Northern Minnesota-Wisconsin Area
Retail Clerks Fringe Benefit Funds

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SUMMARY OF MATERIAL MODIFICATIONS
TO THE
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
OF THE
NORTHERN MINNESOTA-WISCONSIN AREA RETAIL FOOD
HEALTH AND WELFARE FUND
(2019 Restatement)

IMPORTANT NOTICE TO PLAN PARTICIPANTS AND BENEFICIARIES

The Board of Trustees has amended the Plan Document and Summary Plan Description ("SPD"). This notice summarizes the changes in SPD Amendments No. 6 through 9 and the effective dates of the changes.

Amendment No. 6, Effective Date October 28, 2020, except as otherwise indicated.

The Plan was amended to incorporate the Department of Labor's proposed notice to Participants and Beneficiaries regarding the interaction between COBRA continuation coverage and Medicare eligibility. In general, if a Participant or Beneficiary does not enroll in Medicare Part A or B when the individual is first eligible because the individual is still employed, after the Medicare initial enrollment period, the individual has an eight (8) month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of the month after employment ends, or the month after group health plan coverage based on current employment ends. If the individual does not enroll in Medicare and elects COBRA continuation coverage instead, the individual may have to pay a Part B late enrollment penalty and may have a gap in coverage if the individual decides they want Part B later. If the individual elects COBRA continuation coverage and later enrolls in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate continuation coverage. However, if Medicare Part A or B coverage is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if the individual enrolls in the other part of Medicare after the date of the election of COBRA coverage.

The Plan was also amended to clarify that Participants and Beneficiaries may have various options available to them when they lose group health coverage. For example, they may be eligible to buy an individual plan through the Health Insurance Marketplace, gain coverage under another plan (such as a spouse's plan), or enroll for coverage under Medicare, Medicaid, Children's Health Insurance Program (CHIP). Some of these options may cost less than COBRA continuation coverage.

Amendment No. 7, Effective Date April 28, 2021, except as otherwise indicated.

The Plan was amended to phase out certain deadline extensions that were tolled in response to the COVID-19 public health emergency.

Starting on March 1, 2020, the timeframes for Participants and Beneficiaries to request special enrollment, elect COBRA coverage, make COBRA payments, notify the Plan of a qualifying event or determination of disability, file a claim, appeal an adverse benefit determination, and request an external review were 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 Participant or Beneficiary was first eligible for relief from the deadline or timeframe for a circumstance listed above. The calculation of a Participant or Beneficiary's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each Participant or Beneficiary. The Tolling Period may not exceed one (1) year.

Amendment No. 8, Effective Date April 1, 2021.

In response to the American Rescue Plan Act of 2021, the Plan was amended to allow individuals who lost Plan coverage due to an involuntary termination of employment (except for termination due to gross misconduct) or a reduction in hours to either elect or re-elect COBRA continuation coverage during the period from April 1, 2021 through September 30, 2021 if the individual either never elected COBRA or had elected COBRA but stopped making payments to continue COBRA continuation coverage. This extended COBRA election opportunity, however, is only available to the extent that the individual's maximum COBRA continuation coverage period (typically 18 months, but up to 36 months in special circumstances) has not expired or ended because of eligibility for another group health plan or Medicare.

The Plan was also amended to provide that COBRA self-payments are waived during the period from April 1, 2021 through September 30, 2021 for any individual described above who is eligible for and enrolls in COBRA continuation coverage. This also includes individuals who lose Plan coverage due to involuntary termination of employment (except for termination due to gross misconduct) or a reduction in hours during the period from April 1, 2021 through September 30, 2021. Eligibility for the COBRA self-payment waiver ends when an individual becomes eligible for coverage under another group health plan or Medicare.

Amendment No. 9, Effective Date January 1, 2021, except as otherwise indicated.

The Plan was amended generally to clarify that the Plan provides mental health coverage on the same basis as coverage for physical medical conditions, subject to any specific rules, exceptions, or limitations in the SPD regarding specific physical or mental health conditions or treatments. The amendment reflects that sex transformations are not excluded from coverage under the Plan.

The Plan was also amended to clarify that although the Preferred Provider Pharmacy Program does not cover charges for the administration or injection of any drugs, the Program covers administration or injection of immunizations that are otherwise covered by the Plan.

The Plan was also amended to clarify that Plan benefits do not include habilitative services.

Finally, effective June 1, 2021, the Plan was amended so that there is no deductible for prescription drug benefits through Preferred Provider Pharmacies.

Please retain this notice with your current copy of the Plan Document and Summary Plan Description and insert the attached slip pages 1, 3, 7, 8, 10, 24, 36, 36A, 37, 37A, 40, 40A, 41, 42, 43, 43A, 43B, 43C, 43D, 45, 45A, 45B, 58, 60, 63, 73, 73A, 87, 87A, 89, and 89A to replace the current pages of the same number. If you have any questions about the Plan, contact the Fund Office at (218) 728-4231 or (877) 752-3863.

SECTION 1
SCHEDULE OF BENEFITS

1.1 Comprehensive Major Medical Benefits

The Plan covers expenses related to Hospital and Health Care Professionals' services, x-ray and laboratory services, certain prescription drugs and medicines, and other covered items and services when Medically Necessary. For additional information, see Section 2 ("Comprehensive Major Medical Benefits").

