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**MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS  
HEALTH AND WELFARE FUND**

**IMPORTANT NOTICE**

**Summary of Material Modifications**

TO: Participants and Beneficiaries of the Minneapolis Retail Meat Cutters and Food  
Handlers Health and Welfare Fund

FROM: The Board of Trustees

DATE: April 2018

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This is a Summary of Material Modifications (SMM) regarding the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (Fund). The Board of Trustees has amended the Summary Plan Description and Plan Document (amended and restated September 1, 2017) as indicated below.

**Amendment No. 1: Mail-Order Prescription Medications, Generic Substitution and Disability  
Claims Procedures**

Effective November 1, 2017, the Plan has been amended to remove all references to the mail-order prescription service that was eliminated.

Effective January 1, 2018, the Plan has been amended to remove the coverage exclusion for certain prescription medications. It has also been updated to include the Plan's generic substitution requirement. Generic Prescription Medication will be substituted in lieu of any prescribed brand name Prescription Medication if it is commercially available and if such substitution is consistent with the prescription, the dispensing pharmacist's professional judgement, and applicable law.

Effective April 1, 2018, the Plan's disability claims procedures have been updated to comply with the U.S. Department of Labor's final rule entitled "Claims Procedure for Plans Providing Disability Benefits." If a claim is denied, claimants will now be provided with a statement that the claimant has the right to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

If the claim for benefits is denied based upon a disability determination, the notice will provide an explanation of the basis for agreeing or disagreeing with the following:

1. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

2. The review of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
3. A disability determination regarding the claimant made by the Social Security Administration if such determination is presented by the claimant to the Plan.

The procedure for claim appeal reviews have been amended to state that the review will not afford deference to the initial adverse benefit determination and will be conducted by individuals who were neither the individuals who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinates of such individuals. Before the Plan issues an adverse benefit determination, the Plan will provide the claimant, free of charge and sufficiently in advance of the date on which the notice of benefit determination is required to be provided, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan or those involved with the Plan or the claim, to give the claimant a reasonable opportunity to respond prior to the benefit determination date.

If an adverse benefit determination is made, the following will now be required as part of the notice provided to the claimant:

- The statement, "You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."; and
- If the claim is denied based upon a disability determination, the notice will provide an explanation of the basis for agreeing or disagreeing with the following:
  - (a) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - (b) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - (c) A disability determination regarding the claimant made by the Social Security Administration if such determination is presented by the claimant to the Plan.

**Please update your Summary Plan Description and Plan Document booklet (dated September 1, 2017) to reflect these changes by inserting replacement pages 17, 20, 47, 70, 75, 76, 77, and 77A into your booklet to replace existing pages.**

**If you have any questions about these changes to the Plan, please contact the Plan Administrator at (952) 851-5797 or (844) 468-5917.**

**2.2. PRESCRIPTION DRUG BENEFITS**

Only Prescription Medication purchased through the Prime Therapeutics Select Care Network will be covered. Prescription Medication filled at Walgreens, Walmart, Target, Hy-Vee, Sam’s Club, Costco, and Coburns will not be covered or reimbursed. Below is the schedule of benefits for “Prescription Drug Benefits.”

Out-of-pocket maximum per Calendar Year	
Per Eligible Person	\$3,600
Per Family	\$7,200
<b>Prescription</b>	<b>Plan’s Coinsurance</b>
Prescriptions purchased at a retail pharmacy, except as otherwise specifically stated	Plan pays 80%
OTC Prilosec and OTC Loratadine upon a Physician’s written prescription	Plan pays 100%
Prescriptions purchased through the Specialty Drug Program	Plan pays 80%

**2.3. VISION CARE BENEFITS**

Below is the schedule of benefits for “Vision Care Benefits.”

<b>Services and Supplies</b>	<b>Maximum Plan Payment</b>
<b>Examination</b>	
One per Eligible Person over age 19 per Calendar year	\$50
One per Dependent Child under age 19 per Calendar year	100%
<b>Lenses</b>	
One set per Eligible Person per Calendar Year	
Single, each lens	\$37
Bifocal, each lens	\$64
Trifocal, each lens	\$78
Lenticular, each lens	\$140
Contacts, per set (or disposable contacts)**	\$87
<b>Frames</b>	
One set per Eligible Person per Calendar Year	\$70
Maximum payment per set	

The amounts in the Maximum Plan Payment column show what the Plan will pay toward the listed services and supplies. The Eligible Person is responsible for all additional amounts and other charges.

\*\* The contact lens benefit is in lieu of all other lens and frame benefits for the Calendar Year.

**SECTION 3 PREFERRED PROVIDER NETWORKS**

**3.1. PREFERRED PROVIDER PRESCRIPTION DRUG PROGRAM**

When a full-time Eligible Employee or Eligible Dependent or a part-time Eligible Employee (and their Dependent Children, if applicable) opts to purchase Prescription Medications through the Preferred Provider Prescription Drug Program, benefits are payable subject to the following terms and conditions.

The Preferred Provider for the Prescription Drug Program is Prime Therapeutics (“Select Care Network”). Only prescriptions that are purchased through this network will be covered.

**3.3.1. Payment of Benefits**

An Eligible Person must show his or her I.D. card at the network retail pharmacy to receive discounts through the Preferred Provider Prescription Drug Program and pay the required coinsurance at the time of purchase. Benefits are payable at the coinsurance stated in the Schedule of Benefits.

The Plan will provide coverage for specialty Prescription Medications through the specialty drug network. Benefits are payable at the coinsurance stated in the Schedule of Benefits.

**3.1.2. Eligible Expenses**

The expenses for Prescription Medications that are provided in Comprehensive Major Medical Benefits are also covered under the Preferred Provider Prescription Drug Program, except that injections and injectables are covered through the Specialty Drug Program.

**3.1.3. Generic Substitution Requirement**

Generic Prescription Medication will be substituted in lieu of any prescribed brand name Prescription Medication if it is commercially available and if such substitution is consistent with the prescription, the dispensing pharmacist’s professional judgement, and applicable law.

**3.2. PREFERRED PROVIDER NETWORK**

The Plan uses BlueCross BlueShield of Minnesota as its Preferred Provider Network. Although the Plan covers services at in-network and out-of-network Hospitals and services provided by Preferred Providers (“PPO Provider”) and non-participating providers (“Non-PPO Provider”), you will generally pay less if you use an in-network or PPO Provider.

**3.2.1. Payment of Benefits**

Benefits will be payable for Hospital and Physician services and supplies at the Plan’s coinsurance, applied to the Hospital’s or Physician’s negotiated charge according to the contract in effect at the time charges are incurred. The PPO network also offers a smoking cessation program and a Healthy Start Prenatal Support Program.

For charges incurred with PPO Providers, the Plan will pay a discounted amount. Such providers have agreed to accept payment from the Plan as payment in full, except for

As amended by Amendment No. 1 to the Plan Document and Summary Plan Description of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (2017 Restatement)  
Elimination of mail-order services on this slip page of Amendment is effective November 1, 2017  
Addition of generic substitution requirement made on this slip page of Amendment is effective January 1, 2018

Prescription Medication services do not include the following:

1. Supplies or appliances that are not Prescription Medication, even if obtained with a Prescription Order, such as devices, bandages, heat lamps, braces, splints, artificial appliances, diaphragms, and syringes for use with insulin;
  2. Drugs and medications that can be obtained without a Prescription Order, except insulin and smoking cessation medications obtained through the Preferred Provider's Smoking Cessation Program (and OTC Prilosec and Loratadine upon a Physician's written prescription through the Preferred Provider Prescription Drug Program);
  3. Cost of administering a Prescription Medication;
  4. Cost of Prescription Medications for use while the Eligible Person is confined in a Hospital;
  5. Any Prescription Medication that is not approved for sale by the United States Government;
  6. Cosmetic drugs;
  7. Health and beauty aids, cosmetics, and dietary supplements;
  8. State-restricted drugs;
  9. Impotence medications; and
  10. Injections and injectables, except insulin when prescribed by a Physician and prescriptions obtained through the Preferred Provider's Specialty Drug Program.
- F. Hospice care for terminally ill Eligible Persons who otherwise, upon the recommendation of their Physician, would be required to be Hospital-confined. Benefits are payable for home care administered under an approved Hospice Program or Home Health Care Agency at the patient's home, for care in a hospice unit of a Hospital, or for care in a separate hospice facility.

The following hospice care services are covered during the period the Eligible Person otherwise would have to be Hospital-confined:

1. Physicians' visits;
2. Care provided by an R.N. and home health care aides;
3. Assessment visit by a Hospice program staff member;

2. Either:
  - a. A recovery subject to the Plan's subrogation and reimbursement rights has been received (whether before or after the submission of or payment of claims by the Plan); or
  - b. The Plan deems it likely that recovery will be received.

At the discretion of the Trustees, losses, expenses, and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement. As used in this Section, the term "third party" includes any individual, insurer, entity, or federal, state or local government agency who is or may be in any way legally obligated to reimburse, compensate, or pay for an Eligible Person's loss, damages, Injuries or claims relating in any way to the Injury, occurrence, condition, or circumstance giving rise to the Plan's provision of medical, dental, or disability benefits, including but not limited to, insurers providing liability, medical expense, wage loss, uninsured motorist, or under-insured motorist coverages.

- JJ. Any loss, expense, or charge incurred as the result of any Injury, occurrence, conditions or circumstance for which the injured Eligible Person:
1. Has the right to recover payment from a third party (at the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement);
  2. Has recovered from a third party; or
  3. Has not submitted a claim for the loss, expense, or charge prior to resolution of the third party claim.
- KK. Charges for Injury or Illness resulting from the Eligible Person's participation in a riot or the Eligible Person's commission of any act that may be charged as a felony or gross misdemeanor offense, except in circumstances involving domestic violence or when the commission of the gross misdemeanor or felony is caused by a mental health condition.
- LL. Charges for any Injury or Illness that results from an incident occurring on any property where the lessee or lessor or owner of the property is responsible for Injury or Illness or what otherwise is covered under homeowner's insurance. However, the Plan will consider the charges if: no insurance or other form of compensation is available to the Eligible Person; and the Eligible Employee signs a subrogation agreement in the form designated by the Trustees with the Plan.
- MM. Charges for PCSK9 drugs and drugs containing bulk powders unless the Eligible Person receives preauthorization by the Plan for such drugs.

### **7.2.5 Adverse Benefit Determination**

The Plan will notify the claimant of an adverse benefit determination within a reasonable period of time, but not later than thirty (30) days after the Plan's receipt of a claim or fifteen (15) days after the Plan's receipt of claim in the case of a pre-service claim.

If, for any reason, a claim is denied, in whole or in part, the Fund Office will provide the Eligible Employee, Eligible Dependent, Beneficiary, or authorized or legal representatives ("claimant"), as may be appropriate, with written notice of adverse benefit determinations within the time frames previously stated. Notices will contain the following information stated in an easily understandable manner:

- A. The date of service, the health care provider, the claim amount (if applicable), the diagnosis code, the treatment code, and the corresponding meanings of these codes;
- B. The specific reason or reasons for the adverse benefit determination;
- C. Reference to specific Plan provisions on which the adverse benefit determination is based;
- D. A description of additional information, if any, necessary to complete the claim and why the material or information is necessary;
- E. A description of the Plan's internal and external review procedures, how to initiate an appeal, and the time limits applicable to the review procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- F. A statement that the claimant has the right to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim;
- G. If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, a description of such rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse benefit determination and a statement that a copy of such criterion will be provided free of charge to the claimant upon request;
- H. If the adverse benefit determination was based on a Medical Necessity or Experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge to the claimant upon request;
- I. If a medical or vocational expert's advice was obtained on behalf of the Plan in connection with a claim, a statement that the claimant may request the identity of the expert, regardless of whether the advice was relied upon;

- J. Contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act; and
- K. If the claim for benefits is denied based upon a disability determination, the notice will provide an explanation of the basis for agreeing or disagreeing with the following:
  - 1. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - 2. The review of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
  - 3. A disability determination regarding the claimant made by the Social Security Administration if such determination is presented by the claimant to the Plan.

### **7.3 APPEAL PROCEDURE**

If all or part of a claim is denied, if a claimant is otherwise dissatisfied with the determination made by the Plan, or if the claimant has not received the notice of denial of the claimant's claim within the applicable time limits after the Plan has received all necessary claim information, the claimant has the right to appeal the decision and request a review of the claim. The Plan will provide for a full and fair review of a claim and adverse benefit determination, pursuant to the following:

- A. A claimant will have one hundred eighty (180) days after the claimant receives the notice of an adverse benefit determination to file the claimant's appeal in writing to the Fund Office, and it must include the specific reasons the claimant feels denial was improper.
- B. A claimant will be allowed the opportunity to submit written issues and comments, documents, records, and other information relating to the claim for benefits that may have been requested in the notice of denial or that the Eligible Employee may consider desirable or necessary, but neither the claimant nor representative of the claimant will have the right to appear in person before the Board of Trustees.
- C. A claimant or duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all designated, pertinent documents, records, and other information relevant to the Employee's claim for benefits.
- D. The review will take into account all comments, documents, records, and other information related to the claim that are submitted by the claimant, whether or not such information was submitted or considered in the initial benefit determination.
- E. The Board of Trustees, as an appropriate named fiduciary for the Plan, will be the assigned decision maker on appealed claims.

- F. The review will not afford deference to the initial adverse benefit determination and will be conducted by individuals who were neither the individuals who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinates of such individuals.
- G. The Plan will consult with appropriate health care professionals in deciding appealed claims that are based in whole or in part on medical judgment, including determination of experimental or investigational treatments and Medical Necessity.
- Such health care professionals will have appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted for the appeal of an adverse benefit determination will be someone who was not consulted in the initial adverse benefit determination or the subordinate of such individual.
- H. If a medical or vocational expert's advice was obtained on behalf of the Plan in connection with a claim, the claimant may request the identity of the expert, regardless of whether the advice was relied on.
- I. Before the Plan issues an adverse benefit determination, the Plan will provide the claimant, free of charge and sufficiently in advance of the date on which the notice of benefit determination is required to be provided, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan or those involved with the Plan or the claim, to give the claimant a reasonable opportunity to respond prior to the benefit determination date.
- J. For appeals of pre service claims, the Plan will notify the claimant of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receiving the appeal request.
- K. The Board of Trustees will review post service claim appeals at their next regularly scheduled Board of Trustees' meeting (at least quarterly) that follows the receipt of the request for review. However, if the request is filed within thirty (30) days of the date of the meeting, the determination may be made no later than the date of the second meeting following the receipt of the request for review. If special circumstances require a further extension, the appeal decision can be pushed back to the third meeting following the appeal request. However, prior to the extension, the Plan must notify the claimant of the extension, the special circumstances, and the date as of which the determination will be made.

The Plan will provide the claimant with written notice of an adverse benefit determination as soon as possible but within five (5) days of the decision being made. The notice will include the following information stated in an easily understandable manner:

1. The date of service, the health care provider, the claim amount (if applicable), the diagnosis code, the treatment code, and the corresponding meanings of these codes;
2. The specific reason or reasons the claim was denied, including (if applicable) the denial code and its corresponding meaning;

3. Reference to the specific Plan provision(s) on which the adverse benefit determination is based;
4. A statement that the claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his/her claim for benefits;
5. A description of the Plan's internal and external review procedures and the time limits applicable to the review procedures;
6. A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA after the claimant has exhausted the Plan's claims review and appeal procedure;
7. If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, a description of such rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse benefit determination and a statement that a copy of such criterion will be provided free of charge to the claimant upon request;
8. If the adverse benefit determination was based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge to the claimant upon request;
9. Contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act;
10. The statement, "You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."; and
11. If the claim is denied based upon a disability determination, the notice will provide an explanation of the basis for agreeing or disagreeing with the following:
  - (a) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - (b) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - (c) A disability determination regarding the claimant made by the Social Security Administration if such determination is presented by the claimant to the Plan.



**MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS  
HEALTH AND WELFARE FUND**

**IMPORTANT NOTICE**

**Summary of Material Modifications**

**TO:** Participants and Beneficiaries of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund

**FROM:** The Board of Trustees

**DATE:** August 2018

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This is a Summary of Material Modifications (SMM) regarding the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (Plan). The Board of Trustees has amended the Summary Plan Description and Plan Document (amended and restated September 1, 2017) as indicated below.

**Amendment No. 2: Coverage exclusion for out-of-network non-emergency inpatient treatment and services**

Effective October 1, 2018, the Plan has been amended to exclude coverage for charges related to out-of-network inpatient services unless it is a "Medical Emergency." For purposes of this coverage exclusion, the term "Medical Emergency" means a condition that starts suddenly and requires immediate care (within forty-eight (48) hours) to prevent serious harm to a major organ, life, or limb.

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**Please update your Summary Plan Description and Plan Document booklet (dated September 1, 2017) to reflect these changes by inserting replacement pages 16, 16A, 20, 21, 44, 49, 70 and 73 into your booklet to replace existing pages.**

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**If you have any questions about these changes to the Plan, please contact the Plan Administrator at (952) 851-5797 or (844) 468-5917.**

**SECTION 2 SCHEDULE OF BENEFITS**

**2.1. COMPREHENSIVE MAJOR MEDICAL BENEFITS**

Below is the schedule of benefits for “Comprehensive Major Medical Benefits.”

**PLEASE NOTE: Out-of-network non-emergency inpatient services are excluded from coverage (see Section 6).**

Deductible amount per Calendar Year	
Per Eligible Person	\$750
Per Family	\$2,250
Copayment	\$25 per office visit \$50 per specialist visit \$250 per emergency room visit
Plan’s Coinsurance (including In-Hospital and Physician’s Services and Out-of-Hospital Major Medical Services)	Plan pays 80%
Out-of-pocket maximum per Calendar Year (including the deductible)	
Per Eligible Person	\$3,000
Per Family	\$6,000
<i>The Plan generally pays 100% of covered expenses in excess of the out-of-pocket maximum for remainder of that Calendar Year</i>	
Preventive Care (including routine immunizations that are Preventive Care)	Plan pays 100%
Routine Physical Examinations that are not Preventive Care per Eligible Person per Calendar Year	Plan pays 100%
<b>Doctor on Demand</b>	Plan pays 100%

The following are specific maximum amounts applicable to certain services and supplies covered under the Plan's Comprehensive Major Medical Benefits provisions.

<b>Organ Transplants</b> (other than Essential Health Benefits)	
Maximum for professional services per transplant per donor	\$10,000
Maximum for private nursing care per transplant per donor	\$10,000
<b>Skilled Nursing Home Care</b>	
Maximum number of days per Eligible Person per confinement	30
<b>Chiropractic Care</b>	
Maximum number of visits per Eligible Person per Calendar Year	20
<b>Genetic Testing and Counseling</b> (other than amniocentesis, Preventive Care, and Essential Health Benefits)	
Maximum per Eligible Person per calendar year	\$2,000
<b>Hearing Aid Appliances</b>	
Maximum per ear per benefit period	\$500
<b>Wigs and Toupees</b>	
Maximum per lifetime per Eligible Person	\$300

## **SECTION 3 PREFERRED PROVIDER NETWORKS**

### **3.1. PREFERRED PROVIDER PRESCRIPTION DRUG PROGRAM**

When a full-time Eligible Employee or Eligible Dependent or a part-time Eligible Employee (and their Dependent Children, if applicable) opts to purchase Prescription Medications through the Preferred Provider Prescription Drug Program, benefits are payable subject to the following terms and conditions.

The Preferred Provider for the Prescription Drug Program is Prime Therapeutics (“Select Care Network”). Only prescriptions that are purchased through this network will be covered.

#### **3.1.1. Payment of Benefits**

An Eligible Person must show his or her I.D. card at the network retail pharmacy to receive discounts through the Preferred Provider Prescription Drug Program and pay the required coinsurance at the time of purchase. Benefits are payable at the coinsurance stated in the Schedule of Benefits.

The Plan will provide coverage for specialty Prescription Medications through the specialty drug network. Benefits are payable at the coinsurance stated in the Schedule of Benefits.

#### **3.1.2. Eligible Expenses**

The expenses for Prescription Medications that are provided in Comprehensive Major Medical Benefits are also covered under the Preferred Provider Prescription Drug Program, except that injections and injectables are covered through the Specialty Drug Program.

#### **3.1.3. Generic Substitution Requirement**

Generic Prescription Medication will be substituted in lieu of any prescribed brand name Prescription Medication if it is commercially available and if such substitution is consistent with the prescription, the dispensing pharmacist’s professional judgement, and applicable law.

### **3.2. PREFERRED PROVIDER NETWORK**

The Plan uses BlueCross BlueShield of Minnesota as its Preferred Provider Network. Although the Plan covers certain services at in-network and out-of-network Hospitals and services provided by Preferred Providers (“PPO Provider”) and non-participating providers (“Non-PPO Provider”), you will generally pay less if you use an in-network or PPO Provider.

### **3.2.1. Payment of Benefits**

Benefits will be payable for Hospital and Physician services and supplies at the Plan's coinsurance, applied to the Hospital's or Physician's negotiated charge according to the contract in effect at the time charges are incurred. The PPO network also offers a smoking cessation program and a Healthy Start Prenatal Support Program.

For charges incurred with PPO Providers, the Plan will pay a discounted amount. Such providers have agreed to accept payment from the Plan as payment in full, except for applicable deductibles, coinsurance, copayments, maximum benefit limitations or other similar limitations under the Plan.

For charges incurred with Non-PPO Providers within the geographic area of the BlueCross BlueShield of Minnesota AWARE Network, the Plan will pay the Usual and Customary Charge or, if applicable, a separately negotiated amount to the Non-PPO Provider. Additionally, the Eligible Person will be responsible for applicable deductibles, coinsurance, copayments, maximum benefit limitations, and other similar limitations under the Plan and may be billed for the balance by the Non-PPO Provider.

Charges incurred with non-PPO Providers outside the geographic area of the BlueCross BlueShield of Minnesota AWARE Network will generally come through BlueCross' Blue Card Program. The Plan will pay the reasonable expense, as defined in the Blue Card Host Plan in the Blue Card System or, if applicable, an amount separately negotiated with the non-PPO Provider. The Eligible Person will be responsible for applicable deductibles, coinsurance, copayments, maximum benefit limitations, or other similar limitations under the Plan and may be billed for the balance by the non-PPO Provider.

### **3.2.2. BlueCross BlueShield Healthy Start Prenatal Support Program**

Employees and Eligible Dependents have access to the Healthy Start Prenatal Support Program offered by BlueCross BlueShield of Minnesota. This program is designed to assess, educate, and support pregnant women to achieve an optimal childbirth outcome.

The Plan will pay for the cost of participation and a \$50.00 gift card sent to those completing the program.

Additionally, if an Eligible Person enrolls in the Healthy Start Prenatal Support Program prior to the second trimester of pregnancy, the Plan will pay benefits for such pregnancy and delivery-related expenses at ninety percent (90%) instead of eighty percent (80%).

If an Eligible Person is expecting, she should call Healthy Start at 651-662-1818 or 866-489-6948 before the second trimester to enroll and obtain the maximum benefits possible.

### **3.3. ELIGIBLE PERSON'S CHOICE OF COVERED HEALTH CARE PROVIDER**

Eligible Persons will have the sole right to select their own Physician, Dentist, Hospital, and other covered health care Providers.

**PLEASE NOTE: Out-of-network non-emergency inpatient services are excluded from coverage (see Section 6).**

as Injury, Illness, congenital defect, or premature birth) that requires treatment, no coverage will be provided for any expenses incurred by the newborn Dependent Child including charges for Hospital confinement.

2. Confinement in an Intensive Care Unit, including confinement in duration of twenty-four (24) or more consecutive hours in a recovery room of a Hospital if the Eligible Person receives the same care and services as those normally provided in the Intensive Care Unit of the Hospital.
3. Drugs, medicines, diagnostic x-rays, and laboratory tests, and other miscellaneous Hospital services and supplies not included in the room charges (including the anesthetist's fee when charged by the Hospital), if used while confined in the Hospital as a resident patient or while in the outpatient department of the Hospital when outpatient surgery is performed (see paragraph (h) (vi) for coverage of pre-admission testing).
4. Services for confinement in a Hospital and services provided in an intensive day treatment program that are related to treatment of mental illness or nervous disorders. These services are payable the same as for any other disability.
5. Services provided for treatment during confinement in a Hospital or Residential Treatment Program for the treatment of alcoholism, chemical dependency, and substance abuse are payable the same as for any other disability.

Inpatient charges incurred at a detoxification center are not covered unless the center is located within a Hospital or Residential Treatment Program and appropriate medical or psychiatric care is being provided. Confinement strictly for custodial care and out-of-network non-emergency inpatient services or treatment are not covered.

Under federal law, The Plan generally may not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a Provider obtain authorization from the Plan for prescribing a Hospital length of stay not in excess of these periods. 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 forty-eight (48) or ninety-six (96) hours, as applicable.

