Summary Plan Description

Health & Welfare Benefits

Medical, Health Savings Account, Dental, Healthcare and Dependent Care Flexible Spending Accounts, Life Insurance and Accidental Death and Dismemberment Insurance

for Salaried and Nonunion Production Employees

Total Rewards

2020

This Summary Plan Description (SPD) outlines certain key components of our health and welfare programs while you are an eligible employee of the company. This SPD is current as of the beginning of the plan year listed on the front. Be sure to also review any plan changes (also referred to as Summary of Material Modifications (SMM)). Refer to the My Benefits website for additional information. Such programs include:

Medical and Prescription Drug Plan
Health Savings Account
Dental Plan
Flexible Spending Accounts for Healthcare and Dependent Care
Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance
Vision Care Plan

The word "You" and "Your" refers to benefits-eligible employees and where applicable, their dependents.

You may have questions as you review this information. The best place to ask specific questions about these programs is to call the customer service phone number for the program in which you're interested – those phone numbers are on the facing page for your easy reference. If you have questions about your eligibility for these programs, please call the General Mills Benefits Service Center.

Este folleto contiene un resumen de sus derechos y beneficios bajo el Plan y está escrito en inglés. Si tiene alguna dificultad para entender cualquier parte de este folleto, contáctese con su representante local de RRHH. También puede contactarse con el Centro de Servicios de RRHH de General Mills Benefits Servicie Center 1-877-430-4015, Hora Estándar del Centro. Solicite asistencia de "línea de idioma" cuando llame.

Cette brochure, qui est rédigée en anglais, illustre sommairement les droits et les avantages qui vous sont consentis en vertu du régime. Si vous éprouvez des difficultés à en comprendre une portion quelconque, veuillez communiquer avec votre représentant local des RH. Vous pouvez aussi communiquer avec le General Mills Benefits Service Center 1-877-430-4015. Lorsque vous appelez, demandez d'obtenir de l'aide de la « langage line » (ligne linguistique).

Phau ntawv no qhia txog koj tej cai thiab tej kev pab uas koj tau hauv qhov Plan no, thiab lawv muab sau ua lus As Kiv. Yog tias koj tsis to taub ib yam dab tsi hauv phau no, thov tiv tauj ib tug neeg hauv Qhov Chaw Pab Tib Neeg hauv koj lub zos. Koj kuj tiv tauj tau Qhov Chaw Pab Tib Neeg hauv General Mills Benefits Service Center 1-877-430-4015. Thaum koj hu tuaj thov kom lawv muab koj txuas rau "language line (kev pab txhais lus)".

Kjo broshurë përmban një përmbledhje të të drejtave dhe të përfitimeve tuaja sipas Planit dhe është e shkruar në anglisht. Nëse keni vështirësi për të kuptuar ndonjë pjesë të kësaj broshure, ju lutem kontaktoni përfaqësuesin tuaj lokal të zyrës së kuadrit (Burimet Njerëzore). Gjithashtu mund të kontaktoni edhe Qendrën e Shërbimeve të zyrës së kuadrit (Burimet Njerëzore) në General Mills Benefits Service Center 1-877-430-4015. Kur të telefononi, lu lutem thoni "language line" që t'ju ndihmojmë me një përkthyes.

这本以英文书写的小册子概述你加入该计划的权利和福利。若你对本册子文中有任何不了解之处，请联系当地的“人力资源”代表。你也可以联系明尼阿波利斯的“人力资源服务中心”，其服务电话是（877）430-4015，服务时间是周一至周五，中央标准时间上午 7:30 到下午 4:30 。打电话时，请要求“语言热线”协助。

這本以英文書寫的小冊子概述你加入該計畫的權利和福利。若你對本冊子文中有任何不瞭解之處，請聯絡當地的“人力資源”代表。你也可以聯絡明尼阿波利斯的“人力資源服務中心”，其服務電話是（877）430-4015，服務時間是週一至週五，中央標準時間上午 7:30 到下午 4:30 。打電話時，請要求“語言熱線”協助。

Quick Reference Guide

Program	Phone Number	Administrator	Page
Medical	1-866-870-0411	Blue Cross Blue Shield of Minnesota (BCBSMN)	13
For care, 24 hours a day, 7 days a week on minor medical issues	Video Consults-download APP	Doctor On Demand DoctorOnDemand.com/bluecrossmn	
Prescription Drugs	1-800-770-2815	Express Scripts	52
Vision	1-866-723-0514	EyeMed Vision	57
Dental	1-800-448-3815	Delta Dental of Minnesota	62
Health Savings Account (HSA)	1-888-914-2435	HealthEquity	72
Healthcare Flexible Spending Account	1-888-914-2435	HealthEquity	79
Dependent Care Flexible Spending Account	1-888-914-2435	HealthEquity	83
Life Insurance Programs • Company-Paid • Optional Employee-Paid • Optional Employee-Paid Accidental Death and Dismemberment (AD&D) Insurance	1-888-200-5555, option 1	Securian Life Coverage administered by Alight	87
Benefits Continuation/COBRA *including:* • "Direct Billing" • "COBRA"	1-888-200-5555, option 1	General Mills Benefit Service Center via HR Direct	95

General Mills Retirement Service Center via HR Direct at 1-888-200-5555, and select option 3.

PLEASE NOTE: Your address for all vendors will be controlled by General Mills – **Except** for any accounts you have at HealthEquity. It is your responsibility to update your address directly through HealthEquity.

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Eligibility and Enrollment

Medical, Dental, Vision, Healthcare Flexible Spending Account, Dependent Care Flexible Spending Account, Company Paid Life Insurance

You must be a regular employee at an approved location, regularly scheduled to work 50% or more of the normal pay period for that location. Full time Interns are eligible for Medical coverage only.

Eligible Dependents

- Your spouse. Divorced or legally separated spouses are not eligible.
- Your legally recognized common-law spouse (if recognized by the state where you reside or state where your common-law marriage was entered into).
- Your domestic partner (both opposite and same-sex) who are:
    - At least eighteen (18) years of age.
    - Mentally competent to consent to a contract.
    - Not related by blood to a degree of closeness which would prohibit marriage in the state in which they live.
    - Share a close personal relationship and are responsible for each other's common welfare and have no such relationship with anyone else.
    - Not legally married to anyone and have not had another domestic partner within the past twelve (12) months.
    - Have jointly shared the same regular and permanent residence for at least twelve (12) months preceding the date of the affidavit with the intent to continue doing so indefinitely.
    - Jointly and financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household. (Domestic Partners need not contribute equally to the cost of these expenses so long as both are responsible for the cost).
- Your natural children, adopted children, children of your domestic partner, children placed with you in anticipation of adoption, foster and step children who are:
    1. Less than age 26; or
    2. A child, age 26 or older, whom you claim on your federal income tax return as a dependent, and who is physically or mentally incapable of self-support, when coverage would otherwise terminate solely because of their age. To continue coverage for a child under this provision beyond the age of 26, the medical plan must receive proof of incapacity within 31 days after coverage would otherwise terminate. Periodically, the medical plan under which you and your dependents are enrolled will require proof of continuing incapacity. Except for new hires, disabled dependents age 26 or older must be enrolled prior to the date the dependent became disabled. New hires may enroll their physically or mentally incapable of self-support dependents at the time of initial enrollment regardless of age.
- Other eligible dependents that meet the above criteria outlined for eligible children include:
    1. Grandchildren* of the employee, if
        - the employee has legal custody of the dependent or

- the parent is claimed as a dependent on the employee's federal tax return and such parent is enrolled as an eligible dependent in the plan.

2. The person of whom the employee is named as legal guardian*.

*When an employee elects medical and/or dental coverage for another person whom the employee does not claim on their federal tax return, the value of such coverage is imputed income to the employee. These individuals are referred to as non-152 dependents.

This means that the value of the monthly subsidy/contribution towards coverage that General Mills makes on behalf of an employee's non-152 dependent is considered income and federal income, social security and Medicare taxes are withheld from an employee's paycheck based on its value. In addition, federal regulations do not allow an employee to pay any required employee contribution for their non-152 dependent coverage with pre-tax dollars.

The General Mills Benefits Service Center will request that you complete the dependent verification process for newly enrolled dependents and will periodically review eligibility on an ongoing basis. You must notify the General Mills Benefit Service Center of any change in dependent status within 31 days of a change. Failure to do so may result in a retroactive loss of coverage if the dependent no longer qualifies for dependent coverage under the plan. You may be required to repay claims, premiums, and/or other costs incurred while covering an ineligible dependent and any premium payments you have paid will not be refunded.

Enrolling ineligible dependents or otherwise making a misrepresentation regarding the basis for plan coverage is a violation of company policy and the terms of the plan. Such ineligible dependent's coverage may be retroactively canceled and claim payments denied retroactively. In the event of your legal separation or divorce, you are required to complete the Dependent Verification Process for children other than your biological child(ren). A dependent child (other than your biological child as defined above) will be considered an eligible dependent if:

- you are named in a court decree as required to provide health insurance for the named dependent,
- you are named in a court decree as having joint physical custody of the child, or
- the child is covered under a Qualified Medical Child Support Order (QMCSO).

Your spouse or child will not be considered an eligible dependent while he or she is in military service.

Note: Participants and beneficiaries can obtain, without charge, a copy of the Qualified Medical Child Support Order (QMCSO) procedures from the General Mills Benefit Service Center.

If both you, your spouse or dependent child are company employees, you may elect dependent coverage for dental, but not medical.

Note: In order to claim expenses for the Health Savings Account and Healthcare Flexible Spending Account, the dependents listed above must be claimed as dependents on your federal income tax.

Medical Surcharge

If you choose to enroll your spouse or partner in medical benefits and your spouse or partner has access to medical coverage through their own employer, then a surcharge will apply.

The surcharge does not apply to the following groups: General Mills couples, current General Mills employees who are married to retired General Mills employees, or those who are covered by Medicare or military or state programs.

For Salaried employees, the charge is $150/month. For Nonunion Production employees it is $75/month.

Dependent Care Flexible Spending Accounts (Dependent Care FSA) - For expenses to be eligible under the Dependent Care Flexible Spending Account, your dependents must be:

- Claimed on your federal income tax return as a dependent, and
- Reside in your home a minimum of eight hours a day and be either:
    - Under age 13, or
    - Physically or mentally incapable of self-care.

Note: If you are married, you may participate in the Dependent Care FSA only if your spouse is:

- Gainfully employed,
- Looking for work,
- A full-time student for at least 5 months of the year, or
- Incapable of self-care

Life and AD&D Insurance - Dependents eligible for Life Insurance and AD&D coverage include the previous listed eligible dependents.

A person can only be insured once under the plan. Therefore, an employee cannot be insured as a dependent, a child can only be covered by one parent and no insured can be covered as both an ex-employee/dependent under portability and as an active employee/dependent under the plan.

Enrollment

For New Hires and Newly Eligible Employees:

When do I Enroll?	Within 31 days of hire date or newly eligible date
How do I Enroll?	Call the Benefit Service Center or go to the My Benefits website
When does my coverage begin?	Effective on your first day of employment or newly eligible date

Enrollment in the Company-Paid Life Insurance is automatic.

Optional Employee-paid Life Insurance, Spouse Life, Child Life and Accidental Death and Dismemberment: General Mills has contracted with Securian Life Insurance to provide this benefit. You will have 31 days from your first day of employment or eligibility to enroll without providing evidence of insurability for guaranteed amounts (some amounts require evidence of insurability regardless of when you enroll).

For enrollment changes associated with a Qualified Status Change (QSC):

When do I Enroll?	Within 31 days of the qualified status change
How do I Enroll?	Call the Benefit Service Center or go to the My Benefits website
When does my coverage begin?	The effective date of the qualified status change

The changes you make in coverage can be made only if they are consistent with the change in status event. For example, if your spouse starts a new job and becomes covered under the new employer's group health plan, it would not be consistent to add your spouse to your health plan, but it would be consistent to drop your spouse's coverage under your plan. Why is this so restrictive? IRS regulations require that General Mills comply with these rules. The good news about these regulations is that they allow you to pay for certain benefits with pre-tax dollars. The bad news is that because you can pay

with pre-tax dollars, only certain "qualified change in status" events make you eligible to change your elections.

A change in status is one of the following events if it affects the eligibility of you, your spouse, or your dependent under a group health plan:

- Birth or adoption of a child (an adopted child is eligible for coverage when placed in your physical care), gaining or losing custody or legal guardianship of a child or becoming subject to a qualified medical child support order (QMCSO)
- Marriage, divorce, or legal separation, annulment or termination of relationship
- Death of spouse or child
- Termination of employment of you, your spouse or dependent
- Commencement of employment of you, your spouse or dependent
- Change in employment status by you or your spouse, such as switching from full to part-time
- Beginning or returning from an unpaid leave of absence
- Change in dependency status of a dependent
- For the dependent care flexible spending account only, an increase or decrease in day care costs

If you do not enroll a new dependent, including a newborn, within 31 days of the change, you will have to wait until the next Annual Benefits Enrollment period to enroll the dependent. Coverage for the dependent will be effective the following January 1st.

NOTE: you are not able to enroll or change your HSA/Healthcare FSA/Dependent Care FSA contribution for the current year after December 1st.

For enrollment changes not associated with a QSC:

When do I Enroll?	Each year during Annual Benefits Enrollment (usually in the fall)
How do I Enroll?	Call the Benefit Service Center or go to the My Benefits website
When does my coverage begin?	The following January 1

Subject to certain exceptions, Annual Benefits Enrollment is the only time during the year when you can (1) enroll in the medical, dental, vision , legal and flexible spending accounts, or (2) review and make changes to those and other benefit coverages. If your coverage has been terminated due to non-payment of premiums while you are on leave, you are not eligible to enroll in coverage during Annual Benefits Enrollment. The next opportunity to enroll is within 31 days of the date you return to work.

Optional Employee-Paid Life Insurance, Spouse Life, Child Life, and AD&D – coverage is effective on the first day of the month after the date that Securian Life accepts your enrollment application. Dependents are eligible for benefits when you become covered, or when they first become eligible dependents, if later. Note that you cannot cover your dependents unless you are covered. Coverage is effective on the first day of the month after the date Securian Life accepts your enrollment application. However, if your dependent is confined in a hospital or elsewhere when the coverage would normally begin, coverage is not effective for the dependent until the date of discharge.

Dependent Enrollment - Shortly after enrolling any dependents in coverage, you will be contacted by the Dependent Verification team at the General Mills Benefit Service Center detailing the required dependent documentation you need to provide either by electronic upload, fax or mailing. You are required to provide proof of eligibility (i.e. marriage certificate, birth certificates, proof of marriage or tax return for stepchildren etc.) for your dependents, including spouse, who you are enrolling in medical, dental and/or vision coverage. If you are enrolling your spouse or partner in medical coverage, you must also submit a Medical Surcharge Affidavit. You can call the Benefits Service Center for a

complete list of required dependent documentation. You have 30 days from your enrollment date to provide the required documentation or your dependents coverage will be terminated.

If you are enrolling your legally recognized common-law spouse for medical, dental, and/or life insurance coverage, you must submit and have approved a Common-Law Spouse Statement. The Common-Law Spouse Statement is available on My Benefits.

If you are enrolling your domestic partner for medical, dental vision and/or life insurance coverage, you must submit a Domestic Partner Statement in addition to the required documentation.

Note: By enrolling in medical and dental coverage, you and each covered dependent, if any, are authorizing the release of medical information that is necessary to the operation and administration of the Plan or the payment of benefits from the Plan to the Plan Administrator. See "Health Care Privacy" for more information.

Special Enrollment Period - These statutory special enrollment rights described under this heading are only available to active employees and their dependents. If you decline enrollment in the medical and/or dental plans for yourself or your dependents when you first become eligible to enroll because of other group health insurance coverage (including COBRA coverage), you may be able to elect medical, dental and/or vision coverage for yourself or your dependents under the "special enrollment" rules. You may be eligible for a "special enrollment" if the other group health insurance coverage ends because the covered person is no longer eligible for it including: as a result of legal separation, divorce, death, termination of employment; cessation of dependent status; reduction in the number of hours of employment; a situation in which coverage is no longer offered to the class of similarly situated individuals that includes the individual; a situation in which an individual loses coverage because that individual no longer resides, lives or works in the service area or a situation in which the individual's benefit option is terminated or if the other employer stops making contributions to the coverage. To enroll under these circumstances, you must go online to the My Benefits website or call the Benefits Service Center and enroll within 31 days after the other coverage ends.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you must go online to the My Benefits website and enroll within 31 days after the marriage, birth, adoption, and placement for adoption. *NOTE:* you are not able to enroll or change your HSA/Healthcare FSA/Dependent Care FSA contribution for the current year after December 1st.

If you or your eligible dependent loses coverage under Medicaid or Children's Health Insurance Program (CHIP) due to a loss of eligibility (rather than non-payment) or if you or your dependent becomes eligible for government premium assistance under Medicaid or CHIP you will have a special enrollment right to enroll in the plan, by calling General Mills Benefits Service Center or going online to My Benefits website and enroll within 60 days of the event.

Actively at Work Requirement - You must be actively at work on the date your initial coverage or any increase in your coverage is to become effective. If you are not actively at work on such a date, the coverage or increase will be delayed until you return to work. This will not apply if the effective date is a non-work day, such as a holiday, weekend, vacation, or non-medical leave of absences, provided you were actively at work on the work day immediately ~~proceeding~~ preceding the non-work day. Actively at work means you are performing your customary duties at your normal place of business, or at other places that business requires you to be.

Coverage Termination – In all cases, coverage for you and your dependents will terminate at the end of the month in which:

- You have a qualified status change and drop coverage,
- You cease to be an eligible employee,

- You fail to pay any required employee contributions,
- Your dependent ceases to meet the eligibility requirements,
- Your employment terminates, or
- The Plan is discontinued.

Coverage may be continued under COBRA for a certain period of time after losing coverage for some of the above reasons. Please see the "Benefits Continuation/COBRA" section for complete COBRA information.

Plan Cost

Any portion of the premium payable by you as an employee contribution will be deducted from your paychecks. Your enrollment election authorizes these deductions. If you are not receiving paychecks, you will be required to make your premium payments via direct bill. Your contribution is determined by the eligible dependents enrolled for coverage and the plan options you elect. Contact the General Mills Benefit Service Center or go to the My Benefits website for the current employee contribution costs for your plan options.

Plan	**Employee Pays Pre-tax**	**Employee Pays After-tax**
Medical	X	
Dental	X	
Vision	X	
Company Paid Life Insurance*	No cost	No Cost
Optional Life Insurance		X
Accidental Death and Dismemberment		X
Spouse Life Insurance		X
Child Life Insurance		X
Health Savings Account	X	
Healthcare FSA	X	
Dependent Care FSA	X	

*Imputed Income

Medical and Dental:
When an employee elects medical and/or dental coverage for another person whom the employee does not claim on their federal tax return, the value of such coverage is imputed income to the employee. These individuals are referred to as non-152 dependents.

This means that the value of the monthly subsidy/contribution towards coverage that General Mills makes on behalf of an employee's non-152 dependent is considered income and federal income, social security and Medicare taxes are withheld from an employee's paycheck based on its value. In addition, federal regulations do not allow an employee to pay any required employee contribution for their non-152 dependent coverage with pre-tax dollars.

Life Insurance:

Coverage under the company-paid life insurance could result in imputed income depending upon your amount of coverage. The IRS requires that the actual cost of your life insurance in excess of $50,000 be taxable to you and included on your W-2. "Imputed Income" is the value the IRS places on employer paid life insurance coverage that exceeds $50,000. You pay income taxes on the value of this coverage. The value of the coverage is determined by the IRS and depends on your age and the amount of coverage you

have in excess of $50,000. This amount appears in the "Other" section of your paycheck stub as "Life-Imputed".

Special Note: Pre-tax employee contributions will be taken on an after-tax basis for the period of time between:

- *the event date of a qualifying event and the date your enrollment change is received and approved EXCEPTIONS are new hires and in the case of birth or adoption of a child (assuming the change is received within 31 days of the qualifying event date). In those cases, your contributions will be taken out on a pre-tax basis.*

The IRS does not allow you to make retroactive pre-tax deduction elections – that's why there's a brief period of time that your deduction will be taken after-tax.

Payroll Deductions - If you are paid semi-monthly, your monthly employee contributions will be taken 1/2 from each paycheck of the month. If you enroll in coverage prior to the 16th, of the month, you will be charged premiums for the entire month. If you enroll after the 16th, you will be charged premiums for half of the month.

If you are paid weekly, your monthly employee contributions will be taken 1/4 from each of the first 4 paychecks of the month for medical, dental, vision and life insurance. Health Savings Account and Flexible Spending Account deductions will be taken every week.

Annual Tax Reporting Forms

1. **W-2** The value of your health care benefits will be reported on your W-2. This is not taxable income to you and you will not have to pay taxes on it. This W-2 reporting is required under the Patient Protection and Affordable Care Act of 2010 (PPACA).

2. **1095-C** Medical tax form will be provided to you each year and will be available electronically or by mail.

1) For employees enrolled in HSA Gold: **IRS Form 8889** - You must file IRS Form 8889 with your IRS Form 1040 for any year contributions or distributions are made on the account. Please note contributions you elect through GMI payroll are pre-tax contributions from GMI and should not be included on line 2 of Form 8889. Box 12 on your W-2 will show all contributions GMI made to your HSA (including your pre-tax contributions if any). Use the amount shown on Box 12 from your W-2 on line 9 of Form 8889. Forms 8889 and 1040 are available at www.irs.gov or 1-800-tax-form.
2) **Form 1099 SA** - The form is sent in late January for HSA withdrawals or distributions made in the tax year.
3) **Form 5498 SA** – The form is sent in late May which will include total contributions made prior to the tax filing deadline.

Medical Benefits

The HSA Gold and the PPO Gold are plans administered by Blue Cross Blue Shield of Minnesota (BCBSMN) and the prescription benefit by Express Scripts

HSA Gold & PPO Gold Differences

Below is information that shows information and differences between the HSA Gold and PPO Gold. One of the main differences is that with the HSA Gold, you may be eligible for a Health Savings Account (HSA). See additional details on HSA below. Premiums also differ between HSA Gold and PPO Gold. Additional information can be found on the My Benefits website.

HSA GOLD	**In-Network**	**Out-of-Network**
Medical and Prescription Annual Deductibles-Combined both In and Out of Network	Employee Only: $1,400 Family: $2,800	Employee Only: $2,800 Family: $5,600
Prescription Drugs	You pay the full cost of prescription medications-**until you reach the deductible**. After your deductible is met, you pay the coinsurance/copay** for prescription drugs, up to your Out of Pocket Maximum.	
Preventive Drugs	Preventive Drugs are covered at 100%, even if you have not met your deductible. The following rules still apply: 1) generic incentive rules 2) preferred formulary and 3) maintenance medication rules (See Prescription Drug Coverage section for more information).	

PPO GOLD	**In-Network**	**Out-of-Network**
Medical Annual Deductible-Combined both In and Out of Network	$500 per individual, $1,000 per family.	$1,000 per individual, $2,000 per family.
Prescription Drugs	**No deductible for prescription coverage.** You pay the prescription coinsurance/copay** each time you fill a prescription, up to your Out of Pocket Maximum. After the Out of Pocket Maximum the plan pays at 100%. You do not have to satisfy your deductible before the PPO Gold plan begins to pay.	

***Note: Coinsurance and copays for Medical and Prescription coverage are the same across both plans. See below for more details.*

The following plan provisions for the Medical portion of the benefits under the HSA Gold and PPO are the same, unless noted.

Coverage Summary

The following section is a summary of the benefits available under the HSA Gold and PPO Gold Plans. Coverage is based on the allowed amount for medically necessary services and supplies. All services are subject to the annual deductible unless noted. General Mills retains full discretion to interpret the terms of the plan including the coverage and exclusion provisions and to determine whether a particular medical service, treatment, test or other item is covered or excluded from coverage under the plan, in using such discretion the company may refer to its claims administrators' medical policies and/or corporate standards, which are available to you upon request. **The % shown is the coinsurance and is what you pay after the deductible.**

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Acupuncture Notes: • A licensed provider must provide services. • Recommend contacting Medical Management to verify coverage before service received. Not Covered: • Any acupuncture services not medically necessary. • Please refer to the "General Exclusions" section.	20%	40%
Allergy Shots (See "Physician Services" for more information.)	20%	40%
Ambulance (Emergency/Non-Emergency) – Air or ground transportation for basic or advanced life support from the place of departure to the nearest facility equipped to treat the illness or injury. Note: • If the Claims Administrator determines air ambulance was not medically necessary, the Plan pays up to the allowed amount for medically necessary ground ambulance. Not Covered: • Transportation services that are not medically necessary for basic or advanced life support. • Transportation services that are mainly for your convenience. • Please refer to the "General Exclusions" section.	20%	20%

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Birth Control Notes: • Birth control pills are covered and paid by Express Scripts through the prescription drug program. • IUDs, diaphragms, and other devices fitted in a doctor's office are covered under the medical portion of the Plan. Not Covered: • Any birth control methods purchased over-the-counter. • Please refer to the "General Exclusions" section.	20%	40%
Blood and/or Blood Plasma Not Covered: • Blood that is replaced by your donor and/or for which there is no obligation to pay. • Please refer to the "General Exclusions" section.	20%	40%
Breast Surgery (including reconstruction after mastectomy) The Women's Health and Cancer Act of 1998 requires all group health plans to provide, in a manner determined in consultation with the attending physician and the patient receiving Plan benefits, in connection with a covered mastectomy, and who elects breast reconstruction in connection with such mastectomy coverage, for: • Reconstruction of the breast on which the mastectomy was performed, • Surgery and reconstruction of the other breast to produce a symmetrical appearance, and • Prostheses and physical complications for all stages of a mastectomy, including lymph edemas (swelling associated with the removal of lymph nodes). The Plan continues to fully comply with this requirement. Not Covered: • Cosmetic breast surgeries not related to disease. • Please refer to the "General Exclusions" section.	20%	40%

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Chemical Dependency Notes: If you are considering treatment for chemical dependency, contact Medical Management at 1-866-870-0411 where a can advise of benefits and assist with prior authorizations/limitations. Not Covered: • Please refer to the "General Exclusions" section.	20%	40%
Chemotherapy We encourage you to contact Medical Management at 1-866-870-0411 where a representative can help arrange home treatment, if applicable. Not Covered: • Treatment, services or supplies which are not medically necessary. • Charges for or related to care that is investigative, except for certain routine care for approved cancer clinical trials by approved investigators at qualified performance sites and approved by BCBSMN in advance of treatment. • Please refer to the "General Exclusions" section.	20%	40%

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Chiropractic Care Notes: • Services must be medically necessary and be provided by an eligible provider. • 30 visits per covered individual per calendar year. In & Out of network combined. • You pay all charges that exceed the allowed amount when you see an Out-of-Network provider. Not Covered: • Services that are primarily educational in nature. • Self-care and self-help training (non-medical). • Health clubs and spas. • Recreational therapy. • Rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time. • Massage therapy for the purpose of comfort or convenience. • Nutritional supplements. • Services or supplies that are commonly used for non-medical purposes or used for environmental control or enhancement. • Please refer to the “General Exclusions” section.	20%	40%

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Durable Medical Equipment (DME) We encourage you to contact Medical Management at 1-866-870-0411 where a representative can assist with pre-approval of equipment purchases or rentals. Notes: • Applies to purchase or rental expenses (up to purchase price) of Medical Equipment and Supplies; includes diabetic pumps. • Equipment must be medically necessary. Not Covered: • Services or supplies that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat appliances, cooling devices, water purifiers, hypoallergenic mattresses and/or bedding, waterbeds, vehicle lifts, computers and related equipment, and communication devices; such as assistive listening devices and systems and biofeedback devices. • Please refer to the "General Exclusions" section.	20%	40%
Emergency Care (ER) Emergency room or other facility charges for treatment of accidental injuries and medical emergencies. The $120 ER copay charge does not count toward the annual deductible. Note: • If you are admitted to the hospital the same day, the $120 charge is waived.	20% after $120 copay per-visit ER charge Non-emergency care received in an emergency room – 50% after $120 copay per visit ER charge	20% after $120 copay per-visit ER charge Non-emergency care received in an emergency room – 50% after $120 copay per visit ER charge
Hearing Care Notes: • Hearing exams are covered only when required due to an injury or disease. • Routine hearing exams up to age 7 ONLY. • Hearing Aids: one set every 3 years, $3,000 maximum for the 3 years. • Cochlear implants are covered. Not Covered: • No routine hearing exams over the age of seven. • Please refer to the "General Exclusions" section.	20%	40%