Deductible amount (Plan A and B Coverage)	
Per Eligible Person per Calendar Year	$500
Per Family per Calendar Year	$1,000
All covered services are subject to the Calendar Year Deductible, unless otherwise specified.	
Coinsurance of covered expenses	
Plan A and B Coverage	80%
Out-of-Pocket Maximum (Plan A and B Coverage)	
Per Eligible Person per Calendar Year	$4,600
Per Family per Calendar Year	$9,200

Plan pays 100% of covered expenses in excess of such Out-of-Pocket Maximums for the remainder of that Calendar Year.

The Out-of-Pocket Maximum for Comprehensive Major Medical Benefits includes all Deductibles, Copayments, and Coinsurance paid on an Eligible Person's behalf. These Out-of-Pocket Maximums are separate from and do not apply to the Preferred Provider Pharmacy Prescription Drug Benefits (see Section 1.2 below).

The following are specific provisions applicable to certain services and supplies covered as Comprehensive Major Medical Benefits, payable subject to the Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximums unless otherwise specified. **Note:** the Plan does not cover inpatient out-of-network services, except for Emergency treatment.

Emergency services	
Sickness - Deductible waived if Hospital confinement occurs within 24 hours of visit	$100 Deductible per visit
Injury	No separate Deductible

Bariatric Surgery	80%
Medically Necessary inpatient and outpatient Hospital or facility services, including Physician services (subject to prior authorization requirements and use of a Blue Distinction Center for Bariatric Surgery as stated in Section 2.4(H)).	
Immunizations	100%; no Deductible
Rehabilitative therapy Maximum per disability Physical and occupational therapy (combined benefit) Additional physical and occupational therapy per disability (combined benefit requires prior authorization)	 15 visits; 80% 11 visits; 80%
Speech therapy	15 visits; 80%
Benefits for disabilities caused by stroke per disability – Physical and occupational therapy (combined benefit) Speech therapy	 25 visits 25 visits
Ambulance	80%
Infertility treatment Maximum benefit per Eligible Person per Calendar Year (does not count toward the Out-of-Pocket Maximum, is a Non-Essential Health Benefit)	80% $200
Durable Medical Equipment	80%
Acupuncture	$500 annual payment limit

1.2 Preferred Provider Pharmacy Prescription Drug Benefits

Additional information is available in Section 4 ("Preferred Provider Pharmacy")	
Deductible amount Per Eligible Person per Calendar Year Per Family per Calendar Year	Effective June 1, 2021, no Deductible. Effective June 1, 2021, no Deductible.
Prescriptions filled at non-participating pharmacies, Sam's Club, or Wal-Mart pharmacies are not covered under this Plan.	

SECTION 2
COMPREHENSIVE MAJOR MEDICAL BENEFITS

Active Employees and Dependents

When you or your Dependent require covered services or supplies which are Medically Necessary because of Injury or Sickness, benefits are payable as stated in the Schedule of Benefits (Section 1.1), provided you have satisfied any required Deductible. If there are limitations for a particular benefit, they are explained with each benefit. The Plan's "General Exclusions" are provided in Section 12.8.

2.1 Deductible

The "Deductible" is the amount of covered charges which you pay before you are entitled to benefits. The deductible is stated in the Schedule of Benefits. This Deductible does not apply to: Physician office visits, Mental Health Professional office visits, well child care, immunizations, and the following specified routine screenings: mammograms, prostate-specific antigen ("PSA") tests, and Papanicolaou ("Pap") tests. The Deductible applies only once in any Calendar Year even though you may have several different disabilities.

2.2 Coinsurance

After you satisfy the required deductible amount, the Plan pays covered expenses at the "Coinsurance" percentage stated in the Schedule of Benefits. The balance of charges is payable by you.

When the out-of-pocket covered expenses in a Calendar Year not including the Deductible amount reach the "Out-of-Pocket Maximum" stated in the Schedule of Benefits, the Plan pays 100% of the balance of covered expenses for that Eligible Person or that Family for the remainder of that Calendar Year. The term "Family" means one or more Eligible Persons within a family unit, consisting of you and your Dependents.

The Plan does not cover inpatient out-of-network services, except for Emergency treatment.

2.3 Copayment

A "Copayment' is a fixed dollar amount you must pay for certain covered services before the Plan's benefits cover the remainder of the covered expense. Copayments are stated in the Schedule of Benefits and do not count toward the satisfaction of the Deductible or the Out of Pocket Maximum.

