EMPLOYEE WELLNESS AND WELLBEING PROGRAM

NOTE: The program described in this Summary Plan Description is administered by Schwan's Shared Services, LLC for the benefit of eligible employees of the subsidiaries of The Schwan Food Company
This booklet describes the Employee Wellness and Wellbeing Program (the “Wellness and Wellbeing Program”), which is a component benefit program under the Employee Benefit Plan for Employees of the Subsidiaries of The Schwan Food Company (“Employee Benefit Plan”). The Wellness and Wellbeing Program is available to eligible employees of the subsidiaries of The Schwan Food Company (collectively, the “Company”) and, in some circumstances, their eligible dependents. The Wellness and Wellbeing Program includes the following four components, as described in this booklet:

- The Employee and Family Resource Program (the “Family Resource Program”);
- The Wellness Program;
- The Tobacco Cessation Program; and
- The Healthy Start Prenatal Support Program (the “Healthy Start Program”).

The Wellness and Wellbeing Program is committed to helping you achieve your best health. In some cases, rewards for participating in certain aspects of the Wellness and Wellbeing Program may be available. If you think you might be unable to meet a standard for such a reward, you might qualify for an opportunity to earn the same reward by different means. If so, please contact RedBrick Health at 866-322-1711 and the appropriate parties will work with you (and, if you wish, with your doctor) to find an appropriate alternative with the same reward that is right for you in light of your health status.

FAMILY RESOURCE PROGRAM

The Family Resource Program is a confidential life planning and counseling service designed to provide eligible participants with tools and resources to obtain guidance and assistance in resolving personal problems.

Eligibility

All employees of the Company are eligible to use the Family Resource Program immediately upon hire. Members of an eligible employee’s immediate family (i.e., the employee’s spouse and dependent children) are also entitled to use the Family Resource Program.

No enrollment is necessary.

Cost

The Company pays the entire cost of the Family Resource Program. Accordingly, its services are available to employees and their immediate family at no charge.

Benefits

The Family Resource Program is a confidential life planning and counseling service. Searching for information can be frustrating and time-consuming, particularly if you do not know where to start looking. The Family Resource Program offers access to an assistance center that can help you take full advantage of a large variety of resources, including confidential assessment and referral services to assist you with personal problems.

Examples of problems the Family Resource Program can assist with are:

- Buying/selling a home
- Finding daycare/elder care
- Travel and vacation planning
- Auto repairs and finding a mechanic
- Budgeting or credit/debt consultation
- Estate planning and assistance
- Marital and family conflict
- Stress and anxiety
- Alcohol and drug abuse
- Grief and loss
- Depression
- Physical abuse
- Eating disorders

Family Resource Program services are provided by ComPsych, an independent firm retained by the Company to administer the Family Resource Program. ComPsych has a network of psychologists, social workers and marital and family therapists who are trained to deal with a wide variety of personal and emotional problems.

The Family Resource Program is completely confidential. No information about the identity of the caller or the nature of his or her problem is shared with the Company, unless you provide a written authorization for the Family Resource Program to do so. As indicated above, the Company will not find out about a problem addressed through the Family Resource Program unless you either authorize the Family Resource Program to disclose the problem to the Company or independently notify the Company that such a problem exists.

The Nurses on Call program helps you get answers to your health questions. Registered nurses are available around the clock to answer your questions and to provide general information on medical conditions, minor illness or injuries, treatment alternatives and prescription drug side effects.
The FinancialConnect® program offers you telephone access to certified public accountants, certified financial planners and other financial professionals who are trained and experienced in handling personal financial issues and can offer consulting on issues such as family budgeting, credit problems, tax questions, investment options, money management and retirement programs.

The LegalConnect® program provides you with telephone consultations with attorneys who are trained and dedicated to providing legal information and assistance to clients with such issues as divorce, bankruptcy, family law, real estate purchases and wills.

If you need legal representation or extended assistance that cannot be provided by phone, LegalConnect professionals can provide referrals to local attorneys. You or your family member will receive a free 30-minute consultation and, thereafter, a 25% reduction in fees for representation if you choose one of ComPsych’s network attorneys.

ComPsych’s FamilySource® Guidance Specialists offer practical advice through telephonic consultation, referral information and educational literature. Specialists are available to provide assistance on issues such as:

• Finding and evaluating quality daycare
• School selection for the relocating employee
• Planning for your child’s college education
• Understanding programs such as Medicare and Medicaid

Callers receive detailed resource packages containing referral information on community resources, available openings in programs and guidelines for evaluating:

• Daycare centers and after school programs
• Public and private schools and tuition assistance
• Geriatric assessment clinics
• Assisted living and other housing options for the elderly

ComPsych will follow-up to make sure callers have received all the information necessary to meet their specific needs.

**Obtaining Benefits**

Use of the Family Resource Program is entirely voluntary. It begins with a telephone call to ComPsych. Their telephone number is (888) 862-4731 and they are open 24 hours a day, 7 days a week. You can also utilize the service online by going to www.guidanceresources.com.

After contact has been made with ComPsych, they will make a preliminary assessment of the problem based upon information provided to them by the caller. ComPsych will then either recommend that the caller meet with a Family Resource Program counselor in person or refer the caller to another source or agency for assistance.