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Home Health Care If you need continuing professional care and can be treated at home, your physician can recommend a home health care program. The treatment must be for a condition that would otherwise require confinement in a hospital, skilled nursing facility, or convalescent nursing home, and must follow within 15 days of a covered confinement in such a facility for that condition. The patient may also be eligible for Home Health Care if under the care of a case manager from Medical Management. . We encourage you to contact Medical Management (1-866-870-0411) where a representative can advise of benefits, assist with prior authorizations and help to arrange home treatment. Notes: • The covered patient must be under the care of a physician who submits a Home Health Care Treatment Plan. • The care of the covered patient includes part-time skilled nursing care, occupational therapy, physical therapy, or speech therapy. Private Duty Nurse, 20% coinsurance, $10,000 lifetime max, prior authorization recommended. • The Home Health Care agency providing services must be licensed. (A home health care agency is a public or private agency that specializes in providing skilled nursing services and other therapeutic services, such as physical therapy, in your home. • The visit maximum may be higher if approved by Medical Management. Not Covered: • Non-medical services. • Please refer to the “General Exclusions” section.	20% to an annual maximum of 180 visits per year in & out of network combined *Limits are not applicable to mental health or substance abuse diagnosis’	40% to an annual maximum of 180 visits per year in & out of network combined *Limits are not applicable to mental health or substance abuse diagnosis’

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible) In-Network	Out-of-Network
Hospice Care Hospice care is for a terminally ill patient at home or in a hospice facility. We encourage you to contact Medical Management at 1-866-870-0411 where a representative can assist with pre-approval of hospice care. Notes: • Terminally ill is defined as a patient whose medical records indicate a life expectancy of six months or less. • Care may be provided through a hospice facility or at home through a centrally-administered, medically-directed program that is coordinated by a nurse. The program must: (1) use a hospice team, and (2) be available 24 hours a day, 7 days a week. • The services must be ordered and supervised by a physician. Not Covered: • Please refer to the "General Exclusions" section.	20%	40%
Hospitalization You must contact Medical Management at 1-866-870-0411 for pre-admission notification or within 48 hours following an emergency admission. Many tests and x-rays can be done on an outpatient basis before you are hospitalized. Please consider these options to reduce the length of your hospital stay. Note: • Eligible expenses include: semi-private room and board, services and supplies furnished by the hospital such as an operating room, x-rays, lab tests, and medicines, physician visits, and professional services including pathology, radiology, and anesthesia. Not Covered: • Please refer to the "General Exclusions" section.	20%	40%

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Fertility Treatment Notes: • There is a $20,000 lifetime maximum (includes medical and prescriptions) (across all self-insured plans) for fertility treatment including drugs, in-vitro fertilization, and reverse sterilization • Combined both In and Out-of-network. Not Covered: • Please refer to the "General Exclusions" section.	20% to a lifetime maximum of $20,000 per individual	40% to a lifetime maximum of $20,000 per individual
Laboratory Tests and X-Rays (administered on an outpatient basis) Note: • Routine and diagnostic tests are covered. Not Covered: • Please refer to the "General Exclusions" section.	20%	40%

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Maternity Care Maternity Care is covered similar to hospitalization, with the following exceptions: You will not be required to call and pre-certify maternity admissions if the inpatient care for the mother or child is not expected to continue beyond 48 hours following a normal vaginal delivery, or 96 hours following a caesarian section. For inpatient care (for either the mother or the child) which continues beyond the 48 or 96 hour limits, you must notify Health Management at 1-866-870-0411 before the end of these time periods. For any pregnancy-related hospital admission not related to delivery or not resulting in a delivery, a call to Health Management is also required. <u>Newborns' and Mothers' Health Protection Act of 1996:</u> Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Note: • Coverage for midwives is eligible if the provider is a Certified Nurse midwife or a Licensed Traditional midwife. • 100% coverage (no deductible for PPO Gold, deductible for HSA Gold) for electric breast pumps thru in-network durable medical equipment provider. Not Covered: • Please refer to the "General Exclusions" section.	20%	40%

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Mental / Behavioral Health Notes: • If you are considering treatment for mental and/or behavioral health, we encourage you to contact Health Management at 1-866-870-0411 to verify coverage. • Counseling benefits for transgender services are covered. Not Covered: • Please refer to the "General Exclusions" section.	20% *Limits are not applicable to mental health or substance abuse diagnosis'	40% *Limits are not applicable to mental health or substance abuse diagnosis'
Nutritional Counseling, Dietician Visit • Services must be provided by a Licensed Dietician (LD), Licensed Nutritionist (LN) or Registered Dietician (RD). • If diagnosed with an Eating Disorder (Anorexia, Bulimia or Eating disorder NOS), refer to the Mental/Behavior Health section within this SPD. • For medical conditions, for example: diabetes, hyperlipidemia, indigestion, children with failure to thrive, food intolerance or allergies, refer to the Physician Services section within this SPD. Not Covered: • Services by Health Educators and Exercise Physiologists.	20%	40%
Obesity Surgery Obesity surgery services must be medically necessary and must be pre-approved by Health Management (1-866-870-0411). Not Covered: • Please refer to the "General Exclusions" section.	20%	40%

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Occupational Therapy If you are considering therapy, we encourage you to contact Medical Management at 1-866-870-0411 where a representative can assist with determining the provider's eligibility and your medical necessity before you incur costly expenses that may not be covered by the plan.	20% to an annual maximum of 40 visits per year. In & out of network combined.	40% to an annual maximum of 40 visits per year. In & out of network combined.
Note: • Therapy must be performed by a licensed Occupational Therapist and prescribed by a physician. Not Covered: • Please refer to the "General Exclusions" section.	*Limits are not applicable to mental health or substance abuse diagnosis'	*Limits are not applicable to mental health or substance abuse diagnosis'
Outpatient Surgery (see "Surgery")		
Physical Therapy If you are considering therapy, we encourage you to contact Medical Management at 1-866-870-0411 where a representative can assist with determining the provider's eligibility and your medical necessity before you incur costly expenses that may not be covered by the plan.	20% to an annual maximum of 50 visits per year. In & out of network combined.	40% to an annual maximum of 50 visits per year. In & out of network combined.
Note: • Therapy must be performed by a licensed Physical Therapist and prescribed by a physician. Not Covered: • Please refer to the "General Exclusions" section.	*Limits are not applicable to mental health or substance abuse diagnosis'	*Limits are not applicable to mental health or substance abuse diagnosis'
Physician Services Services including office visits for illnesses, allergy testing, serum, and injections, inpatient hospital/facility visits during a covered admission, outpatient hospital/facility visits, surgery (including circumcision and sterilization). Notes: • The Plan covers certain physician services for Preventive care (see "Preventive Care"). • Virtual Doctor On Demand visits–Not Covered: • Please refer to the "General Exclusions" section.	20%	40%

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Podiatrist If you are considering treatment, we encourage you to contact Medical Management at 1-866-870-0411 where a representative can assist with determining the provider's eligibility and your medical necessity before you incur costly expenses that may not be covered by the plan. Not Covered: • Routine foot care. • Please refer to the "General Exclusions" section.	20%	40%
Prescription Drugs (see "Prescription Drug Coverage" administered by Express Scripts) Not Covered: • Over-the-Counter drugs. • Please refer to the "General Exclusions" section.		
Preventive Care In-Network – 100% coverage within Preventive guidelines. We encourage you to maintain your health by providing an enhanced Preventive care benefit. Examples of Preventive care services include well-baby and well-child exams, immunizations, annual physical exams, pap smears, prostrate exams and mammograms. Not Covered: • Please refer to the "General Exclusions" section.	0%-no deductible	40%
Skilled Nursing Care We encourage you to contact Medical Management at 1-866-870-0411 to verify coverage prior to receiving services. Not Covered: • Please refer to the "General Exclusions" section.	20%	40%

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Skilled Nursing Facility We encourage you to contact Medical Management at 1-866-870-0411 to verify coverage prior to receiving services. Notes: • Confinement must begin within 15 days after release from the hospital after a stay of at least 3 consecutive days. • Care must be prescribed by your physician for recovery of the condition for which you were hospitalized. Not Covered: • Please refer to the "General Exclusions" section.	20%	40%
Speech Therapy If you are considering therapy, we encourage you to contact Medical Management at 1-866-870-0411 to determine the provider's eligibility and your medical necessity before you incur costly expenses that may not be covered by the plan. Note: • Therapy must be performed by a licensed Speech Therapist and prescribed by a physician. Not Covered: • Please refer to the "General Exclusions" section.	20% to an annual maximum of 40 visits per year. In & out of network combined. *Limits are not applicable to mental health or substance abuse diagnosis'	40% to an annual maximum of 40 visits per year. In & out of network combined. *Limits are not applicable to mental health or substance abuse diagnosis'

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Surgery (including Outpatient Surgery) We encourage you to contact Medical Management at 1-866-870-0411 to verify coverage. Notes: • Surgery may be performed while inpatient at a hospital or on an outpatient basis at licensed surgical centers, ambulatory surgical centers, freestanding centers, physician offices, or hospital outpatient facilities. • If more than one surgical procedure is performed during the same operative session, the Plan covers the surgical procedures based on the allowable amount for the primary procedure and reduces the allowable amount on the other surgeries since they are secondary. • Eligible knee or hip replacement, spine & certain cardiac procedures performed on date of service at a Centers of Excellence (Blue Distinctions) will be paid at 100%. Other eligible expenses will be paid at 80%. Not Covered: • Charges that are separate from the surgery for pre- and/or post-operative care. • Cosmetic surgery. • Please refer to the "General Exclusions" section.	20% 0% after annual deductible	40% N/A
Temporomandibular Joint Syndrome (TMJ) We encourage you to contact Medical Management at 1-866-870-0411 to verify coverage. Surgical TMJ treatment you pay 20% (in-network) and 40% (out-of-network) after annual deductible. Non-Surgical TMJ - there is a $5,000 lifetime maximum (combined In and Out-of-network) for treatment such as x-ray/lab, PT/OT and Behavioral Modifications. Note: Please refer to the dental plan section for additional coverage information related to non-surgical TMJ benefits under that plan. Not Covered: • Please refer to the "General Exclusions" section.	20%	40%

Summary of Coverage	Coinsurance - HSA Gold and PPO Gold Plans (after annual deductible)	
	In-Network	Out-of-Network
Transplants You must contact BCBSMN Medical Management at 1-866-870-0411 where a representative can assist in arranging a transplant at a nationally-recognized Center of Excellence. Please see "Transplant Benefits" for more information. Notes: • There is a $200,000 maximum benefit for transplants that are not performed at a Center of Excellence. • There is no maximum if the transplant is performed at a Center of Excellence. Not Covered: • Transplants of non-human or artificial organs. • Please refer to the "General Exclusions" section.	20%	40%
Vision Care For Injury or Disease through BCBSMN Not Covered: • Please refer to the "General Exclusions" section.	20% for injury or disease	40% for injury or disease

Annual Out-of-Pocket Maximums - An out-of-pocket maximum represents the most you would pay in the Plan year for eligible expenses. Deductibles, copays and coinsurance, apply to your out-of-pocket maximum. After reaching the out-of-pocket maximum, the Plan will cover 100% of eligible expenses for the remainder of the calendar year.

Coverage – HSA Gold & PPO Gold		
Medical In-Network	$3,600 per Individual	$7,200 Family
Medical Out-of-Network	$7,200 per Individual	$14,400 Family

Overall out of pocket expenses for network charges cannot exceed the per individual amount for each covered individual in a calendar plan year. Out-Pocket Maximums are shared across In and Out-of-Network.

Other maximums and limitations of benefits may also apply. See the Coverage Summary of specific benefits and the Medical Management section for more information.

Lifetime Maximums - There is no maximum lifetime benefit for medical and prescriptions. There is a $20,000 lifetime maximum for infertility treatment (includes drugs) and includes benefits under all company-sponsored self-insured medical plans.

Other maximums and limitations of benefits may also apply. See the Coverage Summary of specific benefits and the Medical Management section for more information.

Prior Authorizations

The BCBSMN prefers that all requests for Prior Authorization be submitted to them in writing to ensure accuracy. Please call Member Services at 866-870-0411 for assistance and to obtain the appropriate mailing address for Prior Authorization requests.

Preadmission Notification

Preadmission notification is required for the following Admissions/facilities:

1. Hospital acute care Admissions (medical and behavioral); and,
2. Residential behavioral health Treatment facilities.

To provide preadmission notification, call Member Service at 1-866-870-0411. They will direct your call.

Choosing a Health Care Provider - General Mills has contracted with Blue Cross Blue Shield of Minnesota to offer a preferred provider network under the BlueCard PPO network. The preferred provider network is a nationwide network of healthcare providers committed to providing quality cost-effective care. One way to get more affordable pricing from health care providers is to contract with a network of preferred providers. Through a network, we are able to take advantage of discounted fees and negotiated limits on cost increases. When you use a network provider for your health care, you may get a better price on the services you require, resulting in a lower out-of-pocket expense for you and lower costs for the Company.

With a network provider, there are no surprises on fees. Please see "Charges That Are Your Responsibility" for more information.

To find out if a specific provider is part of the network, call 1-866-870-0411, or visit Blue Cross Blue Shield's website at http://www.bluecrossmn.com/generalmills. When you see a network provider, you do not need to file a claim, since the provider sends the claim to Blue Cross Blue Shield of Minnesota for you.

You may choose any eligible provider of health services for the care you need. A "provider" is any person, facility, or program that provides covered services that the Claims Administrator determines are within the scope of the provider's license, certification, registration, or training. However, if you use an out-of-network provider, you will likely incur larger out-of-pocket expenses and a lower benefit coverage level.

In-Network Providers - These BlueCard PPO providers submit your claims for you and Blue Cross Blue Shield of Minnesota sends payment to the provider directly for covered services you receive. To find out if a specific provider is in the network call Blue Cross Blue Shield of Minnesota at 1-866-870-0411. You can also find information about providers on the Blue Cross Blue Shield of Minnesota website at http://www.bluecrossmn.com/generalmills. The list of network providers may change as providers enroll or terminate their agreements with Blue Cross Blue Shield of Minnesota.

Network Exception - In-Network Providers may not be located in all geographical areas. A Network Exception may be available when there are no In-Network Providers within 20 miles of your home that are able to perform the required services within their scope, licensure or certification. With a Network Exception, you may receive the In-Network level of benefits for services from Out-of-Network Providers. You are responsible for filing your own claims and for charges above the allowed amount. Contact the Claims Administrator to request a Network Exception.

Wisconsin Providers - Employees who live in Milwaukee and the surrounding communities: When you receive care in Wisconsin, you must use Blue Preferred POS Providers to receive In-Network benefits. Therefore, it is important that you confirm the provider's status before you receive services.

Georgia Providers - Employees who live in Georgia: When you receive care in Georgia, you must use Blue Open Access POS Providers to receive In-Network benefits. Therefore, it is important that you confirm the provider's status before you receive services.

Kansas City Providers – Employees who live in Kansas City, Missouri and the surrounding communities: When you receive care in the Kansas City area, you must see Preferred-Care Blue Providers to receive In-Network benefits. Therefore, it is important that you confirm the provider's status before you receive services.

Out-of-Network Providers - Out-of-network providers may not be willing to submit claims for you or contact Member Services for you. You may need to contact Member Services yourself or file your own claims for benefits. Out-of-network providers have not pre-negotiated fees for their services. As a result, the cost of services may be higher than in-network providers. Because you pay for a portion of these costs, your costs may also be higher. Refer to the next section for a description of charges that are your responsibility.

Emergency Services - An emergency exists when there is reason to believe that a serious medical condition exists or the absence of medical attention would result in a threat to the person's life, limb, or sight and requires immediate medical treatment. This includes the treatment of severe pain.

When determining if a situation is a medical emergency, Blue Cross will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.

Charges That Are Your Responsibility - When you see an in-network provider for covered services, payment is based on the allowed amount. You are not required to pay for charges that exceed the allowed amount. You are required to pay the following amounts:

- deductibles,
- copayments and/or co-insurance,
- charges that exceed the benefit maximum,
- charges for services that are not covered, and
- charges for services that are investigative or not medically necessary.

When you see out-of-network providers for covered services, the charges are processed at the reasonable and customary level. This may result in a larger out-of-pocket expense for you, since you are responsible for payments over the allowed amount. You are required to pay the amounts listed above plus all charges that exceed the reasonable and customary (allowed) amount set by the Plan.

BCBSMN Medical Management - To assure the appropriateness of the care you are receiving, BCBSMN Medical Management oversees hospital stays, mental health and chemical dependency services, and certain other types of care. It is important to call BCBSMN Medical Management whenever you or one of your covered dependents needs to receive care that requires pre-admission notification. The General Mills employee toll-free number for BCBS Member Services Medical Management is 1-866-870-0411.

Medical professionals will ask for information about you or your covered dependent's medical condition and the physician's recommendation. They will then contact the physician to make sure the course of treatment he or she has advised is medically necessary and in the best interest of you or your

dependent. Medical Management will also determine if the proposed treatment is covered by the Medical Plan.

ConsumerMedical

ConsumerMedical's team of doctors, nurse allies and researchers offer personalized, one-on-one support to employees and covered dependents who are enrolled in a General Mills medical plan.

ConsumerMedical can assist with:

- Finding a top-rated specialist or treatment center
- Considering different treatment options
- Providing trusted information about a medical condition
- Providing confirmation of a diagnosis
- Getting a second opinion

Medical Decision Support®
Personalized, one-on-one support from an expert team of doctors, nurses and researchers to help participants:

- Understand any medical condition and all available treatment options (cancer, diabetes, ADHD, fertility and more)
- Ask their doctor the right questions
- Cope with the stress of having a medical condition

Surgery Decision Support®
Information and guidance to help participants decide if surgery is right for them, including:

- Help weighing surgery risks, benefits and alternative treatment options.
- Tips to be better prepared for surgery and expectations for recovery and beyond

If you've been recommended for lower back surgery, hip or knee replacement, weight loss surgery or hysterectomy you may be eligible for a $250 incentive for participating in the Surgery Decision Support program. Contact ConsumerMedical for details at 1-800-835-2362, Monday-Friday, 7:30 a.m. – 10:00 p.m. CST.

Expert Medical Opinion
Helping participants find the most qualified doctors and top-rated hospitals in their area and insurance network, as well as:

- Check credentials and verify a doctor's training, skills and experience.
- Get a second opinion from elite specialists across the country, either in person or virtually for complex cases.

Cancer Support Program
Specialized cancer support program for employees and their covered dependents who are facing a cancer diagnosis. A team of doctors, nurses and other healthcare professionals will help participants take the steps to ensure they receive quality care and assist with medical claims and billing issues.

Participants may be eligible for a $250 incentive for participating in the program. Contact ConsumerMedical for details at 1-833-283-1416, Monday-Friday, 7:30 a.m. – 10:00 p.m. CST.

Livongo

Livongo is a program that makes living with diabetes easier by providing you with an advance glucose meter, free unlimited strips and expert advice and coaching from Certified Diabetes Educators. It is offered at no cost to you and your family members that have been diagnosed with type 1 or type 2 diabetes and are covered under the PPO Gold or HSA Gold medical plans administered by Blue Cross Blue Shield of Minnesota.

Visit www.register.livongo.com Use code GENERALMILLS

Omada
Discover a whole new way to get healthy.

Omada is an online program that can help you lose weight, feel great and lower your risk for type 2 diabetes and heart disease. This program is available at no cost to you and adult family members who are enrolled in the PPO Gold or HSA Gold medical plans administered by Blue Cross Blue Shield of Minnesota. Omada combines science and support to help you develop healthy habits that last. You get personal support and interactive tools to get and keep you motivated.

Visit www.omadahealth.com/generalmills to find out if you qualify by answering a few quick questions – it just takes a minute.

Learn to Live

Life provides us with plenty of opportunities to feel stressed and worried, like relationships, health, work and finances. It's normal to feel sad, lonely, afraid, nervous or anxious. If those feelings don't seem to go away, it may be time to take action.

Learn to Live offers customized online programs for individuals struggling with Stress, Anxiety & Worry, Depression, Insomnia or Social Anxiety. The programs are free, confidential, accessible from anywhere and available to General Mills employees and family members age 13+.

Visit learntolive.com/partners to learn more and get started. Use code: GENERALMILLS

Hospitalization - You must call BCBSMN Member Services Member Services at 1-866-870-0411 if it is an out-of-network facility. Call prior to any non-emergency hospitalization or within 48 hours following an emergency hospitalization. When you call Medical Management, medical professionals review such things as:

- The need for hospitalization
- The appropriateness of the treatment plan
- How long the treatment may be reasonably continued while maintaining the same quality of care for the patient

No benefits are payable for any days of inpatient hospital confinement that are determined not to be medically necessary or are inappropriate for your medical condition.

You will not be required to call and pre-certify maternity admissions if the inpatient care for the mother or child is not expected to continue beyond 48 hours following a normal vaginal delivery, or 96 hours following a caesarian section.

Extension of Hospitalization - Once you or one of your dependents is hospitalized, Medical Management will monitor the length of the hospital stay to make sure a continued stay is necessary. If unforeseen complications develop, Medical Management will discuss the situation with your doctor to assure appropriate level of care and services are being provided.

Centers of Excellence-Nationally known medical centers throughout the country that specialize in the type of transplant you need. Centers of Excellence are selected based on their experience and expertise in performing complex transplant procedures. Eligible participants will receive personal assistance with the planning and coordination of treatment, and when necessary, travel arrangements.

Eligible knee or hip replacement, spine & certain cardiac procedures performed on the day of the procedure at a Centers of Excellence (Blue Distinctions) will be paid at 100%.

Transplant Benefits - If you have a transplant performed at a Center of Excellence coordinated through Medical Management, all covered transplant expenses are included in your unlimited maximum. If you do not use a Center of Excellence for transplant surgery, the maximum benefit for a transplant is $200,000. Utilizing Medical Management will improve the likelihood of a successful outcome and help reduce the stress and anxiety surrounding medical conditions that may require a transplant. Contact Medical Management at 1-866-870-0411 if your doctor has recommended a transplant.

Mayo Clinic Weight Loss Procedure Program - In addition to the obesity/weight loss surgeries previously mentioned as covered by The Plan, The Plan also covers the Mayo Clinic Weight Loss Procedure Program. The program includes coverage for the Mayo Clinic Healthy Living Program which includes education about healthy lifestyle habits, a personalized plan and ongoing support. It also includes coverage for certain endoscopic weight loss procedures. In addition, The Plan will reimburse up to five thousand dollars ($5,000) for travel and lodging expenses, except meals, for the Member if accepted into the program.* Members must meet eligibility requirements in order to be enrolled in the program. Please contact Blue Cross Blue Shield at 1-866-870-0411 for more information about the program, coverage and eligibility.

*This travel and lodging benefit is separate from other travel and lodging benefits and is specific to the Weight Loss Procedure Program through Mayo Clinic.

Notifying Member Services Before Other Services - We encourage you to contact BCBSMN Member Services at 1-866-870-0411 before receiving certain other types of services. The purpose of this notification is to ensure that the care is medically necessary and is being provided by an appropriately licensed provider. Member Services can also verify the coverage the Plan will provide.

- Acupuncture
- Cosmetic procedures
- Chiropractic care
- Chemotherapy for certain routine care for approved cancer clinical trials by approved investigators at qualified performance sites & approved by BCBSMN in advance of treatment
- Durable medical equipment purchases over $500
- Gender Reassignment services (**preauthorization is required**)
- Growth Hormone
- High Risk Pregnancy/complications of pregnancy
- Home Health Care

- Hospice Care
- Inpatient Hospitalization
- Obesity / Weight Loss surgeries
- Pain Rehabilitation programs
- Skilled Nursing Care / Facilities
- Surgery
- Temporomandibular Joint Syndrome (TMJ)
- Transplants
- Uvulopalatopharyngoplasty

Mental Health and Chemical Dependency Services - You may contact Medical Management for mental health and/or chemical dependency services without initially seeing a physician. They can assist you in finding help for a full range of issues such as depression and anxiety, grief and loss, child or adolescent concerns, and drug or alcohol abuse. Inpatient and outpatient mental health and chemical dependency expenses will be reviewed by Medical Management to determine:

- The appropriateness of inpatient hospital care
- Whether an alternative treatment plan or setting for care is more appropriate
- The period of time for which treatment is medically necessary

Eligible facility charges will be paid at 80%.

Out-of-Country Benefits
If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard Service Area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered health care Services.

Eligible Services coordinated through the Blue Cross Blue Shield Global® Core program will process at the in-network level of coverage.

Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard Service Area, you will typically have to pay the providers and submit the Claims yourself to obtain reimbursement for these Services.

Call the Blue Cross Blue Shield Global® Core service center within 24 hours of a Medical Emergency at 1-804-673-1177. You will be advised by the service center if services are not eligible under this program.

If you do not call the Blue Cross Blue Shield Global® Core service center or Services are not eligible under this program, eligible Services will process at the Out-of-Network level of benefits.

Services not covered under the Plan will not be considered for benefits

Preventive Care

Preventive benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors which are the recommendations of the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and Health Resources and Services Administration (HRSA). The Claims Administrator periodically reviews the schedule of Covered Services based on the requirements of the Patient Protection and Affordable Care Act of 2010, and recommendations from USPSTF, ACIP and HRSA. Therefore, the frequency and eligibility of Services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of Covered Services, log onto the Claims Administrator's member website at, www.bluecrossmnonline.com or call Member Service at the telephone number listed on the back of your member ID card.

Benefits for Services identified as Preventive Care are determined based on recommendations and criteria established by professional associations and experts in the field of Preventive Care (e.g., Institute for Clinical Systems Improvement (ICSI), United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), etc.). For all other eligible Services, please refer to "Hospital Services," and "Medical Services."

Birth to 2 Years

Covered Preventive Care Service	**Covered Frequency**
Routine clinical screening exam/visit, including: · Height and weight measurement · Head size · Developmental (milestones) assessment · Vision and hearing assessment	One exam during the first week of birth and again at 2, 4, 6, 9, and 15 months
Rotavirus (Rv)	2, 4 and 6 months
Haemophilus influenza type B (Hib)	2 and 4 months
Pneumococcal conjugate (PCV)	2, 4, 6 and 15 months
Measles, mumps, rubella, varicella (chickenpox) (MMRV)	12-15 months (second dose at 4 to 6 years or before starting kindergarten)
Hepatitis A	12-15 months and 18-23 months
Hepatitis B	At birth, between 1 and 2 months and final dose at 6 to 18 months
Diphtheria, tetanus, pertussis, haemophilus influenza type B (DTaP-Hib)	2, 4, 6, 15, 18 and a booster at 4 to 6 years
Influenza	Once a year for ages 6 months and older
Lead screening	At 12 months if child is at risk
AGPAR (a test to determine how well an infant tolerated the birthing process and is adapting to his or her new environment)	Once – one to five minutes after birth
Congenital Hypothyroidism	Once – before leaving the hospital or at 2 – 4 days of age
Hearing loss	Once – before leaving the hospital or at 1 month
Iron-deficiency anemia	Yearly

Newborn screenings (some states require 29 or more tests for infections and disorders)	Once – before leaving the hospital
Phenylketonuria	Once – before leaving the hospital
Prevention of dental caries	At routine exams; first dental visit recommended at 1 year
Sickle cell disease	Once – birth to 2 months
Visual impairments	At well-child/routine exams

Age 2 – 6 Years	
Covered Preventive Care Service	**Covered Frequency**
Routine clinical screening exam/visit, including: · Height and weight measurement · Body mass index (BMI) · Developmental (milestones) assessment · Vision and hearing assessment · Blood pressure · Obesity · Iron deficiency anemia	Yearly
· Lead screening · Behavioral counseling to prevent sexually transmitted infections · Depression (major depressive disorder)	
Dental carries and other dental problems	Every 6 months
Diphtheria, tetanus, pertussis, (DTaP) Poliovirus (IPV) Measles, mumps, rubella, varicella (chickenpox) (MMRV)	5 years
Influenza	Once a year for ages 2 to 6 years
Human papillomavirus	Three doses total: the second dose give two months after the first dose and the third dose given six months after the first dose
HIV	At routine checkups
Pneumococcal (polysaccharide)	Given once 2 or more months after last dose of pneumococcal conjugate vaccine, based on child's medical condition

Age 18 - 39 Years

Covered Preventive Care Service	**Covered Frequency**
Routine clinical screening exam/visit, including: · Height and weight measurement · Body mass index (BMI) · Physical developmental (milestones) assessment · Blood pressure · Alcohol misuse	Yearly
· Depression	

· HIV · Syphilis · Tobacco use and tobacco related disease · Gonorrhea Women - Chlamydia screening if sexually active.	
Tetanus, diphtheria, pertussis (Td/Tdap)	Td: every 10 years Tdap: substitute a one-time dose of Tdap for a Td booster after age 18, then boost with Td every 10 years
Human papillomavirus (HPV)	Women: three dose series sometime between 13 and 18 years Men: three dose series between ages 22 and 26
Flu (seasonal)	Yearly
Women – Pap test	One in the three years after first sexual intercourse. Between ages 21 and 29 every 3 years. Between ages 30 and 65 every 5 years.
Women – Breast cancer, chemoprevention, BRCA mutation testing for breast and ovarian cancer susceptibility	Clinical breast exam every 3 years. Chemoprevention and BRCA counseling for women at high risk
Chlamydia	Every 3 years
Men - Colorectal cancer	Discuss with your health care provider to m make an informed decision based on your family history, current medical condition, and personal values
Diabetes mellitus, type 2	At least every 3 years
Lipid disorders	At least every 5 years
Meningococcal	One or more doses
Tuberculosis	Check with your health care provider
Vision	At least one complete exam in your 20s and two in your 30s
Diet, behavioral counseling	When diagnosed with hyperlipidemia and other known risk factors for cardiovascular and diet related chronic disease

Age 40 – 64 Years

Covered Preventive Care Service	**Covered Frequency**
Routine clinical screening exam/visit, including: · Height and weight measurement · Body mass index (BMI) · Blood pressure · Health risk assessment · Any necessary immunizations · Screenings for osteoporosis, alcohol and tobacco use	Men – One visit every five years Women – One visit every three to five years

· Preventive counseling; such as use of aspirin, calcium or folic acid to reduce the risk for heart disease, bone fractures or birth defects (for women of child-bearing ages) · Depression · HIV · Syphilis · Women – Chlamydia · Women - Gonorrhea	
Blood pressure	Every two years if less than 120/80 Every year if 120-139/80-89
Tetanus, diphtheria, pertussis (Td/Tdap)	Td: every 10 years Tdap: substitute a one-time dose of Tdap for a Td booster after age 18, then boost with Td every 10 years
Flu (seasonal)	Yearly
Td booster shot (tetanus-diphtheria)	Once every 10 years
Cholesterol screening	Men – Every five years Women – Every five years beginning at age 45
Colon cancer screening	Under 50: Discuss with your health care provider to make an informed decision about screening based on your family history, current medical condition and person values Age 50: Preventive colonoscopy once every 10 years
Men – PSA and prostate exam	According to your Physician's assessment of your individual risk
Women – Clinical breast exam	Yearly
Women – Mammogram	Yearly
Women – Pap test and pelvic exam	Every three years after three normal tests in a row over five years
Postmenopausal women - Osteoporosis	Check with your health care provider
Diabetes mellitus, type 2	At least every 3 years
Tuberculosis	Check with your health care provider
Vision	Baseline comprehensive exam at age 40
Zoster (shingles)	Age 60 and older one dose

Age 65 and Older

Covered Preventive Care Service	**Covered Frequency**
Routine clinical screening exam/visit, including: · Height and weight measurement · Body mass index (BMI) · Blood pressure · Health risk assessment · Any necessary immunizations · Screenings for osteoporosis, depression, alcohol and tobacco use	Every two years

· Hearing screening · HIV · Syphilis · Women – Chlamydia · Women – Gonorrhea · Preventive counseling; such as use of aspirin, calcium or folic acid to reduce the risk for heart disease and bone fractures	
Blood pressure	Every two years if less than 120/80 Every year if 120-139/80-89
Flu (seasonal)	Yearly
Tetanus/diphtheria/pertussis (Td/Tdap) booster	Every 10 years. Tdap is recommended if you have contact with a child younger than 12 months. Either Td or Tdap can be used if you have no contact with infants
Cholesterol screening	Every five years
Colon cancer screening	Preventive colonoscopy every 10 years
Diabetes mellitus, type 2	At least every 3 years
Tuberculosis	Check with your health care provider
Vision	Every 1 to 2 years
Men – PSA and prostate exam	According to your Physician's assessment of your individual risk
Men – Abdominal aortic aneurysm screening	For ages 65-74 who have ever smoked (more than 100 cigarettes in a lifetime)
Women – Clinical breast exam	Yearly
Women – Mammogram	Yearly
Women – Pap test and pelvic exam	Every three years if you have a new sexual partner
Postmenopausal women - Osteoporosis	Check with your health care provider

Instructions for Filing Medical Claims

In-Network Providers - You are not responsible for submitting claims for services received from in-network providers. These providers will submit claims for you and payment will be made directly to them.

