an act of declared or undeclared war (including resistance to armed aggression) occurring while a Participant. This exclusion will not apply to acts of terrorism and will only apply where the Participant is serving in the military forces of the U.S. or another federal government.
- **Not Medically Necessary** Expenses which are not Medically Necessary or which would not have been made in the absence of insurance, except as otherwise provided in the Plan. Further, an expense will also be considered not Medically Necessary for purposes of the Plan if it is not appropriate treatment for the Participant's condition; exceeds the scope, duration or intensity of care to safely, adequately and appropriately treat the Participant's condition; or redundant when combined with other services being used to treat the Participant's condition.
- **Impregnation** Expenses incurred in connection with actual or attempted impregnation or fertilization by any artificial means involving a Participant, a surrogate donor, or a recipient.

- **Infertility** Any expenses incurred for the treatment of infertility, except as otherwise provided in the Plan.
- **Weight Reduction** Expenses for the reduction of weight by diet control, unless otherwise provided in the Plan.
- **Reasonable and Available Charge** The portion of a charge for a service or supply in excess of the Reasonable and Available Charge.
- **Participation** Expenses incurred while not a Participant, except as otherwise provided in the Plan.
- **Illegal Act** Expenses incurred in connection with an Injury or Illness resulting from, or in connection with, a felony or assault committed by a Participant, or an Injury or Illness which arose while the Participant was confined to a penal or correctional facility due to his/her conviction for a criminal or other public offense.
- **Experimental** Services and supplies, including, but not limited to procedures, drugs, screening and research studies, that are experimental or investigational in nature or for research purposes. A service or supply will be considered experimental or investigational or for research purposes if it is not recognized or approved by the American Medical Association (AMA) or the Food and Drug Administration (FDA) as an accepted medical practice necessary or effective for the diagnosis or treatment of the Participant's condition. Any procedures, surgical or otherwise, which are generally considered to have no medical value will also be considered experimental or investigational.
- **Sales Tax, etc.** Expenses for sales tax and shipping, handling and storage fees.
- **Processing** Charges for completing a claim form or any disability application.
- **Personal** Personal convenience and comfort items.
- **Employer Clinic** Services or supplies provided through a medical clinic or other similar facility maintained by an employer.
- **Experimental - Complications** Charges for the treatment of an Injury, Illness or medical complications caused in whole or in part by participation in an experimental procedure or the taking of experimental drugs.
- **Medical Records** Charges for complying with requests for a Participant's medical records necessary to consider a claim of benefits under the Plan.
- **Sexual Dysfunction or Inadequacy** Except as otherwise specifically provided in the Plan, charges for the treatment of sexual dysfunction or inadequacy, unless Medically Necessary.

ADDITIONAL EXCLUSIONS APPEAR IN THE DESCRIPTIONS OF THE PARTICULAR BENEFITS.

COORDINATION OF BENEFITS

Plans Which Coordinate

If a Participant is also covered under another plan which provides health benefits, one plan will be the primary plan and the other plan will be the secondary plan for purposes of paying benefits. The primary plan will pay all benefits due under that plan. The secondary plan will pay any benefits which would not be paid by the primary plan but which are covered by the secondary plan. The Plan will coordinate benefits with other plans, including any provided by the Company, on a non-duplication of benefits basis. This means that when this Plan is secondary, it will only pay for an Eligible Expense which it would have paid if it had been primary, minus whatever the primary plan paid for the same Eligible Expense.

For purposes of this section, “plan” includes the following:

- **Group Plan** A group health care plan or policy, on an insured or self-insured basis, including a plan or policy through a health maintenance organization, medical care corporation, health care corporation, or hospital service corporation;
- **Employer-Assisted Coverage** A plan or policy for which partial or full employer contributions or deductions from a Participant’s compensation, annuity or retirement benefits are made;
- **Employee Organization Coverage** A labor-management trustee, union welfare, employer organization or employee benefit organization plan or policy;
- **Student Plan** Student coverage sponsored or provided by an educational institution;
- **Governmental Plan** Any state or federal governmental plan or policy, except Medicaid or any other federal plan or policy which, by law, must be disregarded in determining or making benefit payments under the Plan. A Participant will be deemed to be covered under a state or federal government plan or policy if the Participant is eligible to be covered, even if the Participant fails to apply for or enroll in the program;
- **Mandated Plan** Any plan or policy whose coverage is mandated by state or federal law, except workers’ compensation and motor vehicle insurance for Michigan residents; and
- **Motor Vehicle Insurance** Any Plan or policy of motor vehicle insurance for non-Michigan residents, whether on a group or individual basis.

Coordination With Other Health Coverage For Injuries Arising Out of Motor Vehicle Accidents Involving Non-Michigan Residents.

For any Participant who is a non-Michigan resident, if the Participant is covered under motor vehicle insurance which provides health benefits, the motor vehicle insurance will be the primary plan and this Plan will be the secondary plan for purposes of paying benefits. The primary plan will pay all benefits due under that plan. Subject to the non-duplication of benefits basis rule (see

the first paragraph of the Plans Which Coordinate subsection above), the secondary plan will pay any benefits which would not be paid by the primary plan but which are covered by the secondary plan.

This rule will not apply to Michigan residents. For any Participant who is a Michigan resident, benefits are not payable with respect to the first \$250,000 in health expenses per accident involving a car or other motor vehicle and are provided on a secondary basis for any expenses in excess of \$250,000 per accident involving a car or other motor vehicle (see the Limitations and Exclusions section).

Coordination with Other Plans

If a Participant is covered by this Plan and another plan, the following rules determine which plan will be primary and which will be secondary:

- If the other plan does not contain a coordination of benefits provision or states that its coverage is primary, it will be the primary plan and this Plan will be the secondary plan.
- If the other plan contains a coordination of benefits provision, benefits will be payable as follows:
 - Benefits under the Plan which cover the claimant other than as a dependent (e.g., as an employee or retiree) will be determined before the plan which covers the claimant as a dependent.
 - The Plan's coordination of benefits with Medicare is generally set forth in the next section. However, there is a special rule if the claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the claimant as a dependent and primary to the plan covering the claimant other than as a dependent (e.g., as a retiree). In that case, the rule described in the immediately preceding paragraph with respect to the two non-Medicare plans is reversed so that the plan covering the claimant as a dependent is primary and the plan covering the claimant other than as a dependent (e.g., as a retiree) is secondary.
 - Except as provided in the next paragraph, if both plans cover the claimant as a dependent, the plan which covers the employee with the birthday which occurs earliest in the year will be the primary plan. This is known as the birthday rule.
 - Notwithstanding the immediately preceding paragraph, if the claimant is a dependent child and the parents of the claimant are divorced or legally separated or never have married and are not jointly living with the child, the following rules will apply:
 - If a court decree says that one of the parents is responsible for the dependent child's health care expenses or health insurance coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has

no health coverage for the dependent child's health care expenses, but that parent's spouse does, the spouse's plan is primary. This rule applies to plan years commencing after that plan is given notice of the court decree.

- If a court decree states that both parents are responsible for the dependent child's health care expenses or health insurance coverage, the birthday rule will determine the order of benefits.
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health insurance coverage of the dependent child, the birthday rule will determine the order of benefits.
- If there is no court decree allocating responsibility for the child's health care expenses or health insurance coverage, the plan covering the custodial parent will pay first. The plan covering the spouse of the custodial parent will pay second, the plan covering the non-custodial parent will pay third and the plan covering the spouse of the non-custodial parent will pay fourth. For this purpose, the custodial parent is the parent awarded custody of the child by court decree. In the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation will be considered the custodial parent.

For purposes of the above subparagraphs, a parent's "plan" includes any plan under which the parent has coverage either as an employee, a dependent spouse or otherwise. Also, if a dependent child is covered under more than one plan of individuals who are not the child's parents, the provisions of the above sub-paragraphs will determine the order of benefits as if the individuals were the parents of the child.

- Benefits under the plan which covers the claimant as an active employee or a dependent of an active employee will be determined before the benefits under the plan which covers the claimant as an inactive employee (e.g., an employee who is laid off or on a leave of absence or a retired employee) or a dependent of such an employee. This rule does not apply if the rules in the preceding paragraphs can determine the order of benefits.
- If a claimant whose coverage is provided under COBRA is also covered under another plan, the plan covering the claimant as an employee or retiree (or as that claimant's dependent) is primary and the COBRA continuation coverage is secondary. This rule does not apply if the rules in the preceding paragraphs can determine the order of benefits.
- If the preceding rules do not establish a primary plan and a secondary plan, the plan which has covered the claimant for the longest period of time will be the primary plan. To determine the length of time a person has been covered under a plan, two or more plans maintained by the same employer

will be treated as one plan if the claimant was eligible under the successor plan within 24 hours after the prior plan ended.

- These coordination of benefit rules are intended to follow the NAIC group coordination of benefits model regulation. The Plan's coordination of benefit rules will be interpreted accordingly and to the extent the NAIC model regulation is subsequently amended, the Plan's coordination of benefit rules will be amended accordingly.

Medicare

- **General Rule** This subsection describes the coordination of benefit rules when a Participant is covered by this Plan and is eligible for or has enrolled in Medicare. These coordination of benefit rules do not guarantee Plan eligibility. In fact, in certain circumstances (see the COBRA Continuation Coverage section) Medicare enrollment can cause Plan benefits to end. If an individual has Plan coverage and is covered by Medicare or is eligible to be covered by Medicare but has not enrolled, benefits under the Plan are provided secondary to Medicare, unless an exception to this general rule applies, as described below.
- **Exceptions** Notwithstanding the general rule, Medicare will be secondary to the Plan to the extent required by law, such as in the following cases:
 - For an active team member age 65 or older and his/her spouse age 65 or older (unless the Participant declines primary coverage under the Plan);
 - For a Participant with end stage renal disease (permanent kidney failure). However, the Plan will only be primary for the period prescribed by law (which is currently, generally 30 months);
 - For a disabled team member, provided the team member's coverage is based upon "current employment status" with the Company. A disabled team member who is no longer actively working for the Company but who has not yet terminated employment is considered to no longer have current employment status for this purpose after the date the team member's COBRA continuation coverage period ends; or
 - For a disabled family member of a team member if the disabled family member is under age 65, provided the team member's coverage is based upon "current employment status" with the Company (as defined above).