Successive Hospital confinements will be considered one (1) confinement unless they are due to entirely unrelated causes or:

1. If the Eligible Person is an active Eligible Employee, the Eligible Person has returned to active work for at least one (1) full working day before the subsequent confinement begins; or

6. Outpatient pre-admission tests and exams provided that:
  - (a) The surgery for which the tests or exams are furnished is performed within seventy-two (72) hours of the date on which they were given; and
  - (b) The Eligible Person is confined as an inpatient in the in-network Hospital immediately following the surgery.
7. Emergency room treatment for accidental Injury or acute medical emergency. Diagnoses that generally would not qualify as acute medical emergencies include:
  - (a) Scheduled diagnostic procedures;
  - (b) Follow-up visits for further injections, such as antibiotics;
  - (c) Suture removal; and
  - (d) Urgent but not life-threatening conditions that are normally treated in a Physician's office, such as, but not limited to, ear ache, sore throat, upper respiratory infections, flu syndrome, and migraine headaches.
8. Services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for private duty nursing, other than a nurse who ordinarily resides in the Eligible Employee's home or is a member of the Employee's immediate family.
9. Artificial limbs or eyes to replace natural limbs or eyes, provided that replacement occurs promptly following the loss and in no event longer than twelve (12) months from the date of the loss, and repair or replacement of artificial limbs or eyes when Medically Necessary.
10. Casts, splints, trusses, braces, crutches, surgical dressings, and prosthetic appliances used only for medical treatment.
11. Rental of Hospital-type bed, wheelchair, iron lung, or other durable medical equipment. (The purchase of such device is covered if the rental would exceed the purchase price. However, the Fund Office must approve the purchase of any durable medical equipment.)
12. X-ray, radium, or cobalt treatment, including the services of a radiologist and the rental, but not the purchase, of such radioactive materials.
13. Outpatient radiation and chemotherapy treatment services.
14. Oxygen and the rental of equipment for its administration. (The purchase of such equipment is covered if the rental would exceed

2. Either:
  - a. A recovery subject to the Plan's subrogation and reimbursement rights has been received (whether before or after the submission of or payment of claims by the Plan); or
  - b. The Plan deems it likely that recovery will be received.

At the discretion of the Trustees, losses, expenses, and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement. As used in this Section, the term "third party" includes any individual, insurer, entity, or federal, state or local government agency who is or may be in any way legally obligated to reimburse, compensate, or pay for an Eligible Person's loss, damages, Injuries or claims relating in any way to the Injury, occurrence, condition, or circumstance giving rise to the Plan's provision of medical, dental, or disability benefits, including but not limited to, insurers providing liability, medical expense, wage loss, uninsured motorist, or under-insured motorist coverages.

- JJ. Any loss, expense, or charge incurred as the result of any Injury, occurrence, conditions or circumstance for which the injured Eligible Person:
1. Has the right to recover payment from a third party (at the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement);
  2. Has recovered from a third party; or
  3. Has not submitted a claim for the loss, expense, or charge prior to resolution of the third party claim.
- KK. Charges for Injury or Illness resulting from the Eligible Person's participation in a riot or the Eligible Person's commission of any act that may be charged as a felony or gross misdemeanor offense, except in circumstances involving domestic violence or when the commission of the gross misdemeanor or felony is caused by a mental health condition.
- LL. Charges for any Injury or Illness that results from an incident occurring on any property where the lessee or lessor or owner of the property is responsible for Injury or Illness or what otherwise is covered under homeowner's insurance. However, the Plan will consider the charges if: no insurance or other form of compensation is available to the Eligible Person; and the Eligible Employee signs a subrogation agreement in the form designated by the Trustees with the Plan.
- MM. Charges for PCSK9 drugs and drugs containing bulk powders unless the Eligible Person receives preauthorization by the Plan for such drugs.
- NN. Charges for out-of-network inpatient services unless it is a "Medical Emergency." For purposes of this coverage exclusion, the term "Medical Emergency" means a condition that starts suddenly and requires immediate care (within forty-eight (48) hours) to prevent serious harm to a major organ, life, or limb.

charged an improper dollar copayment or percentage coinsurance (for example through the Preferred Provider Prescription Drug Program), he or she may submit a formal appeal to have his or her claim reviewed according to the claims review and appeal procedure. The appeal must be submitted to the Fund Office in writing within one hundred eighty (180) days of being charged the coinsurance or copayment.

### **7.1.3. Determination of Eligibility**

On receipt of the completed claim form, the Fund Office will determine, based upon Trust Plan records, whether the claimant was eligible for benefits at the time the charges were incurred. The Fund Office also will assist Eligible Persons in obtaining benefits to which they are entitled.

### **7.1.4. Determination of and Amount of Benefits Payable**

The determination of benefits payable will be based upon the claimant's eligibility and the provisions of the Plan. The amount of benefits payable will be based on the Schedule of Benefits in effect for the applicable class of Eligible Person when the covered charges were incurred.

The determination of the type of benefits payable, if any, and the amount of benefits payable will be the function and responsibility of the claims agent named by the Trustees.

### **7.1.5. Distribution of Benefits Payments**

Generally, benefits the Fund Office determines are payable are automatically paid directly to the provider of service if: (i) the charges were incurred with PPO Providers or Non-PPO Providers outside the geographic area of the Blue Cross Blue Shield of Minnesota Aware Network (subject to the exclusions and limitations provided in Section 6); and (ii) the Fund Office accepts a request to pay the claims directly to the Providers. The Eligible Person will be sent a copy of the processed claim payment for the Eligible Person's records. If the Fund Office does not accept a request to pay the providers directly, or the charges were incurred with Non-PPO Providers within the geographic area of the Blue Cross Blue Shield of Minnesota Aware Network, benefits will be paid directly to the Eligible Person upon proper submission of the claim and proof of payment.

Although the Plan may make payments directly to providers, such payments do not make a provider an assignee for any purposes or otherwise confer on the provider any rights under the Plan or ERISA. Any attempt to assign any rights, claims or causes of action to any person or entity will be null and void absent written consent by the Plan.

## **7.2 CLAIMS REVIEW PROCEDURE**

When a claim for benefits is submitted to the Fund Office, the Fund Office will determine eligibility and calculate the amount of benefit payable, if any.

If the claimant feels that the action taken on his eligibility or claim is incorrect, the claimant immediately must ask the Fund Office to review the claim with him. In some cases, the Fund Office may request additional information that might enable the Fund Office to reevaluate its decision.



**MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS  
HEALTH AND WELFARE FUND**

**IMPORTANT NOTICE**

**Summary of Material Modifications**

**TO:** Participants and Beneficiaries of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund

**FROM:** The Board of Trustees

**DATE:** February 2019

---

This is a Summary of Material Modifications (SMM) regarding the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (Plan). The Board of Trustees has amended the Plan Document and Summary Plan Description (amended and restated September 1, 2017) as indicated below.

**Amendment No. 3: Opt-Out of Coverage Provision**

Effective January 1, 2019, the Plan has been amended to clarify the Plan's opt-out of coverage provisions. The revised language provides that if you are in opted-out status, Employer contributions will not be made on your behalf. If you choose to re-enroll in the Plan, you will need to meet the Plan's eligibility requirements before being allowed to resume coverage.

**Please update your Summary Plan Description and Plan Document booklet (dated September 1, 2017) to reflect these changes by inserting replacement pages 23, 24, 24A, 33 and 33A into your booklet to replace existing pages.**

**If you have any questions about these changes to the Plan, please contact the Plan Administrator at (952) 851-5797 or (844) 468-5917.**

A modified part-time Employee will become eligible as a part-time Eligible Employee even if an occasional full-time contribution is made on behalf of such Employee.

#### **4.2 EFFECTIVE DATE OF ELIGIBILITY**

- A. An Employee becomes eligible under the Plan on the first day of the first month following satisfaction of the provisions in Section 4.1.C. or 4.1.D.
- B. Coverage for Dependents is provided for full-time Eligible Employees only. Dependents become eligible under the Plan on the first day of the first month following the month the Employee satisfies the provisions in Section 4.1.C. If an Employee acquires a Dependent after his or her effective date, the new Dependent will be covered on the date he or she becomes such a Dependent.

Part-time Eligible Employees may purchase coverage for their Dependent Children only. If a part-time Eligible Employee purchases coverage for a Dependent Child, the Dependent Child will be covered under the Plan on the first day of the first month following receipt of the part-time Eligible Employee's payment for such coverage.

Parents and other relatives are not eligible for Dependent coverage even if they are supported by the Eligible Employee.

- C. Opt-Out. An Eligible Employee may choose to "opt out" of coverage under the Plan for the Eligible Employee and his or her Dependents by completing and submitting the form designated by the Trustees to the Plan Administrator if both of the following circumstances are met:
  - 1. The Eligible Employee has satisfied the initial eligibility provisions under the Plan; and
  - 2. The terms of the collective bargaining agreement requiring contributions on behalf of the employee provide an "opt out of coverage" option.

If an Eligible Employee opts out of Plan coverage for himself or herself and his or her Dependents due to enrollment in other health insurance or group health insurance coverage, the Eligible Employee must state in writing that the Plan coverage is being declined due to enrollment in other health coverage at the time the Eligible Employee exercises his or her right to opt out of coverage under the Plan. While you are in opted-out status your employer will not make contributions to the Plan on your behalf even though you continue to work.

Except as provided in Section 4.1.D. below, an Eligible Employee that opts out of Plan coverage for himself or herself and his or her Dependents will not be entitled to re-enroll in the Plan's coverage.

- D. Special Enrollment Rights.

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your

Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within thirty (30) days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Once you submit your enrollment request, your employer will again begin to make contributions to the Plan on your behalf.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within thirty (30) days after the date of marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at (844) 468-5917.

Notwithstanding any other provision of the Plan to the contrary, an Eligible Employee or Dependent is entitled to special enrollment rights under the Plan as required by applicable law under the following circumstances:

1. An Employee or Dependent's coverage under a Medicaid Plan or under a state children's health insurance program is terminated as a result of loss of eligibility for such coverage, and the Employee or Dependent requests coverage under the Plan not later than sixty (60) days after the date of termination of such coverage.
2. An Employee or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid Plan or through a state children's health insurance program with respect to coverage under the Plan and the Employee or Dependent requests coverage under the Plan not later than sixty (60) days after the date the Employee or Dependent is determined to be eligible for the assistance.

**CAUTION** – in order to be able to re-enroll or enroll a Dependent in the Plan after having opted-out, you must be eligible for coverage. If, during the time you were in opt-out status, you lost eligibility because your Employer had stopped making contributions on your behalf, you will be required to again meet the Plan's rules for eligibility before being allowed to resume coverage. For part-time Employees who have not had a break in service and full-time Employees, this means earning at least eight (8) weeks of contributions in twelve (12) consecutive weeks of employment. A part-time Employee who goes six (6) consecutive months with no Employer contributions will suffer a break in service. When that happens, the part-time Employee must re-qualify as a new Eligible Employee by working twelve (12) months during which at least one Employer contribution is made. These rules are further stated in Section 4.6.

#### **4.3 CONTINUATION OF ELIGIBILITY THROUGH EMPLOYMENT**

An Employee's continued eligibility is determined weekly. Once an Employee has established eligibility, it will continue so long as required Employer contributions to the Plan are made on the Employee's behalf for each subsequent week.

The amount of the Employer contribution is based on the number of hours worked per week, the Employee classification and the weekly rate specified by the collective bargaining agreement in effect at the time the contributions are earned. The collective bargaining agreement requires Employer contributions to be paid when an Employee meets the criteria for a specified employment classification (full-time Employee or modified part-time Employee) and works a specified amount of required hours. Generally, the amount of the Employer contribution determine whether the Employee is covered under as a full-time Eligible Employee or a part-time Eligible Employee.

If, in any week, an Employer does not make either the modified part-time or full-time contribution, as applicable, on an Employee's behalf because the Employee has not worked the required number of hours, the Employee may pay that weekly contribution himself to continue coverage, but only if actively working or scheduled to work.

- I. For a Qualified Beneficiary who was entitled to the additional eleven (11) months continuation coverage based on a disability extension, eligibility for continuing the disability extension will terminate when there has been a final determination that the disability no longer exists.

Continuation coverage also may be terminated for any reason the Plan could terminate coverage of a Participant or Dependent not receiving continuation coverage (such as fraud).

#### **4.6. REINSTATEMENT OF COVERAGE**

##### **4.6.1. Full-Time Eligible Employees**

If a full-time Eligible Employee's coverage terminates, the Employee may be reinstated on the first of the month following the date when eight (8) weeks of Employer full-time contributions have been paid to the Fund on the Employee's behalf during a consecutive twelve (12) week period.

##### **4.6.2. Part-Time Eligible Employees**

If a part-time Eligible Employee loses eligibility, but does not incur a break in service (as defined below), he may regain eligibility by completing twelve (12) consecutive weeks of employment during which at least eight (8) weeks of part-time contributions are made to the Plan.

A break in service is the longer of: (A) a period of six (6) consecutive months during which no Employer contributions are made on an Employee's behalf; or (B) the length of an approved leave of absence. If an Employee loses eligibility after having incurred a break in service, he may regain eligibility by once again satisfying the requirements for initial eligibility. Part-time eligibility credit for months preceding a break in service is forfeited and does not count for purposes of obtaining eligibility.

These rules apply when an Employee who has opted-out of Plan coverage seeks to opt-in (and again become an Eligible Employee) under the Special Enrollment Rights stated in Section 4.2.D.

#### **4.7. TERMINATION OF EMPLOYMENT**

In the event an Eligible Employee's employment is terminated, the Employee's eligibility will continue under the Plan for the number of grace weeks the Employee has accrued (as provided below).

Each Eligible Employee who has qualified for health care benefits, for either full-time or modified part-time coverage, will accumulate a total of eight (8) grace period weeks. The Fund Office will use one (1) grace week whenever a current weekly contribution is not received for the coverage in effect. When all of the grace weeks have been used and there are no current contributions, the Employee's full-time or modified part-time coverage, whichever applies, will be terminated. However, the Employee still has, the option of continuing coverage.

It is each Employee's responsibility to keep track of any grace weeks used. An Employee may make contributions on his or her behalf in lieu of using any grace weeks OR may buy back any

grace weeks used. However, such option must be exercised within sixty (60) days of the date the Eligible Employee is notified of either the Employee's termination of coverage or the Employee's reduction to modified part-time Employee status. Employees who are currently working or

# Minneapolis Retail Meat Cutters & Food Handlers Health and Welfare Fund



Preparing today for a *secure* future.

3001 Metro Drive - Suite 500  
Bloomington, MN 55425

Online: [www.663benefits.com](http://www.663benefits.com)  
Phone: (952) 851-5797  
Toll Free: (844) 468-5917



## **IMPORTANT NOTICE**

### **Summary of Material Modifications**

**TO:** Participants and Beneficiaries of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund

**FROM:** The Board of Trustees

**DATE:** February 2020

---

This is a Summary of Material Modifications (SMM) regarding the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (Plan). The Board of Trustees has amended the Plan Document and Summary Plan Description (amended and restated September 1, 2017) as indicated below.

#### **Amendment No. 4: Children's Vision and Dental Coverage Limits**

Effective March 1, 2019, the Plan has been amended to remove certain limits on pediatric vision and dental services. In the vision section of the Schedule of Benefits, the revised language provides that the Plan will pay 100% of the cost of lenses for Eligible Persons or Dependent Children under the age of 19. In the dental section of the Schedule of Benefits, the revised language provides that the maximum annual dollar limit of \$1,250 does not apply to certain dental care benefits for Eligible Employees or Eligible Dependents under the age of 19.

#### **Amendment No. 5: Prior Authorization and Step Therapy**

Effective August 1, 2019, the Plan has been amended to require that certain prescription drugs will be subject to the Plan's Step Therapy, quantity level limits and prior authorization programs.

The Step Therapy program is a "step" approach to providing the medications that treat your condition. If your doctor prescribes you a new medication that is subject to the Plan's Step Therapy program, the Plan will initially only cover the least expensive "step" in that drug class, typically a generic drug. If the first step medication does not safely and effectively treat your condition, the Plan will cover the next "step," typically a formulary brand medication.

If your doctor recommends prescription drugs or quantities that do not comply with the prior authorization and/or Step Therapy protocols, your doctor will need to submit a prior authorization (PA) request that will include the medical reasons supporting that request to Prime Therapeutics.

#### **Amendment 6: Part-Time Self Pay for Ancillary Benefits**

Effective April 26, 2019, the Plan has been amended to allow all regular part-time, Group 3 part-time, and modified part-time Eligible Employees to self-pay for Ancillary Benefits if allowed by the applicable collective bargaining agreement.

"Ancillary Benefits" includes Dental Care, Vision Care, Life Insurance, Accidental Death and Dismemberment, and Employee Assistance Program benefits.

Amendment 7: Coverage for Conditions Related to Gender Dysphoria

Effective August 1, 2019, the Plan has been amended to provide coverage for conditions related to Gender Dysphoria.

Amendment 8: Accidental Death and Dismemberment and Life Insurance Updates

Effective August 1, 2019, the Plan has been amended to update the accidental death and dismemberment benefits and life insurance benefits to Symetra Life Insurance Company.

Amendment 9: Removal of Walgreens Pharmacy Exclusion

Effective January 1, 2020, the Plan has been amended to replace the Walgreens pharmacy exclusion with CVS pharmacy.

**Please update your Plan Document and Summary Plan Description booklet (dated September 1, 2017) to reflect these changes by inserting the attached introduction page and replacement pages 10, 17, 17a, 18, 19, 20, 23, 48, 48a, 48b, 61, 62, 63, 64, 68 and 90.**

**If you have any questions about these changes to the Plan, please contact the Plan Administrator at (952) 851-5797 or (844) 468-5917.**

**MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD  
HANDLERS HEALTH AND WELFARE FUND**

**INTRODUCTION**

To All Participants:

The Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund ("Plan") is developed and maintained pursuant to the Restated Agreement and Declaration of Trust of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund ("Trust Agreement"). Benefits originally were provided according to a mini-premium arrangement with BlueCross BlueShield.

Effective April 1, 1985, the Board of Trustees ("Trustees") cancelled BlueCross BlueShield Master Insurance Policy No. AS314 and began providing health care benefits directly from Plan assets according to the Plan Document and Summary Plan Description, which has been amended from time to time. The benefits and other provisions were continued without modification or change. Life Insurance and Accidental Death and Dismemberment Benefits are insured through Symetra Life Insurance Company, 777 108<sup>th</sup> Avenue NE, Suite 1200, Bellevue, WA 98004 (the "Life Insurance Company") subject to Master Insurance Policy No. is 01-018038-00.

Effective May 1, 2008, the Trustees restated the entire Plan Document. The Trustees have decided to restate the Plan Document as a Plan Document and Summary Plan Description, effective September 1, 2017. The restated Plan Document and Summary Plan Description incorporates all amendments adopted through August 28, 2017. This Plan continues in force until amended by the Trustees or terminated pursuant to the terms of the Trust Agreement. As future changes to the Plan are adopted by the Trustees, amendments will be incorporated into this Plan Document and Summary Plan Description, which then will constitute a continuously updated restatement of the Plan Document and Summary Plan Description.

Yours sincerely,

**THE BOARD OF TRUSTEES**

chiropractor, osteopath, podiatrist, optometrist, doctor of dental surgery, Nurse Anesthetist providing anesthesia services, and Nurse Midwife providing obstetrical services. The Physician must be duly licensed and qualified under the laws of the state in which the eligible Health Services are performed.

**1.30. PLAN YEAR**

“Plan Year” means the twelve (12)-month period beginning March 1 and ending February 28.

**1.31. PREDETERMINATION**

“Predetermination” means the pretreatment review that is used to determine the eligibility of the individual and the amount of coverage for services in accordance with the Schedule of Benefits.

**1.32. PREFERRED PROVIDERS**

A “Preferred Provider” means any of the following who alone or as part of a group enter into a contract with the Trustees agreeing to be compensated for their services and supplies that are covered under this Plan in accordance with the terms of such contract:

- A. Physician, Dentist, R.N., physical therapist, or other licensed health care Provider;
- B. Hospital;
- C. Alcohol and substance abuse treatment facility;
- D. Hospice facility or Program;
- E. Laboratory;
- F. Outpatient surgical facility;
- G. Pharmacy;
- H. Business establishment selling or renting durable medical equipment; or
- I. Any other source for services or supplies covered under this Plan.

Current types of Preferred Providers include the following:

- A. Preferred Provider Prescription Drug Program. Preferred Providers under the Preferred Provider Prescription Drug Program include Pharmacies in the Prime Therapeutics Classic Network.
- B. Preferred Provider Network. The Preferred Provider Network includes only those Hospitals, Physicians, and other health care professionals in the BlueCross BlueShield of Minnesota Network.
- C. Delta Dental Network. The Delta Dental Network includes the Preferred Providers of Dental Care Benefits.

**2.2. PRESCRIPTION DRUG BENEFITS**

Only Prescription Medication purchased through the Prime Therapeutics Classic Network will be covered. Prescription Medication filled at CVS, Walmart, Target, Hy-Vee, Sam’s Club, Costco, and Coborn’s will not be covered or reimbursed. Below is the schedule of benefits for “Prescription Drug Benefits.”

Out-of-pocket maximum per Calendar Year	
Per Eligible Person	\$3,600
Per Family	\$7,200
<b>Prescription</b>	<b>Plan’s Coinsurance</b>
Prescriptions purchased at a retail pharmacy, except as otherwise specifically stated	Plan pays 80%
OTC Prilosec and OTC Loratadine upon a Physician’s written prescription	Plan pays 100%
Prescriptions purchased through the Specialty Drug Program	Plan pays 80%

Certain drugs will be subject to a prior authorization and some will also be subject to “Step Therapy”, split fills (i.e. a 30-day prescription will be filled in two 15-day increments to determine whether the drug is tolerated by participant to reduce waste) and quantity level limits (dispensing only quantities that will actually be used).

The Step Therapy program is a “step” approach to providing the medications that treat your condition. This means that you may first need to try a more clinically appropriate or cost-effective medication before certain higher-cost medications will be approved. Step Therapy programs can help both you and the Plan save money. A medication meets the Plan’s Step Therapy requirements if it is the most cost-effective medication available to treat a disease or condition. This means that if your doctor prescribes you a new medication that is subject to the Plan’s Step Therapy program, the Plan will initially only cover the least expensive “step” in that drug class, typically a generic drug. If the first step medication does not safely and effectively treat your condition, the Plan will cover the next “step”, typically a formulary brand medication.

If your doctor recommends prescription drugs or quantities that do not comply with the prior authorization and/or Step Therapy protocols, your doctor will need to submit a prior authorization (PA) request that will include the medical reasons supporting that request to Prime Therapeutics. Your doctor can visit MyPrime.com to download the PA form. If, as of August 1, 2019, you have started use of a prescription under the Plan’s schedule in a manner that does not follow the above rules, you will be grandfathered with regard to that prescription and with regard to the above rules for Step Therapy and prior authorization. To obtain a current list of these prescriptions, please call the Plan Administrator at (952) 851-5797.

**2.3. VISION CARE BENEFITS**

Below is the schedule of benefits for “Vision Care Benefits.”

<b>Services and Supplies</b>	<b>Maximum Plan Payment</b>
<b>Examination</b>	
One per Eligible Person over age 19 per Calendar year	\$50
One per Dependent Child under age 19 per Calendar year	100%
<b>Lenses</b>	
One set per Eligible Person per Calendar Year	
Single, each lens	\$37
Bifocal, each lens	\$64
Trifocal, each lens	\$78
Lenticular, each lens	\$140
Contacts, per set (or disposable contacts)**	\$87
One set per Eligible Person or Dependent Child under age 19 per Calendar year	100%
<b>Frames</b>	
One set per Eligible Person per Calendar Year	\$70
Maximum payment per set	

The amounts in the Maximum Plan Payment column show what the Plan will pay toward the listed services and supplies. The Eligible Person is responsible for all additional amounts and other charges.

\*\* The contact lens benefit is in lieu of all other lens and frame benefits for the Calendar Year.

**2.4. DENTAL CARE BENEFITS**

“Dental Care Benefits” are payable for full-time Eligible Employees and their Eligible Dependents and part-time Eligible Employees (and their Dependent Children, if applicable). The maximum annual dollar limit of \$1,250 described below in this Section does not apply to the following Dental Care Benefits for Eligible Employees or Eligible Dependents under age nineteen (19):

- A. Routine dental examinations;
- B. Sealants;
- C. Dental prophylaxis;
- D. Topical fluoride treatments; and
- E. X-rays.

Below is the schedule of benefits for Dental Care Benefits for Eligible Persons.

<b>Deductible amount per Eligible Person per Calendar Year for restorative and prosthetic services, including oral surgery</b>	\$25
<b>Plan’s Coinsurance</b> Diagnostic and Preventive Services Restorative Services Prosthetic Services	Plan pays 100% Plan pays 80% Plan pays 80%
<b>Calendar Year maximum aggregate amount payable per Eligible Person for diagnostic and preventive, restorative, and prosthetic services</b>	\$1,250
<b>Orthodontics</b> Deductible Amount Plan’s Coinsurance Orthodontic Lifetime maximum amount payable per Eligible Person Orthodontics services are available only for Eligible Dependents who are ages 8 through 18.	No Deductible Plan pays 50% \$1,500

**2.5. WEEKLY DISABILITY INCOME BENEFITS**

“Weekly Disability Income Benefits” are only available for full-time Eligible Employees.

Percentage of Average Weekly Wage	Plan pays 60%
Maximum weekly amount	\$300
Maximum number of weeks	26

**2.6. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

“Accidental Death and Dismemberment Benefits” are available for part-time Eligible Employees only and are insured through the Life Insurance Company.

F. Principal sum	G. \$1,000
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**2.7. LIFE INSURANCE BENEFITS**

“Life Insurance Benefits” are available for full-time Eligible Employees and their Dependents and part-time Eligible Employees (and their Dependent Children, if applicable) and are insured through the Life Insurance Company.

Full-time Eligible Employee	\$25,000
Full-time Eligible Employee's Spouse	\$2,000
Full-time Eligible Employee's Dependent Children:	
Fifteen (15) days to nineteen (19) years or twenty-five (25) years if full-time student	\$2,000
Part-time Eligible Employee	\$10,000

### **SECTION 3 PREFERRED PROVIDER NETWORKS**

#### **3.1. PREFERRED PROVIDER PRESCRIPTION DRUG PROGRAM**

H. When a full-time Eligible Employee or Eligible Dependent or a part-time Eligible Employee (and their Dependent Children, if applicable) opts to purchase Prescription Medications through the Preferred Provider Prescription Drug Program, benefits are payable subject to the following terms and conditions.