Out-of-Network Providers - If you receive care from Out-of-Network providers, you may have to submit the claims yourself. If the provider does not submit the claim for you, send the claim to:

Blue Cross Blue Shield of Minnesota
P.O. Box 64338
St. Paul, MN 55164-0338

You can obtain a claim form by calling 1-866-870-0411.

Benefits for services you receive from Out-of-Network providers will be paid directly to you, and you will be required to pay your provider. Claims cannot be paid directly to Out-of-Network providers except when parents are divorced. In that case, the custodial parent may request in writing that the Plan pay a provider for covered services for the child.

Filing Medical Claims - When submitting claims, your itemized bill should contain the following information:

- Blue Cross Blue Shield ID number found on your ID card,
- Blue Cross Blue Shield group number found on your ID card,
- Patient name,
- Date of service that charges were incurred,
- Procedure code(s) ("CPT code"),
- Amount billed for each service, and
- Provider Tax Identification Number.

Submit claims to Blue Cross Blue Shield of Minnesota at the address listed above. Do not submit receipts, balance due statements, or bills marked "patient copy" or "not for insurance purposes". Submit original itemized bills only. Keep a copy of submitted bills for your own records. Copies are acceptable only if the General Mills plan is the secondary payer. For an explanation of secondary payer, see the "Coordination of Medical Benefits" section.

If you or a covered dependent have any other group health insurance coverage, or Medicare coverage (if Medicare pays first on your medical expenses), please be sure to include the following information:

- Name of the covered person,
- Name of the insurance plan,
- Effective date of the coverage,
- Complete claim mailing address and telephone number, and
- Policy number.

If other group health insurance pays first on your medical expenses, you must submit a copy of the itemized billing along with the primary payer's statement or Explanation of Benefits (EOB). If your healthcare provider does not file claims for you, you will need to do the following:

- Submit the bill to the primary insurance carrier first.
- Wait for the primary insurance carrier's EOB (Explanation of Benefits).
- Send Blue Cross Blue Shield a copy of the bill and the EOB from the other insurance carrier.

Claims should be filed in writing within 90 days. If this is not reasonably possible, the Plan will accept claims up to December 31 of the following year of the date of service. Normally, failure to file a claim within the required time limits will result in denial of your claim. These time limits are waived if you cannot file the claim because you are legally incapacitated. You may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that you have incurred a covered expense that is eligible for reimbursement.

Right of Examination - The Claims Administrator and the Plan Administrator each have the right to ask you to be examined by a medical provider during the review of any claim. The Plan pays for the exam whenever the exam is requested by either the Claims Administrator or the Plan Administrator.

Failure to comply with this request may result in denial of your claim.

Appeals / Adverse Benefit Determinations - If your claim is denied, you can request a review of the denial. See the "Claims and Appeals" section for more information.

Overpayment of Claims - If you receive an overpayment on a claim submitted to the Plan, the amount of the overpayment may be deducted from future claim payments made to you. You or your provider may also be asked to refund the overpayment.

Coordination of Medical Benefits (COB)

When you and other members of your family are covered by HSA Gold or PPO Gold Plan, referred to collectively as "the Plan", and another group medical plan, you can submit claims to each plan and the benefits will be "coordinated". The member must satisfy contract obligations such as deductibles, coinsurance, and copayments, and as a result may be liable for part of the charges. This Plan contains a provision that determines its share of the total allowable expenses and coordinates its payments with other group plans.

If both you and your spouse are General Mills employees and eligible for the HSA Gold or the PPO Gold Plan, you may **not** both elect dependent coverage.

Primary and Secondary Payers of Benefits - When a claim is made, the coordination provision determines whether the Plan will be the "primary" payer (pay its regular benefit before other plans pay) or the "secondary" payer (may pay a portion of the benefits after another plan has paid its normal benefit). The primary plan pays its benefits without regard to any other coverage, and the payment is not adjusted to allow for a secondary payer. The secondary plan, however, calculates its benefits so that the total payments available from all plans will not exceed the normal amount of allowable expenses under the secondary plan. No plan will pay more than it would without the coordination provision.

A plan without a coordination provision is always the primary plan. If all plans have a coordination provision, the plan covering the patient as an employee is primary.

Coverage for Dependent Children - If a child is covered by both parents' plans, the parent whose birthday occurs first within the calendar year is primary. If both parents have the same birthday, the plan covering the parent for the longest period of time is primary. This is called the "birthday rule". If a child is covered by both parents' plans, and the other plan does not administer benefits according to the birthday rule, the father's plan is primary for both the Plan and the other parent's plan. Coverage for dependent children whose parents are legally separated or divorced is determined in the following order:

1. The parent who has financial responsibility for health care expenses, as established by terms of a court decree including a valid Qualified Medical Child Support Order (QMCSO),
2. The parent who has custody of the child,

3. The stepparent married to the parent who has custody of the child (provided that the child resides with the stepparent).

Definition of "Plans" - The following types of medical benefits are considered "plans":

- Coverage (other than Medicare or Medicaid) under a governmental program or coverage provided under the medical payment ("medpay") or personal injury protection benefit available to you under an automobile insurance policy.
- Group insurance or other coverage for a group of individuals, including student coverage obtained through an educational institution above the high school level, or other group prepayment arrangements.

Employees on Leave of Absence - If you are covered by the Plan during a leave of absence and become employed and covered by another group plan, the other group plan will be primary and the Plan will be secondary.

Employees on Paid Severance Leave - If you are covered by the Plan while on severance leave and gain access to coverage through a new employer, you are required to terminate your enrollment in the General Mills medical plan.

Retired Employees - If you are covered by another plan as a retiree and become covered under the Plan as an active employee, the Plan will be primary and the other plan will be secondary.

Coordination with Medicare - Active employees and covered dependents age 65 and older are currently not required to enroll in Medicare Part B coverage. There is no late penalty for enrolling in Part B at the time of your retirement, provided you enroll for Medicare during the special enrollment period following your retirement. You should check with your local Social Security office about current laws as you near age 65. Medicare enrollment forms are available from your local Social Security office. **At retirement and employees receiving Long-Term Disability benefits, enrollment in both Medicare Part A and Part B is required.**

Under current laws, an individual becomes eligible for both Medicare Parts A and B upon reaching age 65, or before age 65 if the individual is disabled and has received 24 months of disability payments from Social Security. Medicare is also available at any age and without the need to prove disability if the individual has a chronic kidney disease and has received the required number of months of dialysis treatment or requires a kidney transplant.

If you are enrolled in a General Mills sponsored medical plan and Medicare is the primary payer of your medical coverage, Medicare Parts A and B benefits are subtracted from the Plan benefits whether or not you have actually enrolled for Medicare Parts A and B coverage.

Benefits are calculated using the following steps:

1. The amount the Plan will normally pay is first computed,
2. Next, the amount of Medicare Parts A and B benefits is determined, and
3. The Plan pays the difference, if any, between the eligible expenses and the amount payable by Medicare up to the amount the Plan would have paid had it been the primary payer of benefits.

Effects of Medicare on Medical Benefits for Active Employees and Dependents Age 65 and Over and/or Eligible for Medicare Due to Disability - If you are an active employee and you or your spouse are age 65 or older or are eligible for Medicare due to disability, you will continue to have the company medical plan coverage as the primary payer of medical benefits unless you elect, in writing, to have Medicare as the sole payer of your medical expenses.

This means that if you continue to have company medical coverage, the company will be the primary payer of benefits for you and/or your spouse, and Medicare will be the secondary payer of benefits. If, however, you elect Medicare as the sole payer of benefits, you are no longer eligible for any company-sponsored medical plan benefits. Medicare Part B premiums are paid by you without reimbursement by the company. Contact the General Mills Benefits Service Center to terminate your company medical plan and elect Medicare as the sole payer of benefits.

Effects of Medicare on Medical Benefits for Employees Receiving Long-Term Disability (LTD) Benefits and Their Dependents - If you are receiving benefits from the company's Long-Term Disability (LTD) Plan and you become eligible for Medicare (typically after receiving Social Security Disability Income benefits for 24 months), you must enroll in Medicare Part A and Part B and provide documentation of such enrollment. You are required to pay the Medicare Part B premium. Once an LTD participant becomes eligible for Medicare, coverage under the Company plan will continue but Medicare will become the primary payer of benefits. Benefits under this plan (if you elect to continue to carry company plan coverage) will be reduced by the benefits payable under Medicare.

If you are receiving benefits from the company's Long-Term Disability (LTD) Plan and your spouse becomes eligible for Medicare, they must enroll in Medicare Part A and Part B at the later of the time the dependent becomes Medicare eligible or the employee becomes eligible for LTD. You will need to provide documentation of such enrollment. Your spouse is required to pay the Medicare Part B premium.

Effects of Medicare on Medical Benefits for Employees and Dependents with End Stage Renal Disease (ESRD) - Under current laws, if you or your eligible dependents have Medicare coverage because of permanent kidney failure, the company-sponsored medical plan will be the primary payer of benefits for the first 30 months of treatment, with Medicare as the secondary payer of benefits. After the first 30 months, Medicare becomes the primary payer of benefits and company-sponsored benefits are reduced by Medicare Parts A and B benefits, whether or not you or your dependents have actually enrolled for Medicare Parts A and B coverage.

Medical Plan General Exclusions

The Plan does not cover the following expenses:

- Artificial organs and non-human organs whose purpose is to assist or replace a natural body organ. Charges for the implantation, attachment, use, or follow-up care of such artificial organ are not covered, except that the Plan does cover kidney dialysis and pacemakers.
- Autopsies
- Blood that is replaced by your donor and for which there is no obligation to pay.
- Charges:
    - For failure to keep an appointment.
    - For filing claims on behalf of covered persons.
    - Charges from a provider who would waive any deductible and coinsurance payments for the insured.
    - Greater than the reasonable and customary amount for a service or supply as determined by the Plan Administrator
    - That are eligible, paid, or payable, under any medical payment, personal injury protection, automobile, or other coverage that is payable without regard to fault, including charges for services that are applied toward any deductible, copayment or coinsurance requirement of such a policy.

- Copy services for medical records.
- Cosmetic surgery, except if medically necessary:
    - After accidental injury for an individual who is covered at the time of the accident under a company-sponsored medical plan,
    - To correct certain extensive congenital malformations that impair a bodily function, or
    - To correct a defect resulting from previous surgery while covered under a company-sponsored medical plan.

  An accidental injury means the unexpected results of a sudden external force that damages sound and natural body structure.
- Custodial care expenses incurred for room and board, nurses' services and medical services that cannot reasonably be expected to contribute to the improvement of a medical condition.
- Dental hospitalizations required due to the age or emotional status of the individual or due to the extent of the dental procedure (unless documented as medically necessary).
- Dental treatment of periodontal or periapical disease or any condition (other than a malignant tumor and accidental injuries) involving teeth, surrounding tissue or structure.
- Expenses applied toward satisfaction of the deductible.
- Expenses for services that are not appropriate or consistent with the diagnosis.
- Gene therapy as a treatment for inherited or acquired disorders.
- Growth hormones, except those that meet medical necessity criteria.
- Hearing examinations or any expense related to hearing disorders that are not diseases or injury, except for covered preventive/wellness care screenings for children up to age 7.
- Hospital private room rates in excess of the semiprivate room rate.
- Ineligible providers' expenses, including but not limited to: registered nurses, Christian Science practitioners, natural family planning specialists, doulas, herbalists, holistic health providers such as massage therapists (unless licensed by their state and services must be medically necessary and not for the purpose of comfort and convenience), unlicensed clergy, exercise therapists, sports psychologist, sports therapists, sports counselors, lactation consultants, educational consultants, physical therapy assistants, chiropractic assistants, behavior modification counseling, except in conjunction with TMJ treatment, hippotherapy for multiple sclerosis or other related diseases.
- Injury or illness incurred while in active military service for longer than two weeks.
- Injury incurred in connection with and while self-employed or employed by someone else for wages or profit, or a disease normally covered by Worker's Compensation or other similar law. This exclusion applies to any covered person, including the eligible employee and eligible dependents.
- Kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan.
- Kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan.
- Lasik
- Marital counseling.
- Medical books and other printed material.
- Medical treatment, service or supply not ordered by a doctor, or not necessary for medical care or treatment of an illness or injury, or investigative procedures.
- Newborn expenses if birth occurs when the baby is not otherwise eligible for benefits as a covered dependent (or if the newborn is not added to the Plan by you within 31 days of the birth).

- Non-prescribed nicotine gum, nicotine patches or any other aids or classes for the purpose of smoking cessation.
- Nursing care expenses that are not prescribed by a licensed physician who indicates the diagnosis, type of care needed, and the duration of care, and that are:
  - Mainly custodial care,
  - Mainly to assist the patient with the functions of daily living or to dispense oral medications,
  - Furnished by someone who does not have the professional qualifications of a registered graduate nurse, or
  - Not for the treatment of an acute illness or injury.
- Nursing home charges and expenses for custodial care.
- Organ transplants, except as described in the "Coverage Summary Chart."
- Orthognathic surgery, the plan covers charges directly related to the surgery for treatment of obstructive sleep apnea, for direct treatment of acute traumatic injury, tumor or cancer or other (as determined by the claims administrator), such as surgeon's fees, anesthesia and Hospital expenses. There must be a functional impairment; the plan does not cover surgery for an aesthetic or cosmetic reason.
- Over-the-counter drugs, even if prescribed by a physician.
- Penalties associated with failure to notify Medical Management before hospitalization.
- Personal comfort items such as telephone, television, barber and beauty supplies, guest services, etc.
- Physician charges for stand-by physician service unless medically necessary.
- Prescription drug exclusions and limitations
- Professional care by immediate members of your family.
- Radial keratotomy
- Recreational or educational therapy, or forms of non-medical self-care or self-help training, including, but not limited to: health club memberships, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
- Rehabilitation services that would not result in measurable progress relative to established goals.
- Replacement of silicone breast implants from previous breast augmentation.
- Routine refractive eye examinations, for the fitting of eyeglasses and contact lenses, and surgery to correct vision
- Services for developmental delay.
- Services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits.
- Services needed because you engaged in an illegal occupation or committed or attempted to commit a felony.
- Services or supplies (1) furnished by or for the U.S. Government or any other government unless payment is legally required or (2) to the extent provided under any other governmental program or law under which the individual is or could be covered.
- Services or supplies that are primarily and customarily used for non-medical purposes, or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat appliances, water purifiers, hypoallergenic mattresses, waterbeds, vehicle lifts, computers and related

equipment, cooling devices, communication devices; assistive listening devices & systems and biofeedback devices and home blood pressure kits.

- Services performed before the effective date of coverage, and services received after your coverage ends, even though your illness started while your coverage was in force. If your coverage ends while you are confined in hospital, your coverage will continue for that confinement until you are discharged.
- Services, supplies or treatment for which the patient is not financially responsible.
- Services, supplies, or treatments for excessive weight due to overeating (not medically necessary).
- Services, supplies, treatments or tests not considered reasonable and necessary for the diagnosis or treatment of a condition, as determined by the Plan Administrator.
- Services for or related to surrogacy
- Transportation, except for medically necessary local ambulance service to the nearest medical facility equipped to treat the illness or injury.
- Travel, transportation, or living expenses, whether or not recommended by a physician, except for approved organ transplants at a Center of Excellence.
- Treatment considered experimental or investigational in nature as determined by the Plan Administrator. This means that the technology, treatment, procedure, facility, equipment, drug, device or supply:
  - Does not have final approval from all appropriate governmental regulatory bodies, if applicable,
  - Is not available in significant numbers outside the clinical trial or research setting,
  - Is not considered medically necessary or an appropriate treatment,
  - Is not considered safe and efficacious, or
  - Is not considered to be beneficial to the health of the covered person.
- Treatment of compulsive gambling or other lifestyle changes.
- Weight loss programs, fees or dues, nutritional supplements, food, vitamins and exercise therapy, and all associated labs, physician visits, and services related to such programs.

The Plan Administrator has full discretion to interpret these exclusions and to determine whether a particular medical service, treatment, test or other medical item is covered by the Plan or is excluded from coverage under the Plan.

Also see “Coordination of Benefits” and “Subrogation / Right of Reimbursement” in the Plan Administration / ERISA section for more information on what the Plan does and does not cover and how payments are made.

Medical Plan Definitions

Accidental Injury - The unexpected results of a sudden external force that damages sound and natural body structure.

Admission – A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.

Alcoholism and Drug Rehabilitation Center - A licensed facility that provides for the residential treatment of chemical dependency or substance abuse.

Allowed Amount - The amount that payment is based on for a given covered service of a specific provider. The allowed amount may vary from one provider to another for the same service. All benefits are based on the allowed amount.

For In-Network Providers: The allowed amount is the negotiated amount of payment that the In-Network provider has agreed to accept as full payment for a covered service at the time your claim is processed. The Claims Administrator periodically may adjust the negotiated amount of payment at the time your claim is paid as a result of expected settlements or other factors. The negotiated amount of payment with In-Network providers for certain covered services may not be based on a specified charge for each service, and the Claims Administrator uses a reasonable allowance to establish a per-service allowed amount for such covered services. Through settlements, rebates, and other methods, the Claims Administrator may subsequently adjust the amount due to an In-Network provider. These subsequent adjustments will not affect or cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to the Plan Administrator, and the percentage of the allowed amount paid by the Claims Administrator is lower than the stated percentage for the covered service. If the payment to the provider is increased, the Claims Administrator pays that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.

For Out-of-Network Providers: The allowed amount is the lesser of the billed charges or the Reasonable and Customary amount determined by the Plan. Whether a charge is Reasonable and Customary will be determined by the Plan in its sole discretion.

Ambulatory Surgical Center - A public or private institution equipped and operated primarily as a facility for performance of surgical procedures, is licensed by the state in which it is located or meets the following requirements:

- Is operated under the supervision of a staff of physicians, maintains adequate medical records and provides for periodic review of the facility and its operation by a Utilization Committee of physicians other than those owning or supervising the facility,
- Permits a surgical procedure to be performed only by a physician privileged to perform such procedure in a hospital in its area and requires that a licensed anesthesiologist administer the anesthetics and be present during the surgical procedure, unless only local infiltration anesthetics are used,
- Provides no overnight accommodations for patients, has at least two operating rooms, one post-anesthesia recovery room and full-time services of registered nurses in all operating and post-anesthesia recovery rooms,
- Is equipped to perform diagnostic X-ray and laboratory examinations and has the necessary equipment and trained personnel to handle foreseeable emergencies, including a defibrillator for cardiac arrest, a tracheotomy set for airway obstruction, and a blood bank or other supply for hemorrhaging, and
- Maintains written agreements with hospitals in its area for immediate acceptance of patients who develop complications or require postoperative confinement

Board-Certified Specialist - A physician, designated by a consultant or insurance company specified by the Plan Administrator, who holds the rank of Diplomat of an American Board (M.D.) or the osteopathic equivalent, Certified Specialist (D.O.).

Calendar Year - A 12-month period beginning January 1st and ending with the following December 31st. All Plan provisions are based on the calendar year.

Coinsurance - The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copayments.

For covered services from Out-of-Network providers, coinsurance is calculated based on the allowed amount. You are responsible for any excess charge over the allowed amount.

For covered services from In-Network providers, your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the

provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculations will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.

Coinsurance Example:

You are responsible for payment of any applicable coinsurance amounts for covered services. The following is an example of how coinsurance would work for a typical claim:

If the Claims Administrator pays 80% of the allowed amount for a covered service, you are responsible for the coinsurance, which is 20% of the allowed amount. Remember, if In-Network providers are used, your share of the covered charges (after meeting any deductibles) is limited to the stated coinsurance amounts based on the Claims Administrator's allowed amount.

If an Out-of-Network provider ordinarily charges $100 for a service, but the Claims Administrator's allowed amount is $95, the Claims Administrator will pay 60% of the allowed amount ($57). You must pay the 40% coinsurance on the Claims Administrator's allowed amount ($38), plus the difference between the billed charge and the allowed amount ($5), for a total responsibility of $43. If Out-of-Network providers are used, your out-of-pocket costs could be higher as shown in the example above.

Company - General Mills, Inc.

Copayment - The dollar amount you must pay for certain covered services such as prescription drugs. A negotiated payment amount with the provider for a service requiring a copayment will not change the dollar amount of the copayment.

Cosmetic Surgery - Surgery and other cosmetic health services that are primarily intended to improve appearance and/or self-esteem and are not medically necessary as determined by the Plan Administrator.

Covered Service - A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.

Custodial Care - Services that the Plan Administrator determines are for the primary purpose of meeting personal needs. These services can be provided by persons without professional skills or training. Custodial care does not include skilled care. Custodial care includes giving medicine that can usually be taken without help, preparing special foods, and helping you to walk, get in and out of bed, dress, eat, bathe, and use the toilet.

Deductible - The amount of covered medical expenses you must pay each year before the Plan pays a benefit. The amount of your deductible depends on which Plan option you choose.

Domestic Partnership - Two unrelated adults living together in a committed exclusive relationship, with financial interdependence, who are not legally married.

Durable Medical Equipment (DME) - Medically necessary equipment that the Plan Administrator determines meets each of the following requirements:

- Able to withstand repeated use,
- Used primarily for medical purposes,
- Useful only to the person who is ill,
- Determined to be reasonable and necessary
- Represents the most cost-effective option, and
- Prescribed by a physician.

Durable Medical Equipment does not include such things as:

- Vehicle lifts,
- Waterbeds,
- Air conditioners,
- Heat appliances,
- Dehumidifiers, or
- Exercise equipment.

Elective Surgical Procedure - A non-emergency surgical procedure scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient and performed while the patient is confined in a hospital as an inpatient or in an ambulatory surgical center. (Any procedure of an emergency nature will not be considered elective if the operation must be scheduled without delay, as determined by the patient's surgeon.)

Eligible Expense/Service - A charge for medical care that is considered or allowed under the Medical Plan, although it may not always be paid in full or in part. (The charge is considered to be "incurred" on the date of the service or purchase for which the charge is made.)

Emergency Admission - A hospital admission for an inpatient confinement for a condition that, unless promptly treated on an inpatient basis, would put the patient's life in danger or cause serious damage to the patient.

Formulary - A comprehensive list of preferred drugs selected on the basis of quality and efficacy by a professional committee of physicians and pharmacists at Express Scripts. A drug formulary serves as a guide for the provider community by identifying which drugs are covered. It is updated quarterly and includes brand name and generic drugs.

Full Group Rate - The full cost of the Medical Plan without any company contribution, as determined from time to time by the Plan Administrator.

Health Savings Account (HSA) – a portable savings account to be used with qualified high deductible health plans. The HSA is administered by a third-party bank and is not an ERISA benefit plan sponsored or maintained by the Company. All terms and conditions of your HSA are governed by your bank account documents and will apply in the event of conflict.

Home Health Agency - A provider that is a Medicare-certified home health agency. Home health agencies send health professionals and home health aides into a person's home to provide health services.

Home Health Care Treatment Plan - A written program for care and treatment in the patient's home certifying that inpatient confinement in a hospital, convalescent nursing home or skilled nursing facility would have been required if the home health care were not provided.

Hospice Care - A coordinated set of services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition.

Hospital - An institution that is one of the following:

- Accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Healthcare Organizations.
- A legally operated institution that is supervised by a staff of physicians, has 24-hour nursing service and is primarily engaged in providing either:
    - General inpatient medical care and treatment through medical diagnostic and major surgical facilities on its premises or under its control, or

  - Specialized inpatient medical care and treatment through medical and diagnostic facilities (including X-ray and laboratory) on its premises, or under its control, or through a written agreement with a hospital (which itself qualifies under one of the first two points of this definition) or with a specialized provider of these facilities.
- A free-standing ambulatory surgical center or facility that offers constant ambulatory medical service, and has been reviewed and approved by the state to provide health care treatment or service.
- A facility that provides residential treatment for the care of emotionally handicapped children and is licensed in the state in which services are provided. (An "emotionally handicapped child" is a child under age 18 who, in the judgment of a social worker, psychologist or psychiatrist, needs care and treatment in such a residential treatment facility.)
- Licensed by the state as a residential primary treatment center for drug addiction, alcoholism or chemical dependency on an inpatient basis.

  In no event will the term "hospital" include a nursing home or an institution or part of one that is:

- Primarily a facility for convalescence, nursing, rest or the aged,
- Furnishes primarily custodial care, including training in daily living routines, or
- Is operated primarily as a school.

Illness - A sickness, injury, pregnancy, mental illness, chemical dependency, or condition involving a physical disorder.

Immediate Family Members - The following people are considered members of your immediate family or close relatives: your spouse, your child (ren), your brother(s) or sister(s), your parents, or your spouse's parents.

In-Network Provider - A provider that has entered into a service agreement with the Claims Administrator to provide services at negotiated rates. In-Network providers are also known as Participating Providers and are in the "BlueCard PPO" (Preferred Provider Organization) network. Blue Preferred POS Provider network (Wisconsin), Blue Open Access POS Provider network (Georgia), or Preferred-Care Blue (Kansas and Missouri) .

Investigative - A drug, device, diagnostic procedure, technology, or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The Plan Administrator bases its decision upon an examination of the following reliable evidence, none of which is determinative in and of itself:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished,
- The drug, device, diagnostic procedure, technology, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials (Phase I clinical trials determine the safe dosages of medication for Phase II trials and define acute effects on normal tissue. Phase II clinical trials determine clinical response in a defined patient setting. If significant activity is observed in any disease during Phase II, further clinical trials usually study a comparison of the experimental treatment with the standard treatment in Phase III trials. Phase III trials are typically quite large and require many patients to determine if a treatment improves outcomes in a large population of patients),
- Medically reasonable conclusions establishing its safety, effectiveness, or effect on health outcomes have not been established. For purposes of this paragraph, a drug, device, diagnostic procedure,

technology, or medical treatment or procedure will not be considered investigative if reliable evidence shows that it is safe and effective for the treatment of a particular patient.