The Family Resource Program offers, free of charge, up to 6 counseling sessions per problem in any Plan Year (January 1 to December 31). These sessions are available separate and apart from any mental health or other related benefits that may be available under the Company’s other benefit plans.

If a Family Resource Program counselor determines that a problem requires either more than 6 counseling sessions or another type of treatment, such as in-patient medical care, the covered individual will be referred to the most appropriate resource for treatment. If the individual decides to continue counseling beyond 6 visits or obtain treatment after the clinical assessment has been made, the cost of such sessions or treatment will not be paid for by the Family Resource Program, even if the counseling is provided by the same Family Resource Program counselor.

For example, if, after the fifth counseling session, the Family Resource Program counselor determines that more than 6 sessions will be required to resolve the problem, the covered individual will be so advised by the Family Resource Program counselor. If the covered person then decides to continue treatment, whether with the same Family Resource Program counselor or another provider, the cost of those sessions will not be covered by the Family Resource Program.

However, if the covered individual has medical insurance or is covered under a group health plan, benefits for such additional therapy or treatment may be available, depending on the terms and provisions of that policy or plan. If the person is covered under the Company’s group health plan, information about benefits that may be available for such treatment can be found in the plan’s Summary Plan Description.

Participation in the Family Resource Program does not excuse employees from complying with Company policies or from meeting the requirements of their job, either before or after seeking assistance. Accordingly, use of the Family Resource Program will not preclude the Company from taking disciplinary action against an employee for performance problems that occur either before or after the employee seeks assistance through the program.
WELLNESS PROGRAM

The Wellness Program is a voluntary, participatory program designed to promote health and wellness.

Eligibility

All employees of the Company are eligible to participate in the Wellness Program. If an employee is a participant in the Company’s group health plan, the Wellness Program benefits described in this booklet are provided as part of the group health plan and any eligible spouse of the employee who is also enrolled in the group health plan may participate in applicable parts of the Wellness Program. If an employee is not a participant in the Company’s group health plan, the Wellness Program benefits described in this booklet are provided through the Wellness and Wellbeing Program. No enrollment is necessary.

Your participation in the Wellness Program is completely voluntary. You have the option to stop participating in the Wellness Program at any time. Any personal medical information that you share in connection with the Wellness Program will be protected and confidential and may not be used for employment purposes.

Overview of the Wellness Program

The Wellness Program offers the following support to help you stay healthy:

• A RedBrick Health representative for guidance and support in navigating the Wellness Program
• Tools and resources to help you live a healthier life
• Incentives for participation in various programs and activities (eligible employees only)
• Opportunities to learn more about your health through Health Screenings and the Health Assessment
• Free health and wellness programs to help you manage stress, lose weight, get active, eat better, manage chronic conditions and more
• Fun events and contest that motivate you to get healthier through a little friendly competition with your co-workers, family and friends
• Rewards for completing Healthy Activities through RedBrick Health

Healthy Activities available through RedBrick Health are designed to help you learn more about your current health status and take steps towards being the healthiest you. Some examples include:

• Taking the annual Health Assessment, which is a fun, interactive questionnaire that will give you an in-depth snapshot of your current health, along with personalized recommendations for ways to improve it. The Health Assessment can be completed online, by paper or over the phone and is available in English and Spanish.

• Completing a Health Screening, which is a brief appointment during which you will learn about your health by getting your health numbers—things like your blood pressure, weight, cholesterol levels and more. Health Screenings may be available onsite at your workplace (employees only), but can also be obtained through a personal physician or RedBrick Health Community Access Voucher program. Out of pocket costs may apply.

• Working with a Health Coach, who is a certified expert and will work with you by telephone to help answer your health questions, provide support in overcoming obstacles and help set small goals to work on between sessions. Choose from multiple topic areas, including weight management, nutrition and handling stress, diabetes and building a healthy back.

• Choose to work on your own by choosing to participate in an online program. You can also track your exercise through the physical activity tracker.

The purpose of the Wellness Program is to improve your general health and welfare. The Wellness Program will not diagnose or treat any injury, illness or condition. You should discuss any health concerns that may be identified through the Wellness Program with your physician.

You will receive detailed information from RedBrick Health, including how to access, use and benefit from your Wellness Program, in various forms, including, but not limited to, electronic or paper forms. Many of the underlying programs are designed to be accessed through a private, personalized website at www.RedBrickHealth.com/login. If you do not have access to a computer or the internet, you may still participate fully in the Wellness Program over the telephone.

Healthy Rewards & Incentives

The Company may offer an array of programs to encourage engagement in your health, and therefore reward positive actions. For example, the Company may offer opportunities to earn rewards. The type, amount and requirements to earn incentives are determined by the Company in its sole and absolute discretion, and are described in the RedBrick Health materials. If it is unreasonably difficult due to a medical condition or disability to achieve standards or meet participation requirements necessary to earn an incentive under the Wellness Program, you may
file a “Participation Exception Request Form” that is located on your consumer portal. You may also contact a RedBrick Health representative for assistance. If applicable, your RedBrick Health representative will work with you to develop another way to qualify for the reward.

All employees who are enrolled in the Company’s group health plan will be eligible to earn rewards. How those rewards are earned will vary from person to person in accordance with their health plan enrollment, health plan premiums deducted from pay and/or participation in personalized health programs or self directed wellness activities.