2.4 Covered Expenses

Benefits are payable for Reasonable and Customary ("R&C") Charges for the following services and supplies for treatment of an Injury or Sickness:

A. **"Hospital services"** recommended by the attending Physician for the following:

1. Room and board expense, up to the Hospital's semi-private room rate (or up to the private room rate, when Medically Necessary);

2. Intensive Care Unit expenses, including confinement of twenty-four (24) or more consecutive hours duration in a recovery room of a Hospital if you receive 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 Hospital miscellaneous services and supplies not included in room charges (including the anesthetist's fee when charged by the Hospital), if used while confined in the Hospital as a resident patient;

4. Outpatient services in connection with emergency treatment of an Injury or Sickness. There is a separate deductible stated in the Schedule of Benefits for each emergency room visit related to a Sickness; however, this separate deductible is waived if Hospital confinement results from the emergency room visit within twenty-four (24) hours;

5. Hospital charges for confinements related to treatment of Mental Health Conditions are payable subject to the coinsurance stated in the Schedule of Benefits;

   Hospital charges for confinements related to treatment of Substance Use Disorders are payable subject to the coinsurance stated in the Schedule of Benefits;

   If you need assistance locating a Mental Health Professional for the treatment of a known Mental Health Condition or Substance Use Disorder, you can contact the Fund Office for help;

6. A newborn Dependent child during the period its mother is Hospital-confined as the result of giving birth to the child and after the mother's discharge if the newborn has a condition that necessitates further Hospital confinement; and

7. Medical-related dental services for Dependent children are payable at the Coinsurance stated in the Schedule of Benefits (Section 1.4) and do not count toward the out-of-pocket maximum. Covered expenses include outpatient facility charges and anesthesia associated with the provision of certain dental services, when Medically Necessary.

In-Hospital benefits are not payable for hospitalizations starting on weekends for treatment or surgery scheduled to begin the following Monday or later, unless Medically Necessary. The Plan does not cover inpatient out-of-network services, except for Emergency treatment.

The Plan generally may not, under federal law, restrict benefits for any Hospital length of 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 caesarean section, or require that a Physician obtain authorization from the Plan for prescribing a Hospital length of stay not in excess

You must pay the Copayment stated in the Schedule of Benefits (Section 1.1) for each Physician's visit; then, the Plan pays 100% of covered expenses with no deductible requirement.

Please note that if your Physician orders any diagnostic x-ray or laboratory tests during your visit, the charges for those tests are subject to the deductible and coinsurance requirements, except those for mammograms, PSA tests, and Pap tests.

4. Chiropractic fees are payable at the Coinsurance and up to the maximum number of visits per Eligible Person per Calendar Year as stated in the Schedule of Benefits (Section 1.1);

5. Well child care from birth through age twenty-five (25); and

6. Outpatient treatment for Sicknesses, Injuries, Mental Health Conditions, and Substance Use Disorders, provided such outpatient treatment is rendered by, under the supervision of, or on referral from a Physician or Mental Health Professional in a Hospital, outpatient medical facility, or Outpatient Psychiatric Facility, except that a Physician can render such treatment at any location. Outpatient treatment for certain conditions does include collateral interviews with the Eligible Person's family.

   Benefits are payable for outpatient treatment of Sicknesses, Injuries, Mental Health Conditions, and Substance Use Disorders subject to the Coinsurance stated in the Schedule of Benefits (Section 1.1).

   If you need assistance locating a Physician, Mental Health Professional, or other provider for the treatment of a known Sickness, Injury, Mental Health Condition, or Substance Use Disorder, you can contact the Fund Office for help.

D. **Diagnostic x-ray and laboratory services,** including pre-admission testing.

Dental x-rays are excluded, unless rendered for dental treatment of a fractured jaw or Injury to natural teeth within six (6) months after an accident. X-rays and other diagnostic tests that do not require a Physician's order, including, but not limited to, heart scans, life scans, and saliva and hair analysis, are excluded under this Section 2.4 (“Covered Expenses”) and all other sections of this Section 2 (“Comprehensive Major Medical Benefits”).

E. **Prescription drugs and medicines** covered under this Section 2 (“Comprehensive Major Medical Benefits”) include charges for immunosuppressant drugs and prescription drugs purchased at the Hospital pharmacy at the time of discharge if you have been confined to a Hospital and issued prescription medication to use upon arrival home.

See Section 4 (“Preferred Provider Pharmacy”) for coverage for all other prescription drugs.

F. **Routine immunizations,** payable at 100% with no Deductible requirement.

C. Covered prescription medications which are not self-administered or are administered in a Hospital, long-term care facility, or other inpatient setting;

D. All compound medication prescriptions for Eligible Persons age nineteen (19) and older;

If you have a medical need, and there is no FDA-approved alternative medication commercially available, your Physician can provide a written statement of medical necessity to Envision for reconsideration and approval, if appropriate.

E. Therapeutic supplies, devices, or appliances, including support garments, and other non-medicinal substances, except those specifically stated;

F. Experimental or investigational drugs;

G. Human growth hormone;

H. Charges for the administration or injection of any drug, except for immunizations covered by the Plan;

I. Refills of covered drugs which exceed the number of refills the prescription order calls for, or refills after one year from the original date;

J. Cosmetic alteration drugs, except acne medications, are covered up to age forty (40);

K. Erectile dysfunction medications;

L. Fertility agents, including Pergonal (Menotrophins) and Metrodin (Urofollitropins);

M. Prescription vitamin preparations, including prenatal vitamins;

N. Appetite suppressants;

O. Prescription fluoride preparations;

P. Smoking cessation drugs, except as provided elsewhere; and

Q. Certain drugs categorized as non-essential drugs by EnvisionRx at the time the prescription is processed.

Non-Essential drugs are medications from the same active ingredients that are found in other equally effective, lower cost medications currently FDA approved for use and readily available.