Reliable evidence also means consensus opinions and recommendations reported in the relevant medical and scientific literature, peer-reviewed journals, reports of clinical trial committees, or technology assessment bodies, and professional expert consensus opinions of local and national health care providers.

Medical Emergency - Medically necessary care which a responsible layperson believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.

Medically Necessary Services and Supplies - Health care service and supplies that are determined by the Plan to be medically appropriate, and

- Necessary to meet the basic health needs of the patient,
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service,
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by the Plan,
- Consistent with the diagnosis of the condition,
- Required for reasons other than the convenience of the patient or his or her physician,
- Demonstrated through prevailing peer-reviewed medical literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use Is proposed, or
    - Safe with promising efficacy:
    1. For treating a life-threatening illness or condition (for the purpose of this definition, the term “life threatening” is used to describe illnesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment),
    2. In a clinically controlled research setting, and
    3. Equivalent to those defined by the National Institute of Health.

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury or illness does not mean that it is a Medically Necessary Covered Service as defined in this Plan. The definition of Medically Necessary used in this Plan relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary.

Medicare - The federal government’s health insurance program under Social Security (Title XVII). Medicare gives health benefits to people who are age 65 or older, some people with disabilities under age 65; and people with end-stage renal disease. The program has three parts, Part A, Part B and Part D. Part A generally covers the cost of hospitals and extended care facilities. Part B generally covers the cost of physicians, medical and other professional Medicare services. Part D covers outpatient prescriptions drugs. Medicare Parts A, B and D do not pay the entire cost of services and are subject to deductibles and cost sharing requirements and certain benefit limitations. Please see Appendix A for the Notice of Creditable coverage regarding Medicare Part D.

Mental Health Professional – A psychiatrist, psychologist, licensed independent clinical social worker, marriage and family therapist, nurse practitioner or a clinical nurse specialist licensed for independent practice, which provides treatment for mental illness, substance abuse, addictions.

Mental Illness – A mental disorder as defined in the International Classification of Diseases irrespective of whether the condition or disorder has an identifiable congenital, heredity, organic, biochemical or other physiological cause. It does not include alcohol or drug dependence, nondependent abuse of drugs, or mental retardation.

Orthognathic Surgery – the widening, lengthening or shortening of the bones in the jaw to correct severe skeletal facial deformities due to trauma, congenital or acquired conditions or disproportionate growth of the bones in the face or jaw.

Out-of-Network Provider - A provider that is not considered In-Network for the service being provided.

Out-of-Pocket Maximum - The most you will pay in covered medical expenses and prescription drugs during the year after you pay your deductible. After a person reaches the out-of-pocket maximum, the Plan pays 100% of the allowed amount for eligible medical expenses or prescription drugs for that person for the rest of the year. Amounts that exceed the reasonable and customary (see Reasonable and Customary) amount set by the Plan do not apply to meeting the out-of-pocket maximum. For a description of the out-of pocket amounts and exclusions, please refer to the Overview section called Out-of Pocket Maximums and see the Coverage Summary of specific benefits.

Outpatient Care - Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.

Physician - A medical doctor (M.D.), osteopath (D.O.) or surgeon who is licensed to practice within the scope of his or her license.

Plan - The plan of benefits established by the Plan Administrator as described in the governing Plan documents and this Summary Plan Description and known as the "Employees" Benefit Plan of General Mills, Inc."

Plan Administrator - General Mills, Inc.

Practitioner - A licensed chiropractor, podiatrist, optometrist, consulting psychologist, licensed social worker, nurse practitioner or other providers of the healing arts practicing within the scope of his or her license.

Prescription Drugs - Drugs, including insulin, that are required by federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe the drug.

Provider - Any person, facility, or other program that provides covered services within the scope of the provider's license, certification, registration, or training.

Qualified Medical Child Support Order (QMCSO) - A legal judgment, decree, or order issued under a state domestic relations law that creates or recognizes the rights of a child to be covered under a company's health care plan. Under a valid order, the state can require the company to provide coverage to your child who otherwise might not be covered.

Reasonable and Customary - A charge is "reasonable and customary" if:

- The fee for a specific service is the same fee the physician would charge if you were not covered by this Plan, and
- The fee does not exceed the prevailing charge for the same services made by other physicians in the same geographic area as your physician.

  If a charge is above the level considered reasonable and customary, the portion above the reasonable and customary level will not be an eligible expense under the Medical Plan. Whether a charge is "reasonable and customary" will be determined by the Plan in its sole discretion.

Reconstructive Surgery - Surgery performed on abnormal structures of the body that are caused by congenital defects, developmental abnormalities, trauma, infection, tumor or disease. Generally, reconstructive surgery is done to improve function as opposed to cosmetic surgery that improves appearance and/or self-esteem.

Residential Treatment Center - A sub-acute inpatient setting, appropriately licensed through the state, for patients with no imminent risk of harm to self or others and without other acute medical needs, providing continuous (24-hour) supervision by skilled staff under the direct supervision of professional nurses. Nursing and medical care are available each day; psychiatrists and physicians in other appropriate specialties are available on call 24 hours per day. Multi-modal, multi-disciplinary assessment and treatment are provided, though the intensity may be less than in an acute inpatient setting.

Respite Care - Short-term inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.

Skilled Care - Services that are medically necessary and must be provided by registered nurses or other eligible providers.

Skilled Nursing Facility - A legally qualified facility that provides services for persons convalescing from illness or injury; must include room and board and 24-hour nursing care under the supervision of a registered graduate nurse; if not operated by a physician, must have the services of one available under an established agreement. (In no event will the term include an institution that is primarily a facility for rest, custodial care or the aged.)

Supply - Equipment that is medically necessary for the medical treatment or diagnosis of an illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one year.

Supplies do not include such things as:

- Alcohol swabs,
- Cotton balls or swabs,
- Adhesives,
- Informational materials, or
- Q-tips

Surgical Procedures - Includes any cutting, suturing, correcting of fractures, reducing of dislocations, electro cauterization, taping, removing of stones or foreign bodies by endoscopic means, or injecting sclerosing solution.

Terminally Ill Patient - An individual who has a life expectancy of six months or less, as certified by the person's physician.

Treatment - The management and care of a patient for the purpose of combating an illness. Treatment includes medical and surgical care, diagnostic evaluation, giving medical advice, monitoring, and taking medication.

Prescription Drug Coverage

Prescription Drug coverage under the HSA Gold Plan and PPO Gold Plan is administered by Express Scripts. You will receive a separate identification card from Express Scripts for Prescription Drug coverage. Contact Express Scripts at 1-800-770-2815 for questions about your coverage. The prescription drug program features:

- A network of participating pharmacies. To find a participating pharmacy (in the network) call 1-800-770-2815 or Express Scripts' website at www.express-scripts.com.
- No claim forms to file when using participating pharmacies.
- A convenient mail-order program is available for long-term, or maintenance medication.

PPO Gold – You pay the prescription copay each time you fill a prescription, up to your Out of Pocket Maximum. After the Out of Pocket Maximum the plan pays at 100%. You do not have to satisfy your deductible before the PPO Gold plan begins to pay.

HSA Gold – Preventive Drugs are covered at 100%, even if you have not met your deductible. Keep in mind that the following rules still apply: 1) generic incentive rules 2) preferred formulary and 3) maintenance medication rules (See below for more details). For example, Lipitor is on the Preventive list but since there is a generic equivalent, you will pay the difference in cost between the generic and the brand (contact Express Scripts for most current list). For all other prescriptions, you must satisfy your entire deductible before the plan helps pay for your prescriptions and you pay the copay. After the Out of Pocket Maximum the plan pays at 100%.

The following plan provisions for the Prescription portion of the benefits under the HSA Gold and PPO are the same.

Prescription Copayments (Copays)

Type of Drug	**Retail Pharmacy Copay** for up to 30 days' supply	**Mail Order Copay** for up to 90 days' supply
Generic	$15 max	$37.50 max
Brand-Name Formulary Drug*	20% ($20 min/$50 max)	20% ($50 min/$125 max)
Brand-Name Non-Formulary Drug**	40% ($50 min/$125 max)	40% ($125 min/$312.50 max)

** a formulary drug is a preferred medication for a certain condition or illness based on both clinical effectiveness and cost*

*** a non-formulary drug is any brand-name drug that does not appear on the formulary list*

If you reach your out-of-pocket maximum, eligible expenses for prescription drugs will be covered at 100% (however, the Generic Incentive Program still applies). Neither generic incentive penalties nor maintenance medication penalties apply to the out-of-pocket maximum.

Generic Incentive Program – If you purchase a brand-name drug when a generic equivalent drug is available, you will pay the applicable brand-name copayment plus the difference in cost between the brand-name drug and the lower cost generic equivalent drug, up to the actual cost of the medication. The difference is not applied to the out-of-pocket maximum.

No Coordination of Benefits (COB) – There is no coordination of benefits for Prescription Drugs. The Plan will not make payments as a secondary payer.

Retail Pharmacy Network - When you need a prescription drug on a short-term basis (for example, an antibiotic for strep-throat), you should present your identification card at a participating pharmacy. You will not be required to file a claim when you use your identification card at a participating pharmacy. If you do not use your identification card at a participating pharmacy, you will be required to pay the full cost at the time of the purchase and submit the charges on the Express Scripts Health Prescription Drug Reimbursement Form (available by calling Express Scripts at 1-800-770-2815). You will be reimbursed at the Express Scripts discounted rate for the medication, minus the applicable copayment.

If you do not use a participating pharmacy, you will be required to pay the full cost at the time of the purchase and submit the charges on the Express Scripts Health Prescription Drug Reimbursement Form. You will be reimbursed for 50% of the Express Scripts discounted price for the medication. If you were required to use a non-participating pharmacy due to extenuating circumstances, please contact Express Scripts customer service to see if you qualify for reimbursement up to the copayment amount.

Send the Express Scripts Health Prescription Drug Reimbursement Form to:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

Note: In order to have the costs for your prescription drugs count toward your annual deductible and/or out-of-pocket maximum, you must either use your ID card at a network pharmacy or file a claim.

Vaccine Program - Vaccinations help maintain a healthy workforce and lower medical costs. Through this program you may receive vaccines at no cost to you when obtained at your local retail pharmacy – no appointment is necessary. You just need to show your Express Scripts ID card. You may locate a participating pharmacy at www.express-scripts.com or by calling the number on the back of your ID card 1-800-770-2815. Some vaccines available are: flu shots, Zoster (shingles), pneumonia, childhood vaccines and travel vaccines.

Mail Order Program – "Express Scripts by Mail" - For prescription medications you use on a regular basis, you can use the convenient mail order program. Mail Order costs less – and there's no deductible (**Members in the HSA Gold Plan would have to satisfy their deductible before paying just a copay at mail.)** . Using mail order saves you and the company money. Mail Order information and forms are available by calling 1-800-770-2815 or on Express Scripts' Web site at http://www.express-scripts.com.

Send new mail order prescriptions along with the "Express Scripts by Mail Order Form" to:

Express Scripts
P.O. Box 66567 St. Louis, MO 63166

Specialty Medications - Specialty medications are drugs used to treat complex conditions and illnesses, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple

sclerosis and rheumatoid arthritis. These drugs require special handling, special administration or intensive patient monitoring.

Specialty medications must be accessed through Accredo Health Group, Inc., Express Scripts' specialty pharmacy. If you are currently not using Accredo for your specialty medications, you will be required to transfer those prescriptions to Accredo. If you continue to purchase your specialty medications from a retail pharmacy other than Accredo, you will be responsible for the full cost. When you order an eligible specialty medication through Accredo, your cost will be the applicable mail order copayment

If you have questions about specialty medications and services visit Accredo's website at www.accredo.com or call 1-800-770-2815.

Maintenance Medications - You will need to use the Mail Order Program to refill your prescriptions for maintenance (long-term) medications, such as those used to treat high blood pressure or high cholesterol, or you may pay a higher copayment at a retail pharmacy. You can have up to three fills (one original fill and two refills) at a retail pharmacy. If you get a fourth fill at a retail pharmacy, you will pay 100% of the retail cost of the medication. For ongoing prescriptions, always use mail order. You'll get more for less!

If you have general questions about these programs or would like information on the participating pharmacies, call Express Scripts' member services number at 1-800-770-2815.

Step Therapy - The step therapy program is designed for people who have conditions for which certain high-cost prescription drugs might be prescribed when lower cost drugs are interchangeable. If your condition/medication is included, the step therapy program requires you to use a generic alternative or a preferred brand name (sometimes referred to as a step one drug) as the first course of treatment. Step one drugs provide the same health benefits as a non-preferred brand name drugs, at a lower cost. Your doctor should write your prescription based on the step one drugs covered by our Plan. If your doctor does not write your prescription for one of these generic alternatives, your pharmacist will contact your doctor for a new prescription for a step one drug. Keep in mind that if a step one drug does not work for you, your doctor can then prescribe another drug in the next step/classification in step therapy program.

If your doctor believes it is necessary, he or she can bypass the step therapy program by providing Express Scripts with clinical documentation as to why you need a non-preferred brand name drug.

Step therapy applies to a number of drug categories that include but not limited to:

- PPI – Proton Pump Inhibitor (for acid reflux – the purple pill)
- SSRI – Selective Serotonin Reuptake Inhibitors (for depression)
- Hypnotics (sleep aids – the butterfly)
- Migraine Therapies
- Osteoporosis
- Angiotensin Receptor Blockers (for high blood pressure)
- Intranasal Steroids (allergy meds)
- NSA – Non-sedating antihistamines

To confirm if step therapy applies to a particular medication, call Express Scripts at 1-800-770-2815.

Formulary vs. Non-formulary drugs- The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the prescription drug program, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's formulary. Formulary designations are determined by Express Scripts. The Plan's formulary is

updated periodically and subject to change, so to confirm your medication is on the formulary go online to www.express-scripts.com or call ESI Customer Service

Drugs that are excluded from the Plan's formulary are not covered under the Plan unless approved in advance through a formulary exception process managed by Express Scripts on the basis that the drug requested is (1) medically necessary and essential to the covered person's health and safety and/or (2) all formulary drugs comparable to the excluded drug have been tried by the covered person. If approved through that process, the applicable formulary co-pay would apply for the approved drug based on the Plan's cost share structure. Absent such approval, covered persons selecting drugs excluded from the formulary will be required to pay the full cost of the drug without any reimbursement under the Plan. If the covered person's physician believes that an excluded drug meets the requirements described above, the physician should take the necessary steps to initiate a formulary exception review.

The formulary will continue to change from time to time. For example:

- A drug may be moved to a higher or lower cost-sharing formulary tier.
- Additional drugs may be excluded from the formulary.
- A restriction may be added on coverage for a formulary-covered drug (e.g. prior authorization).
- A formulary-covered brand name drug may be replaced with a formulary-covered generic drug.

Please be sure to check before the drug is purchased to make sure it is covered on the formulary, as you may not have received notice that a drug has been removed from the formulary. Certain drugs even if covered on the formulary will require prior authorization in advance of receiving the drug. Other formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as Step-Therapy. As with all aspects of the formulary, these requirements may also change from time to time.

Dispensing Limits

The amount of drug (regardless of dosage forms) which is to be dispensed per prescription or refill will be in quantities prescribed up to a 30-day supply for retail claims and up to a 90-day supply for mail order claims.

Prescription Drug Coverages and Limitations

The following drugs **are covered** unless listed as exclusion below:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes

  Special Note: If you are an insulin-dependent diabetic and have met the Plan's annual deductible, your supplies can be bundled with your insulin purchase(s) you make on the same day under one applicable prescription drug copayment.
- Oral, transdermal, or intervaginal contraceptives
- Contraceptive injections
- Over-the-counter Diabetic Supplies (except Blood Glucose Monitors & Insulin Pumps)
- Allergy Serums
- Retin-A®/Avita through age 35
- Tazorac Cream through age 35

- Drugs to treat Erectile Dysfunction (ED) for males only at age 18 and over – limitations:
    - Drugs including, but not limited to Viagra, Cialis, Levitra, Muse, Edux and Caverject – retail limited to a maximum quantity of 8 per rolling 30 days; mail order limited to a maximum quantity of 24 per rolling 90 days.
- Tamiflu – quantity limits apply

Prior Authorization is required for the following drugs:

- Growth Hormones
- Retin A/Avita (IVRU) age 36 and over
- Tazorac cream age 36 and over
- Hypnotics
- Osteoporosis
- Intranasal Steroids
- PPI – Proton Pump Inhibitor
- SSRI – Selective Serotonin Reuptake Inhibitors

Prescription Drug Exclusions

The following drugs **are excluded** from coverage unless specifically listed as a benefit under "Drug Coverages" above.

- Non-Federal Legend Drugs
- Contraceptive jellies, creams, foams, devices, or implants
- Insulin Pumps
- Nutritional/Dietary Supplements
- Relenza
- Therapeutic devices or appliances
- Mifeprex
- Drugs whose sole purpose is to promote or stimulate hair growth (i.e. Rogaine®, Propecia®) or for cosmetic purposes only (i.e. Renovo®, Vaniqa, TriLuma, Botox cosmetic, Solage, Avage, Epiquin®)
- Immunization agents and vaccines
- Biologicals, blood or blood plasma, Toxoids, select Immune Globulins, Skin Tests
- Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.Charges for the administration or injection of any drug.

Vision Plan

The Vision Plan is administered through EyeMed and is insured through Combined Insurance Company of America. The vision plan is not an ERISA Plan. EyeMed's network of providers includes private practitioners, as well as the nation's premier retailers, LensCrafters®,Target Optical, JCPenney Optical and most Pearle Vision locations. EyeMed's network also includes online providers-contactsdirect.com, glasses.com, lenscrafters.com, ray-ban.com and targetoptical.com. To locate EyeMed Vision Care providers near you, visit www.eyemed.com and choose the Insight Network. You may also call EyeMed's Customer Care Center at 1-866-800-5457. EyeMed's Customer Care Center can be reached Monday through Saturday 7:30 am to 11:00 pm EST and Sunday 11:00 am to 8:00 EST.

Using In-Network Providers - When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or Plan number, located on the front of your ID card. Confirm the provider is an in-network provider for the Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the Plan.

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Using Out-of-Network Providers - If you receive services from an out-of-network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Summary of Vision Care Services. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:

FAA/EyeMed Vision Care, LLC**.**
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

For your convenience, a FAA/EyeMed out-of-network claim form is available at www.eyemed.com or by calling EyeMed's Customer Care Center at 1-866-800-5457.

Summary of Vision Care Services Remove highlighting from the grid

	Your In-Network Cost	**Your Out-of-Network Reimbursement***
Exam	$10 co-pay	Up to $30
Dilation as necessary	$0	
Refraction	$0	
Retinal Imaging	Up to $39	N/A
Exam Options – Contact Lenses		
Standard Fit and Follow-Up	Up to $40	N/A
Premium Fit and Follow-Up	20% off retail price	N/A
Frames	$0 copay, $200 allowance; 20% off balance over $200	Up to $100
Standard Plastic Lenses		
Single Vision	$10 copay	Up to $25

Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $55
Standard Progressive	$10 copay	Up to $40
Premium Progressive Tiers 1-3	$95-$120	Up to $40
Premium Progressive Tier 4	$75 copay plus (80% of charge less $120 allowance)	Up to $40
Standard Lens Options		
UV coating	$15	N/A
Tint (solid and gradient)	$15	N/A
Standard scratch resistance	$15	N/A
Standard polycarbonate – Adults	$40	N/A
Standard polycarbonate – Kids Under 19	$40	N/A
Standard anti-reflective coating	$45	N/A
Premium anti-reflective coating Tier 1-2	$57-68	N/A
Premium anti-reflective Tier 3	20% off retail price	N/A
Polarized	20% off retail price	N/A
Photochromatic / Transitions Plastic	Up to $75	N/A
Other add-ons and services	20% off retail price	N/A
Contact Lenses**		
Conventional	$0 copay; $200 allowance;15% off balance over $200	Up to $**160**
Disposable	$**0** copay; $200 allowance; plus balance over $200	Up to $**160**
Medically necessary	$0 (paid in full by Plan)	Up to $**210**
LASIK or PRK **from US Laser Network**	85% of retail price or 95% of promotional price Whichever is lesser	N/A
Frequency - based on Calendar Year		
Exam	Once every **12** months	Once every **12** months
Lenses or Contact Lenses	Once every **12** months	Once every **12** months
Frames	Once every **12** months	Once every **12** months

* You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

***Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Additional Discounts - Under the Plan, you may receive benefits for eyeglass frames, eyeglass lenses or contact lenses as outlined on the Summary of Vision Care Services. In addition, EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Additional Special offers may be available at certain provider locations. Log onto www.eyemed.com for more details.

Pursuant to Maryland and Texas law, discounts may not be available at all network providers. Prior to your appointment, you should confirm with your provider that discounts are offered.

Medically Necessary Contact Lenses - The Plan provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding –10D or +10D in meridian powers
- **Keratoconus** where the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses
- **Vision Improvement** for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

Retinal Imaging Benefit - Retinal imaging has been provided at a discount to your vision plan. Retinal imaging is a diagnostic tool that provides high-resolution, permanent digital records of your inner eye. Please consult with your Provider to determine if you are a candidate for retinal imaging.

Savings on Laser Vision Correction - EyeMed Vision Care, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers discounts to you for LASIK and PRK. You receive a discount when using a network provider in the U.S. Laser Network. The U.S. Laser Network offers many locations nationwide. For additional information or to locate a network provider, visit www.eyemedlasik.com or call 1-877-5LASER6.

After you have located a U.S. Laser Network provider, you should contact the provider, identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at 1-877-5LASER6 to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded.

You are responsible for scheduling any required follow-up visits with the U.S. Laser network provider to ensure the best results from your laser vision correction procedure.

Plan limitations and exclusions - Your vision care plan contains several limitations and exclusions. Please see your Certificate of Insurance for a complete list.

Sample Savings - The following examples illustrate how your benefit would be applied to the services received at an in-network provider's office or location:

If a member chooses to receive:

A comprehensive vision care examination:	you pay $**10.00**
A frame up to a value of $200:	you pay $ **0.00**
One pair of bifocal lenses:	you pay $**10.00**
Ultraviolet coating:	you pay $**15.00**
The total cost to the member is:	**$35.00**

If a member chooses to receive:

A comprehensive vision care examination:	you pay $**10.00**
A frame up to a value of $250:	you pay $**40.00**
A pair of single vision lenses:	you pay $**10.00**
Standard anti-reflective coating:	you pay $**45.00**
Standard transition lenses:	you pay $**75.00**
The total cost to the member is:	**$180.00**

T**ime Frames for Processing Claims -** First American Administrators, Inc., a third-party administrator and wholly owned subsidiary of EyeMed ("hereinafter "FAA") will decide claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

Time Frames and Procedures for Appealing Claims – First Level

If your claim is denied, in whole or in part, you may file a first-level appeal. The first-level appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit a first-level appeal within 180 days after this 30-day period has expired. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist FAA in completing its review of the member's first-level appeal, such as documents, records, questions or comments.

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care

Attn: Quality Assurance Dept.

4000 Luxottica Place

Mason, OH 45040

Fax: 1-513-492-3259

FAA/EyeMed will review your first-level appeal and notify you in writing of its decision.

Complaint Procedure

If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at **1-866-723-0513** to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

The Insured benefits are underwritten by Combined Insurance Company of America. Discounts are provided by EyeMed Vision Care. If you have any questions or concerns, please contact EyeMed Vision Care at www.eyemed.com or **1-866-800-5457**.

Dental Plan

The Dental Plan is a comprehensive indemnity plan that provides you and your family a broad range of choices and options to manage your dental care. This coverage provides you with the opportunity to receive dental care from the dentist of your choice. Your out-of-pocket costs may be significantly lower if you choose an in-network dental provider that participates under the Delta Dental network. General Mills partners with Delta Dental of Minnesota to provide dental claims processing services and a national dental provider network. Delta Dental has contractual agreements with over 80% of dentists nationwide. You have the freedom to choose a participating Delta Dental dentist or a dentist who does not participate with Delta.

Delta Dental of Minnesota..... 1-800-448-3815
dental coverage ..... http://www.deltadentalmn.org

Important: You cannot end participation in the Plan or change your election during a calendar year unless there is a qualified change in status. Qualified changes in status are not effective unless you make the change on www.mygenmillsbenefits.com or contact the General Mills Benefit Service Center within 31 days of the qualified change in status.

Coinsurance percentages for Dental are:

Type of Dental Service	Coinsurance Amount
Preventive Services	0%
Basic Services	20%
Major Services	40% - $50 annual deductible
Orthodontic Services	40% - $1,750 lifetime max

Maximum Benefits - The Dental plan will pay up to $2,000 each calendar year for you and each of your covered dependents. This maximum applies to the combination of Preventive, Basic and Major services.

The plan will pay up to a maximum lifetime benefit of $2,000 for you and each of your covered dependents for non-surgical Temporomandibular Joint Syndrome (TMJ) services. (Surgical services for TMJ may be available through your medical plan.)

Choosing a Dentist - You may choose any eligible provider of dental services for the care you need. A "provider" is any person, facility, or program that provides covered services that the Claims Administrator determines are within the scope of the provider's license, certification, registration, or training.

Use of Delta Dental providers is voluntary and does not change the level of the benefits provided by the Plan. When you see a Delta Dental provider, you do not need to file a claim, since the dentist files the claim for you.

Delta Dental Providers - A Delta Dental Premier dentist is a dentist who has signed a participating and membership agreement with his/her local Delta Dental Plan. The dentist has agreed to accept Delta Dental's maximum amount payable as payment in full for covered dental care. Delta Dental's maximum amount payable is a schedule of fixed dollar maximums established solely by Delta Dental for dental services provided by a licensed dentist who is a participating dentist. You will be responsible for any applicable deductible and coinsurance amounts listed in the Coverage Summary section. A Delta Dental Premier dentist has agreed not to bill more than Delta Dental's allowable charge. A Delta Dental Premier dentist has also agreed to file the claim directly with Delta Dental.

Names of Participating Dentists can be obtained, upon request, by calling Delta at 1-800-448-3815. You can also find information about participating dentists at www.deltadentalmn.org. The list of participating dentists may change as dentists enroll or terminate their agreements with Delta Dental.

Out-of-Network Providers - If your dentist is not a participating dentist with Delta Dental, he or she may not be willing to file claims for you and you may also have larger out-of-pocket expenses. To avoid any misunderstanding of benefit payment amounts, ask your dentist about his or her status with Delta Dental before receiving care.

If your dentist is not a participating dentist with Delta Dental, the fees are processed at the reasonable and customary level. This may result in a larger out-of-pocket expense for you, since you are responsible for payments over the amount Delta Dental will pay (the allowed amount).

Refer to the next section for a description of charges that are your responsibility.

Charges that are Your Responsibility - When you see a Delta Dental dentist for covered services, payment is based on the allowed amount. You are not required to pay for charges that exceed the allowed amount. You are required to pay the following amounts:

- Deductibles,
- Coinsurance,
- Charges that exceed the benefit maximum, and
- Charges for services that are not covered.

When you see nonparticipating dentists for covered services, payment is still based on the allowed amount. However, because a nonparticipating dentist has not entered into a service agreement with Delta Dental, the dentist is not obligated to accept the allowed amount as payment in full. You are responsible for payment of any billed charges that exceed the allowed amount. This means that you may have substantial out-of-pocket expenses when you see a dentist who does not participate in the Delta Dental network. You are required to pay the amounts listed above plus all charges that exceed the allowed amount.

Claim Payments - A charge is considered incurred on the date the work is performed. Benefits are not payable, however, until the work is completed.

If your dentist is a participating Delta Dental dentist, claim payments will be sent directly to your dentist. If your dentist is not a participating Delta Dental dentist, claim payments will be sent directly to you, and it is your responsibility to make payment to your dentist.

You are responsible for the amount on the Explanation of Benefits shown under “Patient Responsibility” unless you have other dental coverage that may cover all or part of this amount.

Coverage Summary

Preventive Services

Paid at 100% of allowed amount with no deductible	**Limits ***
Routine oral examinations	2 per calendar year
Routine and/or periodontal cleaning	2 per calendar year
Bitewing X-rays	2 sets per calendar year
Diagnostic expenses from a specialist	once every 3 calendar years
Full mouth (panorex) X-rays	once every 3 calendar years
Topical fluoride applications	once per calendar year

Sealants	once per tooth (for permanent bicuspids or molars) every 3 years for children through age 14

Basic Services

Paid at 80% of allowed amount with no deductible	**Limits ***
Emergency treatment for the relief of pain	–
Filling teeth using amalgam (silver); or composite (white) or resin restorations	one service per tooth surface per 24-month period
Consultations by a specialist	once every 3 calendar years
Periodontics including surgical and non-surgical procedures necessary for the treatment of diseases of the gums and bone supporting the teeth (except periodontic splinting)	–
Endodontics including pulpal therapy and root canal treatment	–
Extractions if not hospitalized	–

Major Services

Paid at 60% of allowed amount after the $50 annual deductible	**Limits ***
Oral surgeon's bill for extractions if hospitalized for non-medical reasons	–
Surgical procedures necessary for fitting of full and partial dentures	–
Prosthodontics, bridges, partial dentures, and complete dentures	placement / replacement limited to once every 5 calendar years
Repair, reline, or adjustments of crowns, bridges, and full or partial dentures	–
Crowns, inlays, onlays, and veneers when the tooth cannot be restored with another filling material	once per tooth every 5 calendar years
Implants	once per tooth every 5 calendar years age 16 and over
Extractions if hospitalized for medical reasons	–
Other oral surgery (except pre-prosthetic surgery)	–

* Limits subject to the Plan's overall annual maximum dental benefits.