TOBACCO CESSATION PROGRAM

The Tobacco Cessation Program is a voluntary, participatory program designed to provide eligible participants with certain resources to quit using tobacco.

Eligibility and Enrollment

All employees of the Company are eligible to participate in the Tobacco Cessation Program. If an employee is a participant in the Company’s group health plan, the Tobacco Cessation Program benefits described in this booklet are (1) provided as part of the group health plan and (2) also available to any eligible dependent enrolled in the group health plan who is age 18 or older.

If an employee is not a participant in the Company’s group health plan, the Tobacco Cessation Program benefits described in this booklet are provided through the Wellness and Wellbeing Program.

To enroll and begin participating, call 1-888-662-BLUE (2583).

Cost

The Company pays the entire cost for eligible expenses of the Tobacco Cessation Program. Accordingly, its services are available to employees at no charge.

Benefits

Stop-Smoking Support is a telephone based service designed to help you quit using tobacco. There is no charge for this service.

To participate, call 1-888-662-BLUE (2583). A tobacco cessation specialist (a “Quit Coach”) will work with you one-on-one to develop a personalized quitting plan that addresses your specific concerns. You will receive written materials and personalized help for up to 12 months.

In addition, you are eligible to receive up to 16 weeks of over-the-counter nicotine replacement therapy (“quit medications”) per year to help you quit tobacco; 8 weeks mailed at a time. The Company pays 100 percent of the cost of eligible nicotine replacement therapy (“NRT”) for individuals 18 and older who enroll in the Tobacco Cessation Program. NRT options include the nicotine patch, nicotine gum or nicotine lozenge, and will be mailed directly to participants whose medical history does not preclude them from safely using these medications. Please call to begin your program or to request further information. You may also contact the Benefits Department for further information.

Obtaining Benefits

Use of the Tobacco Cessation Program is entirely voluntary. It begins with a telephone call to 1-888-662-BLUE (2583).

Participation in the Tobacco Cessation Plan does not excuse employees from complying with Company policies or from meeting the requirements of their job, either before or after seeking assistance.

HEALTHY START PROGRAM

The Healthy Start Program is a voluntary, participatory program designed to provide eligible participants with personal, telephone-based prenatal support.

Eligibility and Enrollment

All employees of the Company are eligible to participate in the Healthy Start Program. If an employee is a participant in the Company’s group health plan, the Healthy Start Program benefits described in this booklet are provided as part of the group health plan.

If an employee is not a participant in the Company’s group health plan, the Healthy Start Program benefits described in this booklet are provided through the Wellness and Wellbeing Program.

Benefits

Healthy Start® Prenatal Support is a personal, telephone-based health education program for pregnant women. The program helps moms-to-be learn what they need to know to have the healthiest pregnancy and baby possible. If you enroll, you will be assigned to a registered nurse, who will answer your questions and provide education, support and advocacy. Healthy Start nurses can help with every kind of pregnancy, whether you are a first-time mom or this is your second or third (or more) time around.
Obtaining Benefits

To request further information or to enroll, call (651) 662-1818 or toll-free 1-866-489-6948 or visit the Healthy Start® Prenatal Support website at www.myhealthystart.org. Please contact the Healthy Start® Prenatal Support program when you find out you are expecting. Healthy Start matches moms-to-be with a registered nurse with obstetrics experience for one-on-one personal support by phone. Participants in the Company’s group health plan who enroll in the first trimester and complete the program may receive a $100 reward card.* Participants in the Company’s group health plan who enroll after the first trimester and complete the program may receive a $50 reward card.* We encourage you to call right away to ensure you have all of the information to have the healthiest pregnancy and healthiest birth possible. To learn more, call 651-662-1818 or toll free at 1-866-489-6948 or visit www.myhealthystart.org. *Reward card is taxable, so please consult your tax advisor.

Claims Procedure

This section describes the procedures for processing Wellness and Wellbeing Program claims. You should be aware that, at all steps of the claims process, you or another claimant may be represented by another person, who may be, but is not required to be, an attorney. However, the claimant will be responsible for paying the fees and expenses of his/her representative. Also, the Plan Administrator and/or its designated claims administrator (the “Claims Administrator”) may require evidence that it considers reasonable to establish that an individual is actually the authorized representative of a claimant.

The Claims Administrator has exclusive responsibility for deciding claims for benefits under the Wellness and Wellbeing Program and for deciding any appeals of denied claims. All decisions made by the Claims Administrator shall be final and binding on all employees and dependents.

Initial Denial

If the Claims Administrator determines that your claim for benefits will be denied in whole or in part, it will send a written claim denial. The claim denial will include:

- The specific reason or reasons for the denial;
- The Wellness and Wellbeing Program provisions that are the basis for the denial;
- An explanation of what other material or information is needed to complete the claim and why it is needed;
- An explanation of the Wellness and Wellbeing Program’s claim review procedures;
- The applicable time limit for an appeal; and
- A statement explaining their right to file a civil action under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), if any appeal is denied.

In most cases, written notice of the denial will be sent within 90 days after the claim was filed. If special circumstances require more time, you or your dependent will be informed in writing (before the end of the 90-day period) of the reason for the delay and the date the Claims Administrator expects to make a decision. In no case will the extension exceed 180 days after the claim is filed.