Two or More Family Members Working for the Company

If two or more family members (e.g., both spouses, or a parent and a child) work for the Company and are covered under the Plan as both a team member and a dependent, or as the dependent of two team members, the following rules apply:

- The benefits payable as a result of the person being a team member are paid first.

- Thereafter, subject to the non-duplication of benefits basis rule (see the first paragraph of the Plans Which Coordinate subsection above), the person's benefits as a dependent are coordinated as if they were provided under a different group health plan.
- If a person is a dependent of two team members, the rules described in the Coordination with Other Plans subsection is used to determine which team member's Plan will pay benefits first.
- Notwithstanding any other provision of this subsection, any Plan limits based on quantity (e.g., a 30-day supply, one visit per Plan Year, one cleaning per Plan Year, etc.) will be applied on a per Participant basis regardless of whether an individual has dual coverage under the Plan.

Coordination with HMO

Services which are not covered under an HMO because they were obtained through a non-participating provider or charges that were denied because a proper referral was not obtained will not be coordinated with benefits under the Plan.

Right to Information Regarding Other Plans

The Plan Administrator may obtain information from, or provide information to, any other plan or insurance company regarding the coordination of benefits without the consent of the Participant. The Plan Administrator may also require a Participant to provide information regarding other plans the Participant participates in, or is eligible to participate in, so that the Plan Administrator may implement this section.

<h2>PLAN'S RIGHT TO REIMBURSEMENT AND SUBROGATION RIGHT</h2>

If the Plan pays benefits and another party (other than the Participant or the Plan) is or may be liable for the expenses, the Plan has a right of reimbursement which entitles it to an equitable lien to be reimbursed from the Participant or another party for 100% of the amount of benefits paid by the Plan to the Participant or on the Participant's behalf.

The Plan's 100% reimbursement right applies:

- Not only to any recovery the Participant receives or is entitled to receive from the other party but also to any recovery the Participant receives or is entitled to receive from the other party's insurer or a plan under which the other party has coverage.
- To any recovery from the Participant's own insurance policy, including, but not limited to, coverage under any uninsured or underinsured policy provisions.
- To any recovery, even if the other party is not found to be legally at fault for causing the Participant to become entitled to Plan benefits.

- To any recovery, even if the damages are recovered or recoverable from the other party, its insurer or plan or the Participant's policy are not for the same charges or types of losses and damages as those for which benefits were paid by the Plan.
- To any recovery, regardless whether the recovery fully compensates the Participant for his/her injuries and regardless whether the Participant is made whole by the recovery.
- To the entire amount of the recovery to the extent of the expenses payable by the Plan. The Plan's right to reimbursement from the recovery is in the first priority and is not offset or reduced in any way by the Participant's attorneys fees or costs incurred in obtaining the recovery. The Plan disavows any obligation to pay all or any portion of the Participant's attorneys fees or costs in obtaining the recovery. The "common fund doctrine" and other similar common law doctrines do not reduce or affect the Plan's right to reimbursement.

If the Participant does not bring an action against the other party who caused the need for benefits paid by the Plan within a reasonable period of time after the claim arises, the Plan will have the right to bring an action against the other party to enforce and protect its right to reimbursement. In this circumstance, the Plan will be responsible for its own attorney's fees.

The Participant will do whatever is necessary and will cooperate fully to secure the rights of the Plan. This includes assigning the Participant's rights against any other party to the Plan and executing any other legal documents that may be required by the Plan.

The Plan may withhold payment of benefits when it appears that a party other than the Participant or the Plan may be liable for the expenses until such liability is legally determined. Further, as a pre-condition to paying benefits when it appears that the need for the benefits paid by the Plan was caused by another party, the Plan may withhold the payment of benefits until the Participant signs an agreement furnished by the Plan Administrator setting forth the Plan's right to reimbursement and subrogation right.

All of the following rules are preconditions to participation in the Plan and the receipt of Plan benefits:

- First, the Participant agrees not to raise any make-whole, common fund or other apportionment claim or defense to any action or case involving reimbursement or subrogation in connection with the Plan and acknowledges that the Plan expressly disavows such claims or defenses.
- Second, the Participant agrees not to raise any ERISA jurisdictional or procedural issue which would defeat the Plan's claim to reimbursement or subrogation.
- Third, the Participant specifically acknowledges the Plan's fiduciary right to bring an equitable reimbursement recovery action under Section 502 of ERISA should the Participant obtain or be entitled to obtain a recovery from another party who is or may be liable for the expenses paid by the Plan, and to obtain an equitable lien over any recovery. The equitable lien shall apply over the recovery/property to the extent of the expenses payable by the Plan.
- Fourth, the Participant specifically recognizes that the Plan has the right to intervene in any third party action to enforce its reimbursement rights and the Participant consents to such intervention.

- Fifth, the Participant specifically agrees that the Plan has the right to obtain injunctive relief prohibiting the Participant from accepting or receiving any settlement or other recovery relating to the expenses paid by the Plan until the Plan's right to reimbursement is fully satisfied and the Participant consents to such injunctive relief.

The Participant shall give the Plan Administrator written notice of any claim against another party as soon as the Participant becomes aware that the Participant may recover damages from another party. The Participant will be deemed to be aware that the Participant may recover damages from another party upon the date the Participant retains an attorney in connection with the claim or the date a written notice of the claim is presented to another party or the other party's insurer or attorney by the Participant or the Participant's insurer or attorney, whichever date is earlier. The Participant will not compromise or settle any claim against another party without the prior written consent of the Plan Administrator. If the Participant fails to provide the Plan Administrator with written notice of a claim as required above or if the Participant compromises or settles a claim without prior written consent as required above, the Plan Administrator will deem the Participant to have committed fraud or misrepresentation in a claim for benefits, and accordingly, will terminate the individual's participation in the Plan.

HIPAA PRIVACY AND SECURITY RULES

Permitted and Required Uses and Disclosure of Protected Health Information ("PHI")

The Plan may disclose PHI to Plan Sponsor, provided Plan Sponsor does not use or disclose such PHI except for the following purposes:

- To perform Plan Administrative Functions which Plan Sponsor performs for the Plan.
- Obtaining premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan; or
- Modifying, amending or terminating the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event shall Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

Conditions of Disclosure

Plan Sponsor agrees that with respect to any PHI, it shall:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to Plan Sponsor with respect to PHI.
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor.

- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware.
- Make available to individual Participants who request access, the Plan participant's PHI in accordance with 45 CFR § 164.524.
- Make available to individual Participants who request an amendment, the Participant's PHI and incorporate any amendments to the Participant's PHI in accordance with 45 CFR § 164.526.
- Make available to individual Participants who request an accounting of disclosures of the Participant's PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.
- Make its internal practices, books, and records, relating to the use and disclosures of PHI received from the Plan, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy rules.
- If feasible, return or destroy all PHI received from the Plan that Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.
- Ensure that the adequate separation between Plan and Plan Sponsor, required in 45 CFR § 164.504(f)(2)(iii), is satisfied.
- Plan Sponsor further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, Plan Sponsor shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI and Plan Sponsor shall ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

Certification of Plan Sponsor

The Plan shall disclose PHI to Plan Sponsor only upon the receipt of a Certification by Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that Plan Sponsor agrees to the conditions of disclosure set forth in this Amendment.

Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to Plan Sponsor, provided such Summary Health Information is only used by Plan Sponsor for the purpose of:

- Obtaining premium bids from health plan providers for providing health coverage under the Plan; or
- Modifying, amending or terminating the Plan.

Adequate Separation Between Plan and Plan Sponsor

- The following team members, or classes of team members, shall be given access to PHI:
 - Senior Vice President of Human Resources
 - Corporate Team and Labor Relations Staff
 - Vice President, Total Rewards
 - Director of Benefits
 - Meijer Rewards Service Center Staff
 - Benefits Staff
 - Chief Financial Officer
 - Financial Staff
 - Plan Auditor
 - Senior Vice President of Information Technology and Services
 - Information Technology and Services Staff
 - In-House Legal Counsel
 - In-House Legal Staff
 - Privacy Specialist
 - Field HR Managers, HR Generalists and HR Directors
 - Total Rewards Operations Staff
- The access to and use of PHI by the individuals described above shall be restricted to the Plan Administrative Functions that Plan Sponsor performs for the Plan.
- In the event any of the individuals described above do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.
- To comply with the HIPAA security rule, the Plan Sponsor shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

Disclosure of Certain Enrollment Information to Plan Sponsor

Pursuant to 45 CFR § 164.504(f)(1)(iii), the Plan may disclose to Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from any health insurance issuer or health maintenance organization offered by the Plan.

Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

Plan Sponsor authorizes and directs the Plan, through the Plan Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the HIPAA privacy rules.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the HIPAA privacy rules.

Definitions

For purposes of this Amendment, the following terms shall have the following meanings:

- “Business Associate” means a person or entity who:
 - performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration; data analysis, underwriting, etc.); or
 - provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.
- “Plan Administrative Functions” mean activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan Administrative Functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management. PHI for these purposes may not be used by or between the Plan or Business Associates of the Plan in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Plan Administrative Functions specifically do not include any employment-related functions.
- “Protected Health Information” or “PHI” means information that is created or received by the Plan, or a Business Associate of the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant (whether living or deceased). The following components of a Participant’s information are considered to enable identification:
 - Names;
 - Street address, city, county, precinct, zip code;

- Dates directly related to a Participant's receipt of health care treatment, including birth date, health facility admission and discharge date, and date of death;
- Telephone numbers, fax numbers and electronic mail addresses;
- Social Security numbers;
- Medical record numbers;
- Health plan beneficiary numbers;
- Account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;
- Web Universal Resource Locators (URLs);
- Biometric identifiers, including finger and voice prints;
- Full face photographic images and any comparable images; and
- Any other unique identifying number, characteristic or code.
- "Summary Health Information" means information that may be individually identifiable health information that:
 - Summarizes the claims history, claims expenses or type of claims experienced by individuals for whom Plan Sponsor has provided health benefits under a health plan; and
 - From which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

Fully-Insured Health Benefits Administered Under "Hands Off" Approach

Pursuant to HIPAA, if a group health benefit is fully-insured and only enrollment/disenrollment information and Summary Health Information rather than Protected Health Information is disclosed to Plan Sponsor and Plan Sponsor only uses the Summary Health Information to obtain premium bids and/or to amend/terminate the Plan, then the responsibility to comply with the HIPAA privacy rules generally shifts from the Plan to the insurer. This is known as the "hands off" approach to administration. Any fully-insured health benefits under the Plan which are administered under the hands off approach shall not otherwise be subject to the HIPAA

privacy and security rules set forth in this Article (i.e., simply because they are included in the Plan for Form 5500 filing purposes).