Orthodontic Benefits

Paid at 60% of allowed amount	lifetime maximum of $1,750 per person

Orthodontic services are those used to treat a malocclusion that causes a functional disability and includes one or more of the following conditions:

- Overbite or overjet,
- Open bite,
- Cleft palate,
- Cross-bite,
- Congenitally missing teeth requiring orthodontics, or
- Impactions due to crowding, except third molars.

Eligible Charges **-** For an orthodontic service, total eligible charges include diagnostic procedures and insertion of appliances or placement of bands, continuing for the duration of the active orthodontic treatment.

Orthodontic Claim Payments **-** Since orthodontic treatment is received over an extended period of time, to be eligible for payment as authorized, the employee must maintain continuous eligibility during the entire treatment. For the months without current eligibility, payment will be pro-rated.

Benefits are paid in three payments. One-third of the maximum allowed amount is payable at the appliance placement date. The second payment would become available six months from the date of placement, and the third payment would become available six months following the second payment, subject to continuous eligibility.

Implant Benefits -Single Tooth Implant Body, Abutment and Crown – Covered 1 time per 5-year period for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment. Adjunctive services include recement, repair, remove or x-ray implant if done within six months of the initial seating date by the same dentist.

Temporomandibular Joint Syndrome (TMJ) Services

Paid at 80% of allowed amount with no deductible	lifetime maximum of $2,000 per person

Eligible Charges **-** Any non-surgical service or supply required directly or indirectly to treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint and its associated structures. A licensed dentist or physician must provide the services. Note that these expenses are not eligible for benefits payable under the Medical Plan.

Accidental Injury - If you or a covered dependent require dental services in the six months following an accidental injury to sound natural teeth, these dental charges may be eligible for coverage under the Medical Plan. In this instance, these dental expenses should be sent to your medical plan first for processing. If your medical plan denies the charges, the Explanation of Benefits Statement should be sent to Delta Dental along with the itemized bill to process the charges for possible payment under the dental plan.

Eligible Charges**-** An "eligible charge" is a charge made by a dentist for a dental service covered by this Plan. These charges, for which the patient is either directly or indirectly responsible, are subject to certain limitations or exclusions as explained in this section.

The amount of an eligible charge is generally the same as the amount charged by the dentist, but it cannot exceed the "reasonable and customary" charge for the service. A charge is "reasonable and customary" if:

- The fee for a specific service is the same fee the dentist would charge if you were not covered by this Plan, and
- The fee does not exceed the prevailing charges for the same services made by other dentists in the same geographical area as your dentist.

When evaluating how to treat a particular dental problem, several alternative procedures may be appropriate. The Plan will base its benefit payments on the least costly alternative procedure, as long as the result meets acceptable dental standards. The Plan Administrator and Delta Dental will determine acceptable dental standards.

For example, in certain situations, either a crown or a filling, or the use of different metals (like gold or silver) may be equally satisfactory treatments. Similarly, a removable partial denture may provide an equally satisfactory replacement of missing teeth compared to more expensive fixed bridgework. Any charge in excess of the reasonable and customary charge for the least costly alternative will not be paid by the Plan. By obtaining a pre-estimate of benefits before the treatment begins, you will understand what is covered under this Plan and whether an alternative procedure is recommended.

Pre-Determination of Benefits - The pre-determination of benefits procedure is designed for you and your dentist to make clear the services and supplies that are covered and help you understand your estimated benefits before extensive dental work is started.

Whenever a recommended dental treatment plan includes one or more of the following procedures or is expected to cost more than $300, it is strongly recommended that your dentist submit the treatment plan to Delta Dental of Minnesota for review before treatment begins:

- Crowns
- Implants
- Inlays
- Bridgework
- Laminate veneers
- Orthodontics
- Full or partial dentures
- Periodontal surgery (including curettage)
- Surgical removal of impacted teeth
- Bonding procedures
- TMJ treatment

You and your dentist will be able to review the pre-determination and choose the best course of treatment for you.

Instructions for Filing Dental Claims - If your dentist is a Participating Dentist with Delta Dental, the dentist will file your claims for you. If your dentist does not participate as a Delta Dental provider, claim forms are available by calling Delta Dental of Minnesota at 1-800-448-3815.

The Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.

The dental office will file the claim form with the Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 4).

During your first dental appointment, it is very important to advise your dentist of the following information:

- Your Delta Group Number – # 501,
- Your Group Name – General Mills,
- Your Delta Dental ID number found on your Delta Dental ID card , and
- Your birthday and the birth dates of your spouse and dependent children.

Claim Submission Deadline - To be eligible for reimbursement, claims must be submitted by December 31 of the following calendar year in which the eligible expenses were incurred.

Coordination of Dental Benefits (COB) - When you and other members of your family are covered by this Plan and another group dental plan, you can submit claims to each plan and the benefits will be "coordinated" so that in total you may be covered for up to 100% of allowable expenses. This Plan contains a provision that determines its share of the total allowable expenses and coordinates its payments with other group plans.

If both you and your spouse employees of the company and participate in this Plan, you have individual dental benefits. If only one of you elects family coverage, only that person may submit claims for eligible dependents. If you and your spouse each elect family coverage, both of you will have coverage for each other and your eligible dependents. Together you may be covered for up to 100% of allowable expenses. Please note that both you and your spouse must meet the applicable deductibles.

Primary and Secondary Payers of Benefits - When a claim is made, the coordination provision determines whether this Plan will be the "primary" payer (pay its regular benefits) or the "secondary" payer (pay a portion of the benefits after another plan has paid its normal benefits). The primary plan pays its benefits without regard to any other plans, and the payment is not adjusted to allow for a secondary payer. The secondary plan, however, calculates its benefits so that the total payments available from all plans will not exceed 100% of allowable expenses. No plan will pay more than it would without the coordination provision.

A plan without a coordination provision is always the primary plan. If all plans have a coordination provision, the plan covering the patient as an employee is primary.

Coverage for Dependent Children - If a child is covered by both parents' plans, the parent whose birthday occurs first within the calendar year is primary. If both parents have the same birthday, the plan covering the parent for the longest period of time is primary. This is called the "birthday rule". If a child is covered by both parents' plans, and the other plan does not administer benefits according to the birthday rule, the father's plan is primary for both the company's plan and the other plan.

Coverage for dependent children whose parents are legally separated or divorced is determined according to the following order:

1. The parent who has financial responsibility for health care expenses, as established by terms of a court decree including a valid Qualified Medical Child Support Order (QMCSO),
2. The parent who has custody of the child,
3. The stepparent married to the parent who has custody of the child (provided that the child resides with the stepparent).

Definition of "Plans" - The following types of dental benefits are considered "plans":

- Coverage (other than Medicare or Medicaid) under a governmental program or coverage provided under the dental payment ("medpay") or personal injury protection benefit available to you under an automobile insurance policy.

- Group insurance or other coverage for a group of individuals, including student coverage obtained through an educational institution above the high school level, or other group prepayment arrangements.

Employees on Leave of Absence - If you are covered by this Plan during a leave of absence and become employed and covered by another group plan, the other group plan will be primary and this Plan will be secondary.

Employees on Paid Severance Leave - If you are covered by the Plan while on severance leave and gain access to coverage through a new employer, you are required to terminate your enrollment in the General Mills dental plan.

Appeals / Adverse Benefit Determinations - If your claim is denied, you can request a review of the denial. See the "Claims and Appeals" section for more information.

Dental Plan General Exclusions

The Plan does not cover the following expenses:

- Anesthesiologist services in a hospital.
- Appliances, restorations or other services provided for the purpose of increasing vertical dimension, restoring occlusion or periodontal splinting.
- Bite registration, precision or semi-precision attachments or other specialized prosthetic techniques.
- Charges for any service or supply that does not have uniform professional endorsement or is experimental or investigative in nature.
- Charges for temporary dental services including, but not limited to, temporary fillings, crowns, dentures and bridges (a temporary dental service may be considered part of the final dental service rather than a separate service if performed on the same date).
- Charges for which the covered person has no legal responsibility or that would not have been made if this Plan did not exist.
- Charges that exceed the reasonable and customary amount.
- Completing and processing of claim forms by a dentist.
- Cosmetic services, except for treatment of accidental injury while you are covered or a congenital malformation that results in a functional disability. **NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.**
- Expenses applied toward satisfaction of a deductible.
- Hospital services (room charges, etc.) or services of an outpatient surgical facility.
- Nitrous oxide
- Oral hygiene instructions, dietary planning and other similar services.
- Orthodontic retainers (they are considered part of the total treatment fee and are not considered for separate reimbursement).
- Orthodontic services that are unrelated to the treatment of (1) overbite or overjet, (2) open bite, (3) cleft palate, (4) cross-bite, (5) congenitally missing teeth requiring orthodontics, or (6) impactions due to crowding, except third molars.
- Prescription drugs.
- Radiation therapy or treatment resulting from such therapy.
- Repairs or replacements to occlusal guards or orthodontic appliances.
- Replacement of amalgam with other restorative materials done only to remove mercury.

- Replacement of lost or stolen dentures, crowns, bridges or appliances.
- Replacement or modification of an existing denture, bridgework, crown, cast, implant or other laboratory-prepared restoration unless the existing work is at least five years old and cannot be repaired.
- Sealants (1) on dependents age 15 or over, (2) on teeth other than permanent molars or bicuspids, or (3) performed more than once every three years.
- Services not needed to treat a dental disease or injury to teeth caused by an accident.
- Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents, tooth bonding and veneers.
- Services or procedures, requested or provided, that appear to have a questionable long-term prognosis, as determined by the Plan Administrator and Delta Dental.
- Services or supplies furnished by or for the U.S. Government or any other government, unless payment is required.
- Services or supplies received as a result of (1) an injury arising out of, or in the course of, any work while self-employed or employed by someone else for wage or profit or (2) a disease covered with respect to such work by a Workers' Compensation law, occupational disease law or any similar law. This exclusion applies to any covered person, including the eligible employee and eligible dependents.
- Services or supplies to the extent provided under any governmental program or law under which you are, or could be, covered; (i.e., does not apply to a state program under Medicaid or to any law or program when, by law, its benefits are in excess of those of any private insurance program or other non-governmental program).
- Services provided by someone other than a licensed dentist, physician or someone under a dentist's direct supervision or orders.
- Services received by a person before being covered under the Plan or after coverage ends.
- Supplies normally intended for home use, such as toothpaste or cleaning devices, TENS units, home fluoride treatments and home care devices.
- Treatment of accidental injury to natural teeth if any of the charges are covered by your group medical plan.
- Treatment for any condition not involving teeth, surrounding tissue or structure.
- Treatment of the temporomandibular joint other than those described under "Temporomandibular Joint Syndrome (TMJ) Services".

The Plan Administrator has full discretion to interpret these exclusions and to determine whether a particular dental service, treatment, test or other dental item is covered by the Plan or is excluded from coverage under the Plan.

Dental Plan Definitions

Abutment - A tooth retaining or supporting a bridge or a fixed prosthesis.

Accidental Injury - The unexpected result of a sudden, external force that damages natural teeth (an injury that occurs in the normal course of chewing or biting is not considered an accidental injury unless sustained as a result of chewing or biting on an unexpected and concealed foreign object).

Appliance - A device used to provide function or therapeutic (healing) effect.

- Removable – Held in place by clasps and can be taken out,
- Fixed – Cemented to the teeth or attached by adhesive materials,
- Prosthetic – Used to provide replacement for a missing tooth or teeth,
- Orthodontic – Used to correct a malocclusion.

Bitewing - A dental X-ray used for cavity detection.

Bridgework - A prosthetic appliance used to replace missing teeth.

- Fixed–A partial denture retained with crowns or inlays cemented to the natural teeth,
- Removable–A partial denture retained by attachments (normally clasps) which permits removal of the denture.

Crown - The portion of a tooth covered by enamel or a fixed prosthetic appliance that reproduces the entire surface anatomy of a single natural tooth.

Dental Hygienist - A person who has been licensed to remove calculus or tartar and stains from the teeth, and to provide hygiene instruction and information on the prevention of dental diseases.

Dentist - A person licensed to practice dentistry by the governmental authorities having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered. As used in this dental plan, the term "dentist" also includes a licensed physician authorized by his or her license to perform the particular dental service he or she has rendered.

Denture - A removable prosthetic appliance used to replace missing teeth.

Endodontics - The branch of dentistry dealing with the diagnosis and treatment of the diseases of the dental pulp or nerve of the tooth.

Fluoride - A solution which is applied topically to the teeth for the purpose of preventing dental decay.

Full Mouth X-rays - A series of individual periapical X-rays and bitewing X-rays of each area of the mouth used as a diagnostic tool for dental treatment.

Impression - A negative reproduction of a given area which is then poured in dental stone to create a replica of a person's tooth/teeth.

Implant – Material inserted or grafted into tissue. A device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement; endosteal (endosseous); eposteal (subperiosteal); transosteal (transosseous).

Inlay - Gold, ceramic, or resin restoration made to fit a prepared tooth cavity and then cemented into place.

Nitrous Oxide - A form of analgesia generally used to relieve apprehension, also known as "laughing gas."

Non-Participating Dentist - A dentist who does not have a membership agreement with the Delta Dental Plan. Reimbursement for services will be paid directly to the employee, and the employee is responsible for paying the dentist.

Onlay - A laboratory fabricated restoration that covers the entire occlusal surface of the tooth. It is often used to restore lost healthy tooth structure and is sometimes viewed as a more conservative restoration than a crown.

Oral Surgery - The branch of dentistry that deals with any cutting procedure involving the teeth and surrounding tissue.

Orthodontics - The branch of dentistry primarily concerned with the correction of abnormalities in the positioning of the teeth in their relationship to the jaws (commonly called straightening teeth).

Panorex X-ray - Single extra-oral film that provides a continuous view of the teeth and associated structures.

Partial Dentures - A prosthesis that is supported by the teeth and/or gums that replaces one or more, but not all of any missing natural teeth and associated structure. These appliances may be fixed or removable, and on one side or two sides of the same arch.

Participating Dentist - A Delta Dental participating dentist is a dentist who has signed a participation and membership agreement with the Delta Dental Plan. A participating dentist will file claims directly and Delta Dental will make payment directly to the dentist for the allowed amount.

Periapical X-ray - X-ray showing the entire root and surrounding structures of a tooth.

Periodontics - The branch of dentistry devoted to the study, prevention and treatment of diseases of the gums and bones supporting the teeth.

Pontic - The part of a fixed bridge suspended between the abutments, which replaces a missing tooth or teeth.

Prophylaxis - Cleaning of the teeth by a dentist or dental hygienist to include the removal of calculus or tartar and stains.

Prosthesis - The artificial replacement of one or more natural teeth and/or its associated structures.

Reasonable and Customary - A charge is "reasonable and customary" if:

- The fee for a specific service is the same fee the dentist would charge if you were not covered by this Plan, and
- The fee does not exceed the prevailing charges for the same services made by other dentists in the same geographical area as your dentist.

Whether a charge is "reasonable and customary" will be determined by the Plan in its sole discretion.

Restoration - This term applies to the end result of repairing and restoring or reforming the shape, form, and function of part or all of a tooth or teeth.

Root Canal Therapy (Endodontic Therapy) - Treatment of a tooth with damaged pulp or nerves. Usually performed by completely removing the pulp (nerve tissue), sterilizing the pulp chamber and root canals, and filling these spaces with sealing material.

Scale - The removal of calculus (tartar) and stains from the teeth using special instruments.

Temporomandibular Joint Treatment (TMJ) - Any non-surgical service or supply required directly or indirectly to treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint and its associated structures.

Pre-tax Accounts – HSA, Healthcare FSA and Dependent Care FSA

Different Pre-Tax Health Account Options with General Mills

Account Name	Plan Link	Contributions	2020 Annual Limit	Available to use for:
HSA- Health Savings Account	HSA Gold	Company and Employee – NOTE: Employee contributions are available after each payroll	$3,550 single and $7100 family; +$1,000 Catchup contributions for Age 55+	Medical, RX, Dental, and Vision and other special expenses
HSA Compatible Healthcare Flexible Spending Account	HSA Gold	Employee	$2,700	Dental and Vision only, until you've met the HSA Gold Deductible
Full Purpose Healthcare Flexible Spending Account	PPO Gold or non-enrollee in GMI Medical	Employee	$2,700	Medical, Rx, Dental and Vision expenses.

Health Savings Account (HSA) – HSA Gold Plan

The Health Savings Account (HSA) is available to you if you are enrolled in the HSA Gold Plan; and not covered under another medical plan, including a full purpose Healthcare FSA, that is not a High Deductible Health Plan (HDHP)—such as your spouse's medical plan.

General Mills may contribute to your HSA if you qualify and if elected within required timeframes. You have access to your HSA Using the HealthEquity Health Account Card. No claim forms, no paying out-of-pocket--when you use your HealthEquity card, your eligible expenses are deducted automatically from your health care account.

HSA Gold Plan – Health Savings Account Company Contributions

If you elect the HSA Gold Plan, you become eligible for a Health Savings Account (HSA). The GMI employer contribution will be sent the first of the following month of your effective date to your account for 2020 as follows:

Salary and Coverage Tier	Annual Company HSA Deposit
<$60,000	
Single	$600
Family	$1,200
$60,000 – $150,000	
Single	$350
Family	$700
$150,000+	
Single	$0
Family	$0

If HSA coverage starts after the first day of the plan year, the contribution will be prorated for the year. Contributions will not duplicate if an employee is rehired within the same plan year. Coverage in the HSA starts the first of the month following the date your medical coverage in the HSA Gold Plan is effective.

You can also elect to make your own before tax contributions from your pay check. The 2020 IRS maximum combined contribution for an HSA is limited to $3,550 for individual coverage and $7,100 for family coverage (family is defined as more than individual coverage). If you are age 55 or older, you can make additional catch-up contributions. The maximum catch-up contribution for 2020 is $1,000. Company contributions and your contributions count towards these maximums and these amounts can change for future tax years. It is your responsibility to make sure that you do not contribute more than the maximum amount allowed each year and you cannot rely on the Company, HealthEquity or your bank to determine your contribution limit.

Your HSA will be established for you after you elect the HSA Gold Plan, accept the Terms and Conditions of the HSA Account and complete the Customer Identification Program (CIP). If you do not accept the Terms and Conditions of the HSA account or fail to complete the CIP within 90 days after electing the HSA Gold Plan, you will not be eligible for the company deposit for that year, or eligible to make your own contributions. Any employee contributions taken via payroll deduction will be refunded.

If you participate in the HSA through General Mills and the Healthcare Flexible Spending Account (Healthcare FSA), your Healthcare FSA automatically becomes an HSA compatible Healthcare FSA.

This SPD discusses only some of the rules and limitations that apply to a Health Savings Account (HSA). It focuses only on the Health Savings Account with Company contributions and addresses how the HSA works within the Company's overall benefits. It does not provide a comprehensive discussion of the legal requirements and tax consequences of contributing to an HSA; nor does it address provisions and rules that govern any HSA you might establish on your own. The HSA is a third-party bank account owned by you and is not a benefit plan sponsored or maintained by the Company. You should consult with your tax advisor before electing to contribute to an HSA, as the rules and regulations governing HSA's can be complex and there are some states that do not follow the federal tax rules and may tax HSA contributions and earnings. It is your responsibility to know the rules governing HSA's, in particular those around HSA eligibility, tax filings, maximum contribution amounts and availability and taxation of HSA distributions. If you exceed the maximum contribution amount, the IRS imposes an excise tax on excess contributions and any related earnings, plus income tax.

How the HSA Works - Here's a quick look at how the Health Savings Account (HSA) works:

• You can elect a Health Savings Account when you enroll in the HSA Gold Plan (High Deductible Health Plan) and accept the terms and conditions related to the HSA account.

• You can choose to put before-tax dollars into the HSA through regular payroll deductions. These contributions will be spread out over the pay periods during the remaining calendar year, and will not be in your account until after a period of time following each pay period.

• You may receive a contribution to your HSA from General Mills, if eligible and if elected in the required timelines. The company contribution will be deposited in your HSA the first of the month following the date your medical coverage in the HSA Gold Plan is effective.

If elected during Annual Benefits Enrollment, the money will be in your HSA account coinciding with the first payroll.

• You, your spouse and any IRS eligible dependents can use the money in the HSA to pay for qualified health care expenses incurred after the HSA was established. If you use the money to pay for medical expenses that are not eligible, you will pay income tax on the amount plus a 20% penalty tax.

• You access the money in your HSA using a HealthEquity Health Account card—that can be used anywhere Visa cards are accepted, such as your doctor's office or pharmacy. If you do not use your Visa for your HSA purchases, you will need to request reimbursement online at www.healthequity.com. To get detailed guidelines on potential qualified health care expenses (IRS publication 502) go to www.irs.gov or call the IRS at 1-800-829-3676.

Money left in your HSA at the end of the year stays in your HSA. Money can accumulate in your account year to year and be used as a retirement income supplement. The money left in your account can be used to pay for qualified medical expenses even in retirement on a tax-free basis.

You can open and contribute to a Health Savings Account if you are an "HSA-eligible Individual", which means that you are:

• Enrolled in the HSA Gold Plan, and

- Not a dependent of someone else, and
- Not covered under another health plan, that is not a High Deductible Health Plan—this includes your spouse's medical plan and/or a full purpose healthcare flexible spending account and Medicare, but does not include specified disease coverage (such as a Critical Illness Protection Plan), insurance that pays a fixed amount per day, dental, vision or long-term care coverage. Please consult your tax advisor for more information.

Participation in the HSA will begin on the first day of the month following your coverage start date in the HSA Gold Plan or on January 1, if you enroll during Annual Benefits Enrollment. Changes to HSA contributions will be effective in your next paycheck or as soon as administratively possible.

If you are on an unpaid leave of absence, you can contribute after-tax money to an HSA at any time while you are enrolled in the HSA Gold Plan and meet the other HSA eligibility requirements (i.e., you are an HSA-eligible Individual). These contributions must be made directly by you to HealthEquity using after-tax money.

The HSA allows you to pay for qualified medical expenses with money you put into the HSA before taxes are taken out of your paycheck—before-tax dollars. This reduces your taxable income. Without an HSA, you would still pay for these expenses; however, you would use money remaining in your paycheck after federal taxes are withheld—after-tax dollars. The amount you will save using the HSA depends on your tax bracket. Some states do not follow the federal tax rules and may tax HSA contributions and earnings. You should consult with a tax advisor regarding your particular situation. Because the amounts you put into the HSA are not included in your pay that is reported for Social Security and Medicare, your Social Security benefits may be less than if you do not enroll in the HSA. For most people, the difference is small. The HSA and the medical tax deduction expenses paid with funds from your HSA are not taken into account for determining the amount of income tax deduction allowed for medical expenses that exceed 10% of your adjusted gross income. Regarding this tax-saving approach, it's important to note that any tax savings that may result from your participation in the HSA depends on your own personal situation and income level. Tax information included here is only general information. Because tax laws are complicated and subject to frequent change, you should talk with a qualified tax advisor if you have questions. By law, the Company can't offer you tax advice or advise you on your HSA-related decisions. This law is designed to protect you by ensuring that you always get the most up-to-date advice, and that advice is only available from a qualified tax advisor.

If you participate in the HSA and the Healthcare Flexible Spending Account - You can enroll in both the HSA and the Healthcare Flexible Spending Account (Healthcare FSA). However, if you enroll in both, you may not be reimbursed for medical expenses from your Healthcare Flexible Spending Account—the only expenses that can be reimbursed through your Healthcare Flexible Spending Account are eligible dental and vision expenses and eligible medical expenses you have after you have met your HSA Gold deductible ("post-deductible" expenses). When you are enrolled in both the HSA and the Healthcare Flexible Spending Account, your spending account is called an HSA compatible Healthcare FSA or Limited Purpose Healthcare FSA. Once you have met your medical plan deductible, you can submit this to HealthEquity and they will allow your Healthcare Flexible spending account to be used for medical expenses. Instructions for this are on the HealthEquity website.

Using Your HSA Compatible Healthcare FSA - As an HSA compatible Healthcare FSA participant, you can use your WageWorks or HealthEquity FSA Card for your HSA compatible Healthcare FSA eligible dental, vision and post deductible medical and prescription drug purchases. If you have not spent all the amounts in your HSA compatible Flexible Spending Account by the end of the calendar year, up to $500 will rollover into the next plan year. For the HSA compatible Healthcare FSA, you must submit claims no later than the April 30th after the end of the calendar year. If you don't use your WageWorks or HealthEquity FSA Card for your Healthcare FSA purchases, you will need to submit a claim for reimbursement, more information can be found at www.healthequity.com. You can choose to have your reimbursement deposited directly into your checking or savings account by enrolling in direct deposit online. To enroll, go to www.healthequity.com.

Request for Documentation Letters - If you receive a Request for Documentation letters, this means that you are required to provide documentation to verify that you used your card to purchase an eligible item or service, as regulated by the IRS. If you do not respond, the balance on your card will be locked until you provide the requested documentation or payment. You have three ways to respond:

- Submit an itemized receipt or Explanation of Benefits (EOB) for the transaction(s) listed in the letter; or
- Submit an itemized receipt or Explanation of Benefits (EOB) for another eligible item you purchased during the plan year along with a claim form for this new claim; or
- Send a personal check or money order for the expense if you are unable to provide documentation.

If you do not correct an overpayment, the amount of the overpayment may be withheld from future reimbursements or reported as taxable income to you. If you have any questions, call HealthEquity at 1-888-914-2435.

Contributing Money to the HSA - You decide the amount you want to contribute to your HSA. You can contribute an amount up to the maximum IRS HSA annual contribution limit that applies to you. The maximum contribution to an HSA is determined on an annual basis and you are eligible to make an HSA contribution for each month of the year that you are an HSA-eligible Individual, determined as of the first day of each month. If you are eligible for and participating in an HSA for less than 12 months, you must prorate the maximum annual contribution to account for the months in which you were not eligible or were not participating in the HSA (divide the annual maximum by 12). If, however, you are eligible to contribute to an HSA on December 1 of a year (regardless of when you actually enrolled during that year), you can contribute the maximum annual HSA contribution amount (no proration is required). However, if you do not remain covered by a HDHP and otherwise remain an HSA-eligible Individual for the entire next year (a 13-month period beginning with the December of the year for which your contributions were made and ending on the last day of the 12th month following that December—i.e., December 31), you will generally be required to pay income tax and a 10% penalty tax on the amounts that you contributed and earnings for months in which you were not eligible to contribute to the HSA. In certain circumstances, you may be able to take a distribution of the excess contributions prior to a penalty accruing. For more information, contact HealthEquity at 1-888-914-2435. If you are age 55 or older, you can make additional catch-up contributions. You make contributions to your HSA through payroll deductions. You may also make deposits directly to your HSA.

Please log into www.healthequity.com for instructions. Any money you send directly to your HSA will be after-tax dollars. It is your responsibility to make sure that you do not contribute more than the maximum amount allowed each year and you cannot rely on the Company, HealthEquity or your bank to determine your contribution limit. It also is your responsibility to make sure that the distributions you receive from your HSA are for qualified medical expenses that meet tax requirements.

For more information on the tax requirements of your HSA please consult with your tax advisor. The rules governing HSA's can be complex, especially in the following situations:

- You are enrolled in Medicare;
- Your spouse has medical coverage under the plan of another employer including a full purpose healthcare flexible spending account
- You or your spouse enrolls in an additional HSA

As stated earlier in this section, you should contact your tax advisor about how the HSA works in your personal situation before opening an HSA.

Your HSA Balance and Investment Account – The base account is maintained in your name at HealthEquity. The account is your bank account; it is not a benefit program sponsored or maintained by the Company. All contributions to the HSA will be initially credited to the base account, and all distributions from the HSA will be withdrawn from the base account. Funds in this account are owned entirely by you, the account holder, and are not subject to "use it or lose it" rules. Once you exceed a $1,000 balance in the HSA base account, you may enroll in HealthEquity's investment accounts, one of which is an interest-bearing FDIC Insured deposit account. The HSA also provides the opportunity to select and manage your investments in mutual funds. Once the account is elected, the balance is removed from your HealthEquity Health Care Card account and cannot be used for your health care expenses. Go to www.healthequity.com for more information on investments.

Changing Your HSA Contribution Amount - You can change your HSA payroll deduction contribution at any time during the year, prior to December 1, by calling the Benefits Service Center. You are not eligible to continue contributing to your HSA through payroll deduction if you:

- Stop participating in the HSA Gold Plan
- Become covered under a health plan that does not qualify as a high-deductible plan (such as your spouse's employer's coverage);
- Become enrolled in Medicare (for example, if you become disabled);
- Become a dependent of someone else, or
- Terminate employment or begin an unpaid leave of absence with the Company. You can, however, make direct payments to your account on your own if you are still eligible and use money already in your account to pay for qualified medical expenses.