Appeal

If you disagree with a decision made regarding a claim under the Wellness and Wellbeing Program, you may file a written appeal of the decision with the Claims Administrator and be given a full and fair review. The appeal must be filed within 180 days after the date you receive the claim denial, or the right to appeal will be lost. The appeal should include your name, address, Social Security number, should state the reason(s) you believe that the denial is incorrect, and should include any additional information or documents you believe to be relevant. Upon request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relating to your claim.

The Claims Administrator will reconsider the claim that is appealed taking into account all comments, documents, records and other submitted information, without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will send you the final decision in writing. In most cases, written notice of the final decision will be made within 60 days of the date the appeal was filed. If special circumstances require more time, you will be informed in writing, before the end of the 60-day period, of the reason for the delay and provided with the date when a decision is expected to be made. In no case will the extension exceed 120 days after the appeal is filed.

If your appeal is denied, the decision will include:

- The specific reason or reasons for the denial;
- The Wellness and Wellbeing Program provisions that are the basis for the denial;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits and
- A statement explaining your right to file a civil action under ERISA.
COBRA Continuation Coverage

You or your covered dependents may continue certain Wellness and Wellbeing Program coverage if coverage ends due to any of the qualifying events listed below. You must be covered under the applicable Wellness and Wellbeing Program benefits before the qualifying event in order to continue coverage. In all cases, continuation coverage ends if the Wellness and Wellbeing Program ends or required charges are not paid when due. This continuation coverage is provided in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended (“COBRA”).

Qualifying Events

If you are the employee and are covered, you have the right to elect continuation coverage if you lose coverage because of either of the following qualifying events:

• Voluntary or involuntary termination of your employment (for reasons other than gross misconduct).
• Reduction in the hours of your employment (for example, as a result of a layoff, leave of absence, strike, lockout or change from full-time to part-time employment).

If you are the eligible spouse of a covered employee, you have the right to elect continuation coverage if you lose coverage because of any of the following qualifying events:

• The death of the employee.
• A termination of the employee’s employment (for reasons other than gross misconduct) or reduction in the employee’s hours of employment with the employer.
• Entering of decree in the event of a divorce or legal separation from the employee. (Also, if the employee eliminates coverage for his or her spouse in anticipation of a divorce, and a divorce later occurs, then the later divorce will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the later divorce and can establish that the coverage was eliminated earlier in anticipation of the divorce, then continuation coverage may be available for the period after the divorce.)
• The employee becomes enrolled in Medicare.

In the case of an eligible dependent child of a covered employee, the dependent child has the right to elect continuation coverage if he or she loses coverage because of any of the following qualifying events:

The death of the employee.
• The termination of the employee’s employment (for reasons other than gross misconduct) or reduction in the employee’s hours of employment with the employer.
• Parents’ divorce or legal separation.
• The employee becomes enrolled in Medicare.
• The dependent ceases to be an eligible dependent child under the Wellness and Wellbeing Program.

Your Notice Obligations

You and your dependents must notify the Plan Administrator of any of the following events within 60 days of the occurrence of the event:

• Divorce or legal separation.
• A dependent child no longer meets the Wellness and Wellbeing Program’s eligibility requirements.

Note: Refer to Disability Extensions in Extension of Maximum Coverage Periods below for three (3) additional notification requirements.

If you or your dependents fail to provide this notice during this 60-day notice period, any dependent who loses coverage will NOT be offered the option to elect continuation coverage. Furthermore, if you or your dependents fail to provide this notice, and if any claims are mistakenly paid for expenses incurred after the date coverage was to terminate, then you and your dependents will be required to reimburse the Wellness and Wellbeing Program for any claims paid.

When you notify the Plan Administrator that a divorce or a loss of dependent status will cause a loss of coverage, then the Plan Administrator will notify the affected family member(s) of the right to elect continuation coverage. If you notify the Plan Administrator of a qualifying event or disability determination and the Plan Administrator determines that there is no extension available, the Plan Administrator will provide an explanation as to why you or your dependents are not entitled to elect continuation coverage.

The Plan Administrator will also notify you and your dependents of the right to elect continuation coverage after receiving notice that one of the following events occurred and resulted in a loss of coverage: the employee’s termination of employment (other than for gross misconduct), reduction in hours, death or the employee’s becoming enrolled in Medicare.
Notification Procedures:

- The notice must be in writing (and, if applicable, on a form required by the Plan Administrator).

- The written notice must be sent to the department and location listed below within:
  - 60 days of the latest of:
    a. The event date;
    b. The date the individual would lose coverage due to the event; or
    c. In the case of the employee’s disability, the date of the disability determination by the Social Security Administration.

- 30 days of the loss of Social Security disability status.

- The written notice must include the following information:
  - The Name and Address of the individuals requesting continuation coverage or extension of continuation coverage;
  - A description of the event and event date;
  - If the event is due to the disability of the employee, a copy of the determination letter from the Social Security Administration approving total disability status must be included; and

- Any other documentation specifically requested by the Plan Administrator.

- The written notice must be sent to:
  Employee Benefits Department
  Attn: COBRA
  P.O. Box 100
  Marshall, MN 56258

An untimely qualified event notice is considered to have no effect and shall be rejected. The Plan’s procedures require that you provide the qualifying event notice in writing by mail to the address above. Under no circumstances will a verbal notice be effective.