Hybrid Entity

This Section applies to the extent the Plan provides any non-health benefits such as (but not limited to), disability benefits or group term life insurance benefits. The Plan is a separate legal entity whose business activities include functions covered by the HIPAA privacy rules and non-covered functions. As a result, the Plan is a “Hybrid Entity,” as that term is defined in the HIPAA privacy rules. The Plan’s covered functions are its health benefits (“health care component”). All other benefits are non-covered functions. Therefore, the Plan hereby designates that it shall only be a covered entity under the HIPAA privacy rules with respect to the health care component (the health benefits) of the Plan.

Participant Notification

Participants will be notified of this Plan section via the Meijer Health Plan Notice of Privacy Practices (provided at the end of this document).

ADMINISTRATION

Plan Administrator

Meijer, Inc. is the plan administrator. The plan administrator is the designated named fiduciary and is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan. With respect to the self-funded benefits, Meijer, Inc., as the plan administrator, has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the Plan. However, the plan administrator may delegate claims administration for some or all of the self-insured benefits to one or more third party claims administrators. Such a third party claims administrator may be a named fiduciary for all or some purposes (e.g., benefit appeals pursuant to the applicable benefit). However, the fully-insured benefits are provided pursuant to an insurance policy and the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy. The insurers are the exclusive source of payment for the fully-insured benefits.

Responsibilities of Plan Administrator

The Plan Administrator will have responsibility for the general administration of the Plan and will have the following discretionary authority:

- **Plan Benefits** Establish Eligible Expenses and benefits; Deductible and Coinsurance amounts; and maximum benefits payable under the Plan;
- **Construction** Construe and interpret the Plan; decide all questions of eligibility; and determine the amount, manner, and time of payment of benefits;

- **Procedures** Prescribe procedures and forms to be used by Participants, including procedures and forms regarding application for participation, claims and appeals;
- **Disclosure** Make all disclosures to Participants required by law, including a summary of the Plan and a summary of annual reports to the government;
- **Reporting** File all governmental reports required by law, including annual and periodic reports to the Internal Revenue Service and the U. S. Department of Labor;
- **Information** Receive from, and transmit to, the Company, the trustee, the Claims Administrator, and the Participants all information necessary for the proper administration of the Plan;
- **Financial Reports** Receive and retain reports of the financial condition of the Plan and the trust fund from the trustee;
- **Benefit Payments** Authorize benefits which are to be paid from the trust fund pursuant to the provisions of the Plan; and
- **Agents** Appoint individuals or entities to assist in the administration of the Plan and trust fund and other agents it deems advisable, including legal counsel.

Third Party Claims Administrator Appointment

The Plan Administrator may enter into an administration agreement with one or more third party claims administrators, under which the third party claims administrator will be given broad authority by the Plan Administrator to administer benefit payments under the Plan and to render other administrative services on behalf of the Plan. The third party claims administrator will review, interpret, and evaluate all claims for benefits under the Plan. The third party claims administrator will have no power to modify any terms of the Plan, or any benefit provided by the Plan; or to waive or fail to apply any requirements of eligibility for a benefit under the Plan.

To the extent that these administrative responsibilities are assumed by the third party claims administrator under an administration agreement, the Company will have no responsibility for these functions. The Plan Administrator may, from time to time, amend the administration agreement or enter into similar agreements with any other third party claims administrator as the Plan Administrator will in its discretion select.

Standard of Care

The Plan Administrator will administer the Plan solely in the interest of Participants and for the exclusive purposes of providing benefits to the Participants and their beneficiaries and defraying reasonable expenses of administration. The Plan Administrator will administer the Plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with like matters, would use in the conduct of an enterprise of a like character and with like aims.

The Plan Administrator will not be liable for any act or omission relating to its duties under the Plan, unless the act or omission violates the standard of care described in this section. The Plan

Administrator will not be liable for any act or omission of another relating to the Plan, except as provided in Section 405(a) of ERISA.

Indemnification

The Company will indemnify each team member or agent to whom it has delegated responsibilities for the operation and administration of the Plan against any and all claims, losses, damages, expenses, and liabilities arising from any action or failure to act, except when the action or failure to act is judicially determined to be due to the gross negligence or willful misconduct of the person. The Company may choose, at its own expense, to purchase and keep in effect sufficient liability insurance for each person to cover any and all claims, losses, damages, expenses, and liabilities arising from any action or failure to act in connection with the execution of his/her duties as a team member or agent of the Company. However, this indemnification provision shall not apply if the Company and the agent have agreed otherwise in writing.

Interrelationship of Fiduciaries

Each fiduciary may rely upon any direction, information, or action of another fiduciary as being proper and is not required to inquire into the propriety of the direction, information, or action. Each of the fiduciaries will be responsible for the proper exercise of its own responsibilities.

ADOPTING AND SUCCESSOR EMPLOYERS

Adopting Employer

With the approval of Plan Sponsor, any subsidiary or affiliate corporation may adopt the Plan for the benefit of its eligible team members. Adoption will be in the form of a Plan Amendment which will specify the effective date of the adoption.

Successor Employer

If the Company transfers substantially all of its business by sale, merger, consolidation or reorganization, the Plan may be adopted by the successor entity upon acceptance in writing of the terms of the Plan by the successor. The successor will then succeed to all of the power, rights and duties of the Company under the Plan. If the successor to the Plan Sponsor does not adopt the Plan, then the Plan will terminate as provided in the next section.

AMENDMENT AND TERMINATION OF PLAN

Plan Amendment

Plan Sponsor will have the right to amend the Plan in whole or in part at any time.

Restrictions on Plan Amendment

No amendment to the Plan will:

- Retroactively affect Participants' benefits adversely unless necessary to bring the Plan into conformity with applicable laws and governmental regulations; or

- Increase the duties, liabilities, or obligations of the Plan Administrator or the Claims Administrator without the written consent of the affected party.

Plan Termination

Plan Sponsor may terminate the Plan at any time by action of its Executive Committee. In addition, the Plan will terminate upon either of the following events:

- **Liquidation** The liquidation or discontinuance of the business of Plan Sponsor, the adjudication of Plan Sponsor as a bankrupt, or a general assignment by Plan Sponsor to or for the benefit of its creditors; or
- **Merger** The merger or consolidation of Plan Sponsor into another corporation which is the surviving corporation, the consolidation or other reorganization of Plan Sponsor, or the sale of substantially all of its assets, unless the successor or purchasing corporation adopts the Plan within 90 days thereafter.

Benefits Upon Termination

Upon termination, the Plan will pay benefits for Eligible Expenses incurred prior to the termination date.

DEFINITIONS

This section defines various terms which apply to the Plan. If a term is capitalized it is a defined term for purposes of the Plan.

“Appendix” means one of the appendices attached to, and incorporated in, the Plan. A separate Appendix is provided for each group of team members and dependents. The Basic Provisions and applicable Appendix establish the Sub-Plan for that group of team members and dependents. There will be a new Appendix for each Sub-Plan for each Plan Year. However, if there is not a new Appendix for a Sub-Plan for a Plan Year, it means that there will be no changes in the Appendix for that Sub-Plan for that Plan Year and the Appendix for the Sub-Plan for the immediately preceding Plan Year will continue to apply.

“Basic Provisions” are the provisions of the Plan which apply to all Participants. The Basic Provisions are the terms and conditions of the Plan other than the Appendices.

“Change in Status” means one of the following events:

- **Legal Marital Status** An event that changes the team member’s legal marital status, including marriage, death of the team member’s spouse, divorce, legal separation and annulment. A termination of domestic partnership will be considered a change in status for this purpose. However, with respect to the FSAs, this is only the case where the domestic partner was the team member’s tax dependent;
- **Number of Dependents** An event that changes the number of a team member’s dependents, including birth, adoption, placement for adoption and death of a dependent;

- **Employment Status** An event affecting the employment status of the team member or the team member's spouse, domestic partner (but only if the domestic partner is the team member's tax dependent in the case of the FSAs) or dependent, including a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence and any other change in employment status which affects an individual's eligibility for benefits;
- **Ineligible Dependent** An event that causes a team member's dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age or any similar circumstance; or
- **Residence** A change in the place of residence of the team member or the team member's dependent that affects the team member's previous election.

"Claims Administrator" or **"Third Party Claims Administrator"** means the entity or entities, if any, selected to provide administrative services with respect to one or more of the self-funded benefits under the Plan.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Company" means Meijer, Inc., Meijer Stores Limited Partnership, Meijer Great Lakes Limited Partnership and Town Total Health, LLC. It also means any adopting employer or successor employer that adopts the Plan.

"Eligible Expenses" means the expenses which may be used as the basis for a claim under the Plan.

"Enrollment Date" means the effective date of the individual's coverage under the Plan or, if there is a waiting period, the first day of the waiting period (typically, the date employment begins). For this purpose, the Plan includes any current or new self-funded benefit option or any new or successor fully-insured option.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HMO" means a health maintenance organization established pursuant to the federal Health Maintenance Organization Act of 1973, as amended, or any state law authorizing the establishment of health maintenance organizations.

"Medically Necessary" means a treatment, service or supply which satisfies all of the following requirements:

- It must be legal;
- It must be ordered by a Physician;
- It must be safe and effective in treating the diagnosed Illness or Injury;

- It must be commonly and customarily recognized throughout the Physician's profession as appropriate in treating the diagnosed Illness or Injury;
- It must be of the proper quantity, frequency and/or duration to treat the diagnosed Illness or Injury;
- Its purpose must be to restore health and extend life; and
- It must be obtained or performed in the appropriate setting.

If there is a disagreement between the attending Physician regarding whether a treatment, service or supply is Medically Necessary, a third party consulting Physician may be appointed by the Plan Administrator to make the determination.

A determination that a service or supply is not Medically Necessary may apply to the entire service or supply.

"Open Enrollment Period" means the period during the Plan Year for making elections for the following Plan Year. For each Sub-Plan the Open Enrollment Period will be described in the applicable Appendix. The changes elected during the Open Enrollment Period will become effective the first day of the following Plan Year.

"Participant" means an eligible team member or dependent who has met the eligibility and participation requirements and who is enrolled to receive benefits under the Plan. Participant also means an individual who continues coverage under the Plan in certain situations, such as pursuant to FMLA, COBRA or a military leave.