Qualified Medical Expenses - Qualified expenses are those permitted by Section 213(d) of the Internal Revenue Code and that are otherwise permissible under IRS regulations. When you use your HSA to pay for qualified expenses, you pay with tax-free dollars. Qualified expenses include:

- Prescription drugs

• Doctor's visits, lab, x-ray and other diagnostic and treatment services

• Routine health care (including prenatal care, smoking cessation, obesity weight-loss programs)

• Qualified long-term care services and qualified long-term care insurance

• COBRA premiums • Health & Insurance for those on unemployment compensation

• Medicare Part A and B premiums, Medicare D, Medicare HMO or Medicare Advantage premiums (but not premiums for Medicare supplemental policies/Medigap policies.)

You can use your HSA to pay for expenses incurred by yourself, your spouse and any eligible IRS dependents as long as the expenses were incurred after the HSA was established and are not covered by insurance or otherwise. Please note, just because a child is covered under the Company medical plan option does not mean they are your IRS dependent. If you use the HSA to pay for medical expenses that are not qualified, you will pay income taxes on the amount of the unqualified expenses plus you will pay an additional 20% penalty tax unless the distribution is made after your death, disability or attaining age 65. It is your responsibility to make sure that the distributions you receive from your HSA are for qualified medical expenses to meet the tax-exemption requirements. For more information on the tax requirements of your HSA, see Filing Your Income Tax Return.

Getting Reimbursed from Your HSA - It is easy to access the money in your HSA. You don't have to complete a form, file for reimbursement and wait for a check. Instead, when you establish an HSA you will receive a Visa card for your HSA that can be used anywhere Visa cards are accepted, such as your doctor's office or pharmacy. If you do not use your Visa card for your health care purchases, you can obtain reimbursement online provided the funds are available in your HSA. To be reimbursed, log into www.healthequity.com. Your transaction will be submitted to the bank and can take anywhere from 24 to 48 hours, depending on your bank. You can be reimbursed for expenses up to the amount in your HSA. Your employee contributions are not available until after they have been deducted from your pay check and placed in your HSA account. An HSA does not require third party substantiation for transactions; however, you should save all of your medical expense receipts in the event of an IRS audit.

Filing Your Income Tax Return - Each January you will receive a 1099 Form for any distributions you receive from your HSA in the previous calendar year. You should save all of your medical expense receipts for income tax purposes. Also, during the month of May, you will receive a 5498 Form from HealthEquity, which reports your prior calendar year contribution totals. You will want to retain this form for your records. Be sure to consult your personal tax advisor for more information on this topic.

If You Die - You have the right at any time to designate one or more beneficiaries to whom distribution of your HSA will be made upon your death. You also have the right to revoke a prior beneficiary designation and, if desired, designate different individuals as beneficiaries. To be valid, any such beneficiary designation must be on a form provided by or acceptable to HealthEquity prior to your death. In the absence of a valid beneficiary designation, HealthEquity will distribute the assets comprising the HSA upon your death to your estate. In certain states, a spouse's consent may be necessary if a person other than or in addition to the spouse is named as beneficiary or to change an existing beneficiary designation. You should consult with your attorney before making such a beneficiary designation.

If You Leave the Company - If you leave the Company, your account and card will remain active. HealthEquity will continue to administer the HSA. You are entitled to the full amount funded to your account and allowed to spend the balance on qualified medical expenses even if you're not contributing or enrolled in the high deductible health plan. To request a transfer of assets, contact a representative at HealthEquity. All fees will be your responsibility once you separate from the Company. For any additional questions, contact HealthEquity at 1-888-914-2435.

If You Are On COBRA - While the High Deductible Health Plan is subject to COBRA coverage rules, the Health Savings Account is not. You can contribute after-tax money to your Health Savings Account while you have COBRA coverage under the High Deductible Health Plan and remain an HSA-eligible Individual. You will not receive any company contributions to your HSA account while on COBRA.

Healthcare Flexible Spending Account (Healthcare FSA)

The full purpose Healthcare Flexible Spending Account (Healthcare FSA) allows you to pay for certain eligible medical, dental and vision expenses with pre-tax dollars. If you are enrolled in the HSA account thru General Mills, your Healthcare FSA will be a limited purpose or HSA compatible Healthcare FSA (see the Health Savings Account section for more details on the HSA compatible Healthcare FSA). Your pre-tax contributions are credited into an account with every paycheck. General Mills has partnered with HealthEquity to manage your account and pay your claims. You will receive a debit card from HealthEquity to use for the eligible expenses. The amount you elected for your Healthcare FSA will be available on your debit card on January 1, if elected during Annual Benefits Enrollment.

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Note: Be sure to review the information under "Eligibility, Enrollment, and Cost", "Health Savings Account", "Effective Date of Coverage", "Qualified Change in Status", and "Life Events" for more information about the Healthcare Flexible Spending Account.

Annual Election Amount – Employee Contributions - If you decide to participate in the Plan, you are requesting that your taxable pay be reduced by a specific amount from each of your paychecks. (a Healthcare FSA deduction is not taken from any paycheck that does not cover an entire payroll period.) The maximum election that you may request each year cannot exceed $2,700 for 2020. The minimum election is $100 per calendar year.

A new election is required each year at Annual Benefits Enrollment for the following calendar year.

Important: You cannot end participation in the Plan or change your election during a calendar year unless there is a qualified change in status. Qualified changes in status are not effective unless you contact the General Mills Benefits Service Center within 31 days of the qualified change in status.

NOTE: If you also have an HSA account, please see HSA section for how the Healthcare Flexible spending account becomes limited purpose with the HSA account.

Eligible Expenses - Items eligible for reimbursement generally are those that would qualify as a medical deduction on your income taxes. A few of the most common eligible expenses include:

- Deductibles
- Coinsurance
- Copayments

- Dental care (including Implants & Orthodontics)
- Eye Exams, glasses, and contact lenses (including lens cleaning solution and supplies)
- Hearing aids and batteries
- Chiropractic care
- Mental health / chemical dependency treatment
- Stop-smoking or weight loss programs prescribed by a physician
- Treatment for obesity
- Fluoride treatment of home water if recommended by a dentist

Over-the-Counter (OTC) Drugs & Medications -Only OTC drugs and medications (other than insulin) that are prescribed may be reimbursed. A copy of the prescription must be submitted with the claim for reimbursement. Other OTC medical products, such as supplies are reimbursable without the additional documentation.

For a list of most eligible expenses, refer to Internal Revenue Service publication 502 "Medical and Dental Expenses" or www.healthequity.com.

Exclusions - Per Internal Revenue Service regulations, the following are not eligible for reimbursement:

- Medical, dental and vision expenses reimbursed by insurance
- Insurance premiums
- Over-the-counter health treatments that are not substantiated by medical science, such as aroma therapy items and other such items
- Over-the-counter medications or treatments for maintaining general health, including but not limited to vitamins, sedatives, herbal teas and special foods (even "if prescribed")
- Expenses for cosmetic purposes
- Weight loss programs not prescribed by a physician
- Health club dues

Note: Expenses reimbursed through the Plan may not be claimed as deductions for income tax purposes.

Operation of Healthcare FSA's - General Mills has contracted with HealthEquity for the day-to-day administration of Healthcare FSA's. You must use your WageWorks or HealthEquity FSA debit card or submit a Healthcare FSA Claim Form to HealthEquity in order to be reimbursed for any eligible expenses. The Healthcare FSA reimbursements will be sent to your home via check or directly deposited into your specified bank account. The amount credited to your account will be reduced by the amount of any reimbursements claimed. If you submit a request for reimbursement for eligible expenses in excess of your Healthcare FSA balance, you will be reimbursed for the claim up to your full elected annual contribution. Your future contributions will be used to cover expenses for which you have already been reimbursed. You will be reimbursed only for eligible expenses incurred during the calendar year and expenses must be incurred while you were an active participant in the plan. The amount you are reimbursed for any year cannot exceed the amount credited to your Healthcare FSA for the year.

Claiming Benefits - In order to make a claim from the Healthcare FSA you must either use your WageWorks or HealthEquity FSA debit card or submit a Healthcare FSA Claim Form to HealthEquity or go online to www.healthequity.com. Your request for reimbursement must be accompanied by supporting documentation (e.g. explanation of benefits (EOB) or prescription drug receipts showing prescription number and covered person's name, date of service/purchase, provider name, type of service or supply, and patient's responsibility). Claims for over-the-counter medications must include a

copy of the prescription, receipt showing the name of the vendor, the date of purchase and the cost of the product.

Cancelled checks are not acceptable as a receipt for eligible expenses under the Plan. All expenses incurred during the calendar year must be postmarked by April 30th of the following year for reimbursement. If you fail to file a claim for expenses incurred during the previous calendar year by April 30th of the following year, you will not be reimbursed for those expenses. Please note, check reimbursements are considered paid out from the Healthcare FSA even if you do not cash it. If you lose a check or fail to cash it, you must request reissuance of the check before the April 30th deadline. Any credits remaining in your account (exceeding the $500 Carryover Rule) will be forfeited.

$500 Carryover Rule - The IRS allows plans to have a $500 carryover feature for unused Healthcare FSA funds to rollover into the following plan year. Any amount over $500 that is not used will be forfeited ("use it or lose it" rule). Under the $500 carryover rule, any amount up to $500, carried over from one year to the next will not count toward the annual IRS maximum contribution limit in the new Plan year.

Amounts carried over can only be used to pay or reimburse qualified medical expenses and are subject to termination of participation rules described below. Unused carryover amounts cannot be cashed out and cannot be converted or rolled over to any other taxable or nontaxable benefit account or arrangement.

Tax Treatment of Your Election Amount - Your pre-tax contributions as well as the reimbursements you receive from the Healthcare FSA are not subject to federal income tax, Social Security tax, and most state income taxes.

If you earn less than the Social Security taxable wage base during a calendar year and you authorize pay reduction for credit to a Healthcare FSA, you will pay lower Social Security taxes. As a result, you may receive a smaller Social Security benefit. The actual reduction will vary by individual. The amount of your pay reductions cannot be claimed as a deduction on your Federal income tax return.

The amount of eligible expenses reimbursed to you from your Healthcare FSA will not be included in your taxable income on your W-2 statement.

Leave of Absence - If you are on a paid leave of absence, Healthcare FSA contributions will continue to the end of the calendar year. Any balance in your Healthcare FSA at the time your leave of absence began can only be used to reimburse eligible expenses incurred during the current calendar year.

If you are on an unpaid leave of absence, any balance in your Healthcare FSA at the time your leave of absence began can only be used to reimburse eligible expenses incurred during the current calendar year. Upon returning to work your Healthcare FSA contributions will resume (if your return to work is during the same calendar year). Your contribution amount will be recalculated and spread out over the remaining pay periods.

If you are on a paid FMLA leave of absence you can elect to terminate coverage and contributions to the Healthcare FSA or you may continue coverage or suspend your contributions during your leave of absence, if you suspend contributions you will still be eligible to submit claims. If you suspended your contributions, upon returning to work your Dependent Care FSA contributions will resume (if your return to work is during the same calendar year). Your contribution amount will be recalculated and spread out over the remaining pay periods.

If you do not return to active work at the end of your leave of absence (and within the same calendar year), you may be eligible to continue the Healthcare FSA for the reminder of the calendar year under

COBRA if you have a positive balance; meaning the total amount of your contributions are greater than the total amount you have been reimbursed.

Mid-Year Changes in Participation - If, due to a qualified change in status, you:

- terminate your participation in the Healthcare FSA during the year, you cannot submit claims for reimbursement that are incurred after the termination date; however, if you are active in the plan on the payroll processing date, contributions will be taken through the payroll period date and you would be eligible to claim reimbursements through the date contributions were paid; or
- enroll during the year, you may only submit claims for reimbursement for expenses that you incur on or after the effective date you are eligible in the plan; or
- Increase your election to your Healthcare FSA during the year; you may only use the increased amount for expenses that you incur on or after the date of your election change.
- Decrease your election to your Healthcare FSA during the year, you cannot elect an amount less than the amount already reimbursed.
- Please also see how a Leave of Absence can impact a Healthcare FSA.

NOTE: You are not able to enroll or change your Healthcare FSA/Dependent Care FSA contribution for the current year after December 1st.

Termination of Participation - Your participation in the Healthcare FSA will terminate on the date:

- Your employment terminates for any reason, including retirement or death
- You are transferred to an employment status that is not eligible for participation in the Plan.

If you are active in the plan on the payroll processing date, contributions will be taken through the payroll period date and will be eligible to claim reimbursements through the date contributions were paid.

If your eligibility for coverage terminates during the calendar year, you will not be permitted to make additional pre-tax contributions to your Healthcare Flexible Spending Account beyond the last day of the month in which you were eligible to participate in the Plan. You cannot submit claims for reimbursement that were incurred after the last day of the month in which you were eligible for coverage unless you elect COBRA continuation coverage. See the "Benefits Continuation/COBRA" section for additional information.

Loss or Reduction of Benefits - You may lose benefits under this Plan, or benefits may be reduced under the following circumstances:

- If you elect to participate in the Plan and your eligible expenses during a calendar year are less than the amount of your contributions for that calendar year, the excess dollars in your Healthcare Flexible Spending Account are forfeited. Therefore, it is important that you elect an amount only for the expenses you expect to incur during the year. (See "Carryover Rule")
- If you fail to file a claim for eligible expenses incurred during the calendar (plan) year by April 30th of the subsequent year, you will not be reimbursed for such expenses. (For example, claims for expenses incurred during 2018 must be postmarked by April 30th, 2020.)
- If you elect to participate in the Plan, you may not change the amount of your authorized contributions during a calendar year unless you do so within 31 days of a Qualified Change in Status.
- If you fail to re-enroll in the Plan prior to the end of the annual benefits enrollment period, you will not be eligible to participate for the next calendar year unless there is a Qualified Change in Status.

- Please also see how a Leave of Absence can impact a Healthcare FSA.
- See other allowable changes under Life Events.

Appeals / Adverse Benefit Determinations - If your claim is denied, you can request a review of the denial. See the "Claims and Appeals Procedures" section in the "Plan Administration / ERISA" section.

Dependent Care Flexible Spending Account (Dependent Care FSA)

The Dependent Care Flexible Spending Account (Dependent Care FSA) allows you to pay, on a pre-tax basis, the expenses of hiring someone to care for your eligible dependents while you work. * ***Please note that the Dependent Care FSA is not for the health care expenses of your dependents – for health care expenses of your dependents, see the Healthcare FSA.*** General Mills has partnered with HealthEquity to manage your account and pay your claims. You do not receive a debit card for the Dependent Care FSA.

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Important: You cannot end participation in the Plan or change your election during a calendar year unless there is a qualified change in status. Qualified changes in status are not effective unless you contact the General Mills Benefits Service Center within 31 days of the qualified change in status.

** Please note: If you are married, you must certify that your spouse is gainfully employed, or looking for work, or a full time student for at least 5 months of the year, or incapable of self-care in order to use the Dependent Care FSA.*

For expenses to be eligible under the Dependent Care FSA, your dependents must be: Claimed on your federal income tax return as a dependent, and either: under age 13, or physically or mentally incapable of self-care.

Note: Be sure to review the information under "Eligibility, Enrollment, and Cost", "Effective Date of Coverage", "Qualified Change in Status", and "Life Events" for more information about the Dependent Care FSA.

Annual Election Amount – Employee Contributions -If you decide to participate in the Plan, you are requesting that your taxable pay be reduced by a specific amount from each of your paychecks. (Dependent Care FSA contributions will not be deducted from any paychecks that do not cover an entire pay period.) This pre-tax contribution is then credited to your Dependent Care FSA.

The IRS maximum per family is $5,000 of your earned income and your spouse's earned income if you're married or if your spouse is incapable of self-care or is a full-time student. The minimum election is $100 per calendar year.

A new election is required each year at Annual Benefits Enrollment for the following calendar year.

NOTE: you are not able to enroll or change your Healthcare FSA/Dependent Care FSA contribution for the current year after December 1st.

Company Matching Contributions - General Mills offers a key advantage in our Dependent Care FSA – a company match on your contributions. General Mills will match your contributions to your Dependent Care FSA at a rate of $0.25 for every $1.00 you contribute, up to a maximum company match of $500 per year. This amount will be placed in your account in December of the plan year that you are enrolled, and you must be actively employed, enrolled and contributing to the Dependent Care FSA at the time of the deposit to receive the matching contribution.

Eligible Expenses - The Dependent Care FSA can only be used to pay for the out-of-pocket expenses of hiring someone to care for your eligible dependents while you work (and, if you are married, while your spouse is gainfully employed, looking for work, a full time student for at least 5 months of the year, or incapable of self-care).

Eligible expenses include the following:

- Services rendered in your home for care of your dependents,
- Out-of-household care, provided that the eligible dependent regularly spends at least eight hours per day in your household,
- Services provided by a licensed dependent care center that complies with the laws and regulations of the state in which it is located,
- Nursery school and pre-school, and
- Day camp.

Exclusions - Expenses that are not eligible for reimbursement under the Dependent Care FSA include the following:

- Health care services for your dependents
- Amounts paid directly to one of your children under age 19, your spouse or your other dependents,
- Amounts paid to a convalescent nursing home for care of an invalid,
- Costs incurred before you became a participant in the Plan,
- Kindergarten tuition or costs,
- Tuition for education for children in first grade or above,
- Amounts paid for overnight camps,
- Costs incurred for a nanny search,
- Babysitting expenses not related to work or school, and
- Services solely for the purpose of household cleaning.

Operation of Dependent Care FSA's - General Mills has contracted with HealthEquity for the day-to-day administration of the plan. Once you become a participant in the Dependent Care FSA, the amount of your election you have authorized will be credited to your account after each paycheck. You must submit a Dependent Care FSA Claim Form to HealthEquity (see "Claiming Benefits") to be reimbursed for eligible expenses. The Dependent Care FSA reimbursements will be sent to your home via check or directly deposited into your specified bank account. Your account will be reduced by the amount of any reimbursement paid. If you submit expenses in excess of your Dependent Care FSA, the excess expenses will be retained and will be reimbursed as future pay is credited to your account. You will only be reimbursed amounts that were in your account prior to the current paycheck. A reduction cannot be taken and reimbursed on the same check. You will be reimbursed only for eligible expenses incurred during the calendar year. The amount you are reimbursed for any calendar year cannot exceed the amount credited to your account for the year.

Claiming Benefits - You must submit a Dependent Care FSA Form, which must include the original signature of your provider and your provider's tax identification number. If you do not have your provider's signature on the claim form, a signed receipt must be attached. Canceled checks are not acceptable as a receipt for eligible expenses under the Plan. All expenses incurred during the calendar year must be postmarked by April 30th of the following year. If you fail to file a final claim for expenses incurred during the previous calendar year by April 30th of the following year, you will not be reimbursed for those expenses. Any credits remaining in your account will be forfeited.

Leave of Absence - If you are on a paid leave of absence, Dependent Care FSA contributions will continue to the end of the calendar year. You may have the option to terminate or reduce your Dependent Care FSA contribution if you have a change in your day care expenses due to your leave. You must contact the General Mills Benefits Service Center regarding any changes to your election amount within 31 days of the cost change. Any balance in your Dependent Care FSA at the time your leave of absence began can only be used to reimburse eligible expenses incurred during the current calendar year.

If you are on an unpaid leave of absence, any balance in your Dependent Care FSA at the time your leave of absence began can only be used to reimburse eligible expenses incurred during the current calendar year. Upon returning to work your Dependent Care FSA contributions will resume (if your return to work is during the same calendar year). Your contribution amount will be recalculated and spread out over the remaining pay periods.

If you are on a paid FMLA leave of absence you can elect to terminate coverage and contributions to the Dependent Care FSA or you may continue coverage or suspend your contributions during your leave of absence, if you suspend contributions you will still be eligible to submit claims. If you suspended your contributions, upon returning to work your Dependent Care FSA contributions will resume (if your return to work is during the same calendar year). Your contribution amount will be recalculated and spread out over the remaining pay periods.

Termination of Participation - Your participation in the Dependent Care FSA will terminate on the date:

- Your employment terminates for any reason, including retirement or death,
- You are transferred to an employment status that is not eligible for participation in this Plan,
- You fail to enroll in the Plan prior to the end of the specified Annual Benefits Enrollment period for the following calendar year.

If your employment terminates during a calendar year, you will not be permitted to make additional pre-tax contributions to your account beyond your termination date; however, if you are active in the plan on the payroll processing date, contributions will be taken through the payroll period date. You will, however, be eligible for reimbursement of eligible expenses incurred during the entire calendar year, including the period between your actual termination of eligible employment and December 31, up to the total amount in your account. If you are terminated or are ineligible for the Dependent Care FSA as of the date that the company match is deposited in December, you will not be eligible.

Disability, Retirement, or Termination of Employment - Authorized pay reductions under the Plan will stop when you begin to receive disability benefits, go on an unpaid leave of absence, terminate your employment, or retire. Any balance in your account at that time can be used only for reimbursement of eligible expenses incurred during the calendar year.

Dependent Care FSA versus the Dependent Care Tax Credit - If you do not participate in this Plan, you may qualify to claim eligible child and dependent care expenses as a tax credit on your federal income tax return. You may also be able to claim a tax credit for dependent care expenses for which you are not reimbursed from this Plan. The method that will produce the greatest tax savings for you–depends on your individual tax situation. You may want to consult a tax or financial advisor for guidance before you enroll in this Plan.

Tax Treatment of Your Election Amount - Amounts credited to your Dependent Care FSA are not subject to federal income taxes, Social Security taxes, or the income taxes of most states. Reimbursements from the account are also not subject to these taxes. If you earn less than the Social Security taxable wage base during a calendar year and you authorize pay reduction for credit to a

Dependent Care FSA, you will pay lower Social Security taxes. As a result, you may receive a slightly smaller Social Security benefit. The actual reduction will vary by individual. The amount of your pay reduction cannot be claimed as a deduction on your federal income tax return.

The amount of eligible expenses reimbursed to you from your Dependent Care FSA will not be included in your taxable income on your W-2 statement. However, this amount will appear on your W-2 and be coded "DCB." You must show on your federal income tax return the name, address, and (except for churches or other tax-exempt dependent care centers) the taxpayer identification number of any dependent care providers.

Loss or Reduction of Benefits - You may lose benefits under the Dependent Care FSA, or benefits may be reduced, under the following circumstances:

- If you elect to participate in the Dependent Care FSA and your eligible expenses during a calendar year are less than the amount of your election for that calendar year, the excess dollars in your account at the end of the calendar year are forfeited. Therefore, it is important that you authorize pay reductions only for the amount of expenses you expect to incur during the year.
- If you fail to file a claim for eligible expenses incurred during the calendar (plan) year by April 30th of the subsequent year, you will not be reimbursed for such expenses. (For example, claims for expenses incurred during 2018must be postmarked by April 30th, 2020.)
  If you elect to participate in the Dependent Care FSA, you may not change the amount of your authorized election during a calendar year unless you do so within 31 days of a qualified change in status.
  NOTE: you are not able to enroll or change your Healthcare FSA/Dependent Care FSA contribution for the current year after December 1st.
- If you fail to re-enroll in the plan prior to the end of the specified annual benefits enrollment period, you will not be eligible to participate for the next calendar year unless you incur a qualifying change in status.
- Certain individuals identified as highly compensated under the Internal Revenue Code may have their election reduced if the plan does not meet certain Internal Revenue Code non-discrimination requirements.
- Please also see how a Leave of Absence can impact a Dependent Care FSA.
- See other allowable changes under Life Events.

Appealing a Claim under the Dependent Care FSA / Adverse Benefit Determinations - In the event your request for reimbursement of expenses is denied in whole or in part, you will be notified of the denial within 90 days after you have requested reimbursement (or within 180 days if you are notified in writing of special circumstances requiring additional time for the decision), and you will be informed of the specific reasons for the denial.

In addition, you may file a written request for a review of the denial within 60 days following your receipt of the denial. You may also submit written comments and other evidence as to why the claim should be paid. The Claims Administrator will notify you of its decision in writing within 90 days after the request for review is filed (or within 120 days if you are notified in writing of special circumstances requiring additional time).

If the claim continues to be denied and you choose to bring a civil action, such an action must be brought before the earlier of: (a) 6 months after you receive your final denial from the Committee, or (b) 30 months after you were first denied benefits, or, if earlier, 30 months after you knew or should have known of the facts on which your claim is based. For more information, see the plan document, available upon request.

Life Insurance and Accidental Death & Dismemberment (AD&D)

General Mills provides several life and accident insurance programs through Securian Life. These programs include:

- Company-provided life insurance equal to one times your annual earnings at no cost to you.
- Company-provided business travel accident insurance equal to five times your annual earnings at no cost to you. (For details on the business travel accident insurance program, please see the Summary Plan Description for that program, which is separate from this handbook.)
- Optional life insurance programs available for you to purchase to cover yourself and your eligible dependents.
- Optional accidental death and dismemberment (AD&D) insurance programs available for you to purchase to cover yourself and your family members.

General Mills Benefit Service Center……1-888-200-5555, option 1

My Benefits website……..www.mygenmillsbenefits.com

Securian Life – Claims……..1-888-658-0193

Company-paid Life Insurance - General Mills provides you with company-paid term life insurance. Your basic benefit amount equals one times (1x) your annual earnings rounded to the next higher $1,000, to a maximum benefit of $2,000,000. Life insurance benefit amounts reduce to 65% of full coverage at age 70, and 50% at age 75.

If your basic company-paid life insurance benefit amount is more than $50,000, the value of the premium paid by the Company for the amount above $50,000 will be taxable to you in an amount as determined by the IRS.

Special Tax Note: The IRS requires that the actual cost of your life insurance in excess of $50,000 be taxable to you and included on your W-2. "Imputed Income" is the value the IRS places on employer paid life insurance coverage that exceeds $50,000. You pay income taxes on the value of this coverage. The value of the coverage is determined by the IRS and depends on your age and the amount of coverage you have in excess of $50,000. This amount appears in the "Earnings" section of your paycheck stub as "Life-Imputed".

Life Insurance Coverage Options

Optional Employee-Paid Life Insurance Coverage - You may purchase optional life insurance coverage for yourself. Benefit options are available from one times (1x) to eight times (8x) your annual earnings, rounded to the next higher $1,000, to a maximum benefit of $3,000,000 (combined with company-paid coverage). Life insurance benefit amounts reduce to 65% of full coverage at age 70, and to 50% at age 75.

You must provide evidence of insurability for elected coverage that is more than three times (3x) your annual earnings (or $1,000,000 if less). Also, evidence of insurability may be required for all amounts if you enroll for coverage more than 31 days after you first become eligible to enroll.

Employee life insurance rates are based on age and any form of tobacco use within the last twelve months. The rates for non-tobacco users are less than those charged to tobacco users. Contact the Benefits Service Center for current rates.

Employee contributions are made on an after-tax basis through payroll deduction. Contributions are adjusted each January 1 for age increases. If your annual earnings change during the calendar year, your payroll deduction amounts will not be adjusted until the following February 1st and the new amount of your coverage will be effective as of February 1st. If your tobacco status changes during the year, contact the General Mills Benefit Service Center to report the change.

Optional Employee-Paid Spouse Life Insurance Coverage - You may purchase optional life insurance coverage for your spouse. Benefit options are $25,000, $50,000, $100,000, or $150,000. Life insurance benefit amounts reduce to 65% of full coverage at age 70, and to 50% at age 75.

Your spouse must provide evidence of insurability for elected coverage over $25,000. Also, evidence of insurability may be required for all elected coverage amounts if you enroll for coverage for your spouse more than 31 days after your spouse first becomes eligible.

Spouse life insurance rates are based on age and any form of tobacco use within the last twelve months. The rates for non-tobacco users are less than those charged to tobacco users. Contact the Benefits Service Center for current rates.

Note: If both you and your spouse work for General Mills, neither of you can be covered as a spouse.

Optional Employee-Paid Child Life Insurance Coverage - You may purchase optional life insurance coverage for your children. The benefit amount is $10,000 per child. Please note that if you and your spouse are both employed by General Mills, only one of you may purchase life insurance for your children.

Determination of Benefit Amount - Benefits for employee life insurance are based on your annual earnings, defined as the highest of your:

- annualized base salary at the time of your death, or
- total earnable compensation (including base pay, overtime, commissions, incentive payments or other eligible compensation paid for services rendered) during the preceding calendar year, or
- base pay as of the preceding December 31.

Benefit amounts are adjusted every February 1 and changes to rates based on changed benefit amounts are effective February 1.

Life Insurance Exclusions - There are no exclusions for Life Insurance.

Beneficiary Designation - Your beneficiary may be any person, persons, or trust you name on the beneficiary form. If you do not name a beneficiary, benefits are payable in the following order: To your spouse*, if living, otherwise equally to your living child (ren), otherwise to your parents, or otherwise to your estate.