On the qualifying event notice, you are required to provide certain information regarding the qualifying event, such as an identification of the type of event, the date the event occurred and the name of the individual to whom the event is applicable. The following qualifying events require specific documentation to be attached to the qualifying event notice.

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Documentation Required with Notice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorce or legal separation</td>
<td>Certified copy of the court order granting the divorce or legal separation</td>
</tr>
</tbody>
</table>

Death of covered employee  Copy of death certificate
Qualification for Social Security disability  Copy of Social Security Administration determination
Loss of Social Security disability status  Copy of Social Security Administration determination

To be considered valid, the notice must be completed in full and all required enclosures must be supplied. However, the Plan’s procedures provide that a qualifying event notice that is otherwise received timely, but which does not contain all required information or enclosures, will not be considered untimely if the Plan Administrator is able to identify the Wellness and Wellbeing Program, identify the covered employee or qualified beneficiary, identify the qualifying event or disability and identify the date on which the qualifying event occurred. The Plan Administrator, in such event, may require additional supplementary information from the covered employee or qualified beneficiary.

It is recommended that completed qualifying event notices be sent by registered mail, return receipt requested, but it is not required. When you submit a completed qualifying event notice, you must retain a copy (including copies of all enclosures) and any proof of mailing. If you do not receive a response from the Plan Administrator within 14 days of mailing a qualifying event notice, you should contact the Plan Administrator immediately in writing to determine the status of your COBRA claim.

Election Procedures

You and your eligible dependents must elect continuation coverage within 60 days after coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. If you or your dependents do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage. You or your dependent spouse may elect continuation coverage for all qualifying family members; however, each qualified beneficiary is entitled to an independent right to elect continuation coverage. Therefore, a spouse may not decline coverage for the other spouse and a parent cannot decline coverage for a non-minor dependent child eligible for coverage. In addition, a dependent may elect continuation coverage even if the covered employee does not elect continuation coverage.

You and your dependents may elect continuation coverage even if covered under another employer-sponsored group health plan or enrolled in Medicare.
How to Elect
Specific instructions on how to elect continuation coverage will be provided when the Plan Administrator provides you and/or your family member with notice of the right to elect continuation coverage.

Type of Coverage
Ordinarily, the continuation coverage that is offered will be the same coverage that you or your dependent had on the day before the qualifying event. Therefore, anyone who is not covered under the Wellness and Wellbeing Program on the day before the qualifying event generally is not entitled to continuation coverage. (Exceptions: (1) If coverage was eliminated in anticipation of a qualifying event, such as divorce, and a divorce later occurs, then the later divorce will be considered a qualifying event even though the ex-spouse had lost coverage earlier. The ex-spouse must notify the Plan Administrator within 60 days after the later divorce and establish that the coverage was eliminated earlier in anticipation of divorce. (2) A child born to or placed for adoption with the covered employee during the period of continuation of coverage may be added to the coverage for the duration of the qualified beneficiary’s maximum continuation period.)

Qualified beneficiaries must be provided the same rights and benefits as similarly situated beneficiaries for whom no qualified event has occurred. If coverage is modified for similarly situated active employees or their dependents, then continuation coverage will be modified in the same way. (Examples: (1) If the Plan Administrator offers an open enrollment period that allows active employees to switch between plans without being considered Late Entrants, all qualified beneficiaries on continuation coverage should be allowed to switch plans, as well. (2) If active employees are allowed to add new spouses to coverage if the application for coverage is received within 30 days of the marriage, qualified beneficiaries who get married while on continuation coverage should also be afforded this same right.)

Maximum Coverage Periods
The maximum duration for continuation coverage is described below. Continuation coverage terminates before the maximum coverage period in certain situations described later under the heading “Termination of Continuation Coverage Before the End of the Maximum Coverage Period.” In other instances, the maximum coverage period can be extended as described under the heading “Extension of Maximum Coverage Periods.”

18 Months. If you or your dependent loses coverage due to the employee’s termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period is 18 months from the date of such loss of coverage.

36 Months. If a dependent loses coverage because of the employee’s death, divorce, legal separation, the employee became enrolled in Medicare or because of a loss of dependent status under the Wellness and Wellbeing Program, then the maximum coverage period (for spouse and/or dependent child) is three (3) years from the date of such loss of coverage.

Extension of Maximum Coverage Periods
Maximum coverage periods of 18 or 36 months can be extended in certain circumstances.

• Disability Extension: This extension is applicable when the qualifying event is the employee’s termination of employment or reduction of hours, and the extension applies to all qualified beneficiaries. If you or your dependent who is a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation, then the continuation period for all qualified beneficiaries is extended to 29 months from the date coverage terminated.

Notice Obligation: For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the Plan Administrator of the Social Security Administration disability within 60 days after the latest of: (1) the date of the Social Security disability determination; (2) the date of the qualifying event (the employee’s termination of employment or reduction of hours); (3) the date on which the qualified beneficiary loses (or would lose) coverage under the Wellness and Wellbeing Program as a result of the qualifying event; and (4) the date on which the qualified beneficiary is informed, either through the certificate of coverage or the initial COBRA notice, of both the responsibility to provide the notice of disability determination and the Wellness and Wellbeing Program’s procedures for providing such notice to the Plan Administrator. In addition, the qualified beneficiary must notify the Plan Administrator of the Social Security disability determination before the end of the original 18-month continuation coverage period (on account of the employee’s termination of employment or reduction of hours).