"Physician" means a medical or dental doctor, chiropractor, osteopath, podiatrist, ophthalmologist, optometrist, optician, certified consulting psychologist or psychiatrist, or a limited licensed practitioner (e.g., a physician's assistant or a nurse practitioner) who is licensed by the state in which he/she is practicing, is practicing within the scope of the license, and is performing services for which the charges constitute Eligible Expenses under the Plan.

"Physician" will not include the Participant, the Participant's spouse, the Participant's grandchild or grandparent, or a child, brother, sister, or parent of the Participant or the Participant's spouse, or a person who resides in the Participant's home.

"Plan" means the Meijer Health Benefits Plan.

"Plan Administrator" means the named fiduciary responsible for the operation and administration of the Plan. Meijer, Inc. is the Plan Administrator. Meijer, Inc. may delegate some or all of its duties to an administrative committee.

"Plan Sponsor" means Meijer, Inc.

"Plan Year" means the 12-consecutive-month period used for administration and election purposes. The Plan Year for a team member is generally the calendar year, as further described in the Appendix which applies to the team member.

However, for financial and accounting purposes, the term "Plan Year" means the 52 or 53-week period ending on the Saturday closest to January 31.

“Principal Support” means that the child must have been reported as a dependent on the Participant’s most recent income tax return or must qualify to be taken as a dependent for the current tax year.

“Service” means the period of time beginning on the team member’s date of hire and ending on the date the team member terminates employment with the Company.

“Special Enrollment Period” means the period for an individual with special enrollment rights to make enrollment elections under the Plan. The circumstances under which an individual has special enrollment rights are prescribed by HIPAA and the federal regulations issued pursuant to HIPAA.

“Sub-Plan” means the terms and conditions of the Plan which apply to a specified group of team members and their dependents. For any group of team members and dependents, the Sub-Plan consists of the Basic Provisions and the Appendix which applies to the group of team members and dependents. Each Sub-Plan is intended to be considered to be a separate Plan for purposes of Section 105(h)(2) of the Code. However, to the extent Participants in the Sub-Plan are not eligible for the same self-insured health benefits or to the extent Participants are not subject to the same eligibility rules or Participant contribution rates, those portions of the Sub-Plan shall be tested separately for purposes of Section 105(h)(2) of the Code. Further, the Sub-Plans may be combined for nondiscrimination testing purposes under Section 105(h)(2) of the Code to the extent Participants are eligible for the same self-insured health benefits and are subject to the same eligibility rules and Participant contribution rates.

“Team Member” means a common law employee of the Company, including (for purposes of the Plan) a team leader. However, any references to team leaders means team leaders only and does not include team members. Individuals who the Company classifies as independent contractors and leased employees, and other individuals who are not treated by the Company as common law employees for tax purposes are not considered team members or team leaders.

If an independent contractor or leased employee is subsequently characterized as a common law employee of the Company, the person will not be eligible to participate in the Plan for any time period before the date on which the person is determined to be a common law employee unless earlier participation is necessary to satisfy a legal requirement under Health Care Reform (such as the employer-shared responsibility provisions) or the nondiscrimination requirements of the Code.

“Total Disability” or **“Totally Disabled”** means an Illness or Injury which:

- Wholly and continuously prevents a team member from working for remuneration or profit; or
- Makes a dependent completely unable to engage in substantial gainful activity and which can be expected to result in death or to be of long, continued or indefinite duration.

MISCELLANEOUS

Construction

The Plan will be construed to prevent duplication of benefits and to cover expenses specifically included within each type of benefit. Each type of benefit will be considered exclusive of each other type of benefit to prevent benefits which are not specifically included within a type of benefit from being paid by the Plan.

Nonassignability

No benefit payable under the Plan is subject to alienation or assignment, whether voluntary or involuntary, except for assignment to a health care provider for services rendered or supplies provided, to the federal government in accordance with backup withholding laws, or in accordance with any assignment of rights as required by a state Medicaid program and in accordance with any state law which provides that the state has acquired the rights to payment with respect to a Participant. Any attempt to otherwise alienate or assign any benefit payable under the Plan will be void. The right of a Participant to receive a benefit under the Plan will not be considered an asset of the Participant or beneficiary in the event of his/her divorce, insolvency, or bankruptcy.

Participants Covered by Medicaid

The fact that an individual is eligible for or receives Medicaid assistance will not be taken into account in enrolling the individual as a Participant or in determining or making benefit payments under the Plan.

No Vested Rights

A Participant does not have any vested right to current or future benefits under the Plan. A Participant's right to benefits is limited to the assets held for the Plan under the trust and to claims incurred before the earliest of the following dates: the amendment of the Plan, the termination of the Plan, the expiration of the applicable limitations period and the Participant's termination of participation (including any extension of participation for which the Participant has properly elected and paid).

Employment Rights

The existence of the Plan does not give a Participant any legal right to continue as a team member, nor affect the right of the Company to discharge any Participant.

Participants' Rights

Except as may be required by law, the existence of the Plan will not give any Participant or beneficiary any equity or other interest in the assets, business, or affairs of the Company; the right to challenge any action taken by the Company's officers, directors, or stockholders, or any policy adopted or followed by the Company; or the right to examine any of the books and records of the Company. The rights of all Participants and beneficiaries will be limited to their right to receive payment of their benefits from the Plan when due and payable in accordance with the terms of the Plan.

Severability

The unenforceability of any provision of the Plan will not affect the enforceability of the remaining provisions of the Plan. Further, failure to enforce a provision does not waive other provisions or the enforcement of that provision.

Governing Law

To the extent not preempted by ERISA, the Plan will be construed in accordance with the laws of the state of Michigan.

Form 5500

As stated above, this Plan is funded through the Trust. In addition, other self-funded and fully-insured benefits are funded through the Trust. These benefits shall be collectively referred to as the “other benefits.” Notwithstanding any contrary provision in this Plan or the governing documents for the other benefits, although this Plan has a separate Plan document, this Plan and the other benefits shall be considered a single plan (i.e., the Meijer Health Benefits Plan) for Trust funding purposes and for purposes of satisfying the obligation to file a Form 5500. The Health FSA portion of the Pre-Tax Premium Plan is also included in the Meijer Health Benefits Plan for Form 5500 filing purposes. However, the Health (and Dependent Care) FSAs are funded through the Company’s general assets rather than the Trust. Further, the Dependent Care FSAs, the HSAs and voluntary insurance offered to team members are not subject to ERISA, are not funded through the Trust and are not considered part of the Health Benefits Plan for Form 5500 filing purposes.

The Meijer Assistance Program provides a limited number of telephonic counseling sessions and therefore, is a welfare benefit plan subject to ERISA and the Form 5500 filing requirement. While the terms of the employee assistance program shall be set forth in a separate Plan document/Summary Plan Description, the employee assistance program is hereby incorporated into and made part of the Meijer Health Benefits Plan for Form 5500 filing requirements. Further, where applicable, the legal requirements set forth in this document shall also apply to the employee assistance program including, but not limited to, the COBRA continuation coverage provisions and the HIPAA privacy and security rule provisions.

YOUR RIGHTS AS A PLAN PARTICIPANT

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information About the Plan and its Benefits

- Examine, without charge, at the Plan Administrator’s office, and at other specified locations, such as worksites, all documents governing the Plan, including any 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 a copy of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.
- 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 health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such

coverage. Review this summary plan description on 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 the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently 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 welfare benefit or exercising your rights under ERISA.

Enforce Participant’s Rights

If your claim for a welfare 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 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that 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 federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds the participant’s claim is frivolous.

Assistance With Questions

If you have any questions about the 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, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 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.

THE HEALTH AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PROGRAM

What is the Health and Dependent Care Flexible Spending Account Program?

There are certain health expenses, such as deductibles and copays, that you and your family may incur which are not covered by the group health plan in which you participate. Also, if you have

children or other dependents, you may have to pay others to provide care for them while you are at work. The Health and Dependent Care Flexible Spending Account (“FSA”) Program is a benefit which allows you to elect to reduce your pay on a before-tax basis to be reimbursed for qualifying expenses. As a result, you may pay for these expenses on a before-tax basis rather than with after-tax income.

The FSA is part of the Meijer Pre-Tax Premium Plan. However, the FSA is described below for team member communication purposes. This description is intended to serve as the Summary Plan Description for the FSA Program.

How Does the FSA Operate?

The FSA operates as follows. The Company will establish a separate bookkeeping account in your name for each tax-free reimbursement benefit (health and dependent care) you chose for a Plan Year. The Plan Year is the calendar year (each January 1 through December 31). The Company will allocate your pay reductions to each account in the amount indicated in your election form. When a claim for reimbursement is paid, the amount will be subtracted from the applicable account. Federal law prohibits you from using amounts allocated to one account (for example, health) to receive reimbursement for another type of benefit (for example, dependent care).

Who is Eligible for the FSA and When Does Participation Begin?

A team member must be eligible to participate in the Meijer Health Benefits Plan in order to participate in the Health Flexible Spending Account (HFSA). Team members eligible for the Meijer Health Benefits Plan on their date of hire may enroll in the HFSA and dependent care FSA at the same time. All other team members may participate in the dependent care FSA on the first day of the month on or after completing 60 days of Service. However, team members who are “highly compensated employees” as defined by Section 414(q) of the Internal Revenue Code are **not** eligible to participate in the dependent care FSA. For 2023, a highly compensated employee is a team member who received more than \$135,000 in compensation from the Company during 2022. This dollar threshold is adjusted annually for changes in the cost-of-living.

If you are a salaried team member who becomes eligible to participate in the Meijer Health Benefits Plan upon your date of hire and make an election within your date of hire plus 29 days, the election will be effective as of your date of hire. For other team members, who are eligible on the first day of the month on or after completing 60 days of Service, the team member’s election will be effective as of his or her initial enrollment effective date provided the team member makes an election online on or before that date.

Eligible team members may elect to participate when initially eligible and also during an Open Enrollment Period for a subsequent Plan Year. Dependents and retirees are not eligible to elect to participate in the FSAs.

When Does Participation End?