You may change your beneficiary at any time through the My Benefits website or by contacting the General Mills Benefit Service Center. The change in beneficiary will be in effect immediately.

Payment of Life Insurance Benefits

In the Event of Your Death - In the event of your death from any cause, your beneficiary will be paid the benefit amount of your Company-Paid Life Insurance and any Optional Employee-Paid Life Insurance in force.

In the Event of Death of Your Spouse or Child - In the event of the death of your spouse from any cause, you will be paid the benefit amount of your Spouse Life Insurance in force.

If you have elected and enrolled a dependent under Child Life Insurance, you will be paid the elected benefit amount upon the death of the covered child.

In the Event of Terminal Illness of You, Your Spouse or Child –Accelerated Death Benefit - You may request an accelerated death benefit payment of your life or on the life of a spouse or dependent child insured under your certificate of life insurance in the event you, your spouse, or your child is diagnosed with a terminal illness. A terminal illness is any condition caused by sickness or resulting from an accident that shortens your life expectancy to 12 months or less.

Accelerated benefits are not available if you have assigned your coverage or have an irrevocable beneficiary.

Under this option, you can elect to have the full amount or a partial amount of at least $10,000 of your life insurance paid out prior to your death. The maximum that can be accelerated is $1,000,000. If you wish to receive only a partial accelerated benefit, the remaining death benefit payable must be at least $25,000 and will remain in force until your death.

You will be required to provide Securian Life with evidence that your life expectancy is 12 months or less. To receive complete information on this form of payment, contact Securian Life at 1-800-277-8785.

Optional Employee-Paid Accidental Death & Dismemberment Coverage - You may purchase optional accidental death and dismemberment (AD&D) insurance for you and your family. Benefit options for you are $25,000, $50,000, $100,000, $200,000, $300,000, $500,000, $750,000, or $1,000,000, except that your maximum benefit cannot be more than ten times (10x) your annual earnings. AD&D benefit amounts reduce to 65% of full coverage at age 70; 45% at age 75; 30% at age 80, and 15% at age 85.

Optional family benefit amounts are based on your benefit amount. Spouse-only coverage is 60%. Child (ren)-only coverage is 25% for each child, but not more than $50,000 per child. Spouse and Child (ren) coverage is 50% for your spouse and 15% for each of your children, not to exceed $50,000 per child.

Payment of AD&D Benefits - Your AD&D coverage will be paid for any of the following losses that are the result of an accident occurring on or off the job while insured.

Type of Loss	Percent of Benefit Paid
• Life	100%
• Both Hands or Both Feet • The Sight of Both Eyes • One Hand and One Foot • One Foot and Sight of One Eye • One Hand and Sight of One Eye • Paralysis of Both Arms and Both Legs	100%
• Paralysis of Both Legs	75%
• One Hand or One Foot • The Sight of One Eye • Paralysis of Both the Arm and the Leg on One Side of the Body	50%
• Loss of Thumb and Index Finger of the Same Hand	25%

Loss of sight means the entire and irrecoverable loss of sight, which cannot be corrected by medical or surgical treatment or by artificial means. Loss of a hand or foot means complete severance at or above the wrist or ankle. Loss of thumb and index finger means complete severance of both the thumb and index finger at or above the metacarpophalangeal joints.

If more than one loss occurs due to one accident, only a claim for the loss providing the greatest benefit will be payable.

AD&D Insurance Exclusions - AD&D benefits will not be paid for the following:

- A loss that occurs more than 365 days after the accident,
- A loss caused by declared or undeclared war or an act of war,
- A loss caused by suicide or attempted suicide while sane or insane, or intentionally self-inflicted injury or attempted self-inflicted injury while sane or insane,
- A loss caused by illness, disease or any infection other than a pyogenic infection of an accidental cut or wound,
- A loss caused by engaging in or taking part in aeronautics and/or aviation of any description, or resulting from being in an aircraft, except in consequence of riding as a passenger and not as an operator or crew member, in or on, boarding or disembarking, from any aircraft having a current and valid airworthiness certificate, or any transport type aircraft operated by the Military Airlift Command (MAC) of the United States of America, or by any similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, or
- A loss caused by service on active duty in the military of any nation. This shall not apply while an insured is a member of an Organized Reserve Corps or National Guard and who is (a) in attendance at annual field training, cruise, or other active duty or training of less than thirty days (except that while attending a service school the coverage will extend for the duration of the school even through in excess of thirty days), or is enroute directly to or from such training; or (b) participating in a properly authorized periodic inactive duty training assembly or any other inactive duty training authorized by appropriate unit orders; or (c) participating as a member of his or her unit or detachment in an authorized parade, exhibition or ceremony by official orders.

Filing a Claim for Benefits - For information on filing a claim for a death or AD&D benefit, you or your beneficiary should contact the Securian Life's claims area at 1-888-658-0193. Representatives are available Monday through Friday, 7:00 AM to 5:30 PM Central Time. An original or certified copy of the deceased's death certificate, and the social security number, date of birth and address of the beneficiary may be required by General Mills and Securian Life before any death benefits are paid.

Termination of Coverage - All life insurance and AD&D coverage terminates at the end of the month in which:

- Your employment with the company terminates (and, for life insurance, you do not meet the requirements for retiree life insurance), or
- You cease to be an eligible employee, or
- You fail to make any required premium payments, or
- The group insurance policy is discontinued and not replaced.

Dependent coverage also terminates at the end of the month in which a dependent no longer meets the definition of an eligible dependent.

If your life insurance coverage ends, you may be eligible to continue coverage under Minnesota continuation requirements. See the section entitled "Benefits Continuation" for more information. You may also be eligible to continue your optional life insurance under Portability and/or convert to an individual policy.

Life Insurance and AD&D Definitions

Accelerated Death Benefit - A portion of your life insurance benefits that can be paid while you are still living, if you are terminally ill.

Accidental Death and Dismemberment (AD&D) - Insurance that provides benefits if you die, lose a limb, lose your eyesight, or are paralyzed as the result of an accident.

Accidental Injury - The unexpected result of a sudden external force that damages sound and natural body structure.

Active Employment - You are at work and able to perform the essential functions of your job.

Beneficiary - The person(s) you choose to receive benefits from your life and/or AD&D insurance if you die.

Child Life Insurance - Optional life insurance for which you pay the full cost. Child life insurance pays benefits for the death of your dependent child.

Company - General Mills, Inc.

Company-Paid Life Insurance - Insurance funded by General Mills that provides a benefit to your beneficiary(ies) in the event of your death.

Earnable Compensation - The earnings used to determine life insurance benefit amounts that are based on your pay. It includes base pay, overtime, commissions, incentive payments and other eligible compensation paid to you during a calendar year.

Irrevocable Beneficiary - A beneficiary you cannot change without the beneficiary's consent.

Optional Life Insurance - Life insurance protection that you can purchase for yourself, your spouse or your children.

Plan - The benefits plans established by the Plan Administrator and known as the "Employees' Benefit Plan of General Mills, Inc." and the "General Mills Optional Employee-Paid Life Insurance Plan."

Plan Administrator - General Mills, Inc.

Spouse - An individual who is legally married to an employee in the state in which the employee lives, including a legally recognized common law spouse.

Terminal Illness - Any condition caused by sickness or resulting from an accident that shortens your life expectancy to 12 months or less.

Life Events / "What Happens When…"

The following is a brief summary of your benefit coverages under various circumstances. In cases where coverage continues, and you are on an unpaid leave, it is required that you timely pay any required premiums. If coverage terminates due to non-payment of premiums, the next opportunity you have to enroll in coverage is when you return to work. You must contact the General Mills Benefits Service within 31 days of the date you return to work to make any coverage changes. In situations where your active coverage ends and you can continue your Medical, Dental, Vision or Healthcare FSA participation under COBRA, see the "Benefits Continuation/COBRA" section for more information.

Short Term Disability			
Medical/Vision	Dental	Healthcare FSA	Dependent Care FSA
Continues	Continues	Continues to end of plan year	Continues to end of plan year

Long Term Disability			
Medical/Vision	Dental	Healthcare FSA	Dependent Care FSA
Continues	Continues for 18 months	Continues to end of plan year	Continues to end of plan year

Leave of Absence (non-FMLA)			
	Medical/ Dental/Vision	Healthcare FSA	Dependent Care FSA
Paid	Continues	Continues to end of plan year	Continues to end of plan year
Unpaid	Continues	Continues to end of plan year	Continues to end of plan year

Leave of Absence (FMLA)		
Medical/Dental/Vision	Healthcare FSA	Dependent Care FSA
Continues	Continues to end of plan year	Continues to end of plan year

Unpaid Educational Leave of Absence		
Medical/Dental/Vision	Healthcare FSA	Dependent Care FSA
Ends	Continues to end of plan year	Continues to end of plan year

Layoff		
Medical/ Dental/Vision	Healthcare FSA	Dependent Care FSA
Continues	Continues to end of plan year	Continues to end of plan year

Termination		
Medical/ Dental/Vision	Healthcare FSA	Dependent Care FSA
Continues to end of month	Continues to end of month	Continues to end of month

Death		
Medical/ Dental/Vision	Healthcare FSA	Dependent Care FSA
Continues to end of month – additional survivor benefits*	Date of Death	Date of Death

*Medical and dental coverage for your covered spouse and your covered dependents will continue under active medical and dental plans concurrent with COBRA. Dependents must be enrolled in active medical and dental coverages to continue under COBRA medical and dental coverage. Covered dependents will have 6 months of free active medical and dental coverage under COBRA. After 6 months, the survivor pays full COBRA rates for the remaining 30 months. Immediately, at the end of the 36 months the survivor has a one-time option to elect retiree medical and/or dental coverage at the full premium. Coverage is available until remarriage or your dependent reaching the age limits. Coverage will be subject to payment of any required contribution and will continue until: Your spouse remarries, your dies, or your covered dependents no longer qualify as eligible dependents.

Additional provisions apply, please see each plans benefits section for more details.

Retirement – See Separate Retirement SPD for additional details.

Disability Programs - Coverage ends when you are on an unpaid leave of absence that is not protected by FMLA at the time the leave begins. (In the case of a terminal leave of absence – coverage ends when the terminal leave of absence begins.) Coverage ends on your termination date or date of death.

Life and AD&D Insurance - Company-Paid, Optional Employee-Paid, Optional Spouse, Optional Child (ren), and Optional AD&D Insurance coverage continues, as long as you continue to make employee contribution payments, for up to 18 months for a non-medical leave of absence, or up to 36 months for a qualified military leave of absence, educational leave of absence or a community assignment leave of absence. For terminations, continuation, portability, and conversion options are generally available for Life Insurance. AD&D Insurance ends on your termination date. Contact the General Mills Benefits Service Center for any questions.

Returning From a Leave - Anytime you return from a leave and need to make a qualified change to any of your benefits, you must do so within 31 days of the date you return from leave. Please call the General Mills Benefits Service to make any changes.

Special Note Regarding the Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) allows you to take time off from work under certain circumstances. If you have worked for General Mills for at least one year and have completed 1,250 hours of work within the last 12 months, you may be eligible to take up to 12 weeks of time off during a

rolling twelve-month period of time (i.e., no more than twelve weeks leave during the preceding twelve months). FMLA leave may be taken for:

- Your own serious health condition.
- The serious health condition of a parent, child, or spouse.
- The birth of your child, or adoption or foster placement of a child in your home.
- Military Family Leave

You will not be disciplined or discharged for absences that are approved as FMLA leave, and you may return to work in your same (or equivalent) position upon the completion of your leave.

An FMLA leave may be unpaid, or it may be compensated by pay continuation programs, worker's compensation benefits, Short-Term Disability, sickness and accident benefits, or state non-occupational disability benefits provided that you satisfy the requirements of such programs and/or plans. You may use any available unused vacation days concurrent with unpaid time off in accordance with FMLA, and General Mills may require this usage.

If you receive pay from General Mills during your FMLA leave, the premiums for your health coverage will continue to be deducted. If you do not receive pay from General Mills, you may either terminate your health coverage during your leave or continue it. If you terminate your coverage, you can re-enroll in the coverage upon your return to work.

To re-enroll, you must contact the General Mills Benefits Service Center within 31 days of your return to work. If you wish to continue your health coverage during your unpaid FMLA leave, you must pay the employee portion of your premiums for your FMLA leave period. Please contact the General Mills Benefits Service Center to make payment arrange

Benefits Continuation/COBRA

Federal laws give you and your eligible covered dependents the right to continue certain benefits (including medical, dental, vision and healthcare flexible spending account coverage) for a limited period of time if coverage is lost because of a qualifying life event. These laws include the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA only applies to group health plan benefits and not to any other benefits (such as dependent care flexible spending account, life insurance, disability or accidental death and dismemberment benefits). Nothing in this SPD is intended to expand your rights beyond COBRA's requirements. The term "dependents" as used in the following paragraphs includes a spouse. Contact the General Mills Benefits Service Center for information regarding your COBRA rights.

Medical, Dental and Vision Coverage

If you and/or your dependents are covered under the medical, dental and/or vision plan on the day of a "qualified event," you and your covered dependents may be eligible to continue your coverage under COBRA for a limited period of time. Those eligible to elect COBRA continuation coverage are known as "qualified beneficiaries."

Qualified beneficiaries may also include a child born to, adopted by or placed for adoption with a covered employee during a period of COBRA coverage as long as the covered employee, if a qualified beneficiary, has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special or Annual Benefits Enrollment, and lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (such as age).

Once a qualified event occurs, you may be responsible for providing notice of that event in order to protect your rights under COBRA. Read the following information carefully to determine what to do to protect your rights.

COBRA coverage provides the same coverage to qualified beneficiaries who elect COBRA coverage that the Plan provides for other participants. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries, including Annual Benefits Enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for the coverage.

Qualified Events - The Company will notify the General Mills Benefits Service Center within 30 days following the date coverage ends due to one of the following qualified events:

- Your termination of employment, including severance
- Your reduction in hours worked
- You going on a leave of absence or disability
- Your retirement
- Your death.

You and/or your covered dependents will be notified by the General Mills Benefits Service Center of your continuation rights within 60 days.

You are responsible for notifying the General Mills Benefits Service Center no later than 60 days after one of the following qualified events occurs:

- Your divorce, legal separation, (if a spouse or domestic partner's coverage is reduced or eliminated in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, the divorce or legal separation may be considered a qualifying event even though coverage was reduced or eliminated previously),
- Your entitlement to Medicare (Title XVIII of Social Security Act),
- Your child reaching the Plan's maximum age, or
- Your child's otherwise ceasing to qualify as a dependent under the Plan.

If you fail to give such notice, you and your covered dependent(s) will lose the right to elect continuation coverage. You must contact the General Mills Benefits Service Center no later than 60 days after the occurrence of one of these qualified events.

Once the General Mills Benefits Service Center has been notified of any of the above events within 60 days of the event, you and your covered dependent(s) will be notified of your continuation rights.

Additional Information -The General Mills Benefits Service Center may ask you for additional information or documentation when you provide notification of a qualified event. It is your responsibility to provide the requested information or documentation within ten (10) business days of the request or the end of 60 days after the qualified event, whichever is later. **Failure to provide necessary information or documentation as requested may result in you or your covered dependents losing your right to elect COBRA coverage.**

Eligibility for Continuation of Medical, Dental and Vision Coverage -You and your covered dependents may elect to continue medical, dental and/or vision coverage under COBRA for up to 18 months if you lose coverage for one of the following reasons:

- Your employment terminates for a reason other than gross misconduct,
- You retire and wish to elect COBRA medical coverage instead of retiree medical coverage,
- You retire and wish to elect COBRA dental coverage,
- You go on lay-off or leave of absence,
- Your hours are reduced so that you are no longer eligible for medical and/or dental coverage.

If you take FMLA leave and do not return to work at the end of the leave, you and your covered dependents will be entitled to elect COBRA if (1) you and your covered dependents were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) you and your covered dependents will lose Plan coverage within 18 months because of your failure to return to work at the end of the leave. (This means some individuals may be entitled to elect COBRA coverage at the end of an FMLA leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in this circumstance will begin on the last day of the FMLA leave.

This 18-month coverage period can be extended in some circumstances. See below.

Disability - If you or your covered dependent is determined to be disabled for purposes of the Social Security Act and the Social Security Administration determines that the effective date of the disability occurred during the first 60 days after coverage was lost due to your termination of employment, retirement or reduction in hours, you and your covered dependents will be eligible for 29 months of continuation coverage rather than 18 months-an extension of 11 months. To extend COBRA coverage, you or your covered dependent must send a copy of the Social Security Award letter to the General Mills Benefits Service Center. The date of disability on the award letter must be prior to or within the first 60 days of COBRA coverage. The letter must be sent to the General Mills Benefits Service Center within 60 days of the start date of COBRA, or if later, within 60 days of the date the letter was sent to you or your

covered dependent. The letter must have originated before or within the original 18-month COBRA coverage period.

Death, Divorce, or Legal Separation - Continuation of medical and dental coverage is available to your covered dependents for up to 36 months if they have lost regular coverage due to your:

- Death,
- Divorce, or
- Legal separation from your spouse or domestic partner

If one of these events occurs while your dependents are covered under an 18-month or 29-month COBRA continuation period, your covered dependents' continuation period can be extended to 36 months from the date their 18-month COBRA continuation period began. **You or your dependents must notify the General Mills Benefits Service Center within 60 days of the applicable event in order to qualify your affected dependents for the extension.**

Medicare Entitlement - If you become entitled to Medicare within 18 months before you lose coverage due to your termination of employment or reduction in hours, you, your spouse and your covered dependents can continue coverage for either (i) 18 months from your date of termination or reduction in hours or (ii) 36 months from the date of your Medicare eligibility, whichever is longer.

If you enroll in Medicare (Part A, Part B or both) while receiving COBRA continuation coverage, your covered dependents can extend their COBRA continuation coverage to a maximum total of 36 months from the time their COBRA service began. **You or your dependents must notify the General Mills Benefits Service Center within 60 days of the applicable event in order to qualify your affected dependents for the extension.**

Loss of Dependency Status - 36 months of continuation coverage is also available to your covered dependents if they become ineligible because of Plan requirements for being a dependent, such as reaching the maximum age for coverage. The 36-month continuation period will include all periods of extended coverage from the date that any of the above occurs.

If a dependent loses dependency status under the Plan while your dependent is covered under an 18-month or 29-month COBRA continuation period, your covered dependent's continuation period can be extended to a maximum of 36 months from the date the 18-month (or 29-month) COBRA continuation period began. **You or your dependents must notify the General Mills Benefits Service Center within 60 days of the applicable event in order to qualify your affected dependent for the extension.**

Election of Continuation Coverage -You and your covered dependents will be notified by the General Mills Benefits Service Center of your option to elect continuation coverage after proper notification of a qualified event. The COBRA enrollment notice will include costs for all coverage tiers; employee only, employee plus child(ren), employee plus spouse or employee plus family. The Enrollment notice will include information to contact Securian Life if eligible to continue life insurance benefits.

You and your covered dependents must elect COBRA continuation coverage by contacting the General Mills Benefits Service Center or go to the My Benefits website, within 60 days of the termination of your regular coverage or the date you receive notification of the continuation coverage option, whichever is later. Paper enrollment forms are not supported; you must enroll by contacting the General Mills Benefits Service Center. **IF AN ELECTION IS NOT MADE WITHIN THE ELECTION PERIOD, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

The General Mills Benefits Service Center will ask which family members are enrolling in COBRA; they will not assume all family members are enrolling in COBRA. Any qualified beneficiary may elect

continuation coverage individually even if you and/or your other dependents elect not to continue coverage.

The General Mills Benefits Service Center will mail a confirmation of enrollment with information on the benefit choice, cost and plan-specific coverage end dates.

Special Considerations - In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. You can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA may prevent you from having such a gap. Also, you should consider your special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment rights at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Cost - The cost of COBRA continuation coverage generally is the full company group rate plus a 2% administration charge. If an 18-month period is extended to 29 months due to a disability, the cost for the additional 11 months of coverage for Social Security disability will remain the full company group rate plus 2%. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

After you have elected COBRA continuation coverage, you will have 45 days from the date you make your election to pay for the coverage period from the date that you lost regular coverage (or the date COBRA continuation coverage begins, if later) to the date you made your election. In addition, you must pay any future monthly premium that becomes due during the 45-day period. You are responsible for making sure that the amount of your first payment is correct. If you want to confirm the correct amount of your first payment, contact the General Mills Benefits Service Center. **If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.**

Billing notices will be generated on the 13th of every month and sent by the 18th.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment.

Payments must be made monthly and are due by the first day of the month for that month's coverage. If any payment is not received within 31 days ("the grace period") following the due date, coverage will be terminated and your coverage will not be reinstated.

If you pay a monthly payment later than the first day of the month to which it applied, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

Your first month’s COBRA premium can be paid by check or a one-time payment online through your My Benefits Portal. Your bill must be generated before a payment can be made online. Subsequent monthly COBRA premiums can be paid by check or by setting up reoccurring, ACH withdrawal from your bank account. Your check should be made payable to Alight and mailed to General Mills, Inc. P.O. Box 0794, Carol Stream, IL. 60132-0794. To pay by ACH withdrawal, log into the My Benefits website. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

Trade Act of 2002 Notice - The Trade Act of 2002 created a new health coverage tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282, TTD/TTY 1-866-626-4282. More information about the Trade Act is also available at http://www.dol.gov.

Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee becomes eligible for the health coverage tax credit, but only if the election is made within the six months immediately after the eligible employee's group health plan coverage ended. If you qualify or may qualify for the health coverage tax credit, contact the General Mills Benefits Service Center for additional information. **You must contact the General Mills Benefits Service Center promptly after qualifying for the health coverage tax credit or you will lose your special COBRA rights.**

Termination of Continuation Coverage - COBRA continuation coverage will terminate for you and your covered dependents before the end of the 18-month, 29-month, or 36-month maximum coverage period, whichever is applicable, as soon as one of the following occurs:

- The company terminates all group health plans,
- Coverage is provided under any other group health plan for a qualified beneficiary (which occurs after the date of the COBRA election for continuation) and the coverage provided under the new group health plan does not include a pre-existing condition limitation which applies to the affected qualified beneficiary,
- The premium payment is not received by the payment deadline,
- Your military leave period ends,
- The qualified beneficiary first becomes entitled to Medicare after the date of the COBRA election for continuation coverage, or
- Eligibility for coverage was extended to 29 months due to disability, and there is a determination that the individual is no longer disabled. (Coverage will terminate after the initial 18-month period or at the time of the determination, if later.) You must inform the General Mills Benefits Service Center within 30 days of the date that the determination is made that the individual is no longer disabled.

You must inform the General Mills Benefits Service Center within 30 days of the date that a qualified beneficiary becomes covered under a new group health plan or Medicare.

Failure to notify the General Mills Benefits Service Center within the required 30 days may result in a retroactive termination of COBRA coverage. The qualified beneficiary will be required to repay the Plan for all benefits paid after the termination date.

If You Have Questions - If you have questions about your COBRA continuation coverage, you should contact the General Mills Benefits Service Center, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes -In order to protect your family's rights under COBRA, you should keep the Plan Administrator (and the General Mills Benefits Service Center if you are actually covered by COBRA continuation coverage) informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Health Savings Account

While the HSA Gold Plan is subject to COBRA coverage rules, the Health Savings Account is not. You will continue to have access to your HSA. HealthEquity will send out a new HSA card and welcome letter with information on your new direct personal account. Your prior remaining balance will be transferred to this new direct account. If you become covered under a medical plan that is not a qualified high deductible medical plan, any money remaining in your HSA can still be used for qualified medical expenses. You can contribute after-tax money to your Health Savings Account while you have COBRA coverage under a high deductible health plan and remain an HSA-eligible individual (and qualified after-tax contributions may also be eligible for tax deductions). You will not receive any company contributions to your HSA account while on COBRA.

Healthcare Flexible Spending Account

Generally, the information on COBRA continuation coverage in the medical, dental and vision section, above, applies to COBRA continuation coverage under the Healthcare Flexible Spending Account. The following exceptions apply.

Period of Coverage and Eligibility - COBRA continuation coverage is only available to participants and their spouses and dependents through the end of the calendar year, and only if the participant has a positive account balance at the time of the qualifying event. The continuation of coverage will terminate before the end of the calendar year if one of the following occurs:

- The company terminates all group health plans, or
- The monthly payment is not received by the payment deadline.

Note: The cost of COBRA continuation coverage in the Healthcare Flexible Spending Account is paid on an after-tax basis and is 100% of the monthly premium plus a 2% administration charge.

Election - The General Mills Benefits Service Center will send you a notice of your continuation rights and instructions on how to make an election. Note that you must have a positive account balance to continue your Healthcare Flexible Spending Account.

Dependent Care Flexible Spending Account –

Pre-tax contributions to the Dependent Care Flexible Spending Account will not be permitted beyond the last day of the month in which you lose eligibility. However, you will be allowed to submit claims for reimbursement to your account for charges that were incurred and paid through December 31 of that year. Election of continuation coverage (COBRA or otherwise) is not available.

Life Insurance and AD&D

Your life insurance with General Mills ends the last day of the month in which you terminate employment (or otherwise lose eligibility for coverage). You may continue your life insurance coverage at your own expense through Continuation, Portability, or Conversion. Continuation is the least expensive option. After the Continuation period ends, you can Port or Convert your optional life insurance coverage.

Your AD&D coverage with General Mills ends on the last day of your employment or eligibility. Continuation coverage is not available.

Continuation - The Continuation option lets you pay for your life insurance for up to 18 months. You can continue your Company-Paid, Optional Employee-Paid, Spouse and/or Child (ren) Life Insurance.

Information regarding continuation coverage of your Securian Life Insurance will be included in your COBRA election packet.

You will be eligible for up to 18 months of continuation of your life insurance coverage under Minnesota Continuation Requirements by submitting your premiums directly to Securian Life. The 18-month continuation period will include all periods of extended coverage from the date of your termination, retirement, lay-off, or reduction in hours that would make you ineligible for benefits.

If you die during the 60-day continuation election period after termination, retirement, lay-off, or a reduction in hours that would make you ineligible for benefits, and before electing or rejecting continuation coverage, you will be considered to have elected continuation coverage and your beneficiary (ies) will receive a death benefit equal to the amount of your insurance less any premiums due.

If you elect and pay for continuation coverage, at the end of the 18-month period, you will have 31 days to convert your coverage to an individual life insurance policy with Securian Life. If you die during this 31-day election period, you will be considered to have elected to convert your coverage, and the life insurance benefit will be paid to your beneficiary less any premium payments due.

Election - <u>You must contact Securian Life at 1-800-277-8785 within 60 days of the date your coverage would otherwise end in order to elect continuation coverage.</u>

Cost - The cost of continuation coverage during the 18-month period is the regular company active rate. You will be billed directly from Securian Life and all premium payments should be returned to them. After you have elected continuation coverage, Securian Life will provide you with a period of time from the date you make your election to make the initial payment for the coverage period from the date that you lost regular coverage to the date of your election.

<u>If any payment is not received within 31 days following the due date, Securian Life will terminate coverage.</u>

Termination of Continuation Coverage - Continuation coverage will terminate before the end of the 18-month period if one of the following occurs:

- The company discontinues all group life insurance coverage,
- You obtain coverage under another group life insurance, or
- Your premium payment is not received by the end of the 31-day grace period.

Portability ("Port") - You may port up to a maximum amount of your basic and optional employee- life insurance, optional spouse life insurance, and (if you or your spouse port your coverage) optional child(ren) life insurance. "Portability" means that you can take your coverage with you.

You are eligible to port your coverage if you are age 79 or younger and you were actively at work the day before you lost your eligibility for coverage. You pay your premiums directly to Securian Life.

Up to $750,000 of existing basic and optional employee life insurance may be ported ($486,500 if you are age 65 or older when you port). Up to $150,000 of existing spouse life insurance may be ported ($97,500 if your spouse is age 65 or older). You or your spouse (but not both) may continue the $10,000 child life insurance coverage along with the employee or spouse coverage. (Employee and spouse insurance coverage reduces to 65% at age 65; 50% at age 70; and 25% at age 75.)

To port coverage, you must complete and return a Portable Term Election form to Securian Life within 31 days of termination of coverage. If you elect the Continuation option first, you will need to complete the portability form before your 18-month Continuation ends. Call Securian Life at 1-800-277-8785 to request the form.

Cost - Rates are communicated on the Portable Term Election form. Call Securian Life at 1-800-277-8785 for details.

Termination of Ported Coverage - Your coverage terminates when you reach age 80 or when you stop paying the premiums, whichever is sooner. Your spouse's coverage terminates when he or she reaches age 80 or stops paying premiums, whichever is sooner. Child (ren) coverage terminates when your child (ren) no longer meets the child definition or when you stop paying premiums, whichever is sooner.

Conversion ("Convert") - You can convert all or part of your Company-Paid and Optional Employee-Paid (including Spouse and/or Child (ren)) Life Insurance (but not AD&D) to an individual policy with Securian Life. Conversion allows you to continue your life insurance coverage(s) at your own cost for a longer period of time than the Portability option allows. You are eligible to convert your coverage unless your life insurance ended due to non-payment of premiums. To convert coverage, you must send a completed Conversion Enrollment form, along with your first premium payment, to Securian Life within 31 days of the date coverage ends. Call Securian Life at 1-800-277-8785 to request a form.