Notice Obligation: If, during the 29-month disability extension period, there is a “final determination” by the Social Security Administration that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator within 30 days after the date of this determination. This extension coverage ends for all qualified beneficiaries on the
extension as of the later of (1) the first day of the month that is more than 30 days after a final determination by the Social Security Administration that the formerly disabled qualified beneficiary is no longer disabled or (2) the end of the coverage period that applies without regard to the disability extension.

- **Multiple Qualifying Events:** This extension is applicable when the qualifying event is the employee’s termination of employment or reduction of hours (each of which triggers an 18-month maximum coverage period) is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month maximum coverage period (i.e., death of the employee, divorce, legal separation, the employee becoming enrolled in Medicare or a dependent child losing dependent status). The extension applies to the employee’s dependents that are qualified beneficiaries.

If a second qualifying event occurs within an 18-month or 29-month coverage period that gives rise to a 36-month maximum coverage period for the dependent, then the maximum coverage period (for the dependent) becomes three (3) years from the date of the original loss of coverage. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of continuation coverage will occur.

- **Pre-Termination or Pre-Reduction Medicare Enrollment:** This extension applies when the qualifying event is the reduction of hours or termination of employment that occurs within 18 months after the date of the employee’s Medicare enrollment. The extension applies to the employee’s dependents that are qualified beneficiaries.

If the qualifying event occurs within 18 months after the employee becomes enrolled in Medicare, regardless of whether the employee’s Medicare enrollment is a qualifying event (causing a loss of coverage under the group Wellness and Wellbeing Program), the maximum period of continuation for the employee’s dependents who are qualified beneficiaries is three (3) years from the date the employee became enrolled in Medicare. (Example: Employee becomes enrolled in Medicare on January 1. Triggering/qualifying event, employee’s termination of employment or reduction of hours, is May 15. The employee is entitled to 18 months of continuation from the date coverage is lost. The employee’s dependents are entitled to 36 months of continuation from the date the employee is enrolled in Medicare.)

If the qualifying event (employee’s termination of employment or reduction of hours) is more than 18 months after Medicare enrollment, is the same day as the Medicare enrollment or occurs before Medicare enrollment, no extension is available.

### Termination of Continuation Coverage Before the End of Maximum Coverage Period

Continuation coverage of the employee and dependents will automatically terminate (before the end of the maximum coverage period) when any of the following events occurs:

- The employer no longer provides group health coverage to any of its employees.

- The premium for the qualified beneficiary’s continuation coverage is not paid when due. Charges for continuation can be up to the group rate plus a two (2) percent administration fee. In the event of a disability extension, the charges for continuation can be up to the group rate plus a 50% administration fee for months 19-29. All charges are paid directly to the employer.

- After electing continuation, you or your dependents become covered under another Wellness and Wellbeing Program (as an employee or otherwise) that has no exclusion or limitation with respect to any Preexisting Condition that you have. If the other plan has applicable Preexisting Condition exclusions or limitations, then your continuation coverage will terminate after the exclusion or limitation no longer applies. This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note: An exclusion or limitation of the other Wellness and Wellbeing Program might not apply at all to the qualified beneficiary, depending on the length of his or her creditable Wellness and Wellbeing Program coverage prior to enrolling in the new Wellness and Wellbeing Program.)

- After electing continuation coverage, you or your dependents become enrolled in Medicare. This rule applies only to the qualified beneficiary who becomes enrolled in Medicare.

- You or your dependent became entitled to a 29-month maximum coverage period due to the disability of a qualified beneficiary, but then the
Social Security Administration makes the final determination that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).

- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of for cause with respect to covered employees or their dependents who have coverage under the Wellness and Wellbeing Program for a reason other than the continuation coverage requirements of federal law.

- Voluntarily dropping your continuation coverage.

When termination takes effect earlier than the end of the maximum period of continuation coverage, a notice will be sent from the Plan Administrator. The notice will contain the reason continuation coverage has been terminated, the date of the termination, and any rights to elect alternative coverage that may be available.

**Children Born to or Placed for Adoption With the Covered Employee During Continuation Period**

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary, provided that if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself/herself. The child’s continuation coverage begins when the child becomes eligible for the Wellness and Wellbeing Program and it lasts for as long as continuation coverage lasts for other family members of the employee. To be enrolled in the Wellness and Wellbeing Program, the child must satisfy the otherwise applicable Wellness and Wellbeing Program eligibility requirements.

**Open Enrollment Rights and Special Enrollment Rights**

Qualified beneficiaries who have elected continuation will be given the same opportunity available to similarly situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. Special enrollment rights will apply to those who have elected continuation. Except for certain children described above, dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries – their coverage will end at the same time that coverage ends for the person who elected continuation and later added them as dependents.

**Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes**

If your or your dependent’s address changes, you must notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important continuation notices and other information). Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the terms of the Wellness and Wellbeing Program, you or your dependent must notify the Plan Administrator in writing. In addition, you must notify the Plan Administrator if a disabled employee or family member is no longer disabled.