4.4 Contraceptive Coverage

Contraception is one of the women's Preventive Health Service items under the Affordable Care Act. The law applies only to contraception methods for women, not men. The Plan does not cover products available without a prescription, except emergency contraception.

The rules which allow plans to use reasonable medical management to help define the nature of the covered Preventive Health Services also apply to women’s Preventive Health Services.

your completed request for coverage form has been timely received by the Plan;

B. You become legally responsible for a Dependent child or children through birth, adoption, or placement for adoption. Election for family coverage must be made within thirty (30) days of the date legal responsibility begins. Enrollment is effective on the date of birth, date of adoption, or date of placement for adoption, respectively; or

C. You have family coverage under another health plan under COBRA which was exhausted, or coverage was not under COBRA and was terminated due to loss of eligibility, including legal separation, divorce, death, termination of employment, reduction in hours of employment, or termination of Employer contributions. (However, loss of eligibility does not include a loss due to failure of the individual or the Participant to pay premiums on a timely basis or termination of coverage for cause.) Election for family coverage must be made within thirty (30) days of the exhaustion or termination of the other coverage. Enrollment is effective the first day of the first calendar month beginning after the date the completed request for enrollment is received.

A written application must be filed specifying the change in status, along with a certified copy of the official document demonstrating such change in status, and any additional information the Trustees may require.

If you already have family benefits under this Plan at the time you acquire a new Dependent, the Dependent's coverage will be retroactive to the date of the event when he or she became a Dependent under this Plan if you provide a completed request for coverage form to the Plan within thirty (30) days of the date of such event. If your completed request for coverage form is not received by the Plan within thirty (30) days of the date of the event, coverage will not be available to your new Dependent(s) until the first day of the month following the month in which you provide a completed request for coverage form to the Plan.

If you elect family benefits and then decide to terminate the benefits for some reason, you are not allowed to purchase family benefits in the future except as provided for under the special enrollment periods previously stated.

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:

A. 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

B. 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").

11.4 Special Enrollment Events

Notwithstanding any other provision of the Plan to the contrary, you or your eligible Dependent(s) are entitled to special enrollment rights under the Plan as required by HIPAA under either of the following circumstances:

A. You or your 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 you request coverage under the Plan not later than sixty (60) days after the date of termination of such coverage; or

B. You or your 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 not later than sixty (60) days after the date you or your Dependent is determined to be eligible for such 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:

A. 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

B. 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").

11.5 Alternative Coverage Options

The Plan provides several coverage options that offer different benefits and cost-sharing. These alternative coverage options are referred to as "Plan A" and "Plan B."

Your Employer and the terms of your collective bargaining agreement will determine which benefit plan (A or B) you will be offered, including your eligibility for single versus family coverage as provided in Section 11.1 ("How an Employee Becomes Eligible for Benefits") and Section 11.3 ("Dependent Special Enrollment Period").

A. Plan A Coverage

Plan A coverage includes all of the benefits described in the Plan and as provided in the Schedule of Benefits (Section 1), including:

1. Comprehensive Major Medical Benefits (Section 2);

2. Preferred Provider Pharmacy Prescription Drug Benefits (Section 4);

3. Vision Care Benefits (Section 6);

4. Dental Care Benefits (Section 7);

5. Death Benefits (Section 8);

6. Accidental Death and Dismemberment Benefits (Section 9); and

7. Weekly Disability Benefits (Section 10).

B. Plan B Coverage

Plan B coverage consists of Plan A benefits, but excludes the following ancillary benefits:

1. Vision Care Benefits (Section 6);

2. Dental Care Benefits (Section 7);

3. Death Benefits (Section 8);

4. Accidental Death and Dismemberment Benefits (Section 9); and

5. Weekly Disability Benefits (Section 10)

If you are offered Plan B coverage by your Employer and you would like to have the ancillary benefit coverage, you will need to purchase this coverage at your own cost through payroll deduction. The cost for these benefits would be in addition to any coverage contribution amount your collective bargaining agreement requires you to make. You can only elect family ancillary benefit coverage if you have family medical coverage.

You will be offered the opportunity to elect ancillary benefit coverage at any one of

11.9 Special Classes of Coverage

The Trustees may make available limited coverage to office Employees and others not covered under a collective bargaining agreement. The amount of contributions and benefits provided are established in participation agreements. For such information, contact your Employer or the Fund Office.

11.10 COBRA Continuation

The intent of these Eligibility Rules is to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended in all respects, including those changes required by subsequent legislation including, but not limited to, the Omnibus Budget Reconciliation Acts of 1989, 1990, and 1993, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). 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 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.

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. (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:

The Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund
Wilson-McShane Corporation
2002 London Road, Suite 300
Duluth, MN 55812
(218) 728-4231 or (877) 752-3863

Employees and eligible Dependents may, while they are "Qualified Beneficiaries," continue eligibility for health, vision, and dental benefits, subject to the following conditions.

A. Qualifying Events

Certain events which cause you or your Dependent to lose eligibility under the Plan are "Qualifying Events." Such Qualifying Events occur for you as an Employee eligible because of Employer contributions upon:

1. A reduction in hours of covered employment for any reason, including disability, Sickness, Injury, or retirement; or

2. Voluntary or involuntary termination of covered employment for any reason, including disability, Sickness, Injury, or retirement, unless for gross misconduct on your part.