Your participation in the FSA Program ends at midnight on the earliest of various dates, including the date you are no longer eligible for coverage under the Meijer Health Benefits Plan, the date you terminate employment (whether voluntarily or involuntarily), the date your participation is terminated for cause and the date the Company terminates the Plan. If you terminate participation you will no longer be eligible to set aside additional before tax income to pay for the reimbursement of qualifying expenses and your debit card (see below) will be automatically cancelled. If you have

amounts in your FSAs when you stop participating in the Plan, you may continue to turn in claims for reimbursement of expenses incurred before you terminated participation. In addition, with respect to your dependent care FSA, you may continue to turn in claims for reimbursement of expenses for the balance of the year during which you terminated participation (even after the date you terminated participation), to the extent you have a remaining unused balance in your dependent care FSA. However, you are not eligible to be reimbursed for health FSA claims incurred after you terminated participation unless you elect to continue to participate as described in the following paragraphs.

If you participated in the HFSA during the Plan Year in which you terminate participation, you have the option of continuing to participate in your HFSA for the balance of the Plan Year. Your continued participation is generally governed by the federal law known as “COBRA.”

If you are eligible to elect COBRA with respect to your health FSA, you may continue participation by making after tax contributions to the Plan on a monthly basis in an amount equal to 102% of the pay reductions which were allocated to your health FSA each month before you terminated participation. After-tax contributions for a month must be paid by the first day of that month. However, there is a 30 day grace period for timely payment. Participation will be terminated if contributions are not made on a timely basis.

If you participate in the HFSA and you go on a military leave of absence, the Company will comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 with respect to the Plan. However, these requirements will only apply to the extent they provide you with more favorable coverage than COBRA (i.e., coverage for a longer period of time or less costly coverage).

If you are rehired during the same Plan Year in which you terminate employment and within 30 days of your date of termination, if eligible, you may resume your previous contribution level of participation in the FSAs but may not elect a different level. If you become eligible to participate in the Plan again during the same Plan Year, you should contact the Meijer Rewards Service Center for further details.

What is the Tax Effect of My Pay Reductions?

You may participate in the FSAs by electing to reduce your pay to obtain before tax reimbursement. Your pay will be reduced each pay period in an equal amount. Your W-2 Form (which you use to compute your income taxes) will be reduced by the total amount of your pay reductions so you will not pay income taxes on this portion of your pay. In addition, your pay reductions are not subject to FICA.

The advantage to you is that, unlike money you receive in your paycheck, there is no income tax or FICA withheld on the benefits you receive. Therefore, if you know you will incur an expense which may be reimbursed through your FSAs, you could reduce your pay and pay the reimbursable expense with “before tax” income rather than “after tax” income.

The only disadvantage is that the pay reductions reduce the amount of your pay that is reported to the Social Security Administration. This may cause a small reduction in the amount of your Social Security benefits.

You may elect to reduce your pay when enrolling during an Open Enrollment Period or permissible mid-year circumstance.

Who is Administers the FSAs?

The Company uses a third party to administer the FSA, which may periodically change. The Company will inform you of the current third party that administers the FSA, as well as any changes to that third-party administrator. In addition, you will be able to access that third-party administrator's website through the Meijer Rewards site so you can manage your account online.

How Do I Choose My FSA Benefits?

This section describes the procedure for choosing your FSA benefits. You may generally not change your election during the Plan Year, except as described below. You must make a new election each Plan Year.

Initial Benefit Selection

If you are a salaried team member who is eligible upon your date of hire and make an election (generally online or can be by phone by contacting the Meijer Rewards Service Center) within 30 days, your election will be effective as of your date of hire. For all other team members, your election will be effective as of the first day of the month after your election is made, provided this occurs within 45 days after you become eligible to participate. After you make your choice, you may change your election only during an Open Enrollment Period or if you have one of the events that permits a change during a Plan Year (see below). If you do not timely make an election, you will not be eligible to participate in the health or dependent care FSAs during the remainder of your initial Plan Year.

If you enroll in the health FSA, you will be automatically sent a debit card. The debit card can be used in connection with the health FSA but not the dependent care FSA. You may also request an additional card for use by one of your eligible dependents. Use of the card verifies your acceptance of the health FSA user card agreement. Although it is not a credit card or an ATM card, you should protect it like one (e.g., do not let it out of your sight, report it lost immediately, etc.) because you are responsible for all the charges on the card.

Annual Benefit Selection

There will be an Open Enrollment Period before the start of each Plan Year. You may make a new election (generally online or can be by phone by contacting the Meijer Rewards Service Center) during the Open Enrollment Period. The new election will become effective as of the first day of the next Plan Year and will remain in effect through the last day of that Plan Year. After the Plan Year begins and your initial election is effective, you may change your election only during the next Open Enrollment Period or if you have one of the events that permits a change during a Plan Year (see below). If you do not make a timely election during the next Open Enrollment Period, you will not be eligible to participate in the FSAs for the next Plan Year.

Can I Change My FSA Elections During a Plan Year?

As a general rule, you may only change your FSA benefit elections annually during an Open Enrollment Period. However, you may change your election during a Plan Year in certain situations where federal law permits a new election, as described below.

Change in Status

A change in status is an exception to the rule prohibiting any change during a Plan Year in your election. A change in status is limited to situations where your status has changed and this change affects the election you made earlier.

The following events are changes in status:

- An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation and annulment. A termination of domestic partnership will be considered a change in status for this purpose (where the domestic partner was your tax dependent);
- An event that changes the number of your dependents, including birth, adoption, placement for adoption and death of your dependent;
- An event affecting the employment status of you or your spouse, domestic partner (if your tax dependent), or dependent, including a termination or a commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence (by your spouse or dependent only), a change in work site, and any other change in employment status which affects an individual's eligibility for benefits;
- An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age or any similar circumstance; or
- A change in the place of residence of you or your dependent that affects your previous election. (This event does not apply to your health FSA.)

If you have a change in status, you may change your FSA election only if the election change is on account of, and corresponds with, the change in status. Further, while you may elect to decrease your annual health FSA contribution amount, the decrease may not be below the amount that you have already contributed to your health FSA for the Plan Year. If you stop making FSA contributions midyear due to a change in status but have an unused account balance at that time, you will still be considered an eligible participant for the remainder of the Plan Year in order to incur and submit claims to exhaust the balance.

If you have a change in status, you may request an election change via the Meijer Rewards Service Center within 30 days after the change in status occurs. The election will be effective at the time prescribed by the Plan Administrator. If you do not submit a new election request within 30 days after the change in status, you must wait until the next Open Enrollment Period to change your election.

FMLA Leave, Other Company-Approved Unpaid Leave or Layoff

If you go on an FMLA leave or another Company approved unpaid leave or are laid off, the following rules apply:

- Generally, the maximum FMLA period is 12 weeks per 12-month period (as that 12-month period is defined by the Company). However, if you take an FMLA leave to care for a qualifying military service member injured in the line of active duty, the maximum FMLA period is 26 weeks per 12-month period. The maximum length of other Company-approved leaves and layoffs will be determined by the Company.
- Your FSA elections will be continued during the leave or layoff. If you are paid during your absence the required contributions will continue to be withheld from your paychecks. If your leave or layoff is unpaid, you must make up the missed contributions upon your return. Generally, this will occur by reamortizing your unpaid annual election amount over the remaining balance of the plan year.
- You have the same election rights as an actively working participant during an Open Enrollment Period.
- If you do not return to work at the end of the leave or layoff, your participation in the Plan will terminate.

Dependent Care Changes

With respect to your dependent care FSA, an election change may be made if your dependent attains age 13 or becomes or ceases to be totally disabled. Further, if the cost of your dependent care provider changes during the Plan Year, you may adjust your election. However, this opportunity is not available if the dependent care provider is your relative.

Health FSA

What Amount of Pay Reductions Should I Allocate to My Health FSA?

It is entirely up to you to determine whether to allocate any pay reductions to your health FSA and, if so, how much to reduce your pay. The Company will inform you during the Open Enrollment Period of the minimum and maximum amounts you may have credited to your health FSA for the Plan Year. Currently, the minimum amount is \$200 and the maximum is \$2,000.

If you know you will have qualifying expenses during the Plan Year which will not be covered by the Meijer Health Benefits Plan or by any other source, you should consider putting enough in your health FSA to cover these planned-for expenses. The amount in your health FSA will be used to pay the qualifying expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your health FSA.

In deciding on the amount to put in your health FSA, it is wise not to put in too much. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next Plan Year. At the end of the Plan Year, all unused amounts must be forfeited, subject to the new flex carryover rule (see below). This is known as the use it or lose it rule.

Flex Carryover Rule

IRS rules permit employees to carryover an unused HFSA balance as of the end of a plan year to the following year, up to a maximum of \$610 (this maximum amount may be increased for cost-of-living adjustments in the future).

As a result, if you have an unused HFSA account balance as of the end of a plan year (December 31), you may carryover the balance to the next plan year, up to the applicable maximum for the plan year. This balance will be in addition to any HFSA contributions you elect for the subsequent plan year. This carryover rule will also apply in future plan years.

If you were enrolled in the HFSA and have a carryover amount, and you enroll in the Company's high deductible health plan (the Meijer Advantages Health with HSA medical option) for the immediately following plan year, you may only be reimbursed for certain "limited purpose" expenses with respect to the carryover. This rule is in order to preserve your eligibility for the HSA. Specifically, in this situation, you may only be reimbursed from the carryover for the limited purposes of reimbursement of uninsured dental and vision expenses, certain uninsured preventive care expenses and other uninsured expenses incurred after the minimum annual deductible under the Advantages Health Plan has been satisfied.

If you are enrolled in the limited purpose HFSA and the HSA, when you use your debit card the charges will be first deducted from your HSA.

What Types of Expenses Are Eligible for Reimbursement From My Health FSA?

Qualifying Individuals

Qualifying expenses for the following individuals may be reimbursed under your health FSA:

- You;
- Your spouse (same or opposite gender);
- Your natural child, your adopted child, a child placed with you for adoption, your step-child or your foster child through the end of the calendar year in which the child turns age 26; or
- Other children, relatives and members of your household (such as your domestic partner or your domestic partner's child) who are your "qualifying child" or "qualifying relative" under IRS guidelines.
- A qualifying child is your child or other relative who is younger than you, who lives with you, who does not provide more than half of his or her own financial support and who meets certain other requirements. Such an individual will be your qualifying child until the end of the calendar year in which the individual turns 18 or 23 (if

a full-time student). However, this age requirement is waived for a qualifying child who is totally disabled.

- A qualifying relative is your child, other relative, or member of your household for whom you provide over half the individual's financial support and the individual is not the qualifying child of you or any other individual.