**Special Second Election Period**

Special continuation rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect continuation coverage for themselves and certain family members if they did not already elect continuation coverage during a special second election period. This election period 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 six (6) months of losing coverage. Please contact the Plan Administrator for additional information.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustments assistance. Under the new 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 new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

**Uniformed Services Employment and Reemployment Rights Act ("USERRA")**

If you are called to active duty in the uniformed Services, you may elect to continue coverage for up to 24 months for you and your eligible dependents under USERRA. This continuation right is separate from, and runs concurrent with, your continuation right under COBRA. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States.
Questions
If you have general questions about how to elect continuation of coverage, please call the Plan Administrator.

Security of Health Information
This section describes the medical information security practices of the Wellness and Wellbeing Program and that of any third party that assists in the administration of Wellness and Wellbeing Program claims. Questions about the Wellness and Wellbeing Program’s security procedures should be addressed to the Security Official for the Employee Benefit Plan.

The Company will put into place and follow administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any ePHI (electronic protected health information) that the Company creates, receives, maintains or transmits on behalf of the Wellness and Wellbeing Program, except as stated below.

The Company will put into place and follow reasonable and appropriate security measures to ensure that access to and use of ePHI is restricted to its employees or group of employees who are required to access or use such ePHI for the proper administration of the Wellness and Wellbeing Program, or for such other reasons as may be proper under HIPAA Security Rules. The Company will provide an effective mechanism for resolving any issues of non-compliance with such security measures by ensuring that appropriate sanctions are imposed against any employee who violates or fails to follow them. The Company will require that any of its agents or subcontractors to whom it provides ePHI relating to the Wellness and Wellbeing Program, agrees to implement reasonable and appropriate security measures to protect the ePHI.

The Company will report to the Wellness and Wellbeing Program any security incident of which it becomes aware. The terms of this section shall not apply if ePHI is disclosed to the Company pursuant to an Authorization which meets the requirements of the HIPAA Privacy Rules, or if the ePHI is summary health information which the Company has requested in order (a) to obtain premium bids from health insurers for providing health insurance coverage under the Wellness and Wellbeing Program; or (b) to amend or terminate the Wellness and Wellbeing Program. In addition, the terms of this section shall not apply if the ePHI disclosed to the Company is information concerning whether an individual is participating in the Wellness and Wellbeing Program.

Privacy of Health Information
This section describes the medical information privacy practices of the Wellness and Wellbeing Program and that of any third party that assists in the administration of the Wellness and Wellbeing Program’s group health claims.

Our Pledge Regarding Medical Information
The Wellness and Wellbeing Program is committed to protecting medical information about you. The Wellness and Wellbeing Program may disclose protected health information to the employer under limited circumstances, although this information will be disclosed only upon the receipt of a certification by the employer that the Plan documents have been amended to incorporate the privacy provisions, and that it will abide by them. The Wellness and Wellbeing Program may disclose summary health information to the employer for the purposes of obtaining premium bids, insurance coverage, or modifying, amending, or terminating the Wellness and Wellbeing Program. The Wellness and Wellbeing Program may disclose protected health information to carry out Wellness and Wellbeing Program administration functions that are consistent under applicable law. The Wellness and Wellbeing Program may not disclose protected health information to the employer for the purpose of employment-related actions or decisions in connection with other benefits or employee benefit plans of the employer. A limited number of employees of the employer will have access to protected health information for the purposes of carrying out Wellness and Wellbeing Program administration functions in the ordinary course of business.

How the Wellness and Wellbeing Program May Use and Disclose Medical Information About You
The following categories describe different ways that the Wellness and Wellbeing Program uses and discloses protected health information. Not every use or disclosure in a category will be listed. However, all of the ways the Wellness and Wellbeing Program is permitted to use and disclose information will fall within one of the categories.

For Treatment. The Wellness and Wellbeing Program may use or disclose medical information about you to provide you with medical treatment or services by providers. The Wellness and Wellbeing Program may disclose protected health information about you to providers, including doctors and other health professionals.
For Payment. The Wellness and Wellbeing Program may use and disclose protected health information about you to determine eligibility for Wellness and Wellbeing Program benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Wellness and Wellbeing Program, or to coordinate Wellness and Wellbeing Program coverage. Likewise, the Wellness and Wellbeing Program may share protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. The Wellness and Wellbeing Program may use and disclose protected health information about you for other Wellness and Wellbeing Program operations which are necessary to run the Wellness and Wellbeing Program. For example, the Wellness and Wellbeing Program may use protected health information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Wellness and Wellbeing Program coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Wellness and Wellbeing Program administrative activities.

As Required By Law. The Wellness and Wellbeing Program will disclose protected health information about you when required to do so by federal, state or local law. For example, the Wellness and Wellbeing Program may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety. The Wellness and Wellbeing Program may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To Facilitate Claims Under Company Plans. Your health information may be disclosed to another health plan maintained by the Company for purposes of paying claims under that plan. In addition, medical information may be disclosed to the Company to administer benefits under the Wellness and Wellbeing Program, such as to determine a claims appeal.

Provide You With Information. The Wellness and Wellbeing Program or its agents may contact you to remind you about appointments or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Organ and Tissue Donation. If you are an organ donor, the Wellness and Wellbeing Program may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplants, or to an organ donation bank to help with organ or tissue donation.