Such Qualifying Events occur for spouses and Dependent children upon any of the following events occurring while you are an Employee eligible because of Employer contributions:

1. Termination or reduction of your covered employment for any reason including disability, Sickness, Injury or retirement, unless for gross misconduct on your part;

2. Your death;

3. Divorce or legal separation from you;

4. Your entitlement to Medicare; or

5. Loss of Dependent status.

You or your Dependent become a Qualified Beneficiary for a specific period of time when a Qualifying Event occurs. A Dependent child who is born to or placed for adoption with an Employee during the Employee's period of COBRA continuation

coverage will be treated as a Qualified Beneficiary. As a Qualified Beneficiary, eligibility may be continued for certain benefits through self-payments under the following provisions.

B. Notifications and Due Dates

1. Qualified Beneficiary's Responsibility to Notify the Trustees

When the Qualifying Event relates to your divorce or legal separation, or to a Dependent losing Dependent status under the Plan, the Qualified Beneficiary must notify the Trustees directly in writing within sixty (60) days of the Qualifying Event so the Trustees may provide proper notices and explanations to Qualified Beneficiaries about continued eligibility. When providing notice to the Plan, the Qualified Beneficiary must provide documentation to support the occurrence of the Qualifying Event. In case of divorce or legal separation, a copy of the divorce or legal separation decree or similar documentation evidencing the date of divorce or legal separation will be required. In the case of a loss of Dependent child status, documentation indicating the date Dependent child status was lost will be required. If the Trustees are not notified in writing within sixty (60) days of the Qualifying Event, the person is no longer a Qualified Beneficiary and loses the opportunity to continue coverage.

You must inform the Trustees of the Qualifying Event and when it occurred by providing appropriate supporting documentation, such as certificates of birth, marriage, death and divorce, or a copy of the divorce or legal separation decree.

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:

a. 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

b. 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").

2. The Trustees' Responsibility to Notify a Qualified Beneficiary When the Qualifying Event Is Loss of Coverage Due to the Employee's Divorce or Legal Separation, or to a Change in a Dependent Child's Status

The Fund Office, not later than fourteen (14) days after receipt of notice, will advise the Qualified Beneficiary of the coverages, options, costs, self-payment due dates, and duration of the self-payment privileges.

3. The Trustees' Responsibility to Notify a Qualified Beneficiary When Other Qualifying Events Occur

Based on monthly Employer reports, Trustees are aware of some Qualifying Events, such as loss of eligibility for coverage based on contributions received from contributing Employers because of a reduction

in your hours and your ceasing active work. The Fund Office, not later than fourteen (14) days after receipt of notice of an Employee's loss of coverage from the Employer or by examining monthly contribution reports, will advise the Qualified Beneficiary of the coverages, options, costs, self-payment due dates, and duration of the self-payment privileges.

4. Due Date for Qualified Beneficiary's Response

A Qualified Beneficiary has sixty (60) days from the date of coverage termination or receipt of the Fund Office explanation, whichever is later, to elect whether to continue coverage. The election should be communicated to the Trustees in writing on the form provided. Each Employee, spouse, and Dependent child has the right to make an individual election. However, an election by a parent with custody of minor children to continue coverage will be accepted as the election for both parent and children. Failure to state the election to the Trustees within sixty (60) days terminates rights to continued coverage under this provision.

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:

a. 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

b. 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 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.

5. Due Date for Initial Self-Payment

The required initial self-payment must be made not later than forty-five (45) days following the election to continue coverage. Failure to do so will cause eligibility and coverage to terminate retroactively to the later of the Qualifying Event or loss of eligibility.

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:

a. 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

b. 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").

6. Due Date for Subsequent Self-Payments

Subsequent monthly self-payments must be made before the last day of the month in which eligibility and coverage terminate. The Plan allows a thirty (30) day grace period for making self-payments. Failure to make subsequent self-payments before the end of the grace period will cause coverage and eligibility to terminate at the end of the month for which a timely self-payment was last made.

C. Coverages

If a Qualified Beneficiary elects COBRA continuation coverage, he or she will continue the same benefits that were in effect at the time of the Qualifying Event. Such benefits may include health, vision, and dental benefits.

The Employee may add coverage for a new spouse or new Dependent child as a Qualified Beneficiary upon the child's birth or placement for adoption with the Employee during the Employee's period of COBRA continuation coverage.

The Plan is required to offer continued coverage which, as of the day before coverage terminated, is identical to similarly situated Employees or family members who have not experienced a Qualifying Event. If coverage under the Plan is modified for similarly situated Employees, the Qualified Beneficiary's coverage also will be modified.

A Qualified Beneficiary does not have to show insurability to choose continuation coverage.

D. Cost of Continuation Coverage

The costs are determined annually by the Trustees. There is a separate cost for continued coverage from the nineteenth (19^{th}) through the twenty-ninth (29^{th}) month for those individuals eligible for such disability extension. The Fund Office initially will notify the Qualified Beneficiary of the self-payment amount and due dates.