The Preferred Provider for the Prescription Drug Program is Prime Therapeutics (“Classic Network”). Only prescriptions that are purchased through this network will be covered.

##### **3.1.1. Payment of Benefits**

An Eligible Person must show his or her I.D. card at the network retail pharmacy to receive discounts through the Preferred Provider Prescription Drug Program and pay the required coinsurance at the time of purchase. Benefits are payable at the coinsurance stated in the Schedule of Benefits.

The Plan will provide coverage for specialty Prescription Medications through the specialty drug network. Benefits are payable at the coinsurance stated in the Schedule of Benefits.

##### **3.1.2. Eligible Expenses**

The expenses for Prescription Medications that are provided in Comprehensive Major Medical Benefits are also covered under the Preferred Provider Prescription Drug Program, except that injections and injectables are covered through the Specialty Drug Program.

##### **3.1.3. Generic Substitution Requirement**

Generic Prescription Medication will be substituted in lieu of any prescribed brand name Prescription Medication if it is commercially available and if such substitution is consistent with the prescription, the dispensing pharmacist’s professional judgement, and applicable law.

#### **3.2. PREFERRED PROVIDER NETWORK**

The Plan uses BlueCross BlueShield of Minnesota as its Preferred Provider Network. Although the Plan covers certain services at in-network and out-of-network Hospitals and services provided by Preferred Providers (“PPO Provider”) and non-participating providers (“Non-PPO Provider”), you will generally pay less if you use an in-network or PPO Provider.

A modified part-time Employee will become eligible as a part-time Eligible Employee even if an occasional full-time contribution is made on behalf of such Employee.

Effective April 26, 2019, all regular part-time, Group 3 part-time, and modified part-time Eligible Employees may self-pay for Ancillary Benefits (Dental Care, Vision Care, Life Insurance, Accidental Death and Dismemberment, and Employee Assistance Program benefits) prior to the Effective Date of Eligibility referenced in Section 4.2, if allowed by the applicable collective bargaining agreement.

#### **4.2. EFFECTIVE DATE OF ELIGIBILITY**

- A. An Employee becomes eligible under the Plan on the first day of the first month following satisfaction of the provisions in Section 4.1.C or 4.1.D.
- B. Coverage for Dependents is provided for full-time Eligible Employees only. Dependents become eligible under the Plan on the first day of the first month following the month the Employee satisfies the provisions in Section 4.1.C. If an Employee acquires a Dependent after his or her effective date, the new Dependent will be covered on the date he or she becomes such a Dependent.

Part-time Eligible Employees may purchase coverage for their Dependent Children only. If a part-time Eligible Employee purchases coverage for a Dependent Child, the Dependent Child will be covered under the Plan on the first day of the first month following receipt of the part-time Eligible Employee's payment for such coverage. Parents and other relatives are not eligible for Dependent coverage even if they are supported by the Eligible Employee.

- C. Opt-Out. An Eligible Employee may choose to "opt out" of coverage under the Plan for the Eligible Employee and his or her Dependents by completing and submitting the form designated by the Trustees to the Plan Administrator if both of the following circumstances are met:
  - 1. The Eligible Employee has satisfied the initial eligibility provisions under the Plan; and
  - 2. The terms of the collective bargaining agreement requiring contributions on behalf of the employee provide an "opt out of coverage" option.

If an Eligible Employee opts out of Plan coverage for himself or herself and his or her Dependents due to enrollment in other health insurance or group health insurance coverage, the Eligible Employee must state in writing that the Plan coverage is being declined due to enrollment in other health coverage at the time the Eligible Employee exercises his or her right to opt out of coverage under the Plan.

Except as provided in Section 4.2.D below, an Eligible Employee that opts out of Plan coverage for himself or herself and his or her Dependents will not be entitled to re-enroll in the Plan's coverage.

- D. Special Enrollment Rights.

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your

4. Physical, occupational, speech, and respiratory therapy; and
  5. Drugs and supplies prescribed by a Physician.
- G. Genetic testing and counseling, provided services are rendered for one (1) or more of the following reasons:
1. The Eligible Employee and/or the Employee's Dependents suffer from a disease that is known to have a genetic cause;
  2. A strong family history of a disease that is known to have a genetic cause is present even though neither the Eligible Employee, nor the Employee's Spouse has the disease. A strong family history means at least one (1) first-degree relative or at least two (2) second-degree relatives of the Employee or Spouse has been diagnosed with a disease that is known to have a genetic cause;
  3. The Eligible Employee and/or Spouse has produced a Child with mental retardation, a disease known to have a genetic cause, or a birth defect; or
  4. The Eligible Employee and/or a Spouse has had two (2) or more miscarriages or babies who died in infancy.

Genetic testing, except for amniocentesis and genetic testing that qualifies as Preventive Care, is subject to the separate annual maximum stated in the Schedule of Benefits.

- H. Conditions related to Gender Dysphoria, including supportive mental health counseling and treatment of any additional comorbid mental health conditions, appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, or genital reconstructive surgery where those interventions and treatments comply with all other provisions of the Plan. Any limitations on mental health counseling will be consistent with corresponding limitations on medical/surgical benefits under the Mental Health Parity and Addiction Equity Act ("MHPAEA"). Appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, and genital reconstructive surgery will be provided only if:
1. The Eligible Employee and/or the Employee's Dependents have undergone evaluation by a Qualified Mental Health Professional ("QMHP") experienced in the evaluation and treatment of patients with a variety of mental health issues and has the requisite skill and experience in evaluation of patients with Gender Dysphoria and all relevant comorbid mental health conditions, including familiarity in

the application of the Diagnostic Statistical Manual of Mental Disorders (“DSM V”), or the then current version of the DSM.

A Provider will be considered a QMHP if the Provider is a board-certified psychiatrist, psychologist, or an in-network master’s level Provider with a degree in a clinical behavioral science field from a nationally-accredited credentialing board and appropriately licensed in the jurisdiction in which the Provider practices and is qualified to evaluate and treat patients as noted above.

2. The Eligible Employee and/or the Employee’s Dependent must satisfy all criteria in the current version of the DSM.
3. The Eligible Employee and/or the Employee’s Dependent must have no confounding comorbid mental health conditions, which would be contraindications to treatment.
4. Treatment must have been recommended by a QMHP. The approval of the QMHP is to be administered so it does not constitute a prohibited non-quantitative treatment limitation (“NQL”) under the MHPAEA and the Plan imposes corresponding approval requirements for medical/surgical benefits.
5. Related surgical expenses are covered for an Eligible Employee and/or the Employee’s Dependent, subject to the following conditions:
  - (a) Well documented and persistent Gender Dysphoria;
  - (b) The Eligible Employee and/or the Employee’s Dependent must be age 18 or over;
  - (c) Two referral letters from QMHPs as described above; one of which must be the Eligible Employee’s and/or the Employee’s Dependents treating mental health professional and second from an additional QMHP who has performed an appropriate evaluation of the Participant;
  - (d) Documented control of any comorbid medical or mental health conditions that would render the Eligible Employee and/or the Employee’s Dependents incapable of making a fully informed decision or interfere with the diagnosis of Gender Dysphoria and substantially diminish the likelihood of a reasonable treatment outcome;

- (e) In the absence of a medical contraindication, complete twelve (12) months of continuous hormone therapy appropriate to the Eligible Employee's and/or the Employee's Dependents' gender goals and complete twelve (12) months of living in a congruent gender role;
  - (f) Obtain treatment from a Provider and facility with appropriate experience in the provision of the requested services; and
  - (g) Obtain precertification prior to surgical procedure.
6. Hormone therapy is covered for an Eligible Employees and/or Employee's Dependent under the Prescription Drug Benefit under the following conditions:
- (a) Completion of evaluations as outlined and have a diagnosis of Gender Dysphoria with no contraindications to treatment;
  - (b) Treatment must be ordered and supervised by a Provider experienced in the treatment of individuals with Gender Dysphoria;
  - (c) The Eligible Employee and/or the Employee's Dependent must obtain precertification prior to beginning therapy; and
  - (d) The Eligible Employee and/or the Employee's Dependent must be age 18 or over.
- I. Other covered expenses for:
- 1. Maternity and obstetrical services performed by a Nurse Midwife.
  - 2. Local ground and air ambulance services to the nearest Hospital equipped to furnish the Medically Necessary treatment in a medical emergency, not for family convenience.
  - 3. Blood and blood plasma.
  - 4. Health Services provided for the treatment of a full-time Employee's emotionally handicapped Dependent Children and furnished by a Residential Treatment Facility (included in the inpatient maximum stated in the Schedule of Benefits).
  - 5. Outpatient surgery performed in the outpatient department of a Hospital.

#### **5.4.2. Successive Periods of Disability**

Successive periods of disability separated by less than fourteen (14) days of continuous active employment will be considered one (1) period of disability unless they are due to separate and unrelated causes, in which case, the periods of disability will be deemed separate if the Employee returns to active work for at least one (1) day.

#### **5.4.3. Maximum Payment Amount**

Once the maximum benefit has been paid and the Eligible Employee has returned to work, the Employee will not be eligible for any further Weekly Disability Income Benefits until twelve (12) months from the date the Employee was paid the maximum benefit.

#### **5.4.4. Limitations**

Weekly Disability Income Benefits are not payable when the:

Eligible Employee is not under the care of a Physician;

Disability is due to a self-inflicted Injury, except when caused by or resulting from a physical or mental condition of the Eligible Employee;

Injury or illness arises out of, and in the course of, any occupation or employment for wage or profit; or

Eligible Employee has applied for pension benefits.

NOTE: Weekly Disability Income Benefits cannot be continued through self payments. However, an Employee may continue to self pay for all other coverage while collecting Weekly Disability Income Benefits.

### **5.5. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

I. Accidental Death and Dismemberment Benefits are available for part-time Eligible Employees only and are insured through the Life Insurance Company. In cases of conflict between this Summary Plan Description and the group policy, the group policy will govern.

#### **5.5.1. Determination of Benefit Amount**

If you suffer bodily injury caused by accidental means while you are a part-time Eligible Employee and the injury causes your death or any of the following specified losses within ninety (90) days of the date of the accident, the following benefits are payable based on the principal sum stated in the Schedule of Benefits:

(A) The principal sum for loss of life;

The principal sum for loss of two (2) limbs, sight of both eyes, or one limb and sight of one eye;

One-half of the principal sum for loss of one hand by severance at or above the wrist, loss of one foot by severance at or above the ankle, or irrecoverable loss of the entire sight of one eye; or

- D. One-quarter of the principal sum for loss of thumb and index finger of either hand.

If you suffer more than one (1) loss in an accident, payment will be made only for the loss for which the larger amount is payable. The Trustees may, at their own expense, require a physical examination while considering your claim or, if you die, an autopsy where law permits.

### **5.5.2. Limitations**

Accidental Death and Dismemberment Benefits do not cover losses from:

- (A) Intentionally self-inflicted injury or suicide, except when caused by or resulting from a physical or mental condition of the Eligible Employee;
- (B) Insurrection, war, or any act of war;
- (C) Participation in a riot;
- (D) Commission of an assault or felony;
- (E) Disease of the body, mental infirmity, bacterial infection (unless the infection is a result of accidental injury), or the taking of poison.

## **5.6. LIFE INSURANCE BENEFITS**

Life Insurance Benefits are available for full-time Eligible Employees and their Dependents and part-time Eligible Employees (and their Dependent Children, if applicable) and are insured through the Life Insurance Company. In cases of conflict between this Summary Plan Description and the group policy, the group policy will govern.

If you die from any cause, on or off the job, your Beneficiary will be paid the amount of insurance stated in the Schedule of Benefits. The benefit will be paid in full according to the terms of the policy upon receipt of your claim form, death certificate, and any other required supporting documentation.

Your Beneficiary designation and any change in Beneficiary must be filed in writing with the Fund Office on a properly completed form. It will become effective on the date the request is signed, provided the Life Insurance Benefit had not been paid already before the request is received. Your Beneficiary designation will be made available to you upon request at the Fund Office.

If you become disabled and subsequently die, and if anyone has paid expenses incurred because of your disability and death, the Plan may reimburse the amount paid, up to \$500, from the Life Insurance Benefit. A satisfactory receipt will be proof of expense. The balance of the Life Insurance Benefit will be paid to your Beneficiary.

**5.6.1. Designation of Beneficiary**

If you do not designate a Beneficiary or if your Beneficiary does not outlive you, the life insurance amount will be paid in a single sum to the first of the following classes that survives you:

- (A) Spouse;
- Children;
- Parents;
- Brothers and sisters; or
- Executors or administrators of your estate.

**5.6.2. Coverage During Total Disability**

If you become Totally Disabled before age sixty (60) and remain disabled, your Life Insurance Benefits may be continued with no additional cost to you as long as the disability continues. You must provide the Fund Office with written proof of your Total Disability within one (1) year of the date the disability begins, or as soon as reasonably possible. After the first two (2) years of disability, written proof of disability may be requested annually by Physicians chosen by the Life Insurance Company. The Life Insurance Company will pay for all such exams. Contact the Fund Office for details and appropriate forms to apply for waiver of premiums.

If you die within one (1) year after the date of termination of your insurance under the group life policy, but before written proof of your Total Disability has been received, then written proof that your Total Disability continued uninterrupted until the date of your death must be furnished within one year after your death occurs.

If an individual policy of life insurance has become effective for a Totally Disabled person according to the provisions of the conversion privilege set forth in the group life policy, the Total Disability benefits will apply to that person only if the individual policy is surrendered to the Company without claim thereunder other than for return of the premiums paid, less any indebtedness.

All rights under the Total Disability provisions listed in the group life policy will automatically and immediately cease on the earliest of the following dates:

- (B) The date your Total Disability no longer exists;
- The date you fail to submit to the required medical examination; or
- The date you fail to submit any required proof of the uninterrupted existence of your Total Disability.

If a death benefit is paid under the Total Disability section of the group policy, it will be in lieu of all other life insurance benefits provided by the group life insurance.

### **5.6.3. Employee Continuance of Life Insurance**

If your coverage for Life Insurance Benefits under the Plan ends because you are laid off, your employment ends, or you no longer satisfy the requirements for hours worked, you may continue life insurance for yourself and your Dependents for as long as eighteen (18) months by paying the required premium. You may not continue life insurance if your employment ends because you are discharged for gross misconduct or the policy is discontinued. The life insurance continued is the amount in force on the day insurance otherwise would have ended.

To continue life insurance, you must send the Fund Office written notice that you wish to continue life insurance along with the first monthly premium, payable at the Plan's full cost. You must do so within sixty (60) days of written notification from the Fund Office of your right to continue, including the premium amount and due date.

Continued life insurance ends on the earliest of:

- (A) The day insurance has been continued for eighteen (18) months;
- The day a conversion policy is obtained;
- The day you obtain coverage under another group policy, contract, or plan; or
- The day insurance otherwise would end according to policy provisions.

See the following section regarding conversion privilege when continued life insurance ends.

### **5.6.4. Conversion Privilege**

If your life insurance terminates as a result of termination of employment, transfer to a class of employees not eligible under the policy, or your disability, you may convert your insurance (and insurance on your Spouse and Children if you are a full-time Employee) to any form of individual policy of life insurance (without double indemnity or disability riders) then customarily issued by the Life Insurance Company, except a policy of term insurance.

If the Master Policy terminates or is amended so as to terminate your insurance, and you have been insured under the policy for at least five (5) years, you may convert your insurance (and your Dependents' insurance if you are a full-time Employee) for an amount not in excess of the smaller of:

- (B) \$5,000 for Employees and \$2,000 for Dependents; or

The amount of your terminated insurance, less any amount of life insurance for which you may be eligible under any other group policy that replaces it within thirty-one (31) days.

You have thirty-one (31) days to make application for conversion and pay the required premium following termination of your insurance. If you should die during this thirty-one (31)-day period, the amount of insurance that you would have had under the conversion

- I. Surrogate maternity services.
  - J. Services for which the Eligible Person is not required to pay.
  - K. Transportation, except local emergency ambulance services.
  - L. Abortions.
  - M. Reversal or attempted reversal of a previous sterilization procedure.
  - N. Any services and supplies for, or related to, artificial insemination, invitro fertilization services, or other treatment in an attempt to achieve pregnancy.
  - O. Services to the clergy during normal duty when a charge usually would not be made.
  - P. Reversal of genital surgery; hair replacement or removal; voice therapy or lessons; liposuction; rhinoplasty; breast augmentation; lip reduction; lip augmentation; laryngeal or thyroid cartilage shaving or contouring; abdominoplasty; chest wall contouring; body contouring; facial contouring; skin resurfacing; collagen injections; reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or Gender Dysphoria surgery; cryopreservation of fertilized embryos; oocyte preservation; surrogate parenting; donor eggs; donor sperm and host uterus; or any other service considered to be cosmetic or not Medically Necessary under the Plan.
  - Q. Any diagnostic Hospital admission that can be performed on an outpatient basis.
  - R. The first \$20,000 of charges incurred as a result of any automobile accident if:
    - 1. The Eligible Person fails to maintain the statutory minimum level of no fault automobile medical insurance protection, provided that the Eligible Person is required by applicable state law to maintain the protection;
    - 2. There is applicable no fault coverage but the Eligible Person has failed to apply for coverage;
    - 3. A no fault insurer has determined charges not to be Medically Necessary or Usual and Customary; or
    - 4. In states without a no fault statute, the Eligible Person does not first exhaust medical payment coverage on the vehicle(s) involved in the accident.
- In cases where a no fault carrier disputes coverage of the Eligible Person, the Plan may subrogate its interest in the payment of charges.
- S. Costs associated with the removal of organs from a transplant donor who is a living Eligible Person or who was an Eligible Person prior to his or her death.
  - T. Services privately contracted with a provider that otherwise would be covered by Medicare that are incurred by an Eligible Person for whom Medicare is the primary source of coverage.
  - U. Charges incurred for obtaining additional medical records.
  - V. Claims submitted later than fifteen (15) months from the date incurred.

- C. Apply the Trust Fund to pay for any and all obligations of the Trust and distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Trust and the requirements of law; and
- D. Give any notices and prepare any reports that may be required.

### **9.7. FUNDING OF BENEFITS**

Contribution payments are received and accepted by the Trustees from Employers party to collective bargaining agreements requiring the payment of contributions to this Plan in the amounts specified in the collective bargaining agreements. Self-payments from Eligible Employees with insufficient Employer contribution hours to maintain eligibility, former Employees, and retirees are received and accepted by the Trustees in amounts established by the Trustees from time to time. Investment earnings are used exclusively for providing benefits to Eligible Persons.

Benefits are provided directly from Plan assets, except that Life Insurance and Accidental Death and Dismemberment Benefits are provided through an insurance contract with the Life Insurance Company. Benefits eligible under the life insurance and accidental death and dismemberment policy are submitted to and paid by the Life Insurance Company.

All assets of the Plan are held by a custodian selected by the Trustees. A portion of Plan assets are allocated as reserves to provide future benefits under the Plan. The Trustees may, in their discretion, hire investment managers to invest any assets not needed for the immediate payment of benefits and other Plan expenses.

### **9.8. FUND RESERVES**

The Trustees maintain a reserve that, in their sole judgment, is adequate to maintain the Plan. The Trustees' determination regarding the level of reserves considers the length of the collective bargaining agreements, total Plan costs including claims paid and payable, extended eligibility as provided in the Eligibility Rules, extensions of coverage for benefits if provided in the Plan, and any other data the Trustees may consider necessary.

### **9.9. LIMIT OF FUND LIABILITY**

The Trustees maintain an excess Risk Indemnification Agreement that limits Plan liability for claims to an annual individual maximum. The individual maximum and other provisions are determined in accordance with the agreement, which is a part of the contract in effect between the Trustees and the contracting insurance carrier.

### **9.10. LIMITATION OF BENEFITS PAYABLE**

Benefits otherwise payable under this Plan will be limited by the Plan's assets, regardless of accumulated eligibility.

# Minneapolis Retail Meat Cutters & Food Handlers Health and Welfare Fund



Preparing today for a *secure* future.

3001 Metro Drive - Suite 500  
Bloomington, MN 55425

Online: [www.663benefits.com](http://www.663benefits.com)  
Phone: (952) 851-5797  
Toll Free: (844) 468-5917



## MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS HEALTH AND WELFARE FUND

### IMPORTANT NOTICE

#### Summary of Material Modifications

**TO:** Participants and Beneficiaries of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund

**FROM:** The Board of Trustees

**DATE:** March 2020

---

This is a Summary of Material Modifications (SMM) regarding the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (Plan). The Board of Trustees has amended the Plan Document and Summary Plan Description (amended and restated September 1, 2017) as indicated below.

#### Amendment No. 10: COVID-19 Coverage

Effective March 15, 2020, the Plan has been amended to provide coverage for medically necessary COVID-19 testing and the related office visit. The Plan will cover at 100% (no member cost share) claims incurred on or before April 30, 2020 for COVID-19 diagnostic testing and diagnosis as well as the related office (urgent care, emergency room) visit during which the treating health care provider determined such testing was medically necessary and appropriate according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health.

For purposes of Weekly Disability Income Benefits, the definition of Illness will also include quarantine or self-quarantine for members whose treating health care provider has provided written documentation stating that such quarantine is medically necessary or appropriate according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health because the individual has had exposure or suspected exposure to COVID-19.

**Please update your Plan Document and Summary Plan Description booklet (dated September 1, 2017) to reflect these changes by inserting the attached introduction page and replacement pages 7, 51 and 51A.**

**If you have any questions about these changes to the Plan, please contact the Plan Administrator at (952) 851-5797 or (844) 468-5917.**

- C. Meets the following criteria:
1. The patient and family are seen as the unit of care;
  2. An integrated, centralized administrative structure ensures continuity of care for home care and inpatient care;
  3. Direct provision of care is provided by an interdisciplinary team consisting of Physicians, nurses, social workers, chaplains, and volunteers;
  4. Volunteers are used to assist paid staff members; and
  5. Service is available twenty-four (24) hours a day, seven (7) days a week.

### **1.16. HOSPITAL**

“Hospital” means an establishment that meets all of the following requirements:

- A. Holds a license as a Hospital (if licensing is required in the state in which it is located);
- B. Operates primarily for the reception, care, and treatment of sick, ailing, or injured persons as inpatients;
- C. Provides nursing services by registered nurses (R.N.) twenty-four (24) hours a day;
- D. Has a staff of one (1) or more licensed Physicians available at all times;
- E. Provides organized facilities for diagnostic and major surgical facilities; and
- F. Is not primarily a clinic; nursing, rest, or convalescent home; or similar establishment.

“Hospital” also includes:

- A. A Residential Treatment Facility that is licensed by the Commissioner of Public Welfare (or other equivalent officer) for the state in which it is located for the treatment of emotionally handicapped Dependent Children under age eighteen (18) as defined by the rules of such Commissioner;
- B. A free-standing ambulatory surgical center that is approved as such by the applicable state; and
- C. A free-standing ambulatory medical center staffed to provide care twenty-four (24) hours a day, seven (7) days a week that is approved as such by the applicable state.

### **1.17. ILLNESS**

“Illness” means a bodily disorder or disease, pregnancy, or mental infirmity.

For purposes of Weekly Disability Income Benefits, Illness will also include quarantine or self-quarantine for members whose treating health care provider has provided written documentation

stating that such quarantine is medically necessary or appropriate according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health because the individual has had exposure or suspected exposure to COVID- 19.

24. Mastectomy bras, up to two (2) per Eligible Person per Calendar Year.
25. Jobst stockings, up to two (2) pair per Eligible Person per Calendar Year.
26. Discounted charges for walk-in clinics in retail settings.
27. The Plan will cover at 100% (no member cost share) claims incurred on or before April 30, 2020 for COVID-19 diagnostic testing and diagnosis as well as the related office (urgent care, emergency room) visit during which the treating health care provider determined such testing was medically necessary and appropriate according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health.

### **5.1.3. Preventive Care and Other Routine Care**

The deductible is waived for covered expenses related to the routine services described below. The Plan pays one hundred percent (100%) of the Usual and Customary Charges for products and services that meet the definition of Preventive Care. There is no cost-sharing for Preventive Care.

A. Routine physical examinations including charges for an examination, x-rays, and laboratory tests performed by a Physician or surgeon in a Hospital, clinic, or Physician's office. Covered expenses include:

1. For Eligible Dependents of an Eligible Employee, only routine office visits for the ongoing care of a well-baby and routine well child care, including professional services or supplies related to routine immunizations of Dependent Children. With respect to childhood immunizations, the Plan will cover those recommended by the American Academy of Pediatrics and those that satisfy the definition of Preventive Care.
2. Examinations required by third parties, including, but not necessarily limited to, schools, employers, insurance companies, camps, and adoption agencies.
3. Examinations for the purpose of contraceptive management, including a pelvic examination and pap-smear.

Benefits are not payable under this Routine Physical Examination Benefit for:

1. Routine immunizations or vaccinations, except as specifically stated;
2. Eye or dental examinations; or

3. Routine colonoscopy unless the colonoscopy is Preventive Care.
- B. Routine immunizations. With respect to childhood immunizations, the Plan will cover those recommended by the American Academy of Pediatrics, including but not limited to, those to prevent diphtheria, pertussis, tetanus, polio, measles, mumps, and rubella, and those that satisfy the definition of Preventive Care.



**MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS  
HEALTH AND WELFARE FUND**

**IMPORTANT NOTICE**

**Summary of Material Modifications**

**TO:** Participants and Beneficiaries of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund

**FROM:** The Board of Trustees

**DATE:** August 2020

---

This is a Summary of Material Modifications (SMM) regarding the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (Plan). The Board of Trustees has amended the Plan Document and Summary Plan Description (amended and restated September 1, 2017) as indicated below.