Qualifying Expenses

Qualifying expenses are generally those types of medical expenses normally deductible on your federal tax return (without regard to the adjusted gross income limitation which is generally 10%). They include, for example, expenses you have incurred for:

- Deductibles and copays you must pay before your group health plan begins to pay benefits.
- Vaccines, medicine and drugs that require a prescription (e.g., birth control pills, vitamins, etc.).
- Over-the-counter drugs and medicines, and insulin.
- Over-the-counter medical supplies such as bandages and blood sugar kits.
- Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).
- Medical examinations, x-rays and laboratory services, insulin treatments and whirlpool baths the doctor ordered for a specific medical condition.
- Lasik (laser) eye surgery.
- Nursing help. If you pay someone to do both nursing and housework, only the nursing help may be reimbursed.
- Hospital care (including meals and lodging), clinic costs and lab fees.
- Medical treatment at a center for the treatment of alcohol or other substance abuse.
- Medical aids such as hearing aids (and batteries), dentures, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining these aids.

- Ambulance service and other travel costs to get health care. If you used your own car, you may claim what you spent for gas and oil to go to and from the place you received the care, or you may claim the mileage reimbursement allowed by federal law. You may add parking and tolls to the amount you claim under either method.
- Expenses for weight-loss programs as treatment for obesity. This includes the fees to join the program, but not the cost of food.
- Massage therapy prescribed by a physician to treat a medical condition.
- Body scans and other diagnostic procedures, including pregnancy kits, ovulation monitors and on-site health fairs that check items like blood pressure and cholesterol.
- Teeth whitening to correct discoloration caused by disease, birth defect or injury.
- Cord blood storage if a child is born with a medical condition where cord blood may be needed in the future (but not if storing it just in case of a future need).
- Menstrual care products, such as tampons, pads, liners, cups, sponges, or similar products.

Many of the expenses listed above are covered by the Meijer Health Benefits Plan. Any expense covered by that Plan or any other source will not be treated as a qualifying expense under the health FSA.

Expenses are considered to be incurred when the services are rendered or supplies are provided, not when billed or paid. However, notwithstanding this general rule, orthodontia expenses may be reimbursed before the services are provided but only to the extent that you have actually made payment in advance in order to receive the services. Such orthodontia services are deemed to be incurred when you make the advance payment.

IRS Publication 502 is available on the internet at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. It lists the items which the IRS considers deductible for federal income tax purposes. While the list is not identical to the list of reimbursable expenses under a health FSA (for example, premium costs are deductible but are not reimbursable under a health FSA), IRS Publication 502 provides comparable, useful information. If you have questions as to whether a specific item is reimbursable under your health FSA, contact PayFlex.

Special Rule for Health Reimbursement Account Participants

If you are also enrolled in the Health Reimbursement Account, you will be issued a single debit card for that benefit and your health FSA. When you use the debit card, the charges will first be deducted from your health FSA. (The reason is that

the health FSA has a use-it-or-lose-it forfeiture rule and it is important to exhaust that account before accessing the Health Reimbursement Account which has a rollover feature.) After your health FSA benefit is exhausted, any remaining debit charges will be deducted from your Health Reimbursement Account. If you submit a written claim for benefits with respect to a charge which is eligible for reimbursement from both your Health Reimbursement Account and your health FSA, you may choose on an expense-by-expense basis, to be reimbursed under the health FSA before payment under the Health Reimbursement Account, or vice versa as long as you are not reimbursed from both accounts for the same charge.

Special Rule for Health Savings Account Participants

A health savings account (“HSA”) is a tax-favored IRA type of account established for an eligible individual covered under a qualified high deductible health plan (such as Meijer’s Advantages Health with HSA medical option). If you or any member of your family is an eligible individual who is enrolled in a qualified high deductible health plan and makes contributions to an HSA, either through the Company or the employer of another member of your family, you may not receive coverage under a non-qualified high deductible health plan. Coverage under a non-qualified high deductible health plan causes the person to be ineligible to make HSA contributions.

A health FSA is generally considered a non-qualified high deductible health plan for this purpose. However, the health FSA will not be treated as a non-qualified high deductible health plan if the individual may only be reimbursed under the health FSA for qualifying health care expenses, such as uninsured dental and vision care expenses.

The Plan does not offer this feature. As a result, if you or your spouse or dependent participates in an HSA and the Advantages Health with HSA medical option through the Company or a qualified high deductible health plan through another employer, you and your dependents should **not** participate in the health FSA portion of this Plan for the entire Plan Year in which you or your spouse or dependent participates in the HSA in order for you or your spouse or dependent to be eligible for the HSA. That is because for this group of participants, the health FSA is **not** a limited purpose one, rather it is a general purpose health FSA and accordingly, is a non-high deductible health plan for HSA eligibility purposes. But see the “Flex Carryover Rule” section above.

Non-Qualifying Expenses

You **cannot** obtain reimbursement for the following expenses:

- The cost of health coverage. For example, you cannot obtain reimbursement for the premium you pay to obtain coverage under the Meijer Health Benefits Plan or for the premium your spouse pays to obtain coverage under his or her employer’s group health plan. You also cannot obtain reimbursement for the premium for an individual health policy. However, you may pay your premium for coverage under the Meijer Health Benefits Plan under the Pre-Tax Premium Plan.

- Life insurance or income protection policies.
- The hospital insurance benefits tax withheld from your pay as part of the Social Security tax.
- Illegal operations or drugs.
- Travel your doctor told you to take for rest or change.
- Items which are considered toiletries (such as toothpaste) or cosmetics (such as face cream), or any other item purchased for cosmetic reasons.
- Cosmetic surgery, unless necessary because of injuries you receive, congenital disfigurement, or a disfiguring disease.
- Long-term care expenses.
- Health club dues.
- Expenses reimbursed by the Meijer Health Benefits Plan or any other source.
- Expenses incurred before you begin, or after you stop, making contributions to your health FSA.

How Do I Use the Balance in My Health FSA?

You can obtain reimbursement for certain health care expenses by using the FSA debit card to pay for the services and/or products at the point of purchase. Just present the card like you would a credit card, and the merchant will do the rest. Alternatively, you can always pay for the services and file a claim for reimbursement. There are circumstances where this may be necessary, such as if your service provider cannot accept the card, you forgot to bring your card to your service provider, or more information is needed to determine whether the products or services are eligible expenses.

Your health FSA resembles an insurance policy. You are entitled to uniform coverage throughout the Plan Year. For example, if you incur \$100 of qualifying expenses during the first month of the Plan Year, you may be reimbursed for those expenses immediately, even if you only have \$50 credited to your account during that month. However, claims may not be reimbursed to the extent that they exceed the total amount of pay reductions you have allocated to your health FSA for the Plan Year. Also, only claims for qualifying expenses will be reimbursed.

Where Can I Use My FSA Debit Card?

You can use the debit card at any service provider or merchant that dispenses medical services and products and will accept the card for payment. However, you can't be reimbursed for medical products at Meijer and return the items and convert the refund to pay for non-qualifying expenses.

What if My FSA Debit Card is Rejected by the Service Provider or the Merchant?

This can happen for a number of reasons and it does not mean you have bad credit. For example, if you try to purchase ineligible items and eligible items in the same transaction, such as non-prescription dietary supplements to maintain good health and prescription drugs, your card may be rejected. If the merchant did not re-enter the card for only the eligible items, then the entire transaction will be rejected.

If your debit card is rejected, ask the provider or merchant to call the authorization hot line on the back of the card to provide additional information to get your transaction approved. If you or the merchant chooses not to make that call, or if that call results in your transaction being denied, then you will need to pay for the items and file a paper claim for the eligible items.

How Do I Submit a Claim?

If you do not use your debit card you can submit your request for reimbursement from your HSA by going online to the current third-party administrator's website, which is accessible through the Meijer Rewards site.

Dependent Care FSA

What is the Difference Between My Dependent Care FSA and the Dependent Care Tax Credit?

The Internal Revenue Code gives you two choices in the treatment of dependent care expenses for income tax purposes. First, you may pay for dependent care expenses with "before-tax" income through the Plan. Second, you may claim a tax credit on dependent care expenses (up to \$3,000 for one child and up to \$6,000 for two or more children). However, any amount you claim under the dependent care tax credit will be reduced by the amount you are reimbursed under the Plan.

What Amount of Pay Reductions Should I Allocate to My Dependent Care FSA?

It is entirely up to you to determine whether to allocate any pay reductions to your dependent care FSA and, if so, how much to reduce your pay. The Company will inform you during the Open Enrollment Period of the minimum amount you may have credited to your dependent care FSA for the Plan Year. See "Are There Limits on How Much May Be Reimbursed?" below regarding the maximum limits. If you know you will have dependent care expenses during the Plan Year, you should consider putting enough in your dependent care spending account to cover these planned-for expenses. The amount in your account will be used to pay all the dependent care expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the proper amount to put in your dependent care spending account, it is wise not to put in too much. For example, if you do not have to pay for dependent care on holidays and while you are on vacation, you should take this into consideration when you determine the amount you wish to have credited to your account. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next Plan Year. At the end of the Plan Year, all unused amounts must be forfeited.

What Types of Expenses Are Eligible for Reimbursement From My Dependent Care FSA?

Your dependent care expenses may be reimbursed under the Plan. Dependent care expenses are your expenses for certain services which your dependents need in order for you to be employed by the Company. Who is considered your dependent for this purpose is defined by the Internal Revenue Code. Your dependent includes a qualifying child who lives with you for more than half of the year and who does not provide over half of his or her financial support for the year and who meets certain other requirements. A child of divorced parents who is under age 13 or totally disabled will be treated as a dependent of the custodial parent, even if the child is a dependent of the noncustodial parent for income tax purposes. Your dependent also includes a qualifying relative such as your parent who receives over half of his or her financial support for the year from you.

The types of services covered are:

- Care for your dependent in your home (such as babysitting), if the dependent is either:
 - Your qualifying child under age 13; or
 - Your spouse (same or opposite gender) or qualifying relative who is totally disabled. A person is totally disabled if the person has a mental or physical condition which makes the person incapable of caring for his or her hygienic or nutritional needs, or causes the person to require the full-time attention of another person for his or her personal safety or the safety of others.
- Care for your dependent outside of your home (such as in a day care center), if the dependent is either:
 - Your qualifying child under age 13; or
 - Your totally disabled (as defined above) spouse (same or opposite gender) or qualifying relative who regularly spends at least eight hours per day in your home.