Military and Veterans. If you are a member of the armed forces, the Wellness and Wellbeing Program may release protected health information about you as required by military command authorities. The Wellness and Wellbeing Program may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers’ Compensation. The Wellness and Wellbeing Program may release protected health information about you for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Wellness and Wellbeing Program may disclose protected health information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if the Wellness and Wellbeing Program believes a participant has been the victim of abuse, neglect or domestic violence. The Wellness and Wellbeing Program will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Wellness and Wellbeing Program may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Wellness and Wellbeing Program may disclose protected health information about you in response to a court or administrative order. The Wellness and Wellbeing Program may also disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Wellness and Wellbeing Program may release protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, the Wellness and Wellbeing Program is unable to obtain the person’s agreement; about a death the Wellness and Wellbeing Program believes may be the result of criminal conduct; about criminal conduct at the hospital; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Wellness and Wellbeing Program may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Wellness and Wellbeing Program may also release protected health information about you to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Wellness and Wellbeing Program may release protected health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Wellness and Wellbeing Program may release protected health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
## Important Plan Information

<table>
<thead>
<tr>
<th>Plan Name:</th>
<th>This Employee Wellness and Wellbeing Program is one of the benefit programs offered under the Employee Benefit Plan for Employees of the Subsidiaries of The Schwan Food Company.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Plan:</td>
<td>A limited scope group health plan (a type of welfare benefits plan that is subject to certain provisions of ERISA)</td>
</tr>
<tr>
<td>Plan Year:</td>
<td>January 1 through December 31</td>
</tr>
<tr>
<td>Plan Number:</td>
<td>501</td>
</tr>
<tr>
<td>Funding Medium:</td>
<td>This Plan is partially self-funded by the Company and partially funded by premiums paid by the Company.</td>
</tr>
<tr>
<td>Type of Plan Administration:</td>
<td>Claims are administered by the following Claims Administrators:</td>
</tr>
<tr>
<td>Family Resource Program:</td>
<td>ComPsych</td>
</tr>
<tr>
<td>455 N. Cityfront Plaza Drive 13th Floor Chicago, IL 60611</td>
<td>(312) 595-4000</td>
</tr>
<tr>
<td>Wellness Program:</td>
<td>RedBrick Health</td>
</tr>
<tr>
<td>PO Box 2260 Minneapolis, MN 55402-0260</td>
<td>(866) 322-1711</td>
</tr>
<tr>
<td>Tobacco Cessation Program:</td>
<td>BlueCross BlueShield of Minnesota- R416</td>
</tr>
<tr>
<td>PO Box 64560, R242 St. Paul, MN 55164-0560</td>
<td>(888) 662-BLUE (2583)</td>
</tr>
<tr>
<td>Healthy Start Program:</td>
<td>BlueCross BlueShield of Minnesota- R242</td>
</tr>
<tr>
<td>PO Box 64560, R242 St. Paul, MN 55164-0560</td>
<td>(651) 662-1818 or toll free (866) 489-6948</td>
</tr>
<tr>
<td>Plan Sponsor:</td>
<td>Schwan’s Shared Services, LLC 115 West College Drive Marshall, MN 56258 (507) 532-3274</td>
</tr>
<tr>
<td>Plan Sponsor’s Employer Identification Number:</td>
<td>81-0572771</td>
</tr>
<tr>
<td>Plan Administrator:</td>
<td>Schwan’s Shared Services, LLC 115 West College Drive Marshall, MN 56258 (507) 532-3274</td>
</tr>
<tr>
<td>Named Fiduciary for Claims Administration Purposes:</td>
<td>The applicable Claims Administrator (see above).</td>
</tr>
<tr>
<td>Named Fiduciary for all other Purposes:</td>
<td>Schwan’s Shared Services, LLC 115 West College Drive Marshall, MN 56258 (507) 532-3274</td>
</tr>
<tr>
<td>Agent for Services of Legal Process:</td>
<td>Schwan’s Shared Services, LLC Benefits Manager 115 West College Drive Marshall, MN 56258 (507) 532-3274</td>
</tr>
<tr>
<td>Plan Document:</td>
<td>This booklet / Summary Plan Description (SPD) and its attachments, if any, constitute components of the written plan document required by ERISA.</td>
</tr>
<tr>
<td>Plan Amendment Termination:</td>
<td>The Plan Sponsor reserves the to discontinue, alter or modify the Wellness and right or Wellbeing Program in whole or in part, at any time and for any reason, in its sole and absolute discretion. If the Wellness and Wellbeing Program is terminated, you will not have the right to any other benefits from the Wellness and Wellbeing Program, other than for those claims incurred prior to the date of termination.</td>
</tr>
</tbody>
</table>
Statement of ERISA Rights

As a participant in the Wellness and Wellbeing Program (also referred to below as the “Plan”), you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) (if any) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) (if any) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the summary annual report for a Plan Year.

Continue Group Health Plan Coverage

Continue Wellness and Wellbeing Program coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request, in writing, a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay you up to $110 a day until you receive the materials, unless the requested materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

No action at law or in equity may be brought to recover under the Wellness and Wellbeing Program until the appeal rights herein provided have been exercised and the Wellness and Wellbeing Program benefits requested in such appeal have been denied in whole or in part. If it should happen that Wellness and Wellbeing Program fiduciaries misuse the Wellness and Wellbeing Program’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and 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.

Assistance with Your Questions

If you have questions about the Wellness and Wellbeing Program, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (“EBSA”), formerly known as the Pension and Welfare Benefits Administration (“PWBA”), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.