**Amendment No. 11: COVID-19 Coverage Revised**

Effective April 1, 2020, the Plan has been amended to remove the end date of April 30, 2020 for coverage of diagnostic testing and diagnosis for COVID-19 and to provide coverage for the duration of the national emergency surrounding COVID-19. The Plan also removed the exclusion for telehealth visits and provides coverage for telehealth visits, other than through Doctor on Demand, at the regular cost sharing amounts, unless the visit is for COVID-19, in which case the visit is covered at 100% (no member cost share).

**Amendment No. 12: Extension of Coverage for Cancelled Procedures**

Effective March 1, 2020, the Plan has been amended to extend coverage through December 31, 2020 for a medical or dental procedure for Participants or any Dependents who had the procedure scheduled prior to the declaration of the national emergency concerning COVID-19 but the procedure was then canceled due to COVID-19 and who lost coverage prior to the procedure being completed.

**Amendment No. 13: Extension of Timeframes for Outbreak Period**

Effective May 4, 2020 the Plan has been amended to adopt the Department of Labor's regulations regarding extending timeframes for special enrollment, COBRA coverage, COBRA payments, notification of a qualifying event or determination of disability, filing a claim, appealing an adverse benefit determination, and requesting an external review.

The Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known

as the "Outbreak Period." During the Outbreak Period, the following timeframes are disregarded and will resume at the end of the "Outbreak Period."

- The sixty (60) day window (or thirty (30) day window in the case of acquiring a new Dependent) in which you must request special enrollment under the Plan;
- The sixty (60) day window in which the Fund Office must be notified of a COBRA Qualifying Event;
- The sixty (60) day window in which you may elect for COBRA continuation coverage;
- The forty-five (45) day deadline to make the initial Self Payment, and the thirty (30) day grace period for making subsequent self-payments;
- The sixty (60) day window in which the Qualified Beneficiary must notify the Fund Office of a Social Security Disability Determination;
- The ninety (90) day deadline for filing a post-service claim;
- The one hundred eighty (180) day window in which a claimant may file an appeal of a denial of benefits; and
- The four (4) month window in which you may file a request for an external review

**Please update your Plan Document and Summary Plan Description booklet (dated September 1, 2017) to reflect these changes by inserting the attached introduction page and replacement pages 16, 24, 24A, 27, 27A, 30, 30A, 51, 51A, 60, 60A, 69, 70, 71, 76, 76A and 78.**

**If you have any questions about these changes to the Plan, please contact the Plan Administrator at (952) 851-5797 or (844) 468-5917.**

**SECTION 2 SCHEDULE OF BENEFITS**

**2.1. COMPREHENSIVE MAJOR MEDICAL BENEFITS**

Below is the schedule of benefits for “Comprehensive Major Medical Benefits.”

**PLEASE NOTE: Out-of-network non-emergency inpatient services are excluded from coverage (see Section 6).**

Deductible amount per Calendar Year	
Per Eligible Person	\$750
Per Family	\$2,250
Copayment	\$25 per office visit \$50 per specialist visit \$250 per emergency room visit
Plan’s Coinsurance (including In-Hospital and Physician’s Services and Out-of-Hospital Major Medical Services)	Plan pays 80%
Out-of-pocket maximum per Calendar Year (including the deductible)	
Per Eligible Person	\$3,000
Per Family	\$6,000
<i>The Plan generally pays 100% of covered expenses in excess of the out-of-pocket maximum for remainder of that Calendar Year</i>	
Preventive Care (including routine immunizations that are Preventive Care)	Plan pays 100%
Routine Physical Examinations that are not Preventive Care per Eligible Person per Calendar Year	Plan pays 100%
<b>Doctor on Demand</b>	Plan pays 100%
Telehealth visits other than through Doctor on Demand	Plan pays 80%, unless the visit is for COVID-19, in which case the Plan pays 100%

Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within thirty (30) days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Once you submit your enrollment request, your employer will again begin to make contributions to the Plan on your behalf.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within thirty (30) days after the date of marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at (844) 468-5917.

Notwithstanding any other provision of the Plan to the contrary, an Eligible Employee or Dependent is entitled to special enrollment rights under the Plan as required by applicable law under the following circumstances:

1. An Employee or Dependent's coverage under a Medicaid Plan or under a state children's health insurance program is terminated as a result of loss of eligibility for such coverage, and the Employee or Dependent requests coverage under the Plan not later than sixty (60) days after the date of termination of such coverage.
2. An Employee or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid Plan or through a state children's health insurance program with respect to coverage under the Plan and the Employee or Dependent requests coverage under the Plan not later than sixty (60) days after the date the Employee or Dependent is determined to be eligible for the assistance.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the sixty (60) day window (or thirty (30) day window in the case of acquiring a new Dependent) in which you must request special enrollment under the Plan for the circumstances listed above is disregarded and resumes at the end of the Outbreak Period.

**CAUTION** – in order to be able to re-enroll or enroll a Dependent in the Plan after having opted-out, you must be eligible for coverage. If, during the time you were in opt-out status, you lost eligibility because your Employer had stopped making contributions on your behalf, you will be required to again meet the Plan's rules for eligibility before being allowed to resume coverage. For part-time Employees who have not had a break in service and full-time Employees, this means earning at least eight (8) weeks of contributions in twelve (12) consecutive weeks of

employment. A part-time Employee who goes six (6) consecutive months with no Employer contributions will suffer a break in service. When that happens, the part-time Employee must re-qualify as a new Eligible Employee by working twelve (12) months during which at least one Employer contribution is made. These rules are further stated in Section 4.6.

#### **4.3 CONTINUATION OF ELIGIBILITY THROUGH EMPLOYMENT**

An Employee's continued eligibility is determined weekly. Once an Employee has established eligibility, it will continue so long as required Employer contributions to the Plan are made on the Employee's behalf for each subsequent week.

The amount of the Employer contribution is based on the number of hours worked per week, the Employee classification and the weekly rate specified by the collective bargaining agreement in effect at the time the contributions are earned. The collective bargaining agreement requires Employer contributions to be paid when an Employee meets the criteria for a specified employment classification (full-time Employee or modified part-time Employee) and works a specified amount of required hours. Generally, the amount of the Employer contribution determine whether the Employee is covered under as a full-time Eligible Employee or a part-time Eligible Employee.

If, in any week, an Employer does not make either the modified part-time or full-time contribution, as applicable, on an Employee's behalf because the Employee has not worked the required number of hours, the Employee may pay that weekly contribution himself to continue coverage, but only if actively working or scheduled to work.

Office within sixty (60) days of the Qualifying Event will cause a person to lose the opportunity to continue coverage.

Employers notify the Trustees of Qualifying Events, such as a reduction in an Employee's hours and an Employee ceasing active work, through the Employer Reports. Notices explaining the right to continue coverage will be furnished to Employees and Dependents when such a Qualifying Event occurs.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the sixty (60) day window in which the Fund Office must be notified of a COBRA Qualifying Event is disregarded and resumes at the end of the Outbreak Period.

- B. The Trustees' Responsibility to Notify a Qualified Beneficiary When the Qualifying Event is Loss of Coverage Due to the Employee's Death, Divorce, or Legal Separation or a Dependent Child No Longer Meets the Definition of Dependent. Not later than fourteen (14) days after receipt of notice from an Employee or Dependent, the Fund Office will advise the Qualified Beneficiary of the coverages, options, costs, self-payment due dates, and duration of self-payment privileges.
- C. The Trustees' Responsibility to Notify a Qualified Beneficiary When Other Qualifying Events Occur. Not later than thirty (30) days after receipt of notice of an Employee's loss of coverage from the Employer or by examining monthly contribution reports, the Fund Office will advise the Qualified Beneficiary of the coverages, options, costs, self-payment due dates, and duration of self-payment privileges.
- D. Due Date for Qualified Beneficiaries' Response. A Qualified Beneficiary has sixty (60) days from the date of coverage termination or the receipt of the COBRA notice, whichever is later, to elect whether to continue coverage. The election must be communicated to the Fund Office in writing on an Election Form. Each Employee, Spouse, and Dependent Child has the right to make an individual election; however, covered Employees may elect to continue coverage on behalf of their Spouses, and parents may elect to continue coverage on behalf of their Children. Failure to state the election to the Fund Office within sixty (60) days from the date of coverage termination or the receipt of the COBRA notice, whichever is later, terminates rights to continued coverage.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the sixty (60) day window in which you may elect for COBRA

continuation coverage is disregarded and resumes at the end of the Outbreak Period.

**E. Due Dates for Self-Payments.**

1. The required initial self-payment must be made to the Fund Office not later than forty-five (45) days following the election to continue coverage (which is the post-mark date, if mailed). Failure to do so will cause eligibility and coverage to terminate retroactively to the later of the Qualifying Event or loss of eligibility and will cause loss of all continuation coverage rights under the Plan. The amount of the first self-payment is for the time period beginning with the date of the Qualifying Event and extending through the month in which payment is made.
2. Subsequent monthly self-payments must be made to the Fund Office by the first day of the month for that month of coverage. The Plan allows a thirty (30) day grace period for making self-payments.
3. Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the forty-five (45) day deadline to make the initial Self Payment, and the thirty (30) day grace period for making subsequent self-payments, are disregarded and resume at the end of the Outbreak Period.

1. The Employee has remained continuously employed by the same Employer; and
2. The Employee is ready, willing, and able to return to full-time employment when it becomes available.

F. Cessation of Active Work.

1. If an Employee ceases active work due to lay-off, work stoppage, resignation, or dismissal, coverage may be continued for up to eighteen (18) months from the time coverage ceases.
2. If an Employee ceases active work due to a disability or sick leave:
  - (a) The Employee may continue coverage for of eighteen (18) months; or
  - (b) The Employee (or any other Qualified Beneficiary) may continue coverage for him or herself and his or her Dependents for up to twenty-nine (29) months of disability if:
    - i. The Social Security Administration (SSA) determines that any of the Qualified Beneficiaries are disabled under the Social Security Act either: (i) at the time employment terminated or hours were reduced; or (ii) at any time within sixty (60) days of the Qualifying Event;
    - ii. The disability lasts at least until the end of the eighteen (18) month period of continuation coverage; and
    - iii. The Qualified Beneficiary notifies the Fund Office in writing within sixty (60) days of the SSA determination and before the end of the first eighteen (18) months of continuation coverage and provides a copy of the Social Security Disability Determination to the Fund Office.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the sixty (60) day window in which the Qualified Beneficiary must notify the Fund Office of a Social Security Disability Determination is disregarded and resumes at the end of the Outbreak Period.

Each Qualified Beneficiary who has elected continuation coverage will be entitled to the eleven (11) month disability extension if one (1) of them qualifies. If the Qualified Beneficiary is determined by SSA to no longer be disabled, the Qualified Beneficiary must notify the Fund Office within thirty (30) days after the SSA determination.

Failure to provide notice of a disability may affect the right to extend the period of continuation coverage.

**[SECTION CONTINUES ON NEXT PAGE]**

24. Mastectomy bras, up to two (2) per Eligible Person per Calendar Year.
25. Jobst stockings, up to two (2) pair per Eligible Person per Calendar Year.
26. Discounted charges for walk-in clinics in retail settings.
27. For the duration of the national emergency concerning COVID-19, the Plan will cover at 100% (no member cost share) claims for COVID-19 diagnostic testing and diagnosis as well as the related office (urgent care, emergency room) visit during which the treating health care provider determined such testing was medically necessary and appropriate according to the accepted guidelines of the Federal Food and Drug Administration (“FDA”) and/or the respective state Department of Health.
28. Effective March 1, 2020, the Plan will pay claims for a medical or dental procedure for a Participant or Participant’s Dependent(s) that was scheduled to occur prior to the declaration of the national emergency concerning COVID-19 on March 13, 2020 (“National Emergency”) and was canceled by the health care or service provider due to the National Emergency, and who subsequently had his or her coverage terminated under the Plan before the procedure could be completed. To be eligible for coverage for such procedure, Participants and/or Dependent(s) must provide documentation to the Fund Office demonstrating that (1) the procedure was originally scheduled prior to the National Emergency for a date after such declaration; (2) the procedure was canceled by the health care or service provider after the commencement of the National Emergency; and (3) and the procedure was rescheduled and performed no later than December 31, 2020.

### **2.1.2. Preventive Care and Other Routine Care**

The deductible is waived for covered expenses related to the routine services described below. The Plan pays one hundred percent (100%) of the Usual and Customary Charges for products and services that meet the definition of Preventive Care. There is no cost-sharing for Preventive Care.

- A. Routine physical examinations including charges for an examination, x-rays, and laboratory tests performed by a Physician or surgeon in a Hospital, clinic, or Physician’s office. Covered expenses include:
  1. For Eligible Dependents of an Eligible Employee, only routine office visits for the ongoing care of a well-baby and routine well child care, including professional services or supplies related to routine immunizations of Dependent Children. With respect to childhood immunizations, the Plan will cover those recommended by the

American Academy of Pediatrics and those that satisfy the definition of Preventive Care.

2. Examinations required by third parties, including, but not necessarily limited to, schools, employers, insurance companies, camps, and adoption agencies.
3. Examinations for the purpose of contraceptive management, including a pelvic examination and pap-smear.

Benefits are not payable under this Routine Physical Examination Benefit for:

1. Routine immunizations or vaccinations, except as specifically stated;
2. Eye or dental examinations; or
3. Routine colonoscopy unless the colonoscopy is Preventive Care.

- B. Routine immunizations. With respect to childhood immunizations, the Plan will cover those recommended by the American Academy of Pediatrics, including but not limited to, those to prevent diphtheria, pertussis, tetanus, polio, measles, mumps, and rubella, and those that satisfy the definition of Preventive Care.

- G. Services performed before the effective date of the Eligible Person's coverage under this Plan.
- H. Charges for dental services performed after the termination of the Eligible Person's coverage under this Plan, except for services performed within thirty (30) days after such termination, that are needed to complete a single procedure commencing on or before the termination date.
- I. Charges for dental treatment in excess of the usual and customary charge or in excess of the maximum benefit payable as indicated in the Schedule of Benefits.
- J. Charges for any dental procedures performed solely because the Eligible Person has changed Dentists.
- K. Composite resin or acrylic restorations in occlusal and proximal surfaces of posterior teeth. An allowance will be made for amalgam restorations for those areas.
- L. Crowns and dental implants when used as abutments for prosthetics.
- M. Orthodontic services other than for eligible Dependent Children.
- N. Restorations for identification purposes.
- O. Repair or replacement of a retainer, even if lost or stolen.
- P. Charges for dental procedures performed after the termination of the Eligible Person's coverage under this Plan, except for procedures that were scheduled to occur prior to the declaration of the national emergency concerning COVID-19 on March 13, 2020 ("National Emergency") and were canceled by the health care or service provider due to the National Emergency. To be eligible for extended coverage for such procedure, the Eligible Person must provide documentation to the Fund Office demonstrating that (1) the procedure was originally scheduled prior to the National Emergency for a date after such declaration; (2) the procedure was canceled by the health care or service provider after the commencement of the National Emergency; and (3) and the procedure was rescheduled and performed no later than December 31, 2020.

#### **5.4 WEEKLY DISABILITY INCOME BENEFITS**

Only full-time Eligible Employees are eligible for Weekly Disability Income Benefits, which are subject to the conditions of this Section.

##### **5.4.1. Payment of Benefit**

The Weekly Disability Income rate is stated in the Schedule of Benefits. The Weekly Disability Income Benefit is payable when a full-time Eligible Employee who is covered under the Plan becomes Totally Disabled because of a non-occupational Injury or Illness

that prevents the Employee from working. The Totally Disabled Employee must be under the care of a Physician to receive the benefit. The Schedule of Benefits states how the benefit is calculated, the maximum weekly amount, and the maximum number of weeks the benefit is payable for any one (1) period of disability.

Weekly Disability Income Benefits begin with:

- A. The first (1<sup>st</sup>) day of disability due to an Injury; or
- B. The eighth (8<sup>th</sup>) day of disability due to an Illness.

- W. Medical Expenses a third party (such as the driver of a car that caused an accident for which medical expenses were incurred) was responsible for paying if the Eligible Employee or Dependent, whether or not a minor, did not comply with the subrogation provisions of this Plan stated in Section 8.7.
- X. Charges incurred for any special education rendered to any Eligible Person, regardless of the type of education, except for education that qualifies as Preventive Care or as otherwise specifically stated.
- Y. Charges for special home construction to accommodate a disabled Eligible Person.
- Z. Charges incurred for completing claims forms (or forms required by the Plan for processing claims) by a Physician or other provider of medical services or supplies.
- AA. Any losses incurred by an Eligible Person at a time the Eligible Person owes payment to the Plan because of benefit payments made in reliance upon incorrect, misleading, or fraudulent statements or representations by the Eligible Person, or where such person has failed to honor the Plan's right of subrogation or reimbursement or otherwise failed to cooperate with the Plan as specified.
- BB. Radial keratotomy or Lasik surgery.
- CC. State and local taxes (other than those mandated by law that the Plan must pay, such as MinnesotaCare tax) or shipping and handling charges incurred on covered expenses.
- DD. Drugs or medicines prescribed by a Physician that are available as over-the-counter (OTC) purchases, including but not limited to, cough medicine, vitamin supplements, etc. (except as specifically provided through the Preferred Provider Pharmacy Program for OTC Prilosec and Loratadine), unless the prescription qualifies as Preventive Care.
- EE. Charges incurred for travel, whether or not recommended by a Physician, except if specified as a covered expense under the Plan.
- FF. Charges incurred for gambling addiction in a residential treatment program.
- GG. Any loss caused by, or resulting from, mental deficiency, mental retardation, developmental deficiencies, genetics, or any treatment for learning disabilities, except as otherwise specifically stated.
- HH. Any loss, expense, or charge for which:
  - 1. A third party may be liable; and

2. Either:
  - a. A recovery subject to the Plan's subrogation and reimbursement rights has been received (whether before or after the submission of or payment of claims by the Plan); or
  - b. The Plan deems it likely that recovery will be received.

At the discretion of the Trustees, losses, expenses, and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement. As used in this Section, the term "third party" includes any individual, insurer, entity, or federal, state or local government agency who is or may be in any way legally obligated to reimburse, compensate, or pay for an Eligible Person's loss, damages, Injuries or claims relating in any way to the Injury, occurrence, condition, or circumstance giving rise to the Plan's provision of medical, dental, or disability benefits, including but not limited to, insurers providing liability, medical expense, wage loss, uninsured motorist, or under-insured motorist coverages.

- II. Any loss, expense, or charge incurred as the result of any Injury, occurrence, conditions or circumstance for which the injured Eligible Person:
  1. Has the right to recover payment from a third party (at the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement);
  2. Has recovered from a third party; or
  3. Has not submitted a claim for the loss, expense, or charge prior to resolution of the third party claim.
- JJ. Charges for Injury or Illness resulting from the Eligible Person's participation in a riot or the Eligible Person's commission of any act that may be charged as a felony or gross misdemeanor offense, except in circumstances involving domestic violence or when the commission of the gross misdemeanor or felony is caused by a mental health condition.
- KK. Charges for any Injury or Illness that results from an incident occurring on any property where the lessee or lessor or owner of the property is responsible for Injury or Illness or what otherwise is covered under homeowner's insurance. However, the Plan will consider the charges if: no insurance or other form of compensation is available to the Eligible Person; and the Eligible Employee signs a subrogation agreement in the form designated by the Trustees with the Plan.
- LL. Charges for PCSK9 drugs and drugs containing bulk powders unless the Eligible Person receives preauthorization by the Plan for such drugs.
- MM. Charges for out-of-network inpatient services unless it is a "Medical Emergency." For purposes of this coverage exclusion, the term "Medical Emergency" means a condition that starts suddenly and requires immediate care (within forty-eight (48) hours) to prevent serious harm to a major organ, life, or limb.

## SECTION 7 CLAIMS, REVIEW, AND APPEAL PROCEDURES

### 7.1. CLAIMS PROCEDURE

The following procedures have been established by the Trustees for processing claims. For claims involving Plan benefits that are insured, the terms of the insurance policy will govern in the event of a conflict.

#### 7.1.1. Notice of Claim

A. Pre-Service Claims. An Eligible Person must obtain:

1. Prior authorization for prophylactic mastectomies;
2. Certification of Medical Necessity for chiropractic visits exceeding twenty (20) per Eligible Person per Calendar Year;
3. Prior approval for the purchase of certain durable medical equipment specified in Subsection **Error! Reference source not found.**; and
4. Predetermination for certain dental services as specified in Section **Error! Reference source not found.**

The claims listed above are called “pre-service claims,” which are claims that require approval of the benefit in advance of obtaining medical care. Claims requiring prior authorization must be submitted in writing to the Fund Office.

There are special provisions in the Claims Procedure Regulations for “urgent care claims” (referred to under the Plan as “emergencies”), but, by definition, these provisions do not apply because the Plan does not require prior authorization of emergency admissions.

B. Post-Service Claims. Any Claim for benefits that is not a pre-service claim is considered a “post-service claim.” An Eligible Person must submit all post-service claims in writing within ninety (90) days of the occurrence of the accident or illness or as soon as reasonably possible. In no event (except in the absence of legal capacity) can a claim be submitted later than fifteen (15) months from the date of service.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the “Outbreak Period.” During the Outbreak Period, the ninety (90) day deadline for filing a post-service claim is disregarded and resumes at the end of the Outbreak Period.

- J. Contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.
- K. If the claim for benefits is denied based upon a disability determination, the notice will provide an explanation of the basis for agreeing or disagreeing with the following:
  - 1. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - 2. The review of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
  - 3. A disability determination regarding the claimant made by the Social Security Administration if such determination is presented by the claimant to the Plan.

### **7.3 APPEAL PROCEDURE**

If all or part of a claim is denied, if a claimant is otherwise dissatisfied with the determination made by the Plan, or if the claimant has not received the notice of denial of the claimant's claim within the applicable time limits after the Plan has received all necessary claim information, the claimant has the right to appeal the decision and request a review of the claim. The Plan will provide for a full and fair review of a claim and adverse benefit determination, pursuant to the following:

- A. A claimant will have one hundred eighty (180) days after the claimant receives the notice of an adverse benefit determination to file the claimant's appeal in writing to the Fund Office, and it must include the specific reasons the claimant feels denial was improper.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the one hundred eighty (180) day window in which a claimant may file an appeal of a denial of benefits is disregarded and resumes at the end of the Outbreak Period.
- B. A claimant will be allowed the opportunity to submit written issues and comments, documents, records, and other information relating to the claim for benefits that may have been requested in the notice of denial or that the Eligible Employee may consider desirable or necessary, but neither the claimant nor representative of the claimant will have the right to appear in person before the Board of Trustees.
- C. A claimant or duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all designated, pertinent documents, records, and other information relevant to the Employee's claim for benefits

- D. The review will take into account all comments, documents, records, and other information related to the claim that are submitted by the claimant, whether or not such information was submitted or considered in the initial benefit determination.
- E. The Board of Trustees, as an appropriate named fiduciary for the Plan, will be the assigned decision maker on appealed claims.

#### **7.4. EXTERNAL REVIEW**

The Plan will permit external review of benefit determinations in accordance with Section 2719 of the Public Health Service Act and its implementing regulations. If the Plan denies your claim and your appeal, you may seek external review of the Plan's decision. To seek external review, you must file a request with the Fund Office within four (4) months from the date you receive notice that the Plan denied your appeal. For more information on external review, contact the Fund Office.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the four (4) month window in which you may file a request for an external review is disregarded and resumes at the end of the Outbreak Period.

#### **7.5. PHYSICAL EXAMINATIONS**

The Plan, at its own expense, will have the right and opportunity to examine an Eligible Person whose illness is the basis of a claim when, and as often as, it may reasonably require during pendency of a claim under the Plan.

#### **7.6. RECORDS**

Each Eligible Person authorizes and directs any provider that has attended, examined, or treated him to furnish the Fund, at any time upon its request, any and all information and records or copies of records relating to provided services. The Fund agrees that any information and records obtained pursuant to this Section will be considered confidential and will be protected in accordance with HIPAA requirements and Section 10.2.

#### **7.7. ACTIONS AGAINST THE PLAN**

No Eligible Person may bring an action at law or in equity, including proceedings before administrative agencies, to recover from the Plan until the Claims Review and Appeal Procedure stated in Section 7.2 has been exhausted. No action may be brought at all unless it is brought within two (2) years from the time the claim was required to be filed with the Plan.

#### **7.8. ASSIGNMENT OF RIGHTS AND APPOINTING AN AUTHORIZED REPRESENTATIVE TO ACT ON YOUR BEHALF**

An authorized or legal representative may act on behalf of a claimant in filing a claim or pursuing an appeal of an adverse benefit determination. The claimant must first submit a signed letter to the Fund Office specifically identifying the person as the authorized or legal representative of the claimant. Neither the claimant nor any duly authorized representative will have the right to make a personal appearance before the Board of Trustees or any committee created by the Board of Trustees. Although a claimant may appoint an authorized representative to act on their behalf, under no circumstances may a claimant assign any rights under the Plan or ERISA, including any rights to appeal adverse benefit determinations or any causes of action that may arise after the denial of benefits.



## MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS HEALTH AND WELFARE FUND

### IMPORTANT NOTICE

#### Summary of Material Modifications

TO: Participants and Beneficiaries of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund

FROM: The Board of Trustees

DATE: October 2021

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This is a Summary of Material Modifications (“SMM”) regarding the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (the “Plan”). The Board of Trustees has amended the Plan Document and Summary Plan Description (amended and restated September 1, 2017) as indicated below.