This also includes expenses, per an agreement with your day care provider, which are required in order to hold a place for your child(ren) during your temporary absence from work (for example, during your vacation or short term illness).

- Household services for the maintenance of your home (such as for a domestic maid or cook), as long as the services are performed in part for the benefit of your dependent.

May Amounts Paid to My Relatives Be Reimbursed?

You may hire whomever you want to provide services to your dependents. However, federal law provides that dependent care expenses cannot be reimbursed under the Plan if one of the following relatives provides the care:

- One of your dependents;
- Your spouse (same or opposite gender); or
- Your child (even if not your dependent), if your child is under age 19 on December 31 of the year during which the care is provided.

Are There Limits on How Much May Be Reimbursed?

Federal law limits the amount of dependent care expenses which may be reimbursed under the Plan. Generally, the limit is \$5,000 per calendar year (or \$2,500 if you are married and file a separate tax return).

However, if you earn less than \$10,000 or your spouse earns less than \$5,000, the limit is the lesser of your spouse's pay or ½ of your pay. A further limit applies if you and your spouse are filing separate tax returns. If your spouse is a full-time student or is totally disabled (as defined above) for any month in which you have dependent care expenses, your spouse will be considered to have the following pay for that month:

- \$250, if you have dependent care expenses for one dependent; or
- \$500, if you have dependent care expenses for more than one dependent.

How Do I Submit a Claim?

You can request reimbursement from your dependent care FSA by going online to the third-party administrator's website, which is accessible through the Meijer Rewards site.

Common Questions Applying to Both the Health and Dependent Care FSA

What Are the Procedures for Filing an Appeal When My Claim is Denied?

If your claim for benefits under the FSA has only been partially reimbursed or denied, you will be given notice of the nonpayment or denial in the same manner as a post service claim under the Meijer Health Benefits Plan and the claim and appeal rules for post service claims under the Meijer Health Benefits Plan will generally apply. However, there will only be one level of appeal (not two). A second level of appeal is available on a voluntary basis.

Is There a Deadline for Submitting Claims?

All claims incurred during a Plan Year must be turned in no later than 90 days after the end of the Plan Year. If you do not turn in a claim by this date, the claim will be denied. Any amount then remaining in your FSA will be forfeited.

Is My FSA Insured?

Your FSA is not insured and the third-party administrator is not an insurance company, rather, it merely processes the claims. If for any reason the Plan or the Company does not ultimately reimburse you for submitted expenses, you may be liable for the expenses.

How Do I Know What My Account Balance Is?

You can go to the third-party administrator's website (which is accessible through the Meijer Rewards site) to check your account balance. Account activities are normally updated daily.

Do the Limitations and Exclusions, Coordination of Benefits and Reimbursement/Subrogation Provisions of the Meijer Health Benefits Plan Apply to the FSA Program?

No. These provisions do not apply to the health and dependent care FSA Program.

OTHER BASIC INFORMATION ABOUT THE PLAN

Name of Plan:	Meijer Health Benefits Plan
Name, Address, Telephone Number and Taxpayer Identification Number of Company/Plan Sponsor:	Meijer, Inc. 2929 Walker Ave., N.W. Grand Rapids, MI 49544-9428 (616) 453-6711 38-1274536
Name and Address of Participating Related Company:	Meijer Stores Limited Partnership 2929 Walker Ave., N.W. Grand Rapids, MI 49544-9428 Meijer Great Lakes Limited Partnership 2929 Walker Ave., N.W. Grand Rapids, MI 49544-9428 Town Total Health, LLC 2929 Walker Ave., N.W. Grand Rapids, MI 49544-9428
Plan Number:	501
Type of Plan:	Group Health Plan
Type of Administration:	Self-funded benefits administered by Plan Administrator and Third Party Claims Administrators
Plan Administrator:	Plan Sponsor
Name, Address and Telephone Number of Third Party Claims Administrators for self-funded benefits:	<u>For Medical:</u> Blue Cross Blue Shield of Michigan (see the Health Care Handbooks and Benefit Documents for addresses and telephone numbers) <u>For Prescription Drug:</u> Express Scripts, Inc. P.O. Box 390873 Bloomington, MN 55439-0873 1 (866) 804-7647 <u>For Dental:</u> Delta Dental of Michigan (see the Dental Care Handbook for addresses and telephone numbers)

For Vision:

EyeMed Vision Care, L.L.C.
4000 Luxottica Place
Mason, OH 45040
1 (866) 723-0514

For the Health Reimbursement Account, Health Savings Account and Flexible Spending Accounts:

Meijer Rewards
1 (866) 681-6116

For Surgery Care Benefit:

Transcarent
2 S Park Street
San Francisco, CA 94107
855-265-9803
<https://experience.transcarent.com/meijer/>

For Cancer Support Program:

AccessHope
1500 E. Duarte Road
Duarte, CA 91010
844-520-0584
<https://members.myaccesshope.org/meijer>

For Diabetes Case Management:

Livongo Health, Inc.
444 N. Michigan Ave. Suite 3400
Chicago, IL 60611
1 (800) 945-4355
welcome.livongo.com/Meijer

Virta
501 Folsom Street
San Francisco, CA 94105
Email: support@virtahealth.com
Virtahealth.com/join/meijer

Agent for Service of Legal Service:

Office of the General Counsel
Meijer, Inc.
2929 Walker Ave., N.W.
Grand Rapids, MI 49544-9428

Service of legal process may also be made on a
Plan trustee or the Plan Administrator.

Name and Address of Plan Trustees:

Brad Freiburger
Michelle Hall
Wendy Brummel
Keith Morrison
Meijer, Inc.
2929 Walker Ave., N.W.
Grand Rapids, MI 49544-9428

Plan Fiscal Year End:

The Saturday closest to January 31

IMPORTANT NOTICE FROM MEIJER ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE
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Prescription drug coverage is available to everyone eligible for Medicare. This Notice provides information about your current prescription drug coverage under the Meijer Health Benefits Plan and Medicare's prescription drug coverage.

*This Notice affects individuals who are enrolled in or eligible to enroll in Medicare. You or a family member may be enrolled in Medicare based on age (on or after attaining age 65), a disability or permanent kidney failure (end-stage renal disease). If no one in your family is enrolled in or eligible to enroll in Medicare, the information in this Notice does **NOT** apply to you.*

Important Information You Need to Know

- Prescription drug coverage is available to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or a Medicare Advantage plan (like an HMO or PPO) that offers prescription drug coverage.
- You can join a Medicare prescription drug plan or a Medicare Advantage plan when you first become eligible for Medicare and each year from October 15 through December 7. In addition, if you lose coverage under the Meijer Health Benefits Plan through no fault of your own, you will be eligible for a two-month Special Enrollment Period ("SEP") to join a Medicare drug plan.
- All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may offer more coverage for a higher monthly premium.
- Team members can select from many different coverage options under the Meijer Health Benefits Plan. The prescription drug benefit under some of those options may be, on average for all participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay, and is considered "non-creditable coverage." This is important, because most likely, you will get more help with your prescription drug costs if you join a Medicare prescription drug plan than if you only have prescription drug coverage under a non-creditable option. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
- However, currently all coverage options under the Meijer Health Benefits Plan provide prescription drug coverage that is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. In other words, for most Medicare beneficiaries those options will provide prescription drug coverage that is at least good as the coverage they can get from a Medicare prescription drug plan. This is known as "creditable coverage." If you have coverage under one of these options, you can keep that coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Meijer Creditable Coverage Options	Meijer Non-Creditable Coverage Options
Health Select with HRA Advantages Health with HSA	None

Questions Regarding Which Coverage Option You Currently Have?

If you do not know which coverage option you are currently enrolled in under the Meijer Health Benefits Plan, you should contact the Meijer Rewards Service Center (toll-free at 1-866-681-6116).

Frequently Asked Questions for Team Members With Creditable Coverage

1. *Can my family and I keep coverage under the Meijer Health Benefits Plan if one or more of us enrolls in a Medicare prescription drug plan?*

Yes. A person's enrollment in a Medicare prescription drug plan will generally not affect his or her eligibility for coverage under the Meijer Health Benefits Plan.

However, as long as you are actively working for Meijer, coverage under the Meijer Health Benefits Plan will usually be the primary coverage for you and your family. Therefore, as long as you remain enrolled in a coverage option that provides creditable coverage, it may not make sense for you or a family member to enroll in a Medicare prescription drug plan (or Medicare Part B) while you are actively working for Meijer.

2. *If a family member or I decide to enroll in a Medicare prescription drug plan and Medicare Parts A and B and drop health coverage through Meijer, can we get our health coverage through Meijer back if we decide we don't like the Medicare coverage?*

Yes, as long as you are otherwise eligible for coverage. However, if you drop coverage under the Meijer Health Benefits Plan, you will generally not be able to re-enroll until the next Open Enrollment Period.

Before dropping coverage under the Meijer Health Benefits Plan, you and your family should consider that the coverage under the Meijer Health Benefits Plan pays for other health expenses in addition to prescription drugs, which may or may not be covered under Medicare Parts A and B and Medicare's prescription drug coverage to the same extent they are covered under the Meijer Health Benefits Plan.

You should compare your current coverage under the Meijer Health Benefits Plan with the coverage and cost of the Medicare prescription drug coverage plans providing coverage in your area (and Medicare Parts A and B) before deciding whether to drop coverage under the Meijer Health Benefits Plan.

3. *What happens if I elect to keep my coverage under the Meijer Health Benefits Plan and not enroll in Medicare prescription drug coverage until I leave Meijer?*

As long as you remain enrolled in a coverage option under the Meijer Health Benefits Plan that provides creditable coverage, you can choose to join a Medicare prescription drug plan later without paying a higher premium (penalty).

Each year, Medicare beneficiaries will have the opportunity to enroll in a Medicare prescription drug plan between October 15 and December 7. In addition, you will have a two-month special enrollment period if your coverage under the Meijer Health Benefits Plan ends through no fault of your own.

However, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium will go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium will always be at least 19% higher than the Medicare base beneficiary premium. You will have to pay this higher premium (a penalty) as long as you have Medicare coverage. In addition, you may have to wait until the following October to enroll.