E. Duration of Continuation Coverage

When eligibility is lost due to termination of employment or reduction a in hours, a Qualified Beneficiary may continue eligibility for up to eighteen (18) consecutive months, less the number of months eligibility was continued without Employer contributions or self-payments. However, you (or any other Qualified Beneficiary) may continue coverage for yourself and your Dependents for up to twenty-nine (29) months of disability provided:

1. The Social Security Administration (SSA) determines that any of the Qualified Beneficiaries are disabled under the Social Security Act either: at the time employment terminated or hours were reduced; or at any time within sixty (60) days of such Qualifying Event; and

2. The Qualified Beneficiary notifies the Trustees 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 SSA determination of disability.

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 an SSA determination.

Starting on March 1, 2020, the sixty (60) day window in which the Qualified Beneficiary must notify the Fund Office of an SSA 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 an SSA determination. The earliest date that a Qualified Beneficiary was first eligible for relief from a deadline to request extended COBRA continuation coverage due an SSA determination was either:

1. March 1, 2020 for SSA 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 an SSA 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 SSA 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 SSA 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 the SSA determination occurred prior to March 1, 2020, the extension periods are shortened by the number of days between the determination and March 1, 2020.

When eligibility is lost due to any other Qualifying Event, a Qualified Beneficiary (other than you) may continue eligibility for up to thirty-six (36) months, less the number of months eligibility was continued without Employer contributions or self-payments.

F. Multiple Qualifying Events

Your spouse or Dependent child, as a Qualified Beneficiary, may experience more than one Qualifying Event. An extension of coverage will be available to spouses and Dependent children who are receiving COBRA coverage if a second Qualifying Event occurs during the eighteen (18) months (or in the case of a disability extension, the twenty-nine (29) months) following the covered Employee's termination of employment or reduction of hours. The combined continuation coverage period for all such events may not exceed thirty-six (36) consecutive months from the date of the original Qualifying Event. The second or later Qualifying Event(s) may include the death of a covered Employee, divorce or legal separation from the covered Employee, or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan (This extension is not available under the Plan when a covered Employee becomes entitled to Medicare after his or her termination of employment or reduction of hours). These events can be a second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. For example, where the spouse of a terminated Employee continues coverage, as a Qualified Beneficiary, for herself and children for fifteen (15) months.

8. 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; or

9. The Qualified Beneficiary becomes entitled to Medicare after such person's COBRA election date (although other family members not entitled to Medicare will continue to be eligible for COBRA continuation). However, if a Qualified Beneficiary becomes entitled to Medicare due to End Stage Renal Disease ("ESRD"), his coverage under COBRA will not terminate automatically because of eligibility for Medicare. In the case of ESRD, the Plan is the primary source of coverage for up to thirty (30) months from the date of ESRD-based Medicare entitlement, provided the person is an active Eligible Employee or Dependent or is covered under the Plan with COBRA continuation coverage. In the event the Plan's liability as the primary source of coverage for ESRD ends before the COBRA continuation period ends, the Plan becomes secondary to Medicare for the balance of the continuation coverage for such person.

H. Temporary Waiver of COBRA Continuation Coverage Self-Payments

An Assistance Eligible Individual is not required to make required self-payments (including any administrative fee) 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 COBRA self-payments during the Subsidy Period described in this section for any month of coverage that begins on or after the earlier of:

1. 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, or a qualified small employer health reimbursement arrangement) or Medicare; or

2. The date following the expiration of the period of COBRA continuation coverage elected (or re-elected) pursuant to Section 11.10(I).

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 COBRA continuation coverage self-payment in accordance with the regular COBRA self-payment rules of the Plan.

I. 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 has does not have a COBRA continuation coverage election in effect or has discontinued COBRA continuation coverage

before April 1, 2021, 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 11.10(J).

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 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.

J. Notice to Assistance Eligible Individuals

The Plan Administrator is required to provide Assistance Eligible Individuals and individuals described in Section 11.10(I) who become 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.

K. 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 COBRA continuation coverage self-payments during the Subsidy Period under Section 11.10(H)(1) due to eligibility for another group health plan or Medicare must notify the Plan in accordance with rules established by the Plan Administrator.

L. 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.

11.11 Coverage for Employees and Their Dependents When Employee Enters Military Service

Notwithstanding any terms of the Plan to the contrary, the Plan will comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

A. Eligibility Status

1. You, or an appropriate officer, must submit advance written notice of military service to the Fund Office (unless circumstances of military

necessity as determined by the Department of Defense make it impossible or unreasonable to give such advance notice).

2. If you, or an appropriate officer, do not submit notice, your coverage will terminate on the date your eligibility has been exhausted.

3. For military leaves that are fewer than thirty-one (31) days in duration and for which you, an appropriate officer, or an Employer, submit the required notice and otherwise satisfy the reemployment requirements described as follows, coverage for you and your eligible Dependents will be continued as though you are actively at work for the duration of such leave.

4. For military leaves that are thirty-one (31) or more days in duration and for which you, an appropriate officer, or an Employer, submit the required notice, coverage for you and your eligible Dependents will cease and your eligibility status will be frozen as of the date you leave employment for the purpose of performing military service with the uniformed services of the United States, unless you elect to continue coverage as described in the following Section 11.11(B) (“Continuation of Coverage”).