#### Amendment No. 14: COBRA Continuation Coverage and Medicare Eligibility

Effective October 14, 2020, the Plan has been amended to incorporate the Department of Labor’s proposed notice to Participants and Beneficiaries regarding the interaction between COBRA continuation coverage and Medicare eligibility, which is summarized below.

You may have other options available to you other than COBRA continuation coverage if you lose group health coverage through the Plan. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally does not accept late enrollees. There may also be other coverage options for you and your family through Medicare, Medicaid, Children’s Health Insurance Program (“CHIP”), or other group health plan coverage options. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at <https://www.healthcare.gov>.

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period you have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

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

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A

or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. For more information, see <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information, visit <https://www.medicare.gov/medicare-and-you>.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator, whose contact information is below. For more information about your rights under the Employee Retirement Income Security Act (“ERISA”), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (“EBSA”) in your area or visit <https://www.dol.gov/ebsa>. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

To protect your family’s rights, let the Plan Administrator know about 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.

#### Amendment No. 15: Tolling Period Updates

Effective April 9, 2021, in response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes relating to certain notification, payment, and claims-related deadlines for Plan participants and beneficiaries.

Starting on March 1, 2020, the timeframes for you to request special enrollment, elect COBRA coverage, make COBRA self-payments, notify the Plan of a qualifying event or determination of disability, file a claim, appeal an adverse benefit determination, or request an external review were suspended during a “Tolling Period,” which ends on the earlier of:

- Sixty days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the “Outbreak Period”); or
- One year from the date you were first eligible for relief from the deadline or timeframe for a circumstance listed above. The earliest date that you were first eligible for relief from a deadline or timeframe for a circumstance listed above was either:
  - March 1, 2020 for events occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline or timeframe must have been on or after March 1, 2020; or
  - Upon the occurrence of an event initiating a deadline or timeframe occurring after March 1, 2020, but before March 1, 2021.

The following timeframes are disregarded during a Tolling Period:

- The 60-day window (or 30-day window in the case of acquiring a new Dependent) in which you must request special enrollment under the Plan;
- The 60-day window in which the Fund Office must be notified of a COBRA Qualifying Event;
- The 60-day window in which you may elect for COBRA continuation coverage;
- The 45-day deadline to make the initial COBRA self-payment and the 30-day grace period for making subsequent self-payments;
- The 60-day window in which the Qualified Beneficiary must notify the Plan Administrator of a Social Security Disability Determination;
- The 90-day deadline for filing a post-service claim;
- The 180-day window in which you may file an appeal of a denial of benefits; and
- The four-month window in which you may file a request for an external review.

#### Amendment No. 16: COBRA Subsidies and Extended Election Period

Effective April 1, 2021, the Plan was amended to provide subsidized COBRA continuation coverage and extended election opportunities as provided by federal law.

During the period from April 1, 2021 through September 30, 2021 (the “Subsidy Period”), any “Assistance Eligible Individual” is not required to make self-payments for COBRA continuation coverage. An “Assistance Eligible Individual” is an individual who is enrolled in COBRA continuation coverage during the Subsidy Period if he or she became eligible for COBRA continuation coverage due to a loss of coverage under the Plan resulting from the Employee’s involuntary termination of employment (other than termination for gross misconduct) or a reduction of hours.

In addition, any individual who could be an Assistance Eligible Individual during the Subsidy Period except for the fact that he or she stopped making the required COBRA continuation coverage self-payments or never enrolled in COBRA continuation coverage is allowed another opportunity to elect (or re-elect) COBRA continuation coverage during the 60-day period following the date that he or she received the initial notice from the Plan Administrator about the special COBRA continuation coverage election opportunity. If an individual becomes an Assistance Eligible Individual enrolled in COBRA continuation coverage under this extended election period, the maximum COBRA continuation coverage period will not extend beyond the last day that the Assistance Eligible Individual would have been eligible for COBRA continuation coverage had he or she not stopped making self-payments or had enrolled in COBRA continuation coverage when it was first offered.

Subsidized COBRA continuation coverage will end if an Assistance Eligible Individual becomes eligible for coverage under another group health plan or Medicare. If this is the case, an Assistance Eligible Individual is required to notify the Plan Administrator about the group health plan or Medicare eligibility.

Amendment No. 17: Dental Care Benefits Schedule

Effective January 1, 2021, the Plan was amended to change the schedule for certain covered diagnostic and preventive dental services from a rolling 12-month basis to a Calendar Year basis.

**Please update your Plan Document and Summary Plan Description booklet (dated September 1, 2017) to reflect these changes by inserting the attached replacement/supplemental pages 24, 24A, 25, 25A, 27, 27A, 27B, 27C, 30, 30A, 30B, 33, 33A, 33B, 57, 71, 71A, 76, 76A, 78, and 78A.**

**If you have any questions about these changes to the Plan, please contact the Plan Administrator at (952) 851-5797 or (844) 468-5917.**

Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within thirty (30) days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Once you submit your enrollment request, your employer will again begin to make contributions to the Plan on your behalf.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within thirty (30) days after the date of marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at (844) 468-5917.

Notwithstanding any other provision of the Plan to the contrary, an Eligible Employee or Dependent is entitled to special enrollment rights under the Plan as required by applicable law under the following circumstances:

1. An Employee or Dependent's coverage under a Medicaid Plan or under a state children's health insurance program is terminated as a result of loss of eligibility for such coverage, and the Employee or Dependent requests coverage under the Plan not later than sixty (60) days after the date of termination of such coverage.
2. An Employee or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid Plan or through a state children's health insurance program with respect to coverage under the Plan and the Employee or Dependent requests coverage under the Plan not later than sixty (60) days after the date the Employee or Dependent is determined to be eligible for the assistance.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes in which you must request special enrollment under the Plan for the circumstances listed above.

Starting on March 1, 2020, the deadline for you to request special enrollment under the Plan for the circumstances listed above was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date you were first eligible for relief from the deadline to request special enrollment under the Plan for the circumstances listed above. The earliest date that you were first eligible for relief from a deadline to request special enrollment under the Plan for the circumstances listed above was either:

1. March 1, 2020 for special enrollment events occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. Upon the occurrence of a special enrollment event occurring after March 1, 2020, but before March 1, 2021.

The calculation of your Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to you specifically. The Tolling Period may not exceed one (1) year. If your eligibility to request special enrollment under the Plan began prior to March 1, 2020, the number of days by which you are required to take action after the Tolling Period is shortened by the number of days between the date your eligibility to request special enrollment under the Plan began and March 1, 2020 (the “Proration Rule”).

**CAUTION** – in order to be able to re-enroll or enroll a Dependent in the Plan after having opted-out, you must be eligible for coverage. If, during the time you were in opt-out status, you lost eligibility because your Employer had stopped making contributions on your behalf, you will be required to again meet the Plan’s rules for eligibility before being allowed to resume coverage. For part-time Employees who have not had a break in service and full-time Employees, this means earning at least eight (8) weeks of contributions in twelve (12) consecutive weeks of employment. A part-time Employee who goes six (6) consecutive months with no Employer contributions will suffer a break in service. When that happens, the part-time Employee must re-qualify as a new Eligible Employee by working twelve (12) months during which at least one Employer contribution is made. These rules are further stated in Section 4.6.

#### **4.3 CONTINUATION OF ELIGIBILITY THROUGH EMPLOYMENT**

An Employee’s continued eligibility is determined weekly. Once an Employee has established eligibility, it will continue so long as required Employer contributions to the Plan are made on the Employee’s behalf for each subsequent week.

The amount of the Employer contribution is based on the number of hours worked per week, the Employee classification and the weekly rate specified by the collective bargaining agreement in effect at the time the contributions are earned. The collective bargaining agreement requires Employer contributions to be paid when an Employee meets the criteria for a specified employment classification (full-time Employee or modified part-time Employee) and works a specified amount of required hours. Generally, the amount of the Employer contribution determines whether the Employee is covered under as a full-time Eligible Employee or a part-time Eligible Employee.

If, in any week, an Employer does not make either the modified part-time or full-time contribution, as applicable, on an Employee’s behalf because the Employee has not worked the required number of hours, the Employee may pay that weekly contribution himself to continue coverage, but only if actively working or scheduled to work.

In the event the minimum hourly requirements are not satisfied and all grace weeks have been used, the Employee will lose eligibility unless the Employee makes self-payments as provided in Section 4.5.

Continued eligibility will be given to Employees who are absent from active work due to work-related Injury up to a total of twenty-six (26) weeks inclusive of any Family and Medical Leave contribution requirement under Section 4.13.

#### **4.4. EFFECTIVE DATE OF CHANGE IN COVERAGE**

The amount and type of benefits payable are determined by the Plan under which the Employee is covered when the claim is incurred.

##### **4.4.1. Full-Time Employees**

If a full-time Eligible Employee works only the number of hours that require the Employer to make modified part-time contributions on the Employee's behalf, the plan of benefits that covers the Employee will change. In that event, the change in benefits will become effective on the first day following the end of the Employee's eight (8) week grace period (reduced by the number of grace weeks previously used).

If the full-time Eligible Employee continues to work part-time under the terms of the collective bargaining agreement with modified part-time contributions made on the Employee's behalf, the Eligible Employee will be eligible for modified part-time Eligible Employee benefits.

When the full-time Eligible Employee becomes eligible for modified part-time Eligible Employee benefits, he or she may purchase coverage for their Dependent Children only.

##### **4.4.2. Part-Time Employees**

In the event that a modified part-time Eligible Employee works the number of hours that require the Employee's Employer to make full-time contributions on the Employee's behalf, the Eligible Employee and the Employee's Dependents will become eligible for full-time benefits if the Eligible Employee is reclassified by the Employer as full-time and has eight (8) weeks of full-time contributions within a twelve (12) week period. Full-time coverage will become effective on the first day of the first month following the month in which the Employer paid contributions for eight (8) full-time weeks in a consecutive twelve (12)-week period.

#### **4.5. CONTINUATION OF ELIGIBILITY THROUGH SELF-PAYMENTS AND COBRA CONTINUATION RIGHTS**

When circumstances described in this Section cause a reduction in, or a loss of, coverage, some of the coverages in effect at the time can be continued by making self-payments. The following terms incorporate COBRA and HIPAA requirements as amended in all respects. Any future IRS guidance will be incorporated even if it conflicts with existing Plan provisions.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly

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premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty (30) day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees. There may also be other coverage options for you and your family through Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight (8) month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

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

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. For more information, see <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit <https://www.medicare.gov/medicare-and-you>.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

To protect your family's rights, let the Plan Administrator know about 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.

**Plan Contact Information:**

Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund  
Wilson-McShane Corporation  
3001 Metro Drive, Suite 500  
Bloomington, MN 55425  
Phone: (952) 851-5797

Employees and Dependents may, as Plan Participants or as Qualified Beneficiaries, continue coverage and eligibility for certain benefits subject to the following conditions:

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Office within sixty (60) days of the Qualifying Event will cause a person to lose the opportunity to continue coverage.

Employers notify the Trustees of Qualifying Events, such as a reduction in an Employee's hours and an Employee ceasing active work, through the Employer Reports. Notices explaining the right to continue coverage will be furnished to Employees and Dependents when such a Qualifying Event occurs.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to notifying the Fund of a COBRA Qualifying Event.

Starting on March 1, 2020, the deadline to notify the Fund Office of a COBRA Qualifying Event was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the Qualified Beneficiary was first eligible for relief from a deadline related to notification of the Fund Office of a COBRA continuation coverage Qualifying Event. The earliest date that a Qualified Beneficiary was first eligible for relief from a deadline related to notification of the Fund Office of a COBRA continuation coverage Qualifying Event was either:

1. March 1, 2020 for a COBRA continuation coverage Qualifying Event occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
2. Upon the occurrence of a COBRA continuation coverage Qualifying Event after March 1, 2020, but before March 1, 2021.

The calculation of a Qualified Beneficiary's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each Qualified Beneficiary. The Tolling Period may not exceed one (1) year. If a COBRA continuation coverage Qualifying Event occurred prior to March 1, 2020, the number of days by which the Qualified Beneficiary is required to take action after the Tolling Period is shortened by the number of days between the date the Qualified Beneficiary was first required to notify the Fund Office of a COBRA continuation coverage Qualifying Event and March 1, 2020 (the "Proration Rule").

**B. The Trustees' Responsibility to Notify a Qualified Beneficiary When the Qualifying Event is Loss of Coverage Due to the Employee's Death, Divorce, or Legal Separation or a Dependent Child No Longer Meets the Definition**

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of Dependent. Not later than fourteen (14) days after receipt of notice from an Employee or Dependent, the Fund Office will advise the Qualified Beneficiary of the coverages, options, costs, self-payment due dates, and duration of self-payment privileges.

- C. The Trustees' Responsibility to Notify a Qualified Beneficiary When Other Qualifying Events Occur. Not later than thirty (30) days after receipt of notice of an Employee's loss of coverage from the Employer or by examining monthly contribution reports, the Fund Office will advise the Qualified Beneficiary of the coverages, options, costs, self-payment due dates, and duration of self-payment privileges.
- D. Due Date for Qualified Beneficiaries' Response. A Qualified Beneficiary has sixty (60) days from the date of coverage termination or the receipt of the COBRA notice, whichever is later, to elect whether to continue coverage. The election must be communicated to the Fund Office in writing on an Election Form. Each Employee, Spouse, and Dependent Child has the right to make an individual election; however, covered Employees may elect to continue coverage on behalf of their Spouses, and parents may elect to continue coverage on behalf of their Children. Failure to state the election to the Fund Office within sixty (60) days from the date of coverage termination or the receipt of the COBRA notice, whichever is later, terminates rights to continued coverage.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to electing COBRA continuation coverage.

Starting on March 1, 2020, the deadline for a Qualified Beneficiary to elect COBRA continuation coverage was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the Qualified Beneficiary was first eligible for relief from a deadline to elect COBRA continuation coverage. The earliest date that a Qualified Beneficiary was first eligible for relief from a deadline to elect COBRA continuation coverage was either:

1. March 1, 2020 for COBRA continuation coverage election triggering events occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
2. Upon the occurrence of a COBRA continuation coverage election triggering event after March 1, 2020, but before March 1, 2021.

The calculation of a Qualified Beneficiary's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is

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analyzed as to each Qualified Beneficiary. The Tolling Period may not exceed one (1) year. If the COBRA continuation coverage election triggering event occurred prior to March 1, 2020, the number of days by which a Qualified Beneficiary is required to take action after the Tolling Period is shortened by the number of days between the COBRA continuation coverage election triggering event and March 1, 2020 (the "Proration Rule").

A Qualified Beneficiary may elect COBRA continuation coverage up until sixty (60) days after the end of the Tolling Period, subject to the Proration Rule. The Plan must still provide a Qualified Beneficiary with COBRA continuation coverage election notices within the normal timeframe.

Under the Proration Rule, if a COBRA continuation coverage election triggering event occurred prior to March 1, 2020, the extension periods are shortened by the number of days between the event and March 1, 2020.

**E. Due Dates for Self-Payments.**

1. The required initial self-payment must be made to the Fund Office not later than forty-five (45) days following the election to continue coverage (which is the post-mark date, if mailed). Failure to do so will cause eligibility and coverage to terminate retroactively to the later of the Qualifying Event or loss of eligibility and will cause loss of all continuation coverage rights under the Plan. The amount of the first self-payment is for the time period beginning with the date of the Qualifying Event and extending through the month in which payment is made.
2. Subsequent monthly self-payments must be made to the Fund Office by the first day of the month for that month of coverage. The Plan allows a thirty (30) day grace period for making self-payments.
3. In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor guidance providing extended timeframes related to COBRA Continuation Coverage.

Starting on March 1, 2020, the deadline to make the first COBRA continuation coverage payment was suspended during a "Tolling Period" which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the COBRA continuation coverage Qualified Beneficiary was first eligible for relief from the deadline to make the first COBRA continuation coverage payment. The earliest date that a COBRA continuation coverage Qualified Beneficiary was first eligible for relief from a deadline related to making the first COBRA continuation coverage payment was either:

1. March 1, 2020 for COBRA continuation coverage payment grace periods ending on or before March 1, 2020. To be in this window, the last day of the grace period must have been on or after March 1, 2020; or
2. The last date of a COBRA continuation coverage payment grace period after March 1, 2020, but before March 1, 2021.

The calculation of a Qualified Beneficiary's Tolling Period and relief from deadlines and suspension of certain requirements is fact specific and is analyzed as to each Qualified Beneficiary. The Tolling Period may not exceed one (1) year. If the COBRA continuation coverage payment grace period began but did not end prior to March 1, 2020, the number of days by which a COBRA continuation coverage payment grace period ends after the Tolling Period is shortened by the number of days by which the payment due date preceded March 1, 2020 (the "Proration Rule").

1. The Employee has remained continuously employed by the same Employer; and
  2. The Employee is ready, willing, and able to return to full-time employment when it becomes available.
- B. Cessation of Active Work.**
1. If an Employee ceases active work due to lay-off, work stoppage, resignation, or dismissal, coverage may be continued for up to eighteen (18) months from the time coverage ceases.
  2. If an Employee ceases active work due to a disability or sick leave:
    - (a) The Employee may continue coverage for of eighteen (18) months; or
    - (b) The Employee (or any other Qualified Beneficiary) may continue coverage for him or herself and his or her Dependents for up to twenty-nine (29) months of disability if:
      - i. The Social Security Administration (SSA) determines that any of the Qualified Beneficiaries are disabled under the Social Security Act either: (i) at the time employment terminated or hours were reduced; or (ii) at any time within sixty (60) days of the Qualifying Event;
      - ii. The disability lasts at least until the end of the eighteen (18) month period of continuation coverage; and
      - iii. The Qualified Beneficiary notifies the Fund Office in writing within sixty (60) days of the SSA determination and before the end of the first eighteen (18) months of continuation coverage and provides a copy of the Social Security Disability Determination to the Fund Office.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to the sixty (60) day window in which the Qualified Beneficiary must notify the Fund Office of a Social Security Disability Determination.

Starting on March 1, 2020, the sixty (60) day window in which the Qualified Beneficiary must notify the Fund Office of a Social Security Disability

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Determination was suspended during a “Tolling Period,” which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the “Outbreak Period”); or

One (1) year from the date the Qualified Beneficiary was first eligible for relief from a deadline to request extended COBRA continuation coverage due to Social Security disability. The earliest date that a Qualified Beneficiary was first eligible for relief from a deadline to request extended COBRA continuation coverage due to Social Security disability was either:

1. March 1, 2020 for Social Security disability determinations occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
2. Upon the occurrence of a Social Security disability determination after March 1, 2020, but before March 1, 2021.

The calculation of a Qualified Beneficiary’s Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each Qualified Beneficiary. The Tolling Period may not exceed one (1) year. If the Social Security disability determination occurred prior to March 1, 2020, the number of days by which a Qualified Beneficiary is required to take action after the Tolling Period is shortened by the number of days between the Social Security disability determination and March 1, 2020 (the “Proration Rule”).

A Qualified Beneficiary’s obligation to notify the Plan of a disability qualifying for a disability extension of COBRA Continuation Coverage is extended to sixty (60) days after the end of the Tolling Period, subject to the Proration Rule.

Under the Proration Rule, if a disability occurred prior to March 1, 2020, the extension periods are shortened by the number of days between the event and March 1, 2020.

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Each Qualified Beneficiary who has elected continuation coverage will be entitled to the eleven (11) month disability extension if one (1) of them qualifies. If the Qualified Beneficiary is determined by SSA to no longer be disabled, the Qualified Beneficiary must notify the Fund Office within thirty (30) days after the SSA determination.

Failure to provide notice of a disability may affect the right to extend the period of continuation coverage.

**[SECTION CONTINUES ON NEXT PAGE]**

- I. For a Qualified Beneficiary who was entitled to the additional eleven (11) months continuation coverage based on a disability extension, eligibility for continuing the disability extension will terminate when there has been a final determination that the disability no longer exists.

Continuation coverage also may be terminated for any reason the Plan could terminate coverage of a Participant or Dependent not receiving continuation coverage (such as fraud).

#### **4.5.8. Temporary Waiver of COBRA Continuation Coverage Self-Payments**

An Assistance Eligible Individual is not required to make any required self-payments for COBRA continuation coverage for any period of coverage during the period from April 1, 2021 through September 30, 2021 (the “Subsidy Period”) and is treated as having made such self-payments for all purposes.

An Assistance Eligible Individual is not eligible for relief from the requirement to make self-payments for COBRA continuation coverage during the Subsidy Period described in this section for any month of coverage that begins on or after the earlier of:

- A. The first date that the Assistance Eligible Individual is eligible for coverage under any other group health plan (other than a group health plan that consists of only excepted benefits), a flexible spending arrangement, a qualified small employer health reimbursement arrangement, or Medicare; or
- B. The earlier of:
  1. The date following the expiration of the Assistance Eligible Individual’s maximum period of COBRA continuation coverage; or
  2. The date following the expiration of the period of COBRA continuation coverage as extended by Section 4.5.9.

For periods of COBRA continuation coverage following the Subsidy Period, Assistance Eligible Individuals who remain eligible for and continue COBRA continuation coverage must make the applicable required self-payment in accordance with the Plan’s regular COBRA self-payment rules.

#### **4.5.9. Temporary Extension of COBRA Election Period**

Any individual who, as of April 1, 2021, would be an Assistance Eligible Individual except for the fact that he or she does not have a COBRA continuation coverage election in effect or has discontinued COBRA continuation coverage before April 1, 2021 prior to the expiration of his or her initial COBRA continuation coverage period, is eligible to elect (or re-elect, as the case may be) COBRA continuation coverage during the period from April 1, 2021 through the date that is 60 days after the date that the Plan Administrator provides the individual with the notice required by Section 4.5.10.

If a Qualified Beneficiary elects (or re-elects) COBRA continuation coverage pursuant to the extended election period described in this section, such COBRA continuation coverage will become effective on the first date of the coverage period that begins on or after April 1, 2021, but such COBRA continuation coverage will not extend beyond the last date

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that such Assistance Eligible Individual would have been eligible for COBRA continuation coverage in the absence of the temporary extended election period described in this section.

#### **4.5.10. Notice to Assistance Eligible Individuals**

The Plan Administrator is required to provide Assistance Eligible Individuals and individuals described in Section 4.5.9 who became entitled to elect COBRA continuation coverage before April 1, 2021 with notice of the availability of and information about COBRA continuation coverage self-payment assistance, along with the forms required to establish eligibility for self-payment assistance, no later than 60 days after April 1, 2021.

#### **4.5.11. Requirement to Report Notice of Eligibility for Another Group Health Plan or Medicare**

Any Assistance Eligible Individual who becomes ineligible for the temporary waiver of the requirement to make COBRA continuation coverage self-payments during the Subsidy Period under Section 4.5.8(A), due to eligibility for another group health plan or Medicare must notify the Plan in accordance with rules established by the Plan Administrator.

#### **4.5.12. Assistance Eligible Individual**

An Assistance Eligible Individual is, with respect to any period of COBRA continuation coverage during the period beginning on April 1, 2021 and ending on September 30, 2021, a COBRA Qualified Beneficiary who elects COBRA continuation coverage and became eligible for COBRA continuation coverage due to a loss of coverage resulting from either the Employee's termination of employment (other than the Employee's voluntary termination of employment or involuntary termination of employment due to the Employee's gross misconduct) or a reduction in the Employee's hours of employment.

### **4.6. REINSTATEMENT OF COVERAGE**

#### **4.6.1. Full-Time Eligible Employees**

If a full-time Eligible Employee's coverage terminates, the Employee may be reinstated on the first of the month following the date when eight (8) weeks of Employer full-time contributions have been paid to the Fund on the Employee's behalf during a consecutive twelve (12) week period.

#### **4.6.2. Part-Time Eligible Employees**

If a part-time Eligible Employee loses eligibility, but does not incur a break in service (as defined below), he may regain eligibility by completing twelve (12) consecutive weeks of employment during which at least eight (8) weeks of part-time contributions are made to the Plan.

A break in service is the longer of: (A) a period of six (6) consecutive months during which no Employer contributions are made on an Employee's behalf; or (B) the length of an approved leave of absence. If an Employee loses eligibility after having incurred a break in service, he may regain eligibility by once again satisfying the requirements for initial eligibility. Part-time eligibility credit for months preceding a break in service is forfeited and does not count for purposes of obtaining eligibility.

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These rules apply when an Employee who has opted-out of Plan coverage seeks to opt-in (and again become an Eligible Employee) under the Special Enrollment Rights stated in Section 4.2.D.

#### **4.7. TERMINATION OF EMPLOYMENT**

In the event an Eligible Employee's employment is terminated, the Employee's eligibility will continue under the Plan for the number of grace weeks the Employee has accrued (as provided below).

Each Eligible Employee who has qualified for health care benefits, for either full-time or modified part-time coverage, will accumulate a total of eight (8) grace period weeks. The Fund Office will use one (1) grace week whenever a current weekly contribution is not received for the coverage in effect. When all of the grace weeks have been used and there are no current contributions, the Employee's full-time or modified part-time coverage, whichever applies, will be terminated. However, the Employee still has the option of continuing coverage.

It is each Employee's responsibility to keep track of any grace weeks used. An Employee may make contributions on his or her behalf in lieu of using any grace weeks OR may buy back any grace weeks used. However, such option must be exercised within sixty (60) days of the date the Eligible Employee is notified of either the Employee's termination of coverage or the Employee's reduction to modified part-time Employee status. Employees who are currently working or

**5.3.7. Description of Services**

Dental Care Benefits are subject to the maximums stated in the Schedule of Benefits in Section 2.4, the limitations described within each coverage category, and the exclusions specified in Section 5.3.8.