For More Information About Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is available in the “Medicare & You” handbook. Medicare beneficiaries will get a copy of the handbook in the mail from Medicare each year. More information about Medicare prescription drug plans is also available from these places:

- ☐ Visit www.medicare.gov.
- ☐ Call your State Health Insurance Assistance Program (see your copy of the “Medicare & You” handbook for their telephone number).
- ☐ Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You and/or your family members may get mail from insurance companies offering Medicare prescription drug plans in your area. The information you receive will describe the coverage offered by those companies and the costs of the plan(s) offered by each company.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Notice. If you decide to enroll in a Medicare prescription drug plan you may be required to provide a copy of this Notice when you join to show whether you have maintained creditable coverage and whether you are required to pay a higher premium (a penalty).

NOTICE OF PRIVACY PRACTICES FOR MEIJER HEALTH PLAN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective January 1, 2023.

We are required by law to maintain the privacy and security of your protected health information and provide you with information about your rights and our responsibilities. We must follow the duties and privacy practices in this notice and give you a copy of it.

We will not use or share your information other than as described in this privacy notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

If the privacy or security of your health information has been compromised, we will let you know.

What is protected health information?

For us to provide you with services, we need to know and maintain certain information about you. Information we have about you that can be used to identify who you are is protected health information. Your name, contact information, and information about your health, medical conditions and prescriptions are some examples. This information may relate to your past, present, or future physical or mental health or condition, providing you health care products and services, or your payment for our products or services.

We May Change this Notice.

We can change the terms of this notice and the changes will apply to all information we have about you. We will provide you with a copy of the revised notice if you ask us. Copies are available at the benefits website.

YOUR RIGHTS

You have certain rights to your health information. To help you, we designated a privacy specialist to answer your questions, respond to requests, and receive complaints. You may contact our privacy specialist by:

<i>Writing:</i>	Meijer Privacy Specialist 2929 Walker Avenue NW Grand Rapids, MI 49544
<i>Calling:</i>	1-800-543-3704, option 2
<i>E-mailing:</i>	privacyspecialist@meijer.com
<i>Faxing:</i>	1-616-791-5332

To make it easier to communicate with us, we have request forms available at benefits website, but they are not required.

You have the right to file a complaint if you feel your rights are violated. If you believe your privacy rights were violated, you may file a complaint with our privacy specialist. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you if you file a complaint.

You have the right to ask us to limit what information we use or share about you. You may ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request. We are not likely to agree to a request that may affect your care. We require you to make these types of requests in writing.

If you pay out-of-pocket for the full cost of our services, you may ask us not to share that information for payment purposes or our operations with your health insurance. You must make this request separately at each of our pharmacies before we submit the claim to your health insurance following our normal operations. We will agree to your request unless the law requires us to share that information with your health insurance.

You have the right to ask us to communicate with you confidentially. You may ask us to contact you in a specific way, such as calling you at home or your workplace or sending mail to a different address. You must make your request in writing and tell us how or where you would like to be contacted. We will agree to reasonable requests, but in an emergency we will contact you in a manner we believe is necessary and appropriate.

You have the right to get an electronic or paper copy of your pharmacy record and other health information we have about you. We keep your health information in a designated pharmacy record for a time period necessary to comply with laws. We make it easy for you to quickly get a free paper copy of a Medical Expense Statement at the pharmacy, which is a list of your recent prescriptions and how much you paid for them. You can print your own copy using your personal online account on Meijer.com/pharmacy. You will need your userid and password to access your records.

You may also access or receive a copy of your pharmacy record by submitting a written request. We may charge you a reasonable, cost-based fee. Tell us whether you want a paper or electronic copy, such as on a CD or thumb-drive, and where and who we should send the copy to. We have 30 days from the day we receive your request to respond. While unlikely, if we deny your request to access or copy your health information, you may ask to have the denial reviewed.

You have the right to ask us to correct your pharmacy record. If you believe your information is incomplete or incorrect, ask us to correct the information. You can ask the pharmacy to amend your information. If the pharmacy is unable to amend information you believe is incomplete or incorrect, you must ask our privacy specialist in writing to amend your information. Your request must include a reason that supports your request. We may deny your request. If we deny your request it will be in writing within 60 days. You may file a statement of disagreement with our decision and we may give you a rebuttal to your statement.

You have the right to ask us for a list of those with whom we shared your information. This list is called an accounting and it will not include disclosures about treatment, payment, and health care operations. Certain other disclosures are excluded from the accounting, such as any you asked us to make, those made directly to you or to friends or family members involved in your care, and disclosures for notification purposes.

You should tell us what time period you want your accounting for, but it may not be longer than six years. One accounting every 12 months is available free of charge. If you ask for another accounting and it has been less than 12 months since your free copy, we may charge you a reasonable, cost-based fee. We will not charge you the fee if we fail to first notify you of the cost and give you an opportunity to cancel or change your request.

You have the right to choose someone to act for you. If you give someone medical power of attorney or someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

You have the right to get a copy of this privacy notice at any time. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. Paper copies are available at any pharmacy or by contacting our privacy specialist and are also available at Meijer.com/pharmacy.

HOW WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION

Your health plan may include: medical, dental, optical, flexible spending accounts, and wellness plans. You may or may not be enrolled in one or more of these plan types.

We use and share your health information for payment and our health care operations.

Payment means the activities we do to collect premiums and pay for your medical care. For example, your health information is used to send you premium billings, collect premiums through Meijer payroll, and shared with third party administrators to pay claims we receive (claims may include your medical condition). We may also share your health information with another insurance company if you are covered under more than one health plan.

Health Care Operations are the activities we do to perform our everyday work. Examples of health care operations where we may use or share your health information include eligibility, medical reviews, care management, training, legal services and compliance programs, auditing functions, business planning and management activities, customer service, and resolving complaints. We will also provide plan updates, treatment alternatives, and information about other health-related products or services we provide. Your health information is used for underwriting, enrollment, and other activities related to creating, renewing, or replacing a benefits plan. . Because the quality of health care you receive is important to us, we conduct quality assessment and improvement activities that review your health plan's performance and we evaluate qualifications of health care providers, conduct quality assessment and improvement activities, and review population-based activities to help improve your health or find ways to reduce health care costs. We also use or share your health information to achieve or maintain accreditations, certifications, and other licensing and credentialing activities and for ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance).

We will not use or share your genetic information for underwriting purposes.

SITUATIONS YOU HAVE A CHOICE ABOUT WHAT WE SHARE

In some situations, you can tell us your choices about what we share. If you have a clear preference for how we share your health information in the situations described below, tell us what you want us to do. If you are not able to tell us your preference, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Disaster Relief. We may, using professional judgment as to what is in your best interest, use or share your health information for disaster relief purposes including providing information to organizations authorized by law or charter to assist in disaster relief efforts.

Fundraising. We may contact you for fundraising efforts, but you can tell us not to contact you again.

Individuals involved in your health care or payment. In your absence, our team of pharmacists and other professionals will use professional judgment to share your health information with a family member, close relative, close friend, or any person you identify to be involved in your health care or payment. This allows you to have another person drop off or pick up your prescriptions. Upon your death, we may release your information to the person who was either involved with your health care or has documented authority to act on your behalf or for your estate, unless there is a restriction in place.

OTHER WAYS WE USE OR SHARE YOUR HEALTH INFORMATION

Your participation, enrollment and disenrollment information may be shared with the plan sponsor for enrollment administration. Summary health information may also be shared with the sponsor, if requested, to obtain premium bids for health plan coverage, or to modify, amend, or terminate the group health plan. When we do this, your identifying information is usually removed, such as your name, age, and address (we will share your zip code), but your health information is used to summarize the amount, type, and history of claims paid by the sponsor's group health plan.

We are also allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes, but we do not need your written authorization. Other ways we may use or share your health information are:

Business associates. We contract with vendors (called business associates) to help us perform our services. We may share your health information with our business associates so they can do the job we asked them to do for us.

Public health and safety activities. When allowed or required by law, we may share your health information with a public health authority, such as the Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Occupational Safety and Health Administration, and State or local health departments, for the purpose of preventing or controlling disease, injury, or disability.

Public health activities may include reporting child abuse or neglect, reporting information to the FDA (such as quality, safety or effectiveness information about FDA regulated products, adverse events, product defects or product deviations, tracking FDA products, product recalls, repairs, replacements, lookbacks, or post marketing surveillance), and notification of communicable diseases for intervention or investigation. If we report to your employer information for an evaluation relating to medical surveillance of the workplace or to evaluate if you have a work related illness or injury, we will first notify you. Immunization reporting to your school, if required by state law for enrollment purposes, requires your consent.

Victims of abuse, neglect, or domestic violence. We may share your health information to a government authority, such as a social service or protective services agency, if we reasonably

believe you are a victim of abuse, neglect, or domestic violence. We will only share this type of information to the extent required by law.

Health oversight activities. We may share your health information to a health oversight agency for activities allowed by law, such as audits, inspections, investigations, legal proceedings, licensure or disciplinary actions, other activities necessary for oversight of the health care system, eligibility for government benefit programs, compliance with government regulatory program standards, and compliance with civil rights laws.

Judicial and administrative proceedings. If you are involved in a lawsuit or a dispute, we may share your health information in response to a court or administrative order. We may also respond to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts were made to tell you about the request or obtain an order protecting the requested information.

Law enforcement. We may share your health information for law enforcement purposes when required by law or to respond to a valid subpoena or other legal process. If law enforcement asks us for help, we may assist in locating or identifying a suspect, fugitive, material witness, or missing person. If you commit a crime on our premises, we may share your health information with law enforcement.

Coroners, medical examiners, and funeral directors. We may release your health information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We may share your health information to a funeral director consistent with applicable law to carry out their duties.

Organ or tissue procurement organizations. We may share your health information with organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Research. We may share your health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure your privacy and has altered or waived the requirement of your written authorization.

To avert a serious threat to health or safety. We may use and share your health information when necessary to prevent a serious and imminent threat to your health and safety or the health and safety of the public or another person.

Military and veterans. If you are a member of the armed forces, we may share your health information as required by military command authorities. We may also release information about foreign military personnel to the appropriate military authority.

National security and intelligence activities. We may share your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective services for the President and others. We may disclose information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or conduct special investigations.

Correctional institutions. If you are or become an inmate of a correctional institution, we may share your health information with the institution or its agents necessary for your health and the health and safety of others.

De-identified information. We may use or share your health information if it is altered in a way that it does not and cannot be used to identify you.

Notifications. We may use or share your health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, about your location and general condition.

Required by law. We will use or share your health information when we are required to by law.

Workers' compensation. We may share your health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

For more information, go to www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.