5. Your eligibility will be reinstated on the date you return to work for a contributing Employer (or upon making yourself available for work if no

covered by the Plan. Examples of cosmetic surgery include, but are not limited to:

1. Reduction mammoplasty (breast reduction surgery), unless Medically Necessary because of organic condition;

2. Augmentation mammoplasty (breast enlargement surgery), unless part of reconstruction following breast surgery due to cancer;

3. Rhinoplasty (plastic surgery of the nose), unless the result of an accident and the surgery is within one year of the accident or chronic nasal obstruction;

4. Otoplasty (plastic surgery on ears), sometimes referred to as “lop” or “cauliflower ears;”

5. Blepharoplasty (repair of drooping eyelids), unless the droop restricts the field of vision as verified by an Ophthalmologist;

6. Rhytidectomy (face lift);

7. Dyschromia (tattoo removal);

8. Panniculectomy or lipectomy (removal of layer of excess fat of the abdomen), sometimes called “tummy tuck;” and

9. Genioplasty (chin augmentation).

I. Care for conditions suffered while engaged in the commission of a felony or while attempting to commit conduct that could be charged as a felony;

J. Services performed or supplies rendered by a person who is part of your family (comprised of you, your spouse, or your or your spouse's child, brother, sister, parent, or grandparent) or by an entity in which you are an owner of more than a ten (10%) percent interest;

K. All charges related to weight loss programs;

L. Premarital tests or examinations, to include premarital counseling and/or marital counseling;

M. Routine physical examinations for occupation, school, travel, or purchase of insurance;

N. [RESERVED];

O. Charges for infertility treatment, except as specifically provided, and prescription drugs for infertility treatment;

P. Hearing aids, audio aids, examinations, or any charges for the fitting thereof, including external or implantable hearing aids;

FF. Arch supports, foot orthotics, and orthopedic shoes, including, but not limited to, biomechanical evaluation, range of motion measurements and reports and negative mold foot impressions, unless the shoe is an integral part of a brace or when required following surgery, or charges for routine foot care such as treatment of corns, calluses, and paring of toe nails, except required because of diagnosis of Sickness;

GG. Charges for failure to keep a scheduled visit, completion of any form, or for medical information;

HH. Gene therapy as a treatment for inherited or acquired disorders;

II. Growth hormones, except due to a hormone deficiency due to pituitary only;

JJ. Charges for or related to fetal tissue transplants;

KK. Maintenance and custodial therapy;

LL. Charges for any service not specifically covered under this Plan;

MM. Aquatic therapy;

NN. Orthotics prescribed by a chiropractor;

OO. More than one office visit charge per day by the same Physician or Mental Health Professional;

PP. Any charge incurred unless it is for treatment or diagnosis of an Injury or Sickness and the service or supply is prescribed by a Physician or Mental Health Professional;

QQ. Any charge incurred unless you are obligated to pay for it and you would have been billed for it, even if you did not have these benefits;

RR. Wigs;

SS. Reversals of sterilizations;

TT. Diet consultations, except when related to diabetes and as specifically provided;

UU. Surgery for obesity, except as specifically provided;

VV. Charges for transplant donor-related services;

WW. Injury or Sickness resulting from an Eligible Person’s participation in a riot, or in the commission of any illegal act. "Illegal act" means any illegal occupation or any conduct that constitutes and may be charged as a gross misdemeanor or felony offense under the laws in the States of Minnesota or Wisconsin, regardless of whether the Eligible Person is actually charged with or convicted of the illegal act

2. The Trustees deem 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 provision of the Plan's first priority right of subrogation and reimbursement and the provisions of Section 12.5 ("Subrogation and Reimbursement").

EEE. Any loss, expense, or charge incurred by an individual at a time that the individual owes a payment to the Plan, or any losses incurred by an individual who performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact in connection with coverage under this Plan;

FFF. Services or supplies to treat any Injury or Sickness incurred in, or aggravated during, an Eligible Person's past or present participation in an "Act of War." For purposes of this exclusion, "Act of War" includes any act or conduct during war, declared or undeclared, act of terrorism, or warlike action by any individual, government, military, sovereign group, terrorist, or other organization;

GGG. Inpatient out-of-network services, except for Emergency treatment; and

HHH. Habilitative services.

12.9 Termination of the Plan

This Plan may be terminated:

A. As to Participants (and their Dependents) in a particular collective bargaining unit, by agreement of the Union and Employer Association (or individual Employers, where applicable) which negotiate the labor agreements covering such collective bargaining units; or

B. When the Trustees determine that the Trust Fund is inadequate to carry out the intent and purpose of the Trust Agreement or is inadequate to meet the payments due or to become due Participants and/or Dependents under the Trust Agreement or under this SPD. Benefits incurred before the termination date will be paid to Eligible Persons (or their provider, as applicable) as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets. Benefit payments will be limited to the funds available in the Trust Fund for these purposes. The Trustees will not be liable for the adequacy or inadequacy of the funds.

In the event of termination, the Trustees will:

A. Make provision out of the Trust Fund for the payment of expenses incurred up to the date of termination of the Trust and the expenses incidental to such termination;

B. Arrange for a final audit and report of their transactions and accounts, for the purpose of termination of their trusteeship;

C. Apply the Trust Fund to pay 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, provided however, any use

SECTION 14
HOW TO APPLY FOR BENEFITS

14.1 Time for Filing Claims

Notice of claim must be filed as soon as possible, but not more than ninety (90) days after the date the covered expense is incurred.