- A. Diagnostic and Preventive Services. The below diagnostic and preventive services are covered.
  - 1. Examinations, no more frequently than two (2) in a Calendar Year. Coverage will be provided for two (2) additional oral examinations each Calendar Year, provided such services are Medically Necessary due to a systemic disorder. Such services will require Predetermination.
  - 2. Full mouth x-rays once each three (3) years.
  - 3. Two (2) bitewing x-rays, no more frequently than twice in a Calendar Year.
  - 4. Panagraphic x-rays once each three (3) years unless special need is indicated.
  - 5. Dental prophylaxis (teeth cleaning), limited to two (2) in a Calendar Year. Coverage will be provided for two (2) additional prophylaxes each Calendar Year, provided such services are Medically Necessary due to a systemic disorder. Such services will require Predetermination.
  - 6. Topical fluoride treatments for Eligible Persons under age nineteen (19), limited to once in a Calendar Year.
  - 7. Oral hygiene instruction when prescribed by a Dentist but limited to once in a Calendar Year.
  - 8. Sealants for Eligible Persons under age nineteen (19). No charges for dental fillings or reapplications of sealants will be payable within three (3) years after the initial sealant has been applied.
- B. Restorative Services. The below restorative services are covered.
  - 1. Emergency treatment for the relief of pain.
  - 2. Space maintainers.
  - 3. Restorations of amalgam, silicate, synthetic porcelain, acrylic, plastic, resin (white), or composite type filling material. Gold foil

## SECTION 7 CLAIMS, REVIEW, AND APPEAL PROCEDURES

### 7.1. CLAIMS PROCEDURE

The following procedures have been established by the Trustees for processing claims. For claims involving Plan benefits that are insured, the terms of the insurance policy will govern in the event of a conflict.

#### 7.1.1. Notice of Claim

A. Pre-Service Claims. An Eligible Person must obtain:

1. Prior authorization for prophylactic mastectomies;
2. Certification of Medical Necessity for chiropractic visits exceeding twenty (20) per Eligible Person per Calendar Year;
3. Prior approval for the purchase of certain durable medical equipment specified in Subsection **Error! Reference source not found.**; and
4. Predetermination for certain dental services as specified in Section **Error! Reference source not found.**

The claims listed above are called “pre-service claims,” which are claims that require approval of the benefit in advance of obtaining medical care. Claims requiring prior authorization must be submitted in writing to the Fund Office.

There are special provisions in the Claims Procedure Regulations for “urgent care claims” (referred to under the Plan as “emergencies”), but, by definition, these provisions do not apply because the Plan does not require prior authorization of emergency admissions.

B. Post-Service Claims. Any Claim for benefits that is not a pre-service claim is considered a “post-service claim.” An Eligible Person must submit all post-service claims in writing within ninety (90) days of the occurrence of the accident or illness or as soon as reasonably possible. In no event (except in the absence of legal capacity) can a claim be submitted later than fifteen (15) months from the date of service.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing a post-service claim.

Starting on March 1, 2020, the deadline to file a post-service claim was suspended during a “Tolling Period,” which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the “Outbreak Period”); or

One (1) year from the date the Eligible Person was first eligible for relief from the deadline related to filing a post-service claim. The earliest date that an Eligible Individual was first eligible for relief from a deadline related to filing a post-service claim was either:

1. March 1, 2020 for medical services provided on or before March 1, 2020, including periods during which a claim was required or permitted to be filed that began before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
2. The date medical services were provided after March 1, 2020, but before March 1, 2021.

The calculation of an Eligible Person's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each Eligible Person. The Tolling Period may not exceed one (1) year. If the medical services were provided prior to March 1, 2020, the number of days by which an Eligible Person is required to take action after the Tolling Period is shortened by the number of days between the date that medical services were provided and March 1, 2020.

- J. Contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.
- K. If the claim for benefits is denied based upon a disability determination, the notice will provide an explanation of the basis for agreeing or disagreeing with the following:
  - 1. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - 2. The review of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
  - 3. A disability determination regarding the claimant made by the Social Security Administration if such determination is presented by the claimant to the Plan.

### **7.3 APPEAL PROCEDURE**

If all or part of a claim is denied, if a claimant is otherwise dissatisfied with the determination made by the Plan, or if the claimant has not received the notice of denial of the claimant's claim within the applicable time limits after the Plan has received all necessary claim information, the claimant has the right to appeal the decision and request a review of the claim. The Plan will provide for a full and fair review of a claim and adverse benefit determination, pursuant to the following:

- A. A claimant will have one hundred eighty (180) days after the claimant receives the notice of an adverse benefit determination to file the claimant's appeal in writing to the Fund Office, and it must include the specific reasons the claimant feels denial was improper.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing claim appeals.

Starting on March 1, 2020, the deadline to file a claim appeal was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the claimant was first eligible for relief from a deadline related to filing a claim appeal. The earliest date that a claimant was first eligible for relief from a deadline related to filing a claim appeal was either:

- 1. March 1, 2020 for claim denials or adverse benefit determinations occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

*As amended by Amendment No. 15 to the Plan Document and Summary Plan Description of the  
Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (2017 Restatement)  
Previously amended by Amendment No. 13  
Amendment Effective Date – April 9, 2021*

2. The date of a claim denial or adverse benefit determination was after March 1, 2020, but before March 1, 2021.

The calculation of a claimant's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each claimant. The Tolling Period may not exceed one (1) year. If the claim denial or adverse benefit determination occurred prior to March 1, 2020, the number of days by which a claimant is required to take action after the Tolling Period is shortened by the number of days between the date of the claim denial or adverse benefit determination and March 1, 2020.

- B. A claimant will be allowed the opportunity to submit written issues and comments, documents, records, and other information relating to the claim for benefits that may have been requested in the notice of denial or that the Eligible Employee may consider desirable or necessary, but neither the claimant nor representative of the claimant will have the right to appear in person before the Board of Trustees.
- C. A claimant or duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all designated, pertinent documents, records, and other information relevant to the Employee's claim for benefits.
- D. The review will take into account all comments, documents, records, and other information related to the claim that are submitted by the claimant, whether or not such information was submitted or considered in the initial benefit determination.
- E. The Board of Trustees, as an appropriate named fiduciary for the Plan, will be the assigned decision maker on appealed claims.

#### **7.4. EXTERNAL REVIEW**

The Plan will permit external review of benefit determinations in accordance with Section 2719 of the Public Health Service Act and its implementing regulations. If the Plan denies your claim and your appeal, you may seek external review of the Plan's decision. To seek external review, you must file a request with the Fund Office within four (4) months from the date you receive notice that the Plan denied your appeal. For more information on external review, contact the Fund Office.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing a request for an external review.

Starting on March 1, 2020, the deadline to file a request for an external review was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the claimant was first eligible for relief from the deadline related to filing a request for an external review. The earliest date that a claimant was first eligible for relief from a deadline related to filing a request for an external review was either:

1. March 1, 2020 for claim appeal denials occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
2. The date of a claim appeal denial after March 1, 2020, but before March 1, 2021.

The calculation of a claimant's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each claimant. The Tolling Period may not exceed one (1) year. If the claim appeal denial was provided to the claimant prior to March 1, 2020, the number of days by which the claimant is required to take action after the Tolling Period is shortened by the number of days between the date that the claim appeal denial was provided and March 1, 2020.

#### **7.5. PHYSICAL EXAMINATIONS**

The Plan, at its own expense, will have the right and opportunity to examine an Eligible Person whose illness is the basis of a claim when, and as often as, it may reasonably require during pendency of a claim under the Plan.

#### **7.6. RECORDS**

Each Eligible Person authorizes and directs any provider that has attended, examined, or treated him to furnish the Fund, at any time upon its request, any and all information and records or copies of records relating to provided services. The Fund agrees that any information and records obtained pursuant to this Section will be considered confidential and will be protected in accordance with HIPAA requirements and Section 10.2.

**7.7. ACTIONS AGAINST THE PLAN**

No Eligible Person may bring an action at law or in equity, including proceedings before administrative agencies, to recover from the Plan until the Claims Review and Appeal Procedure stated in Section 7.2 has been exhausted. No action may be brought at all unless it is brought within two (2) years from the time the claim was required to be filed with the Plan.

**7.8. ASSIGNMENT OF RIGHTS AND APPOINTING AN AUTHORIZED REPRESENTATIVE  
TO ACT ON YOUR BEHALF**

An authorized or legal representative may act on behalf of a claimant in filing a claim or pursuing an appeal of an adverse benefit determination. The claimant must first submit a signed letter to the Fund Office specifically identifying the person as the authorized or legal representative of the claimant. Neither the claimant nor any duly authorized representative will have the right to make a personal appearance before the Board of Trustees or any committee created by the Board of Trustees. Although a claimant may appoint an authorized representative to act on their behalf, under no circumstances may a claimant assign any rights under the Plan or ERISA, including any rights to appeal adverse benefit determinations or any causes of action that may arise after the denial of benefits.



## MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS HEALTH AND WELFARE FUND

### IMPORTANT NOTICE

#### Summary of Material Modifications

TO: Participants and Beneficiaries of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund

FROM: The Board of Trustees

DATE: April 2022

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This is a Summary of Material Modifications ("SMM") regarding the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (the "Plan"). The Board of Trustees has amended the Plan Document and Summary Plan Description (amended and restated September 1, 2017) as indicated below.

#### Amendment No. 18: Surprise Billing Protections & Diabetic Supply Coverage

Effective March 1, 2022 (the first day of the plan year), the Plan was amended to comply with the requirements of the federal No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021. Under the No Surprises Act, the Plan will cover claims for certain "surprise" out-of-network health care costs as if they were in-network expenses. For claims subject to the No Surprises Act, this means that you will not be "balance billed" by the out-of-network provider or health care facility for additional expenses beyond the recognized amount that is covered subject to the Plan's standard cost-sharing rules (copayments, coinsurance, and deductibles).

The No Surprises Act protections will apply to the following three categories of claims:

- Emergency Services provided by an out-of-network provider and/or at an out-of-network health care facility;
- Certain Non-Emergency Services provided by an out-of-network provider at an in-network health care facility; and
- Out-of-network Medically Necessary Air Ambulance Services.

"Emergency Services" are defined as appropriate medical screening examinations and treatment for an Emergency medical condition. Emergency Services also may include services after the patient stabilizes, such as observation and inpatient or outpatient stays in connection with the Emergency.

Non-Emergency Services provided by an out-of-network provider at an in-network health care facility include, but are not limited to, services such as anesthesiology, pathology, radiology, and neonatal care as well as services provided by assistant surgeons, hospitalists, intensivists, and, generally, any out-of-network provider at the facility if there is no in-network provider at the facility who can provide the items or services that provider provides.

In certain cases, however, Emergency Services provided by an out-of-network provider and/or at an out-of-network health care facility and non-Emergency Services provided by an out-of-network provider at an in-network health care facility will not be treated as in-network claims under the No Surprises Act if the provider or facility provides the patient with a notice regarding the out-of-network status of the services or facility and the patient consents to receive those out-of-network services (except for specific circumstances described below).

This notice and consent exception never applies to the following:

- Unforeseen urgent medical needs;
- Pre-stabilization Emergency Services;
- Post-stabilization Emergency Services, unless:
  - The attending provider determines that the patient is able to travel without Emergency medical transportation; and
  - The patient is provided a list of any in-network providers at the facility who are able to furnish the Medically Necessary items or services and is offered a referral to those providers; and
- Certain “ancillary” services provided by an out-of-network provider at an in-network facility, specifically:
  - Anesthesiology, pathology, radiology, and neonatal care;
  - Services provided by an assistant surgeon, hospitalist, or intensivist; and
  - Diagnostic services such as radiology and laboratory services; and
- Items and services provided by an out-of-network provider if there is no in-network provider at the facility who can provide those items and services at the in-network facility.

In other cases where the notice and consent exception is available, the notice must contain specific information required by the No Surprises Act, including a statement of out-of-network status, a good faith estimate of the charges and notice that the estimate is not a binding contract, notice that prior authorization may be required by the Plan, and a clear statement about the option to obtain care from an in-network provider and that obtaining services from an in-network provider would result in no balance billing.

The notice must be provided to you at least 72 hours before an appointment (if the appointment is scheduled at least 72 hours in advance) or at least three hours before an appointment (if the appointment is scheduled fewer than 72 hours in advance).

Consent must be provided voluntarily, and the signed consent must contain a clear statement that the patient understands the consequences of receiving out-of-network services instead of in-network services, such as balance billing. The notice and consent must be made available upon request in the 15 most common non-English languages in the state or geographic region, or for other languages, the services of a qualified interpreter must be provided to help the patient understand the notice and consent. The consent must state the time and date of the patient’s receipt of the written notice described above and the time and date of the consent.

Finally, for coverage of out-of-network Air Ambulance Services, the Plan will cover such services as if they were in-network services (i.e., without balance billing but still subject to the Plan's cost sharing rules) but only to the nearest health care facility qualified to provide Medically Necessary treatment for an Emergency or a provider-initiated transfer to another health care facility qualified to provide Medically Necessary treatment. Air ambulance services are only covered if Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would result in a serious adverse impact on the patient's health status.

Additionally, the Plan was amended to provide that diabetic supplies are covered under the Plan's prescription drug program.

#### Amendment No. 19: Over-the-Counter COVID-19 Test Coverage

The United States government is also providing free at home COVID test kits. Please visit [www.covidtests.gov](http://www.covidtests.gov) to order up to two sets of four free tests per household. The test kits will ship through the USPS and are expected to ship out seven to 12 days after the order date to most residential addresses.

Effective January 15, 2022, the Plan was amended to provide coverage for at-home over-the-counter ("OTC") COVID-19 test kits. The Plan will provide coverage for at-home OTC COVID-19 test kits purchased on and after January 15, 2022 subject to the following provisions. (Please see below for information specific to participants covered under the Plan's Ancillary Benefits package only.)

- ***The Plan will only cover COVID-19 test kits available "over the counter" that have been approved by the FDA for use at home or elsewhere without involvement of a health care provider*** purchased January 15, 2022 through the end of the COVID-19 Public Health Emergency that was declared by the Department of Health and Human Services. Please go to [www.fda.gov](http://www.fda.gov) to learn which tests are currently FDA approved or check the packaging on the test kit before purchasing.
- The Plan will cover 100% of the cost (no Deductible or Copay) for up to eight at-home OTC COVID-19 test kits per Covered Person under the Plan every 30 days.
  - You must purchase the OTC COVID-19 test at the pharmacy counter of a pharmacy in the Express Scripts Choice Plus network and present your Plan Prescription card at the time of purchase. If the in-network pharmacy is set up to process test kits in the same manner as a prescription, you will not pay any amount for the OTC COVID-19 test kits at the time of purchase.
  - Some pharmacies in the Express Scripts Choice Plus network are not set up to process at-home OTC COVID-19 test kits in the same manner as a prescription. You must pay 100% of the cost for at-home OTC COVID-19 test kits you purchase at one of these pharmacies. The Plan will reimburse you for the entire cost of these at-home OTC COVID-19 test kits if you save your receipt of purchase and submit the receipt along with the "*Over-The-Counter (OTC) COVID-19 Test Kit Claim Reimbursement Request*" form to Express Scripts at their address noted on the reimbursement request form. Reimbursement request forms are available at [www.express-scripts.com](http://www.express-scripts.com).
- Plan reimbursement for at-home OTC COVID-19 test kits that you do not purchase at an Express Scripts Choice Plus in-network pharmacy will be limited to the cost of the test or

\$12, whichever is less. You are responsible for any amount that you pay in excess of \$12 for an at-home OTC COVID-19 test kit purchased at a pharmacy that is not in the Express Scripts Choice Plus network, or any other retailer or supplier. The Plan will not count these costs towards your Prescription Drug Benefit Annual Out-of-Pocket Maximum.

- Save your receipt of purchase and submit the receipt along with the “Over-The-Counter (OTC) COVID-19 Test Kit Claim Reimbursement Request” form to Express Scripts at their address noted on the reimbursement request form. Reimbursement request forms are available at [www.express-scripts.com](http://www.express-scripts.com).
- The Plan will cover only OTC COVID-19 test kits for at-home medical use by you or your covered household family members. Tests for employment purposes or resale will not be covered or reimbursed under this program.
- For participants who are only covered under the Plan’s Ancillary Benefits package, the Plan will cover 100% of the cost (no Deductible or Copay) for up to eight at-home OTC COVID-19 test kits per covered Eligible Person under the Plan per 30-day period.
  - You must pay 100% of the cost for at-home OTC COVID-19 test kits. The Plan will reimburse you for the entire cost of these at-home OTC COVID-19 test kits if you save your receipt of purchase and submit the receipt along with the “*Over-The-Counter (OTC) COVID-19 Test Kit Claim Reimbursement Request*” form to the Fund Office at its address noted on the reimbursement request form.
  - The Plan will cover only OTC COVID-19 test kits for at-home medical use by you. Tests for employment purposes or resale will not be covered or reimbursed under this program.

The above provisions only apply to at-home OTC COVID-19 test kits and do not affect previous Plan provisions regarding coverage of non-at-home OTC COVID-19 test kits.

#### Amendment No. 20: Medical Necessity Determinations

Effective April 8, 2022, the Plan was amended to state that whether a covered item or service is Medically Necessary will be determined in accordance with UnitedHealthcare’s medical policy.

**Please update your Plan Document and Summary Plan Description booklet (dated September 1, 2017) to reflect these changes by inserting the attached replacement and supplemental pages IV, 1, 1A, 3, 3A, 4, 7A, 9, 9A, 10, 11, 14, 16, 17, 20, 20A, 21, 21A, 21B, 21C, 21D, 43, 43A, 44, 44A, 47, 48B, 48C, 49, 51, 51A, 51B, 68, 68A, 69, 70, 71, 73, 73A, 78, 78A, 79, and 98.**

**If you have any questions about these changes to the Plan, please contact the Plan Administrator at (952) 851-5797 or (844) 468-5917.**

## **THE BOARD OF TRUSTEES**

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UFCW Local 663  
6160 Summit Drive North, Suite 600  
Brooklyn Center, MN 55430

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5101 Vernon Avenue S  
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Fred Miller  
Lund Food Holdings, Inc.  
4100 W 50<sup>th</sup> Street  
Edina, MN 55424

## **FUND OFFICE**

Wilson-McShane Corporation  
3001 Metro Drive, Suite 500  
Bloomington, MN 55425

PHONE: (952) 851-5797  
FAX: (952) 854-1632

OFFICE HOURS: Monday-Friday 8 a.m. to 5 p.m.

**SECTION 1 DEFINITIONS**

Words used in the masculine or feminine gender will be construed as the feminine gender or masculine gender, respectively, where appropriate. Words used in singular or plural form will be construed as plural or singular, respectively, where appropriate.

**1.0. AIR AMBULANCE SERVICES**

“Air Ambulance Services” means medical transport by a rotary wing air ambulance or fixed wing air ambulance for patients.

**1.1. AVERAGE WEEKLY WAGE**

“Average Weekly Wage” means the average weekly amount earned by an Eligible Employee during the last four (4) weeks before the Eligible Employee became Totally Disabled. Such wage does not include overtime or bonuses.

**1.2. BENEFICIARY**

“Beneficiary” means a person designated by a Participant or by the terms of the Plan (such as a Dependent or member of the family of a Participant) who is or may become entitled to a benefit under this Plan.

**1.3. CALENDAR YEAR**

“Calendar Year” means January 1 through December 31 of each year.

**1.4. DENTAL HYGIENIST**

“Dental Hygienist” means any person who is currently licensed (if licensing is required by the state) to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene and who works under the supervision or direction of a Dentist.

**1.5. DENTIST**

“Dentist” means a doctor of dental surgery or doctor of dental medicine who is currently and duly licensed to practice dentistry under the laws of the state where the Dentist’s practice is located and who is acting within the usual scope of such practice.

**1.6. DEPENDENT**

A. “Dependent” means:

1. Spouse; or

2. Child who is:

a. Under twenty-six (26) years of age; or

b. Incapable of self-sustaining employment by reason of developmental cognitive disability or physical handicap and

- i. Who became so incapable prior to attaining age twenty-six (26); and

release of information requested by the Plan and cooperating with the Plan in obtaining this information.

4. Any foster child placed with an Eligible Employee by an authorized placement agency or the court.
5. Any grandchild of an Eligible Employee or Spouse if:
  - a. Legal guardianship of the grandchild has been awarded to the Eligible Employee or Spouse; or
  - b. The parent of the grandchild is: (a) unmarried; (b) an Eligible Dependent; and (c) under age nineteen (19).

If, as of February 28, 2011, a grandchild of an Eligible Employee was enrolled in this Plan and the parent of the grandchild was over age eighteen (18) and an Eligible Dependent by reason of his or her enrollment as a full-time student or by reason of a developmental cognitive disability or physical handicap, the grandchild will remain an Eligible Dependent until the parent of the grandchild would have ceased to be an Eligible Dependent under the terms of this Plan that were in effect on February 28, 2011.

Both the parent and the grandchild must be primarily financially dependent upon and reside with the Eligible Employee, unless guardianship or adoption of the grandchild has been awarded to the Eligible Employee or Spouse.

6. A child who is named in a Qualified Medical Child Support Order with which an Eligible Participant and the Plan are obligated to comply.

### **1.7. ELIGIBLE EMPLOYEE**

“Eligible Employee” means any Employee, former Employee, or retiree of an Employer, who is eligible for benefits in accordance with the Eligibility Rules of the Plan described in Section 4.

### **1.8. ELIGIBLE PERSON**

“Eligible Person” means either the part-time or full-time Eligible Employee or the Eligible Dependent of a full-time Eligible Employee or the Dependent Child of a part-time Eligible Employee (if applicable).

#### **1.8A. EMERGENCY**

“Emergency” means:

- A. A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain)

such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
  2. Serious dysfunction of any bodily organ or part; or
  3. Serious impairment of bodily functions; or
- B. With respect to a pregnant woman who is having contractions:
1. That there is inadequate time to effect a safe transfer to another Hospital before delivery; or
  2. That transfer may pose a threat to the health or safety of the woman or the unborn child.

**1.8B. EMERGENCY SERVICES**

- A. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department and ancillary services routinely available to the emergency department to evaluate such Emergency medical condition; and
- B. Such further medical examination and treatment to stabilize the patient as are within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department (regardless of the department of the Hospital in which such further examination or treatment is furnished).

**1.9. EMPLOYEE**

“Employee” means:

- A. Any employee represented by the Union and working for an Employer and with respect to whose employment an Employer is required to make contributions into the Trust Fund.

- B. A full-time officer or employee of the Union who has been proposed for benefits under the Plan by the Union and who has been accepted by the Trustees and for whom the Union agrees in writing to contribute to the Plan at the rate fixed for contributions for other Employers.
- C. Employees of the Plan, if any, who are not employed by an Employer as defined in Section 1.10, but who are proposed and accepted for Plan benefits by the Trustees. Any Trustee who is not already receiving full-time pay from an Employer or Association of Employers, whose employees are Participants in the Plan or from an employee organization whose members are Participants in the Plan may be considered as an employee of the Plan for the limited purpose of the definition of Employee under this Plan. As to persons described in this paragraph, the Trustees will be deemed to be an Employer within the meaning of the Trust Agreement and may provide benefits for such employees.
- D. Any other employees that the Trustees may agree to include and on whose behalf contributions are made to the Trust Fund and whose inclusion will not impair the tax-exempt status of the Fund or contributions to the Fund, but not including any owner-operator, partner, independent contractor, self-employed person, subject to the modification that, unless prohibited by law from being covered under the Fund, the definition of Employee will not exclude any person who works regularly as a food employee.

#### **1.10. EMPLOYER**

“Employer” means:

- A. An employer who is bound by a collective bargaining agreement with the Union that provides for the making of payments to the Trust Fund with respect to Employees represented by the Union.
- B. The Union, but only with respect to the Employees of the Union for whom the Union contributes to the Trust Fund and only for the limited purpose of making the required contributions into the Trust Fund.

Employers as described in this Section will, by the making of payments to the Trust Fund pursuant to such collective bargaining or other written agreements, be deemed to have accepted and be bound by the Trust Agreement.

#### **1.11. ESSENTIAL HEALTH BENEFITS**

“Essential Health Benefits” means any benefits covered by the Plan that constitute Essential Health Benefits as that term is defined under the Patient Protection and Affordable Care Act (“Affordable Care Act”) or related regulations, rules, or guidance. As defined under the Affordable Care Act, Essential Health Benefits include, at minimum:

- A. Ambulatory patient services;
- B. Emergency Services;
- C. Hospitalization;

stating that such quarantine is medically necessary or appropriate according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health because the individual has had exposure or suspected exposure to COVID-19.

**1.17A. INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT**

“Independent Freestanding Emergency Department” means a health care facility that is geographically separate and distinct and licensed separately from a Hospital under applicable state law and provides any Emergency Services.

H. Are not furnished in connection with medical or other research.

**1.22. MENTAL HEALTH FACILITY**

“Mental Health Facility” means a community mental health clinic that is established for the purpose of providing consultation, diagnosis, and treatment of a mental illness or nervous disorder, and that is approved as such by the state in which it is located.

**1.23. NON-RESIDENTIAL TREATMENT PROGRAM**

“Non-Residential Treatment Program” means a facility that is licensed or approved by the state in which it is located for treatment of alcoholism on an outpatient basis, chemical dependency, or substance addiction.

**1.24. NURSE ANESTHETIST**

“Nurse Anesthetist” means a licensed R.N. who has gained additional knowledge and skills through an organized program of study and clinical experience and who meets the criteria for a Nurse Anesthetist established by the professional nursing organization having authority to certify a licensed R.N. in advanced nursing practice.