Cost - Rates are communicated on the Conversion Enrollment form. Call Securian Life at 1-800-277-8785 for details.

Plan Administration / ERISA

Introduction - General Mills, Inc. is the Plan Administrator and will make determinations that may be required from time to time in the administration of the Plan, in its role as Plan Administrator. General Mills, Inc. will have the sole right, authority, discretion, and responsibility to interpret and apply the terms of the Plan, resolve inconsistencies, ambiguities and omissions in and among the Plan documents, and to determine all factual and legal questions under the Plan policies and procedures. Benefits under these programs will be paid only if the Plan Administrator or the person or entity to which it has delegated authority decides in its discretion that the claimant is entitled to them. The Plan Administrator may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the Plan Administrator shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan. Any determination made by the Plan Administrator shall be given deference in the event the determination is subject to judicial review and shall be overturned only if it is arbitrary and capricious.

Plan Name and Number - The Plan is called the Employees' Benefit Plan of General Mills, Inc. The Plan is a health and welfare benefit plan under the Employee Retirement Income Security Act ("ERISA"). The Plan number is 501.

Plan Sponsor

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

Telephone Number: 1-763-764-7600

Plan Sponsor Identification Number (EIN) - The benefits described in this document are identified and filed with the federal government using the Employer Identification Number (EIN) assigned by the Internal Revenue Service. The EIN for General Mills, Inc. is 41-0274440.

Plan Administrator

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

Telephone Number: 1-763-764-7600

Type of Plan Administration

MEDICAL:

1. The Plan Administrator has delegated its authority to Blue Cross Blue Shield of Minnesota, 1-866-870-0411, to handle the day-to-day administration of the medical benefits. Blue Cross Blue Shield of Minnesota does not insure the benefits.
2. Insured medical benefits options under the Plan are: CIGNA International (for employees on international assignment) 1-800-441-2668 or collect out of the USA 1-302-797-3100.

PRESCRIPTION DRUGS:

The Plan Administrator has delegated its authority to Express Scripts, 1-800-770-2815 to handle the day-to-day administration of the prescription drug benefits provided. Express Scripts does not insure the benefits.

DENTAL:

The Plan Administrator has delegated its authority to Delta Dental of Minnesota, 1-800-448-3815, to handle the day-to-day administration of the dental benefits under the Dental option. Delta Dental of Minnesota does not insure the benefits.

VISION:

The Plan Administrator has delegated its authority to EyeMed Vision, 866-723-5014, to handle the day-to-day administration of the vision benefits under the EyeMed Vision option.

LIFE INSURANCE:

The Plan Administrator has delegated its authority to General Mills Benefits Service Center, to handle the day-to-day administration of life insurance and accidental death and dismemberment insurance. These coverages are insured through policies issued by Securian Life Insurance Company.

DISABILITY:

The Plan Administrator has delegated its authority to Sedgwick, 1-877-491-5295, to handle the day-to-day medical case management for the Disability Programs. The company administers Disability Program payments. Sedgwick does not insure the benefits.

SPENDING ACCOUNTS:

The Plan Administrator has delegated its authority to HealthEquity, 1-888-914-2435, to handle the day-to-day administration of the flexible spending accounts (Healthcare and Dependent Care Flexible Spending Accounts). HealthEquity does not insure the benefits.

Agent for Service of Legal Process

Corporate Secretary
General Mills, Inc.
One General Mills Boulevard
Minneapolis, MN 55426-1348

Telephone Number: 1-763-764-7600

Plan Benefits Provided By / Contribution Source - Plan benefits are paid either from the general assets of the Plan Sponsor or from the funds of the applicable insurer. Contributions are made by the Plan Sponsor and, in some cases, by participants.

Plan Year - The Plan Year is a 12-month period used for determining the Plans' financial records. The Plan Year for all benefit plans is January 1 through December 31.

Your Rights as a Participant - As a participant in the ERISA benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator’s office, all plan documents, insurance contracts, collective bargaining agreements, and copies of all documents filed by the plans with the U.S. Department of Labor, such as detailed annual reports and plan descriptions,

- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator (the administrator may make a reasonable charge for the copied materials), and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Additional Information - Participants may review the Plan document, federal government disclosure reports, or any other instrument under which the Plan is established and operated at their General Mills Human Resources Department. Copies of these documents may be obtained by submitting a written request to the Human Resources Department or to the Plan Administrator. The Plan name and the Employer Identification Number should be included with the request. A reasonable charge may be made for the copies.

Duties of Plan Fiduciaries - In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of these benefit plans. The people who operate your plans, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and the other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

If your claim for a plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from a plan and do not receive them within 30 days, you may file suit in federal court in Minnesota. 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 Minnesota.

In the event that plan fiduciaries misuse a plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court in Minnesota. 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 your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory. Or, you may also contact the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington DC, 20210.

Plan Document Controls/Not a Contract of Employment- The summary plan description provides detailed information about the plan and its programs. The SPD does not constitute an implied or expressed contract or guarantee of employment.

Amendment & Termination - The Company reserves the right to amend or terminate the Plan at any time, for any reason and in any respect at its sole discretion. The Company's right to amend or terminate the Plan includes, but is not limited to:

- Changes in the eligibility requirements;

- Changes to premiums, costs, or other employee payments charged;
- Changes to benefits provided;
- Termination of all or a portion of coverages provided under the Plan.

If the Plan is amended or terminated, you will be subject to all of the changes resulting from the amendment or termination and your rights will be reduced, terminated, altered or increased accordingly on the effective date of the amendment or termination. You do not have ongoing rights to any plan benefit, other than payment of covered expenses you incurred before the plan amendment or termination. You do not have vested benefit rights under this Plan.

Rescissions - The Plan may not rescind (retroactively cancel) coverage for an enrolled individual except in limited circumstances like fraud or intentional misrepresentation of a material fact. Fraud or intentional misrepresentation of a material fact includes a false or misleading representation whether by words, conduct or concealment that deceives the Plan or Third Party Administrator so that the same will act upon it to its injury. Examples include, but are not limited to, falsely enrolling an individual as your eligible dependent, failure to timely notify the Plan in the event of a change such as loss of dependent eligibility and the failure to furnish full, true, and complete documents, data or other information reasonably related to the administration of the Plan and requested by the Plan.

The non-payment or untimely payment of premiums will result in the retroactive cancellation of coverage but does not constitute a rescission. Also, some normal administrative processing and reasonable administrative delays will result in the retroactive cancellation of coverage but do not constitute a rescission.

You will receive 30 calendar days advance notice before coverage is rescinded. You will have the opportunity to appeal the rescission or look for alternative coverage, as appropriate.

Limitations on Assignment - Your rights and benefits under the Plan cannot be assigned, sold, transferred or pledged by you or reached by your creditors or anyone else except under limited circumstances (e.g., qualified medical child support order).

Subrogation / Right of Reimbursement - As a condition of participating in the Plan, you agree to and acknowledge that with payment of any benefits, the Plan reserves the right to be subrogated to your rights, or your dependent(s)' rights, or your heirs, guardians, executors, or other representatives' rights of recovery that any of these parties may have in respect to any third party as a result of injuries, sicknesses, or other conditions sustained by you or your dependents.

In addition, if the Plan pays any benefits and you or your dependent(s) later obtain a recovery, you are obligated under the terms of the Plan to reimburse the Plan for the benefits paid. The Plan will be reimbursed in full for its costs, regardless of your legal and attorney fees or whether you or your dependents have been fully compensated by any party or insurer alleged to be legally responsible to you, including your own automobile or liability carrier, and regardless of whether medical expenses are itemized in a payment or award. Equitable doctrines concerning relief shall not be applied, including theories of unjust enrichment, the attorney's fund doctrine, the "common-fund" doctrine, and all other legal notions.

You must cooperate with the Plan Administrator in assisting it to protect its legal rights under these provisions. The Plan maintains both a right of reimbursement and a separate right of subrogation. You must do nothing to prejudice the Plan's rights under this provision, either before or after the need for services or benefits. You have the obligation to immediately inform the Plan Administrator of any injury or illness which you or your dependent(s) suffer for which a claim for damages may be made against any party or your own automobile or liability carrier. You acknowledge that the Plan's subrogation and

reimbursement rights shall be considered the first priority claim against any third party or your own automobile or liability carrier, to be paid before any other claims which may exist are paid, including claims by you or your dependents for general damages. You further assign to the Plan any amounts you receive as a judgment, recovery, or settlements, to the full extent of the Plans' costs for benefits paid, and also consent to an equity lien against such amount.

The Plan may take such action as may be necessary and appropriate to preserve its rights, including bringing suit in your name or intervening in any lawsuit involving you or your dependent(s) following injury. The Plan may initiate any suit against you or your dependent(s) or your legal representatives to enforce the terms of the Plan. Any proceeds collected, held or received by you, your dependent, your attorney, or any other party to whom such proceeds may be paid by virtue of a settlement of, or judgment relating to, any claim of yours or your dependent that arises from the same event to which payment by the Plan are related, are held for the benefit of the Plan and for satisfaction of the Plans' subrogation and/or reimbursement claims. The Plan also reserves the right to require you to sign a reimbursement agreement before releasing payment when any party or your own automobile or liability carrier may be responsible for payment of medical expenses. A violation of the reimbursement agreement is considered a violation of the terms of the Plan.

The Plan Administrator may delegate these functions.

Should you or your dependent(s) obtain a settlement, judgment, or other recovery from any person or entity, including your own automobile or liability carrier, and fail to reimburse the Plan, the Plan may decline to pay for any additional care or treatment for you or your dependent(s) until the Plan is reimbursed in accordance with its terms or until the cost of additional care or treatment exceeds the amount you or your dependent(s) recover. This right to offset will not be limited to benefits for the insured person or to treatment related to the injury, but will apply to all benefits otherwise payable under the Plan for you and your dependents.

Health Care Privacy / HIPAA - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As employee medical welfare benefit plans under ERISA, the Employees' Benefit Plan of General Mills, Inc. (Plan 501) and the Healthcare Flexible Spending Account portion of the General Mills Flexible Benefits Plan (Plan 669) are subject to the HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the Plans will not use or disclose your protected health information (PHI) without your authorization, except for purposes of treatment, payment, health care operations, Plan administration or as required or permitted by law. Furthermore, with respect to electronic PHI, General Mills has implemented administrative, physical and technical safeguards to protect the electronic PHI and will ensure that any agents (including subcontractors) to whom it provides electronic PHI agree to implement reasonable and appropriate security measures to protect the information. A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the plan's Notice of Privacy Practices, which has previously been furnished to you and can also be accessed from your local HR representative, or by contacting the Plan's Privacy Officer. (Note: Your enrollment in this Plan constitutes authorization for any and all third-party administrators or insurers to provide your health information to the Plan Administrator to the extent necessary for the Plan Administrator to administer the Plans and the benefits provided under the Plan. See the Privacy Notice that was sent to you or your local HR representative for more information.

Claims and Appeals Procedures

The Plan offers a variety of coverage options. Some of these coverage options are self-insured and others are fully-insured. Under the self-insured coverage options, General Mills contracts with a third-party administrator (the "Claims Administrator") to provide administrative services to the Plan, including the review of benefit claims. A list of these administrators is included in this SPD. These benefits are paid directly from General Mills' general assets. These third-party Claims Administrators have been delegated the power and discretion of the Plan Administrator and as such have the discretionary authority to determine if a claim is payable under the terms of the Plan and to interpret all terms of the Plan including determinations related to whether a particular service, treatment, test or item is covered or excluded from coverage (in using such discretion the administrators may refer to administrative policies).

If an option is fully-insured, General Mills purchases an insurance contract from an insurer. All claims are paid from the insurer's assets. Other than for questions related to eligibility, the insurer retains all final, discretionary authority to determine whether a claim is payable under a fully-insured option under the Plan. If you participate in an insured option, any claim for benefits and any appeal should be filed according to the insurance company claims procedures.

This section lists the Claims Administrators for each coverage option under the Plan, the contact information for each Claims Administrator, and whether each coverage option is insured or self-insured. If you have any questions, you should contact the Claims Administrator at the number listed in this SPD.

Either you or your authorized representative may file claims for benefits. An "authorized representative" means a person you authorize, in writing, to act on your behalf. To appoint an authorized representative, a claimant must complete a form that can be obtained from the Claims Administrator. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an Urgent Care Claim, a health care professional with knowledge of your condition may always act as your authorized representative. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

Your claims should be filed with the applicable Claims Administrator listed in this section. All claims are treated as filed on the date they are received by the Claims Administrator. If your claim is denied in whole or in part, you will receive a written notice of the denial directly from the Claims Administrator. The notice will explain the reason for the denial and the procedures you must follow to appeal the Claims Administrator's decision.

No legal action may be commenced until all claims and appeals procedures have been exhausted and the explicit and implicit determinations by the Claims Administrators shall be afforded the maximum deference permitted by law.

Medical Claim and Appeal Procedures

Urgent Care Claims

If the Plan requires advance approval of a service, supply, or procedure before a benefit will be payable, and if the Plan or your provider determines that the request for advance approval is an Urgent Care Claim, you will be notified, either orally or in writing, whether the service, supply, or procedure is payable under the Plan no later than 72 hours after the claim is received.

"Urgent Care Claim" means a claim for services to treat an illness, injury or condition that could seriously jeopardize your life or health or your ability to regain maximum function or a condition that, in your treating provider's opinion, could subject you to severe pain that cannot adequately be managed without such care or treatment.

For Urgent Care Claims that name a specific person to be treated, medical condition, and service or supply for which approval is required, and that are submitted to the Claims Administrator responsible for handling benefit matters, but that otherwise fail to follow the Plan's procedures, you will be notified of the failure within 24 hours of receipt of the claim. You also will be informed of the proper procedures to follow to submit the claim properly. The notice may be provided to you orally unless you or your authorized representative request written notification.

If there is not sufficient information to decide the claim, you or your provider will be notified of the specific information necessary to complete the claim as soon as possible, but no later than 24 hours after receipt of the claim. You or your provider will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information. You or your provider will be notified of the decision no later than 48 hours after the end of the additional time period (or after receipt of the information, if earlier). The decision may be provided orally unless you or your representative requests a written notification. If you receive an oral notification, you or your provider will be provided a written or electronic notification no later than three days after you received the oral notification.

Pre-Service and Post-Service Claims

If the Plan requires you to obtain advance approval of a service, supply, or procedure before a benefit will be payable, such a claim will be considered a Pre-Service Claim. You will be notified of the decision no later than 15 days after the Claims Administrator receives your Pre-Service Claim. All other claims will be deemed to be Post-Service Claims. You will be notified of a Post-Service Claim decision no later than 30 days after the Claims Administrator receives your claim.

For Pre-Service Claims that name a specific person to be treated, medical condition, and service or supply for which approval is required, and that are submitted to the Claims Administrator responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures, you will be notified of the failure within 5 days for Pre-Service Claims. You also will be informed of the proper procedures to follow to submit the claim properly. The notice may be provided to you orally unless you or your representative request written notification.

For either a Pre-Service or a Post-Service Claim, the time period in which the decision must be made may be extended up to an additional 15 days due to circumstances beyond the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period.

If there is not sufficient information to decide the claim, the notice of extension will specifically describe the information necessary to complete the claim. You will have at least 45 days from the date you receive the notice to provide the specified information. The Claims Administrator's period for making the determination will be extended by the period of time from the date the notification of the extension is sent to you until the date you respond to the request for additional information. If you do not supply the requested information within the 45-day period, your claim will be denied.

Concurrent Care Claims

A Concurrent Care Claim is when the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the Claims Administrator determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Claims Administrator has approved. If the Plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Claims Administrator to request an extension of a course of treatment. The claimant follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-service claim.

Notification of Initial Benefit Decision

The Claims Administrator will provide the claimant with written notice of an adverse benefit determination on a claim. A decision on a claim is an "adverse benefit determination" if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit. The Claims Administrator will provide the claimant written notice of the decision on a Pre-service or Urgent Care Claim whether the decision is adverse or not. The Claims Administrator may provide the claimant with oral notice of an adverse benefit determination on an Urgent Care Claim, but written notice will be furnished no later than three (3) days after the oral notice.

Medical Appeal Procedures

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination.

The Claims Administrator will follow these procedures when deciding an appeal:

1. An adverse benefit determination includes a denial, reduction, termination of or failure to make a payment for a benefit, or a rescission of coverage;

2. A claimant must file an appeal within 180 days following receipt of a notice of an adverse benefit determination;

3. A claimant will have the opportunity to submit written comments, documents, records, other information, other evidence, and testimony relating to the claim for benefits;

4. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual, and no individual who reviews and decides appeals is compensated or promoted based on the individual's support of a denial of benefits;

5. The Claims Administrator will give no deference to the initial benefit decision;

6. The Claims Administrator will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision;

7. The Claims Administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;

8. The Claims Administrator will provide the claimant, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the Claims Administrator did not rely upon their advice;

9. The Claims Administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and information regarding any voluntary appeals offered by the Claims Administrator;

10. The Claims Administrator will provide a claimant any new evidence considered, generated, or relied upon prior to making a final benefit determination;

11. The Claims Administrator will provide a claimant any new rationale for an adverse benefit determination prior to making a final benefit determination; and

12. The Claims Administrator will provide required notices in a culturally and linguistically appropriate manner as directed by the Plan Administrator.

Filing Appeals

A claimant must file an appeal within 180 days following receipt of the notice of an adverse benefit determination. A claimant's failure to comply with this important deadline may cause the claimant to forfeit any right to any further review under these claims procedures or in a court of law. An appeal is filed when a claimant (or authorized representative) submits a written request for review to the Claims Administrator at the appeal address. A claimant is responsible for submitting proof that the claim for benefits is covered and payable under the Plan.

Urgent Care Appeals

An urgent care appeal may be submitted to the BCBSMN Claims Administrator by telephone at 1-866-870-0411. The BCBSMN Claims Administrator will transmit all necessary information, including the Claims Administrator's determination on review, by telephone, fax, or other available similar methods.

Timeframes for Deciding Appeals

Urgent Care Claims

The Claims Administrator will decide the appeal of an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the request for review.

Pre-Service Claims

The Claims Administrator will decide the appeal of a Pre-service Claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review.

Post-service Claims

The Claims Administrator will decide the appeal of a Post-service Claim within a reasonable period, but no later than 60 days after receipt of the written request for review.

Concurrent Care Claims

The Claims Administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. The Claims Administrator will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for Pre-service, Urgent Care, or Post-service Claims described above, as appropriate to the request.

Notification of Appeal Decision

The Claims Administrator will provide the claimant with written notice of the appeal decision. The notification will include the reason for the final adverse benefit determination, reference to the relevant plan provision(s) and other information as required by ERISA. The Claims Administrator may provide the claimant with oral notice of an adverse decision on an Urgent Care Claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. If the claimant does not receive a written response to the appeal within the timeframes described above, the claimant may assume that the appeal has been denied. Unless these procedures are deemed to be exhausted, the decision by the Claims Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **These claims procedures must be exhausted before any legal action is commenced.**

Following notification of the appeal decision, a claimant may appeal further to a voluntary internal appeal or to an external appeal (for eligible claims). An adverse benefit determination relating to a claimant's failure to meet eligibility requirements is not eligible for external review.

Voluntary Appeals

A voluntary appeal may be available to a claimant receiving an adverse decision on a Pre-service or Post-service Claim appeal. A claimant must file a voluntary appeal within 60 days following receipt of the adverse Pre-service or Post-Service Claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the Claims Administrator. The Claims Administrator will provide the claimant with written notice of voluntary appeal decision. For more information on the voluntary appeals process, contact the Claims Administrator.

External Review

Standard External Review

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

1. Within five (5) business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether:

   a. you are or were covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the plan at the time the health care item or service was provided;

b. the adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the plan;

c. you have exhausted the plan's internal appeal process (unless exhaustion is not required); and

d. you have provided all the information and forms required to process an external review. You will be notified if the request is not eligible for external review. If your request is not complete, but eligible, the Claims Administrator will tell you what information or materials are needed to complete the request and will give you 48 hours (or more) to provide the required information.

2. The Claims Administrator will assign an accredited independent review organization (IRO) to conduct the external review.

The IRO will utilize legal experts where appropriate to make coverage determinations under the plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

The Claims Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

The IRO will review all of the information and documents timely received and are not bound by the Claims Administrator's prior determination. The IRO may consider the following in reaching a decision:

a. your medical records;

b. the attending health care professional's recommendation;

c. reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your treating provider;

d. the terms of the Plan;

e. evidence-based practice guidelines;

f. any applicable clinical review criteria developed and used by the claims administrator; and

g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its d

Expedited External Review

1. You may request an expedited external review when you receive:

   a. an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   b. a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your 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 you received emergency services, but have not been discharged from a facility.

2. Immediately upon receipt of the request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.

3. When the Claims Administrator determines that your request is eligible for external review an IRO will be assigned. The Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

The IRO must consider the information or documents provided and are not bound by the Claims Administrator's prior determination.

4. The IRO will provide notice of the final external review decision as expeditiously as your 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 IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the Plan.

Prescription Appeals Procedures

Express Scripts' role as a pharmacy benefit manager is to determine what constitutes a covered drug for purposes of adjudicating claims and making claims payments and denials in accordance with the plan design adopted by General Mills. Express Scripts will follow a consistent methodology for making determinations that will be included as part of the plan design adopted by General Mills.

Express Scripts Enhanced Reviews and Appeals process consists of an:

- Initial determination (standard and urgent)
- Internal appeals process
- Level 1 appeal
- Level 2 appeal
- Urgent appeals
- External review with an independent review organization (IRO).

Express Scripts has entered into an arrangement with the IRO's, which have been accredited by a nationally recognized private accrediting organization. The IRO's will conduct an independent, external

review of an adverse benefit determination and issue a final external review decision. Any fees incurred by the IRO during the review will be paid by General Mills.

You must file an appeal within 180 days following receipt of a denial notice.

Express Scripts internal claim reviews and appeals processes will include the following:

1. Specific content requirements for denial notices; date of service, healthcare provider name, reason(s) for the claim or appeal denial, your right to appeal and how to request an appeal, the internal and external appeal process and patient rights information.
2. Denial notices will be provided in a "culturally and linguistically appropriate manner"
3. Deference given to the healthcare providers determination of urgency (urgent claim appeals)

Dental Claim & Appeal Procedures

Initial Claim Determinations
An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive a written notice of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the end of the initial 30-day period. We will tell you the reasons we require an extension and the date by which we expect to make a decision. If the extension is needed for us to get additional information from you, the notice will describe the specific information we need. You will have 45 days from the receipt of the notice to provide us with the information. Without complete information, your claim will be denied.

Dental Appeals

In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted to us within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal.

Your appeal must include your name, your identification number, group number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to:

Delta Dental of Minnesota
Attention: Appeals Unit
PO Box 551
Minneapolis, MN 55440-0551

You may submit written comments, documents, or other information that you feel supports your appeal. Upon request, you will also be given reasonable access to and copies of all relevant records that are used in making the decision. These records will be given to you at no charge. The review will take into account all information about the denied or reduced claim, even if the information was not present or available at the time of the initial determination. In this review, the initial determination of the claim will not be given any weight.

The review will be done by someone different from the original decision-makers and will not take into consideration any prior decisions made in your claim. Because all decisions are based on a preset schedule of dental services that are covered by your plan, claims are not reviewed to determine dental

necessity or appropriateness. If we need to consult a professional to determine if a service is covered under your plan's schedule of benefits, we will consult with a dental professional who has appropriate training and experience. This professional will not be the same person who was involved in the initial adverse benefit determination (nor a subordinate of any such person). We will identify any dental professional whose advice was obtained on our behalf, even if the advice was not used in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

To the extent your plan is covered by ERISA, after you have exhausted all appeals, you may file a civil action under section 502(a) of ERISA.

Exhaustion of Remedies, Limitation Period and Venue for all Claims

If you file your claim within the required time, complete the entire claims procedure, and your appeal is denied, you may sue over your claim (unless you have executed a release of your claim). You must, however, commence that suit within 30 months after you knew or reasonably should have known of the facts behind your claim or, if earlier, within six (6) months after the claims procedure is complete. Any controversies, disputes, and claims arising hereunder shall be submitted to the United States District Court for the District of Minnesota.

Vision Appeals

Time Frames for Appealing Claims - If your claim is denied, in whole or in part, you may appeal. The appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit an appeal within 180 days after this 30-day period has expired. Your appeal will be decided within 60 days after receipt. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the FAA denial information or Explanation of Benefits, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist FAA in completing its review of the member's appeal, such as documents, records, questions or comments.

You may authorize someone else to file and pursue a complaint or appeal on your behalf. If you do so, you must notify FAA/EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number, and a statement indicating the extent to which he or she is authorized to pursue the complaint and/or appeal on your behalf. A consent form that you may use for this purpose will be provided to you upon request

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040

Fax: 1-513-492-3259

FAA/EyeMed will review your appeal for benefits and notify you in writing of its decision.

Complaint Procedure - If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at 1-866-800-5457 to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

Enforce Your Rights - If your claim for vision benefits 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.

When you have completed all appeals mandated by ERISA, additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. You should contact the U. S. Department of Labor or the state insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)), *see*, 29 U.S.C. 1132(a)(1)(B), you have the right to bring a civil (court) action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and you disagree with the outcome.

Assistance with Your Questions - If you have any questions about your Plan, you should contact EyeMed. If you have any questions about this summary of vision care services or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue 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 Pension and Welfare Benefits Administration.

The Insured benefits are underwritten by Combined Insurance Company of America. Discounts are provided by EyeMed Vision Care. If you have any questions or concerns, please contact EyeMed Vision Care at eyemed.com or 1-866-800-5457.

Claims and Appeals Administrators

Plan / Program	Administrator
Medical Benefits (self-insured) HSA Gold, PPO Gold	Claims: Blue Cross Blue Shield of Minnesota P.O. Box 64338 St. Paul, MN 55164-0338 Telephone: 1-866-870-0411 Appeals: Blue Cross Blue Shield of Minnesota Attn: Consumer Service Center P.O. Box 64560 St. Paul, MN 55164-0560 Telephone: 1-866-870-0411
Prescription Drug Benefits (self-insured) HSA Gold, PPO Gold	Claims: Express Scripts P.O. Box 14711 Lexington, KY 40512 Telephone: 1-800-770-2815 Clinical Appeals: Express Scripts Attn: Coverage Reviews 8111 Royal Ridge Irving, TX 75063 Telephone: 1-800-864-1135
Vision Benefits (fully-insured)	Claims & Appeals: EyeMed Vision 4000 Luxottica Place Mason, OH 45040 Telephone: 1-866-723-0514
CIGNA International (fully-insured)	Claims & Appeals: CIGNA International 590 Naamans Road Claymont, DE 19703 Telephone: 1-800-441-2668

Plan / Program	Administrator
Dental Benefits (self-insured)	Claims: Delta Dental of Minnesota P.O. Box 9120 Farmington Hills, MI 48333- 9120Telephone: 1-800-448-3815 Delta Group Number – 501 Appeals: Delta Dental of Minnesota Attention: Appeals Unit PO Box 30416 Lansing, MI 48909
Healthcare Flexible Spending Account, Dependent Care Flexible Spending Account and Health Savings Account	Claims & Appeals: HealthEquity Claims Appeal Board P.O. Box 60010 Phoenix, AZ 85082 1-888-914-2435
Long-Term Disability Programs	Claims General Mills Leave & Disability Service Center PO Box 14424 Lexington, KY 40512-4424 Telephone: 1-877-491-5295 Appeals: General Mills, Inc. Attn: Claims Appeal Administrator M03-13 One General Mills Boulevard Minneapolis, MN 55426-1348 Telephone: (763) 764-7600
Life Insurance and Accidental Death and Dismemberment	Claims & Appeals: Securian Life Insurance Company P.O. Box 64114 Saint Paul, MN 55164-0114 Telephone: 1-888-277-8785

Appendix A

DISREGARD IF YOU ARE NOT AGE 65 OR MEDICARE ELIGIBLE

****Notice of Creditable Coverage****
Important Notice from General Mills About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with General Mills and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **General Mills has determined that the prescription drug coverage offered by the General Mills Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current General Mills prescription drug coverage will not be affected. Your current coverage under the General Mills Health Plan pays for other healthcare expenses in addition to prescription drugs. You will still be eligible to receive all of your current healthcare benefits and prescription drug benefits if you also choose to enroll in Medicare prescription drug plan.
However, you are not able to drop your current prescription drug coverage without also dropping your healthcare coverage as well. You can only drop coverage during Annual Benefits Enrollment or if you have a qualifying status change as defined by the General Mills Health Plan. If you do decide to join a Medicare drug plan and drop your current General Mills prescription drug coverage (and healthcare coverage) be aware that you and your dependents will not be able to get this coverage back until the next Annual Benefits Enrollment effective the following January 1.

Please contact the General Mills Benefits Service Center at 1-877-430-4015 for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current creditable coverage with General Mills and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may 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 nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the General Mills Benefit Service Center at 1-877-430-4015. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through General Mills changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).