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 claim.

Starting on March 1, 2020, the deadline to file a 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 claim. The earliest date that an Eligible Person was first eligible for relief from a deadline related to filing a 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.

14.2 Compliance With Claim Rules

To obtain benefits, all claimants must comply with every applicable claim rule.

The Trustees reserve the right to deny benefits to any claimant who, in their opinion, is attempting to subvert the purpose of the Plan or who does not present a bona fide claim.

14.3 Pre-Service Claims

You must obtain prior authorization from the Fund Office for Bariatric Surgery. See Section 2.4(H) for details on how to obtain such prior authorization. Claims such as this are called "pre-service claims," which means any claim which requires approval of the benefit in advance of obtaining medical care.

Please note that there are special provisions in the U.S. Department of Labor's ("DOL") "Claims Procedure Regulations" for "urgent care claims" (referred to under the Plan as "emergencies"), but, by definition, these provisions do not apply to your Plan because the Plan does not require prior authorization of emergency admissions.

14.4 Post-Service Claims

Any claim for benefits that is not a pre-service claim is considered a "post-service claim." You must submit post-service claims in writing within ninety (90) days of the date a medical charge is incurred or a disability occurs. In no event (except in the absence of legal capacity) can you submit a claim later than one year after the date the claim was incurred.

Once you become eligible, you will receive an identification card from the Plan which identifies you and contains the name and address of Wilson-McShane Corporation, the Plan's claims administrator who certifies eligibility, processes claims, and issues the benefit payments.

When you obtain health care services or supplies, make sure you present your identification card to the provider. Your identification card will give them all the information necessary to submit the claim for payment. If the provider does not submit the claim, you must do so yourself.

Post-service claims must be submitted in writing to the appropriate party as follows:

Blue Cross Blue Shield of Minnesota network providers automatically will file your claims for you, if you present your identification card and sign the appropriate form.

Please follow these steps for all out-of-network health claims:

Step 1: File claims with the Fund Office promptly, on forms provided by the Trustees. Contact the Fund Office for a claim form.

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. You will have one hundred eighty (180) days after you receive the notice of an adverse benefit determination to file your appeal in writing to the Fund Office and it must include the specific reasons you feel 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 you were first eligible for relief from a deadline related to filing a claim appeal. The earliest date that you were 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

2. The date of a claim denial or adverse benefit determination was 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 specifically as to you. 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 you are 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. You will be allowed the opportunity to submit written issues and comments, documents, records, and other information relating to the claim for benefits which may have been requested in the notice of denial or which you may consider desirable or necessary.

C. You or your duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all designated documents, records, and other information relevant to your claim for benefits.

D. Your review will take into account all comments, documents, records, and other information submitted by you relating to the claim, 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 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 Professional 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 nor the subordinate of such individual.

G. If a medical or vocational expert's advice was obtained on behalf of the Plan in connection with your claim, you may request the identity of the expert, regardless of whether the advice was relied on.

H. The Plan must provide you, free of charge, any new or additional evidence or rationale considered, relied on, or generated in connection with an appeal. Such information will be provided as soon as possible and sufficiently in advance of the date on which notice of the Plan's final adverse benefit determination must be provided.

I. The Plan must ensure that all claims and appeals are adjudicated with the utmost impartiality and avoid conflicts of interest. The claims or appeals adjudicator must be independent from and impartial to the Plan.

J. For appeals of pre-service claims, the Plan will notify you 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 and disability claim appeals at their

A. Standard External Review

1. Request for External Review

You may file a request for an external review within four (4) months after the date you received notice from the Plan of a final adverse benefit determination.

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:

(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 related to filing a request for an external review. The earliest date that you were first eligible for relief from a deadline related to filing a request for an external review was either:

a. March 1, 2020 for 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

b. The date of a claim appeal denial 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 the adverse benefit determination was provided to you 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 that the adverse benefit determination was provided to you and March 1, 2020.

2. Preliminary Review

The Plan must complete its preliminary review within five (5) business days following receipt of the external review request to determine whether:

a. You were covered under the Plan at the time the health care service or item in question was requested, or in the case of a retrospective review, if you were covered under the Plan at the time the health care service or item was provided;

b. The adverse benefit determination or final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

c. You have exhausted the Plan's internal appeal process, unless you are not required to do so under the appeals rules; and

d. You have provided all the information and forms required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing if:

a. Your request is eligible for external review;

b. If your request is complete, but you are not eligible for an external review, the Plan will provide you with the reasons it has been determined that you are ineligible for an external review and the contact information for the Employee Benefits Security Administration (toll-free (866) 444-3272); or

c. If your request is not complete, the notice will describe the missing information and materials needed to make the request complete. You may revise your complaint if you do so within the four (4) month filing period or within forty-eight (48) hours after the receipt of the notice, whichever is later.

3. Referral to IRO

If your request is eligible for external review, the matter will be assigned to an IRO that is accredited by the URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan has contracted with three (3) IROs and rotates external review assignments