**1.25. NURSE MIDWIFE**

“Nurse Midwife” means a licensed R.N. who has gained additional knowledge and skills through an organized program of study and clinical experience and who meets the criteria for a Nurse Midwife established by the professional nursing organization having the authority to certify the licensed R.N. in advanced nursing practice.

**1.26. OPTICIAN, OPTOMETRIST, AND OPHTHALMOLOGIST**

“Optician,” “Optometrist,” and “Ophthalmologist” mean any person who is qualified and currently licensed (if licensing is required in the state) to practice the profession by the appropriate governmental authority having jurisdiction of the licensure and practice of the profession and who is acting within the usual scope of such practice.

**1.27. PARTICIPANT**

“Participant” means any Employee or former Employee of an Employer who is or may become eligible to receive a benefit of any type from this Plan or whose Beneficiaries may be eligible to receive any such benefit.

**1.27A. PARTICIPATING HEALTH CARE FACILITY**

“Participating Health Care Facility” means any health care facility that has a contractual relationship directly or indirectly with the Plan setting forth the terms and conditions on which a relevant item or service is provided to an Eligible Person under the Plan.

**1.28. PHARMACY**

“Pharmacy” means a facility licensed by the state in which it is located to dispense Prescription Medication by licensed pharmacists.

**1.29. PHYSICIAN**

“Physician” means any individual who is licensed to practice medicine by the governmental authority having jurisdiction over such licensure and who is acting within the usual scope of such practice. “Physician” will be interpreted to include, but will not be limited to, a doctor of medicine,

chiropractor, osteopath, podiatrist, optometrist, doctor of dental surgery, Nurse Anesthetist providing anesthesia services, and Nurse Midwife providing obstetrical services. The Physician must be duly licensed and qualified under the laws of the state in which the eligible Health Services are performed.

**1.30. PLAN YEAR**

“Plan Year” means the twelve (12)-month period beginning March 1 and ending February 28/29.

**1.31. PREDETERMINATION**

“Predetermination” means the pretreatment review that is used to determine the eligibility of the individual and the amount of coverage for services in accordance with the Schedule of Benefits.

**1.32. PREFERRED PROVIDER**

A “Preferred Provider” means any of the following who alone or as part of a group enter into a contract with the Trustees agreeing to be compensated for their services and supplies that are covered under this Plan in accordance with the terms of such contract:

- A. Physician, Dentist, R.N., physical therapist, or other licensed health care Provider;
- B. Hospital;
- C. Alcohol and substance abuse treatment facility;
- D. Hospice facility or Program;
- E. Laboratory;
- F. Outpatient surgical facility;
- G. Pharmacy;
- H. Business establishment selling or renting durable medical equipment; or
- I. Any other source for services or supplies covered under this Plan.

Current types of Preferred Providers include the following:

- A. Preferred Provider Prescription Drug Program. Effective June 1, 2021, Preferred Providers under the Preferred Provider Prescription Drug Program include Pharmacies in the Express Scripts network.
- B. Preferred Provider Comprehensive Major Medical Network. Effective June 1, 2021, the Preferred Provider network for Comprehensive Major Medical Benefits includes only those Hospitals, Physicians, and other health care professionals in the UnitedHealthcare Choice Plus Network.
- C. Preferred Provider Dental Care Network. The Delta Dental Network includes the Preferred Providers of Dental Care Benefits.

**1.33. PRESCRIPTION MEDICATION**

“Prescription Medication” means a drug or biological obtained or dispensed only by a Prescription Order of a Physician, including OTC Preventive Care medications, proton-pump inhibitors, and non-sedating antihistamines upon a Physician’s Prescription Order. Prescription Medication also includes insulin and diabetic supplies.

**1.34. PRESCRIPTION ORDER**

“Prescription Order” means a Physician’s written order for dispensing a Prescription Medication.

**1.35. PREVENTIVE CARE**

“Preventive Care” means products and services for which the Plan may not impose cost-sharing requirements under Section 2713 of the Public Health Services Act and its implementing regulations. Preventive Care includes:

- A. Preventive care recommended by the United States Preventive Services Task Force;
- B. Immunizations for children, adolescents, and adults recommended by the advisory committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- C. Preventive care and screenings for infants, children, adolescents, and women recommended by the Health Resources and Services Administration.

The recommendations that define Preventive Care change regularly. Products and services described in new recommendations will be covered as Preventive Care beginning on the first day of the Plan Year following the date the recommendation was issued. When a recommendation is retracted, the Plan will immediately cease covering the recommended products or services as Preventive Care. To the extent that Preventive Care recommendations do not specify the method, treatment, or setting for the provision of Preventive Care, the Plan will establish reasonable medical management conditions for Preventive Care. If you incur costs for a product or service in a manner that is inconsistent with the Plan’s medical management conditions, the Plan will not treat the product or service as Preventive Care. For more information regarding Preventive Care or to determine whether a product or service is currently covered as Preventive Care, contact the Plan Administrator.

**1.36. PROVIDER**

“Provider” means an institution, organization, or person that furnishes Health Services either directly or pursuant to a prescription or directive from a person licensed by the state to make such a prescription or directive.

**1.43. TOTAL DISABILITY**

“Total Disability” means any physical condition that begins after the Eligible Person becomes covered under the Plan, results from Injury or disease, and wholly and continuously prevents the Eligible Employee from engaging in his regular or customary occupation or, in the case of a Dependent, prevents the Dependent from engaging in substantially all of the normal activities of a person of like age and sex in good health. An Eligible Employee’s Total Disability status must be verified periodically by an attending Physician’s statement that the Eligible Employee remains Totally Disabled.

**1.44. TREATMENT PLAN**

“Treatment Plan” means a written report showing the recommended treatment of any dental disease, defect, or Injury prepared by a Dentist as a result of the Dentist’s examination of an Eligible Person.

**1.45. TRUST AGREEMENT**

“Trust Agreement” means the Restated Agreement and Declaration of Trust of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund, including all amendments and modifications as may from time to time be made.

**1.46. TRUSTEES**

“Trustees” means the Board of Trustees designated in the Trust Agreement of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund, together with their successors designated and appointed in accordance with the terms of the Trust Agreement. The Trustees, collectively, will be the “Administrator” of this Plan.

**1.47. TRUST FUND**

“Trust”, “Trust Fund” or “Fund” means the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund.

**1.48. UNION**

“Union” means any of the following locals:

- A. Effective September 1, 2018, the United Food and Commercial Workers Union District Local 663 and the Food Handlers Division of District Local 663, Section A;
- B. Effective September 1, 2018 other Local Union that is or may become a part of the United Food and Commercial Workers Union District Local 663 and the Food Handlers Division of District Local 663, Section A; and
- C. Any Local Union that represents Employees of any employer who is required to become a Contributing Employer to this Plan.

**SECTION 2 SCHEDULE OF BENEFITS**

**2.1. COMPREHENSIVE MAJOR MEDICAL BENEFITS**

Below is the schedule of benefits for “Comprehensive Major Medical Benefits.”

**PLEASE NOTE: Out-of-network inpatient non-Emergency Services are excluded from coverage, except that the Plan will cover certain non-Emergency Services furnished to you by a non-Preferred Provider at a Participating Healthcare Facility subject to the conditions described below in Section 3.2.1A.B, the Plan’s generally applicable cost-sharing and coordination of benefits provisions, and in accordance with the Consolidated Appropriations Act, 2021.**

Deductible amount per Calendar Year	
Per Eligible Person	\$750
Per Family	\$2,250
Copayment	\$25 per office visit \$50 per specialist visit \$250 per emergency room visit
Plan’s Coinsurance (including In-Hospital and Physician’s Services and Out-of-Hospital Major Medical Services)	Plan pays 80%
Out-of-pocket maximum per Calendar Year (including the deductible)	
Per Eligible Person	\$3,000
Per Family	\$6,000
<i>The Plan generally pays 100% of covered expenses in excess of the out-of-pocket maximum for remainder of that Calendar Year</i>	
Preventive Care (including routine immunizations that are Preventive Care)	Plan pays 100%
Routine Physical Examinations that are not Preventive Care per Eligible Person per Calendar Year	Plan pays 100%
<b>Doctor on Demand</b>	Plan pays 100%
Telehealth visits other than through Doctor on Demand	Plan pays 80%, unless the visit is for COVID-19, in which case the Plan pays 100%

**2.2. PRESCRIPTION DRUG BENEFITS**

Effective June 1, 2021, only Prescription Medication purchased through the Express Scripts network will be covered. Prescription Medication filled at CVS, Walmart, Target, Hy-Vee, Sam’s Club, Costco, and Coborn’s will not be covered or reimbursed. Below is the schedule of benefits for “Prescription Drug Benefits.”

Out-of-pocket maximum per Calendar Year	
Per Eligible Person	\$3,600
Per Family	\$7,200
<b>Prescription</b>	<b>Plan’s Coinsurance</b>
Prescriptions purchased at a retail pharmacy, except as otherwise specifically stated	Plan pays 80%
OTC proton-pump inhibitors and OTC non-sedating antihistamines upon a Physician’s written prescription	Plan pays 100%
Prescriptions purchased through the Specialty Drug Program	Plan pays 80%

Certain drugs will be subject to prior authorization and some will also be subject to “Step Therapy,” split fills (i.e. a 30-day prescription will be filled in two 15-day increments to determine whether the drug is tolerated by participant to reduce waste) and quantity level limits (dispensing only quantities that will actually be used).

The Step Therapy program is a “step” approach to providing the medications that treat your condition. This means that you may first need to try a more clinically appropriate or cost-effective medication before certain higher-cost medications will be approved. Step Therapy programs can help both you and the Plan save money. A medication meets the Plan’s Step Therapy requirements if it is the most cost-effective medication available to treat a disease or condition. This means that if your doctor prescribes you a new medication that is subject to the Plan’s Step Therapy program, the Plan will initially only cover the least expensive “step” in that drug class, typically a generic drug. If the first step medication does not safely and effectively treat your condition, the Plan will cover the next “step,” typically a formulary brand medication.

Effective June 1, 2021, if your doctor recommends prescription drugs or quantities that do not comply with the prior authorization and/or Step Therapy protocols, your doctor will need to submit a prior authorization (PA) request that will include the medical reasons supporting that request to Express Scripts. Your doctor can visit [www.express-scripts.com](http://www.express-scripts.com) to download the PA form. If, as of August 1, 2019, you have started use of a prescription under the Plan’s schedule in a manner that does not follow the above rules, you will be grandfathered with regard to that prescription and with regard to the above rules for Step Therapy and prior authorization. To obtain a current list of these prescriptions, please call the Plan Administrator at (952) 851-5797.

## **SECTION 3 PREFERRED PROVIDER NETWORKS**

### **3.1. PREFERRED PROVIDER PRESCRIPTION DRUG PROGRAM**

When a full-time Eligible Employee or Eligible Dependent or a part-time Eligible Employee (and their Dependent Children, if applicable) opts to purchase Prescription Medications through the Preferred Provider Prescription Drug Program, benefits are payable subject to the following terms and conditions.

Effective June 1, 2021, the Preferred Provider for the Prescription Drug Program is Express Scripts. Only prescriptions that are purchased through the Express Scripts network will be covered.

#### **3.1.1. Payment of Benefits**

An Eligible Person must show his or her Plan Participant I.D. card at the network retail Pharmacy to receive discounts through the Preferred Provider Prescription Drug Program and must pay the required coinsurance at the time of purchase. Benefits are payable at the coinsurance stated in the Schedule of Benefits.

The Plan will provide coverage for specialty Prescription Medications through the specialty drug network. Benefits are payable at the coinsurance stated in the Schedule of Benefits.

#### **3.1.2. Eligible Expenses**

The expenses for Prescription Medications that are provided in Comprehensive Major Medical Benefits are also covered under the Preferred Provider Prescription Drug Program, except that injections and injectables are covered through the Specialty Drug Program.

#### **3.1.3. Generic Substitution Requirement**

Generic Prescription Medication will be substituted in lieu of any prescribed brand name Prescription Medication if it is commercially available and if such substitution is consistent with the prescription, the dispensing pharmacist's professional judgement, and applicable law.

### **3.2. PREFERRED PROVIDER NETWORK**

Effective June 1, 2021, the Plan uses the UnitedHealthcare Choice Plus Network as its Preferred Provider network. Although the Plan covers certain services at in-network and out-of-network Hospitals and services provided by Preferred Providers and non-Preferred Providers, you will generally pay less if you use an in-network or Preferred Provider.

Subject to the Plan's standard cost-sharing requirements (coinsurance, copayments, and deductibles) and coordination of benefits rules, the Plan will cover certain claims for services provided by non-Preferred Providers as if the services were provided by Preferred Providers (i.e., you will not be subject to balance billing). This rule applies to: (i) claims for Emergency Services provided by a non-Preferred Provider and/or at a non-Participating Health Care Facility; (ii) claims for certain non-Emergency Services furnished to you by a non-Preferred

Provider at a Participating Health Care Facility; and (iii) claims for non-Preferred Provider Air Ambulance Services. in accordance with the Consolidated Appropriations Act, 2021. The exact costs payable by you and the Plan for such claims will be determined in accordance with rules and regulations established pursuant to the Consolidated Appropriations Act, 2021.

### **3.2.1. Payment of Benefits**

Benefits will be payable for Hospital and Physician services and supplies at the Plan's coinsurance, applied to the Hospital's or Physician's negotiated charge according to the contract in effect at the time charges are incurred. Effective June 1, 2021, the Plan's Preferred Provider network also offers Wellness CARE (a tobacco and nicotine cessation program) and Maternity CARE (a prenatal support program).

For charges incurred with Preferred Providers, the Plan will pay a discounted amount. Such Providers have agreed to accept payment from the Plan as payment in full, except for applicable deductibles, coinsurance, copayments, maximum benefit limitations, or other similar limitations under the Plan.

For charges incurred with non-Preferred Providers, the Plan will pay the Usual and Customary Charge or, if applicable, a separately negotiated amount to the non-Preferred Provider. Additionally, the Eligible Person will be responsible for applicable deductibles, coinsurance, copayments, maximum benefit limitations, and other similar limitations under the Plan and may be billed for the balance by the non-Preferred Provider, except as described below in Section 3.2.1A.

#### **3.2.1A. Certain Non-Preferred Provider Services Treated as Preferred Provider Services**

Effective March 1, 2022, subject to the Plan's standard cost-sharing requirements (coinsurance, copayments, and deductibles) and coordination of benefits rules, the Plan will cover certain claims for services provided by non-Preferred Providers as if the services were provided by Preferred Providers (i.e., you will not be subject to balance billing). This rule applies only to: (i) claims for Emergency Services provided by a non-Preferred Provider and/or at a non-Participating Health Care Facility; (ii) claims for certain non-Emergency Services furnished to you by a non-Preferred Provider at a Participating Health Care Facility; and (iii) claims for non-Preferred Provider Air Ambulance Services. The exact costs payable by you and the Plan for such claims will be determined in accordance with rules and regulations established pursuant to the Consolidated Appropriations Act, 2021.

- A. Emergency Services Provided by a Non-Preferred Provider and/or at a Non-Participating Health Care Facility. Emergency Services provided by a non-Preferred Provider and/or at a non-Participating Health Care Facility will be covered to the same extent as if provided by a Preferred Provider at a Participating Health Care Facility. This may include costs for additional services after the patient stabilizes, such as post-stabilization outpatient observation or inpatient or outpatient stays with respect to the visit for which the Emergency Services were initially furnished. Post-stabilization items and services will not be treated as in-network Emergency Services, however, if both of the following are true:
  - 1. The attending Emergency Physician or treating Provider determines that the individual is able to travel using nonmedical transportation or nonemergency medical transportation to an

available Preferred Provider or Participating Health Care Facility located within a reasonable travel distance, taking into account the individual's medical condition; and

2. Except in cases where unforeseen, urgent medical needs arise, the non-Preferred Provider or non-Participating Health Care Facility furnishing the post-stabilization items or services satisfies the notice and consent criteria described below for non-Emergency Services provided by a non-Preferred Provider at a Participating Health Care Facility, but subject to the following additional conditions:
  - (a) If the Hospital or Independent Freestanding Emergency Department is a Participating Health Care Facility, but the Provider is a non-Preferred Provider, the written notice must contain a list of any Preferred Providers at the Participating Health Care Facility who are able to furnish the items and services involved and must notify the patient that he or she may be referred, at his or her option, to such a Preferred Provider; or
  - (b) If the Hospital or Independent Freestanding Medical Department is not a Participating Health Care Facility, the written notice must include a good faith estimate of the charges for items or services furnished by the facility or Providers for the visit (and any items or services reasonably expected to be furnished by the facility or non-Preferred Providers in conjunction with those items or services).

**B. Non-Emergency Services Provided by a Non-Preferred Provider at a Participating Health Care Facility.**

1. When an Eligible Person receives non-Emergency Services at a Participating Health Care Facility, the Plan will cover the following to the same extent as if provided by Preferred Providers (provided that all other criteria for coverage are met, e.g., the services are Medically Necessary):
  - (a) Ancillary services, which are:
    - i. Items and services related to Emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner;
    - ii. Items and services provided by assistant surgeons, hospitalists, and intensivists;
    - iii. Diagnostic services, including radiology and laboratory services; and

- iv. Items and services provided by a non-Preferred Provider if there is no Preferred Provider who can furnish such item or service at such facility; and
  - (b) Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-Preferred Provider satisfied the notice and consent criteria described below.
- 2. Non-Emergency Services provided by a non-Preferred Provider at a Participating Health Care Facility will not be covered to the same extent as if provided by a Preferred Provider if the Provider or the Participating Health Care Facility (on behalf of the Provider) satisfies the following notice and consent criteria by:
  - (a) Providing the patient a written notice within the time frame noted below, in paper form or, as practicable, electronic form (as selected by the patient), provided separately from other documents and containing the following information:
    - i. A statement that the Provider is a non-Preferred Provider;
    - ii. A good faith estimate of the charges for the items and services involved or reasonably expected to be provided;
    - iii. Notice that the estimate of charges or the patient's consent to be treated by the non-Preferred Provider is not a contract for the estimated charges or a contract to be treated by that Provider or at that facility;
    - iv. A statement that prior authorization or other care management limitations may be required before receiving further items or services at the facility; and
    - v. A clear statement that consent to receive items or services from the non-Preferred Provider is optional, that the patient may instead seek care from an available Preferred Provider, and that, in such cases, cost-sharing would be limited to Preferred Provider cost-sharing amounts;
  - (b) Providing the written notice:
    - i. Not later than 72 hours before the date on which the individual is furnished the items or services, when the appointment is scheduled at least 72 hours in advance; or

- ii. Not later than three hours before the appointment, when the appointment is not scheduled at least 72 hours in advance;
    - (c) Obtaining from the patient (or Participant, Beneficiary, or other authorized representative) a signed consent that is current (i.e., has not been revoked), that was obtained voluntarily (i.e., the individual must be able to consent freely, without undue influence, fraud, or duress), and that is in a form specified by the Department of Health and Human Services. The consent must:
      - i. Acknowledge in clear and understandable language that the patient (or Participant or Beneficiary) has been provided the written notice described above in the form (mail or email) he or she selected and informed that the payment of non-Preferred Provider charges might not count toward a deductible, out-of-pocket maximum, or other cost-sharing limitation;
      - ii. State that by signing the consent, the individual agrees to be treated by the non-Preferred Provider and understands that he or she may be billed for the balance and subject to cost-sharing requirements that apply to services furnished by a non-Preferred Provider; and
      - iii. Document the time and date of receipt of the written notice described above and the time and date of the signed consent;
    - (d) Providing the patient with a copy of the signed written notice and consent in person, by mail, or by email; and
    - (e) Making the notice and consent available upon request in any of the 15 most common languages in the state or geographic region and, for other languages, if the individual does not understand the notice and consent, obtaining the services of a qualified interpreter to assist the individual with understanding the notice and consent.
- C. Non-Preferred Provider Air Ambulance Services. Air Ambulance Services provided by a non-Preferred Provider may be treated as Preferred Provider expenses as described below in Section 5.1.I.2.

### **3.2.2. UMR Maternity Management Service**

Effective June 1, 2021, Employees and Eligible Dependents have access to UMR's maternity management service, UMR Maternity CARE. Enrolling in this program can help

you learn how healthy lifestyle choices and proper medical care before and during your pregnancy can boost your odds of having a healthy, full-term baby.

The Plan will pay for the cost of participation and a \$50.00 gift card sent to those completing the program.

Additionally, if an Eligible Person enrolls in the maternity management service prior to the second trimester of pregnancy, the Plan will pay benefits for such pregnancy and delivery-related expenses at ninety percent (90%) instead of eighty percent (80%).

If an Eligible Person is expecting, she should call UMR at 888-438-8105 or visit [www.umar.com](http://www.umar.com) before the second trimester to enroll and obtain the maximum benefits possible.

### **3.3. ELIGIBLE PERSON'S CHOICE OF COVERED HEALTH CARE PROVIDER**

Eligible Persons will have the sole right to select their own Physician, Dentist, Hospital, and other covered health care Providers.

**PLEASE NOTE:**      **Out-of-network inpatient non-Emergency Services are excluded from coverage, except that the Plan will cover non-Emergency Services furnished to you by a non-Preferred Provider at a Participating Healthcare Facility subject to the conditions described above in Section 3.2.1A.B, the Plan's generally applicable cost-sharing and coordination of benefits provisions, and in accordance with the Consolidated Appropriations Act, 2021.**

## SECTION 5 BENEFIT DESCRIPTIONS

Benefits payable under this Plan are subject to the terms and provisions of the Plan in the amounts specified in this Section or in the applicable Schedule of Benefits.

### 5.1. COMPREHENSIVE MAJOR MEDICAL BENEFITS

Comprehensive Major Medical Benefits are payable for full time Eligible Employees and their Eligible Dependents and part time Eligible Employees (and their Dependent Children, if applicable), subject to the conditions of this Section.

#### 5.1.1. Cost-Sharing

- A. Deductible. The Deductible Amount must be satisfied each Calendar Year for each Eligible Person before expenses will be payable under this Section for the Eligible Person. The deductible amount per Eligible Person and per family for each Calendar Year is stated in the Schedule of Benefits.
- B. Copayments. A copayment, which is a fixed dollar amount you pay toward a Health Service, is required for some Health Services, such as office, specialist, and emergency room visits. Copayments do not count toward the deductible or coinsurance and are stated in the Schedule of Benefits.
- C. Coinsurance. After satisfaction of the required deductible amount, the Plan provides for payment of covered expenses at the coinsurance percentage stated in the Schedule of Benefits. The Eligible Person is responsible for the balance of covered expenses.
- D. Out-of-Pocket Maximum. When the out of pocket expenses in any one (1) Calendar Year reaches the maximum stated in the Schedule of Benefits, the Plan generally pays one hundred percent (100%) of the balance of covered expenses that exceed the out of pocket maximum for the remainder of that Calendar Year. The out of pocket maximum includes the deductible amount.

#### 5.1.2. Covered Health Services

Benefits are payable for the Usual and Customary Charges incurred by an Eligible Person for the following services and supplies that are Medically Necessary for the treatment of an Injury or Illness (including pregnancy). Whether a covered item or service is Medically Necessary will be determined in accordance with UnitedHealthcare's medical policy.

- A. Hospital inpatient services recommended by the attending Physician for:
  - 1. Room and board expenses, up to the semi-private room rate and isolation when Medically Necessary. This benefit is also payable for a newborn Dependent Child of a part time Eligible Employee during the period the mother of the Child is Hospital confined as the result of giving birth to such Child, even though part time Eligible Employees are not provided Dependent coverage (unless coverage

for the Dependent Child is purchased by the part-time Eligible Employee). If the newborn Dependent Child has a condition (such

as Injury, Illness, congenital defect, or premature birth) that requires treatment, no coverage will be provided for any expenses incurred by the newborn Dependent Child including charges for Hospital confinement.

2. Confinement in an Intensive Care Unit, including confinement in duration of twenty-four (24) or more consecutive hours in a recovery room of a Hospital if the Eligible Person receives the same care and services as those normally provided in the Intensive Care Unit of the Hospital.
3. Drugs, medicines, diagnostic x-rays, and laboratory tests, and other miscellaneous Hospital services and supplies not included in the room charges (including the anesthetist's fee when charged by the Hospital), if used while confined in the Hospital as a resident patient or while in the outpatient department of the Hospital when outpatient surgery is performed (see paragraph (h)(vi) for coverage of pre-admission testing).
4. Services for confinement in a Hospital and services provided in an intensive day treatment program that are related to treatment of mental illness or nervous disorders. These services are payable the same as for any other disability.
5. Services provided for treatment during confinement in a Hospital or Residential Treatment Program for the treatment of alcoholism, chemical dependency, and substance abuse are payable the same as for any other disability.

Inpatient charges incurred at a detoxification center are not covered unless the center is located within a Hospital or Residential Treatment Program and appropriate medical or psychiatric care is being provided. Confinement strictly for custodial care and out-of-network inpatient non-Emergency Services are excluded from coverage, except that the Plan will cover inpatient non-Emergency Services furnished to you by a non-Preferred Provider at a Participating Healthcare Facility subject to the conditions described above in Section 3.2.1A.B, the Plan's generally applicable cost-sharing and coordination of benefits provisions, and in accordance with the Consolidated Appropriations Act, 2021.

Coverage for Emergency Services will be provided without the need for any prior authorization. The Plan will not impose any administrative requirement or limitation to coverage for Emergency Services from out-of-network Providers that is more restrictive than for Emergency Services from Preferred Providers.

The Plan will cover out-of-network Emergency Services, non-Emergency Services furnished to you by a non-Preferred Provider at a Participating

Healthcare Facility, and out-of-network Air Ambulance Services in accordance with the Consolidated Appropriations Act, 2021, as more fully described above in Section 3.2.1A. Your cost-sharing requirements for these specific out-of-network services will be no greater than would apply if the services were provided by Preferred Providers.

Under federal law, the Plan generally may not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a Provider obtain authorization from the Plan for prescribing a Hospital length of stay not in excess of these periods. 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 forty-eight (48) or ninety-six (96) hours, as applicable.

Successive Hospital confinements will be considered one (1) confinement unless they are due to entirely unrelated causes or:

1. If the Eligible Person is an active Eligible Employee, the Eligible Person has returned to active work for at least one (1) full working day before the subsequent confinement begins; or

Prescription Medication services do not include the following:

1. Supplies or appliances that are not Prescription Medication, even if obtained with a Prescription Order, such as devices, bandages, heat lamps, braces, splints, artificial appliances, and diaphragms, except for diabetic supplies;
  2. Drugs and medications that can be obtained without a Prescription Order, except insulin, OTC Preventive Care medications, OTC proton-pump inhibitors, and OTC non-sedating antihistamines upon a Physician's written prescription through the Preferred Provider Prescription Drug Program);
  3. Cost of administering a Prescription Medication;
  4. Cost of Prescription Medications for use while the Eligible Person is confined in a Hospital;
  5. Any Prescription Medication that is not approved for sale by the United States Government;
  6. Cosmetic drugs;
  7. Health and beauty aids, cosmetics, and dietary supplements;
  8. State restricted drugs;
  9. Impotence medications; and
  10. Injections and injectables, except insulin when prescribed by a Physician and Prescription Medications obtained through the Preferred Provider's Specialty Drug Program.
- F. Hospice care for terminally ill Eligible Persons who otherwise, upon the recommendation of their Physician, would be required to be Hospital confined. Benefits are payable for home care administered under an approved Hospice Program or Home Health Care Agency at the patient's home, for care in a hospice unit of a Hospital, or for care in a separate hospice facility.

The following hospice care services are covered during the period the Eligible Person otherwise would have to be Hospital confined:

1. Physicians' visits;
2. Care provided by an R.N. and home health care aides;
3. Assessment visit by a Hospice program staff member;

- (e) In the absence of a medical contraindication, complete twelve (12) months of continuous hormone therapy appropriate to the Eligible Employee's and/or the Employee's Dependent's gender goals and complete twelve (12) months of living in a congruent gender role;
  - (f) Obtain treatment from a Provider and facility with appropriate experience in the provision of the requested services; and
  - (g) Obtain precertification prior to surgical procedure.
6. Hormone therapy is covered for an Eligible Employees and/or Employee's Dependent under the Prescription Drug Benefit under the following conditions:
- (a) Completion of evaluations as outlined and have a diagnosis of Gender Dysphoria with no contraindications to treatment;
  - (b) Treatment must be ordered and supervised by a Provider experienced in the treatment of individuals with Gender Dysphoria;
  - (c) The Eligible Employee and/or the Employee's Dependent must obtain precertification prior to beginning therapy; and
  - (d) The Eligible Employee and/or the Employee's Dependent must be age 18 or over.
- I. Other covered expenses for:
- 1. Maternity and obstetrical services performed by a Nurse Midwife.
  - 2. Local ground ambulance services to the nearest health care facility qualified to provide Medically Necessary treatment for an Emergency or acute illness, or a Provider-initiated inter-health care facility transfer to the nearest health care facility qualified to provide the Medically Necessary treatment.

Subject to the Plan's generally applicable cost-sharing and coordination of benefits provisions, the Plan also covers Medically Necessary Air Ambulance Services to the nearest health care facility qualified to provide Medically Necessary treatment for an Emergency. The Plan also will cover, subject to the Plan's generally applicable cost-sharing and coordination of benefits provisions, a Provider-initiated inter-health care facility transfer to the nearest health care facility qualified to provide the Medically Necessary treatment. Charges are payable for Medically Necessary Air Ambulance Services subject to the Plan's deductible and coinsurance and the reimbursement terms available to the Plan

through the Preferred Provider's contract. Air Ambulance Services will be provided only as Medically Necessary: (i) due to inaccessibility by ground transport; and/or (ii) if the use of ground transport would result in a serious adverse impact on the Eligible Person's health status.

Out-of-network Air Ambulance Services will be covered, subject to the Plan's generally applicable cost-sharing and coordination of benefits provisions, in accordance with the Consolidated Appropriations Act, 2021. The cost-sharing requirements will be the same as Air Ambulance Services provided by a Preferred Provider.

Expenses incurred for transportation and/or ambulance services, including Air Ambulance Services, are not covered if such services are incurred for the convenience of the Eligible Person, the Eligible Person's health care Provider, or the Eligible Person's family or another individual involved in the Eligible Person's care. Expenses for any transportation and/or ambulance services are not covered if the Plan determines that the transportation and/or ambulance services are not Medically Necessary.

3. Blood and blood plasma.
4. Health Services provided for the treatment of a full-time Employee's emotionally handicapped Dependent Children and furnished by a Residential Treatment Facility (included in the inpatient maximum stated in the Schedule of Benefits).
5. Outpatient surgery performed in the outpatient department of a Hospital.

6. Outpatient pre-admission tests and exams provided that:
  - (a) The surgery for which the tests or exams are furnished is performed within seventy-two (72) hours of the date on which they were given; and
  - (b) The Eligible Person is confined as an inpatient in the in-network Hospital immediately following the surgery.
7. Emergency room treatment for accidental Injury or an Emergency.
8. Services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for private duty nursing, other than a nurse who ordinarily resides in the Eligible Employee's home or is a member of the Employee's immediate family.
9. Artificial limbs or eyes to replace natural limbs or eyes, provided that replacement occurs promptly following the loss and in no event longer than twelve (12) months from the date of the loss, and repair or replacement of artificial limbs or eyes when Medically Necessary.
10. Casts, splints, trusses, braces, crutches, surgical dressings, and prosthetic appliances used only for medical treatment.
11. Rental of Hospital-type bed, wheelchair, iron lung, or other durable medical equipment. (The purchase of such device is covered if the rental would exceed the purchase price. However, the Fund Office must approve the purchase of any durable medical equipment.)
12. X-ray, radium, or cobalt treatment, including the services of a radiologist and the rental, but not the purchase, of such radioactive materials.
13. Outpatient radiation and chemotherapy treatment services.
14. Oxygen and the rental of equipment for its administration. (The purchase of such equipment is covered if the rental would exceed

24. Mastectomy bras, up to two (2) per Eligible Person per Calendar Year.
25. Jobst stockings, up to two (2) pair per Eligible Person per Calendar Year.
26. Discounted charges for walk in clinics in retail settings.
27. For the duration of the national emergency concerning COVID-19, the Plan will cover at 100% (no member cost share) claims for COVID-19 diagnostic testing and diagnosis as well as the related office (urgent care, emergency room) visit during which the treating health care provider determined such testing was Medically Necessary and appropriate according to the accepted guidelines of the Federal Food and Drug Administration ("FDA") and/or the respective state Department of Health.
28. Effective March 1, 2020, the Plan will pay claims for a medical or dental procedure for a Participant or Participant's Dependent(s) that was scheduled to occur prior to the declaration of the national emergency concerning COVID-19 on March 13, 2020 ("National Emergency") and was canceled by the health care or service provider due to the National Emergency, and who subsequently had his or her coverage terminated under the Plan before the procedure could be completed. To be eligible for coverage for such procedure, Participants and/or Dependent(s) must provide documentation to the Fund Office demonstrating that (1) the procedure was originally scheduled prior to the National Emergency for a date after such declaration; (2) the procedure was canceled by the health care or service provider after the commencement of the National Emergency; and (3) and the procedure was rescheduled and performed no later than December 31, 2020.
29. Effective January 15, 2022, and for the duration of the public health emergency concerning COVID-19, the Plan will provide coverage for at-home over-the-counter ("OTC") COVID-19 test kits subject to the following provisions. The Plan will only cover COVID-19 test kits available "over-the-counter" that have been approved by the FDA for use at home or elsewhere without involvement of a health care provider. The Plan will provide coverage for up to eight at-home OTC COVID-19 test kits per Eligible Person covered under the Plan every 30 days.

For Eligible Persons other than those covered under the Plan's Ancillary Benefits package, the Plan will cover 100% of the cost of an at-home OTC COVID-19 test kit purchased at a Preferred Provider Pharmacy. Plan reimbursement for at-home OTC COVID-19 test kits that are not purchased at a Preferred Provider Pharmacy will be limited to the cost of the test or \$12, whichever is

less. The Eligible Person is responsible for any amount in excess of \$12 for an at-home OTC COVID-19 test kit purchased at a non-Preferred Provider Pharmacy or any other retailer or supplier. The Plan will not count these costs towards the Prescription Drug Program annual out-of-pocket maximum.

For Eligible Persons covered only under the Plan's Ancillary Benefits package, the Plan will cover 100% of the cost of an at-home OTC COVID-19 test kit purchased at any Pharmacy or other retailer or supplier.

The above provisions only apply to at-home COVID-19 test kits and do not affect the Plan provisions regarding coverage at non-at-home OTC COVID-19 test kits described in Paragraph (27) above.

### **5.1.3. Preventive Care and Other Routine Care**

The deductible is waived for covered expenses related to the routine services described below. The Plan pays one hundred percent (100%) of the Usual and Customary Charges for products and services that meet the definition of Preventive Care. There is no cost-sharing for Preventive Care.

A. Routine physical examinations including charges for an examination, x rays, and laboratory tests performed by a Physician or surgeon in a Hospital, clinic, or Physician's office. Covered expenses include:

1. For Eligible Dependents of an Eligible Employee, only routine office visits for the ongoing care of a well-baby and routine well child care, including professional services or supplies related to routine immunizations of Dependent Children. With respect to childhood immunizations, the Plan will cover those recommended by the American Academy of Pediatrics and those that satisfy the definition of Preventive Care.
2. Examinations required by third parties, including, but not necessarily limited to, schools, employers, insurance companies, camps, and adoption agencies.
3. Examinations for the purpose of contraceptive management, including a pelvic examination and pap smear.

Benefits are not payable under this Routine Physical Examination Benefit for:

1. Routine immunizations or vaccinations, except as specifically stated;
2. Eye or dental examinations; or
3. Routine colonoscopy unless the colonoscopy is Preventive Care.

- B. Routine immunizations. With respect to childhood immunizations, the Plan will cover those recommended by the American Academy of Pediatrics, including but not limited to, those to prevent diphtheria, pertussis, tetanus, polio, measles, mumps, and rubella, and those that satisfy the definition of Preventive Care.

- I. Surrogate maternity services.
  - J. Services for which the Eligible Person is not required to pay.
  - K. Transportation, except ambulance services, including Air Ambulance Services, as described in Section 5.1.2.1.2.
  - L. Abortions.
  - M. Reversal or attempted reversal of a previous sterilization procedure.
  - N. Any services and supplies for, or related to, artificial insemination, in vitro-fertilization services, or other treatment in an attempt to achieve pregnancy.
  - O. Services to the clergy during normal duty when a charge usually would not be made.
  - P. Reversal of genital surgery; hair replacement or removal; voice therapy or lessons; liposuction; rhinoplasty; breast augmentation; lip reduction; lip augmentation; laryngeal or thyroid cartilage shaving or contouring; abdominoplasty; chest wall contouring; body contouring; facial contouring; skin resurfacing; collagen injections; reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or Gender Dysphoria surgery; cryopreservation of fertilized embryos; oocyte preservation; surrogate parenting; donor eggs; donor sperm and host uterus; or any other service considered to be cosmetic or not Medically Necessary under the Plan.
  - Q. Any diagnostic Hospital admission that can be performed on an outpatient basis.
  - R. The first \$20,000 of charges incurred as a result of any automobile accident if:
    - 1. The Eligible Person fails to maintain the statutory minimum level of no-fault automobile medical insurance protection, provided that the Eligible Person is required by applicable state law to maintain the protection;
    - 2. There is applicable no-fault coverage but the Eligible Person has failed to apply for coverage;
    - 3. A no-fault insurer has determined charges not to be Medically Necessary or Usual and Customary; or
    - 4. In states without a no-fault statute, the Eligible Person does not first exhaust medical payment coverage on the vehicle(s) involved in the accident.
- In cases where a no-fault carrier disputes coverage of the Eligible Person, the Plan may subrogate its interest in the payment of charges.
- S. Costs associated with the removal of organs from a transplant donor who is a living Eligible Person or who was an Eligible Person prior to his or her death.

- T. Services privately contracted with a provider that otherwise would be covered by Medicare that are incurred by an Eligible Person for whom Medicare is the primary source of coverage.
- U. Charges incurred for obtaining additional medical records.
- V. Claims submitted later than fifteen (15) months from the date incurred.

- W. Medical Expenses a third party (such as the driver of a car that caused an accident for which medical expenses were incurred) was responsible for paying if the Eligible Employee or Dependent, whether or not a minor, did not comply with the subrogation provisions of this Plan stated in Section 8.7.
- X. Charges incurred for any special education rendered to any Eligible Person, regardless of the type of education, except for education that qualifies as Preventive Care or as otherwise specifically stated.
- Y. Charges for special home construction to accommodate a disabled Eligible Person.
- Z. Charges incurred for completing claims forms (or forms required by the Plan for processing claims) by a Physician or other provider of medical services or supplies.
- AA. Any losses incurred by an Eligible Person at a time the Eligible Person owes payment to the Plan because of benefit payments made in reliance upon incorrect, misleading, or fraudulent statements or representations by the Eligible Person, or where such person has failed to honor the Plan's right of subrogation or reimbursement or otherwise failed to cooperate with the Plan as specified.
- BB. Radial keratotomy or Lasik surgery.
- CC. State and local taxes (other than those mandated by law that the Plan must pay, such as MinnesotaCare tax) or shipping and handling charges incurred on covered expenses.
- DD. Drugs or medicines prescribed by a Physician that are available as over the counter (OTC) purchases, including but not limited to, cough medicine, vitamin supplements, etc. (except as specifically provided through the Preferred Provider Prescription Drug Program for OTC proton-pump inhibitors and OTC non-sedating antihistamines), unless the prescription qualifies as Preventive Care.
- EE. Charges incurred for travel, whether or not recommended by a Physician, except if specified as a covered expense under the Plan.
- FF. Charges incurred for gambling addiction in a residential treatment program.
- GG. Any loss caused by, or resulting from, mental deficiency, mental retardation, developmental deficiencies, genetics, or any treatment for learning disabilities, except as otherwise specifically stated.
- HH. Any loss, expense, or charge for which:
  - 1. A third party may be liable; and

2. Either:
  - a. A recovery subject to the Plan's subrogation and reimbursement rights has been received (whether before or after the submission of or payment of claims by the Plan); or
  - b. The Plan deems it likely that recovery will be received.

At the discretion of the Trustees, losses, expenses, and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement. As used in this Section, the term "third party" includes any individual, insurer, entity, or federal, state or local government agency who is or may be in any way legally obligated to reimburse, compensate, or pay for an Eligible Person's loss, damages, Injuries or claims relating in any way to the Injury, occurrence, condition, or circumstance giving rise to the Plan's provision of medical, dental, or disability benefits, including but not limited to, insurers providing liability, medical expense, wage loss, uninsured motorist, or under-insured motorist coverages.

- II. Any loss, expense, or charge incurred as the result of any Injury, occurrence, conditions, or circumstance for which the injured Eligible Person:
  1. Has the right to recover payment from a third party (at the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement);
  2. Has recovered from a third party; or
  3. Has not submitted a claim for the loss, expense, or charge prior to resolution of the third party claim.
- JJ. Charges for Injury or Illness resulting from the Eligible Person's participation in a riot or the Eligible Person's commission of any act that may be charged as a felony or gross misdemeanor offense, except in circumstances involving domestic violence or when the commission of the gross misdemeanor or felony is caused by a mental health condition.
- KK. Charges for any Injury or Illness that results from an incident occurring on any property where the lessee or lessor or owner of the property is responsible for Injury or Illness or what otherwise is covered under homeowner's insurance. However, the Plan will consider the charges if: no insurance or other form of compensation is available to the Eligible Person; and the Eligible Employee signs a subrogation agreement in the form designated by the Trustees with the Plan.
- LL. Charges for PCSK9 drugs and drugs containing bulk powders unless the Eligible Person receives preauthorization by the Plan for such drugs.
- MM. Charges for out-of-network inpatient services except in the case of an Emergency and as provided in Section 3.2.1A.B.

## SECTION 7 CLAIMS, REVIEW, AND APPEAL PROCEDURES

### 7.1. CLAIMS PROCEDURE

The following procedures have been established by the Trustees for processing claims. For claims involving Plan benefits that are insured, the terms of the insurance policy will govern in the event of a conflict.

#### 7.1.1. Notice of Claim

A. Pre-Service Claims. An Eligible Person must obtain:

1. Prior authorization for prophylactic mastectomies;
2. Certification of Medical Necessity for chiropractic visits exceeding twenty (20) per Eligible Person per Calendar Year;
3. Prior approval for the purchase of certain durable medical equipment specified in Subsection 5.1.2.H.11; and
4. Predetermination for certain dental services as specified in Section 5.3.

The claims listed above are called “pre-service claims,” which are claims that require approval of the benefit in advance of obtaining medical care. Claims requiring prior authorization must be submitted in writing to the Fund Office.

There are special provisions in the Claims Procedure Regulations for “urgent care claims,” but, by definition, these provisions do not apply because the Plan does not require prior authorization of urgent care or Emergency Services.

B. Post-Service Claims. Any Claim for benefits that is not a pre-service claim is considered a “post-service claim.” An Eligible Person must submit all post-service claims in writing within ninety (90) days of the occurrence of the accident or illness or as soon as reasonably possible. In no event (except in the absence of legal capacity) can a claim be submitted later than fifteen (15) months from the date of service.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing a post-service claim.

Starting on March 1, 2020, the deadline to file a post-service claim was suspended during a “Tolling Period,” which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the “Outbreak Period”); or

charged an improper dollar copayment or percentage coinsurance (for example through the Preferred Provider Prescription Drug Program), he or she may submit a formal appeal to have his or her claim reviewed according to the claims review and appeal procedure. The appeal must be submitted to the Fund Office in writing within one hundred eighty (180) days of being charged the coinsurance or copayment.

### **7.1.3. Determination of Eligibility**

On receipt of the completed claim form, the Fund Office will determine, based upon Plan records, whether the claimant was eligible for benefits at the time the charges were incurred. The Fund Office also will assist Eligible Persons in obtaining benefits to which they are entitled.

### **7.1.4. Determination of and Amount of Benefits Payable**

The determination of benefits payable will be based upon the claimant's eligibility and the provisions of the Plan. The amount of benefits payable will be based on the Schedule of Benefits in effect for the applicable class of Eligible Person when the covered charges were incurred.

The determination of the type of benefits payable, if any, and the amount of benefits payable will be the function and responsibility of the claims agent named by the Trustees.

### **7.1.5. Distribution of Benefits Payments**

Generally, benefits the Fund Office determines are payable are automatically paid directly to the Provider of service if: (i) the charges were incurred with a Preferred Provider; and (ii) the Fund Office accepts a request to pay the claims directly to the Provider. The Eligible Person will be sent a copy of the processed claim payment for the Eligible Person's records. If the Fund Office does not accept a request to pay the Provider directly, or the charges were incurred with a non-Preferred Provider, benefits will be paid directly to the Eligible Person upon proper submission of the claim and proof of payment.

Notwithstanding the previous paragraph, the Fund Office will make payments directly to non-Preferred Providers and non-Participating Health Care Facilities for Emergency Services, certain non-Preferred Providers for non-Emergency Services performed at Participating Health Care Facilities, and non-Preferred Provider Air Ambulance Services in accordance with the Consolidated Appropriations Act, 2021 and Section 5.1.2.1.2 above.

Although the Plan may make payments directly to Providers, such payments do not make a Provider an assignee for any purposes or otherwise confer on the Provider any rights under the Plan or ERISA. Any attempt to assign any rights, claims or causes of action to any person or entity will be null and void absent written consent by the Plan.

## **7.2. CLAIMS REVIEW PROCEDURE**

When a claim for benefits is submitted to the Fund Office, the Fund Office will determine eligibility and calculate the amount of benefit payable, if any.

If the claimant feels that the action taken on his eligibility or claim is incorrect, the claimant immediately must ask the Fund Office to review the claim with him. In some cases, the Fund Office may request additional information that might enable the Fund Office to reevaluate its decision.

#### **7.4. EXTERNAL REVIEW**

The Plan will permit external review of adverse benefit determinations in accordance with Section 2719 of the Public Health Service Act and its implementing regulations. If the Plan denies your claim (including a claim involving consideration of whether the Plan is complying with the surprise billing prohibitions of Sections 716 and 717 of ERISA and the regulations issued thereunder, as provided by the Consolidated Appropriations Act, 2021) or if your coverage is rescinded, and your appeal of that adverse benefit determination is denied, you may seek external review of the Plan's decision. To seek external review, you must file a request with the Fund Office within four (4) months from the date you receive notice that the Plan denied your appeal of the initial adverse benefit determination. For more information on external review, contact the Fund Office.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing a request for an external review.

Starting on March 1, 2020, the deadline to file a request for an external review was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the claimant was first eligible for relief from the deadline related to filing a request for an external review. The earliest date that a claimant was first eligible for relief from a deadline related to filing a request for an external review was either:

1. March 1, 2020 for claim appeal denials occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
2. The date of a claim appeal denial after March 1, 2020, but before March 1, 2021.

The calculation of a claimant's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each claimant. The Tolling Period may not exceed one (1) year. If the claim appeal denial was provided to the claimant prior to March 1, 2020, the number of days by which the claimant is required to take action after the Tolling Period is shortened by the number of days between the date that the claim appeal denial was provided and March 1, 2020.

#### **7.5. PHYSICAL EXAMINATIONS**

The Plan, at its own expense, will have the right and opportunity to examine an Eligible Person whose illness is the basis of a claim when, and as often as, it may reasonably require during pendency of a claim under the Plan.

#### **7.6. RECORDS**

Each Eligible Person authorizes and directs any provider that has attended, examined, or treated him to furnish the Fund, at any time upon its request, any and all information and records or copies

of records relating to provided services. The Fund agrees that any information and records obtained pursuant to this Section will be considered confidential and will be protected in accordance with HIPAA requirements and Section 10.2.

#### **7.7. ACTIONS AGAINST THE PLAN**

No Eligible Person may bring an action at law or in equity, including proceedings before administrative agencies, to recover from the Plan until the Claims Review and Appeal Procedure stated in Section 7.2 has been exhausted. No action may be brought at all unless it is brought within two (2) years from the time the claim was required to be filed with the Plan.

#### **7.8. ASSIGNMENT OF RIGHTS AND APPOINTING AN AUTHORIZED REPRESENTATIVE TO ACT ON YOUR BEHALF**

An authorized or legal representative may act on behalf of a claimant in filing a claim or pursuing an appeal of an adverse benefit determination. The claimant must first submit a signed letter to the Fund Office specifically identifying the person as the authorized or legal representative of the claimant. Neither the claimant nor any duly authorized representative will have the right to make a personal appearance before the Board of Trustees or any committee created by the Board of Trustees. Although a claimant may appoint an authorized representative to act on their behalf, under no circumstances may a claimant assign any rights under the Plan or ERISA, including any rights to appeal adverse benefit determinations or any causes of action that may arise after the denial of benefits.

## SECTION 8 PAYMENT OF BENEFITS

### 8.1. COORDINATION OF BENEFITS (COB)

This Section is applicable to all Eligible Persons.

#### 8.1.1. Summary

Benefits payable under this Plan will be coordinated with benefits payable under any "Other Group Plan," as defined in this Section, so that the aggregate amount paid under this Plan and by any "Other Group Plan" does not exceed one hundred percent (100%) of the charge incurred. In no event will this Plan's payment exceed the amount that would have been paid if there were no other plan involved. Benefits payable under another plan include the benefits that would have been payable even if no claim was actually filed.

#### 8.1.2. Definitions

- A. "Other Group Plan," as used in these COB provisions, means any plan providing benefits or services for, or by reason of, medical, dental, or vision care or treatment or healing under:
1. Group, blanket, franchise, or any other arrangement for coverage of individuals in a group whether on an insured or non-insured basis;
  2. Group UnitedHealthcare or other prepayment coverage provided on a group basis;
  3. Group-Type Contracts other than individual insurance issued on a franchise basis, with "Group-Type Contract" meaning a contract that is not available to the general public and can only be obtained and maintained through membership or affiliation with a particular organization or group;
  4. Any group or group-type and individual automobile "no-fault" and traditional automobile "fault" type contracts;
  5. A school or other education institution that covers grammar, high school, and college students for accidents, including athletic injuries, either on a twenty-four (24) hour basis or on a "to and from school" basis;
  6. Any federal or state or other governmental programs, except Medicare, and any coverage required or provided by statute;
  7. A labor-management trusteed plan, union welfare plan, employer organization plan, or employee benefit organization plan; and
  8. Medicare, both Part A and Part B, whether or not the Eligible Individual is enrolled in both parts.

comply with the Affordable Care Act, that term or provision will not be enforced to the extent that it does not comply with the Affordable Care Act. A determination that a term or provision of the Plan cannot reasonably be construed to comply with the Affordable Care Act will not affect any other term or provision of the Plan.

**10.4. GENETIC INFORMATION NONDISCRIMINATION ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

**10.5. CONSOLIDATED APPROPRIATIONS ACT, 2021**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Consolidated Appropriations Act, 2021 ("CAA"). The Plan has been amended to comply with the requirements of the CAA as of the effective date of Amendment No. 18: March 1, 2022.