Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund

Plan Document and Summary Plan Description

January 1, 2019

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Effective January 1, 2019

To All Active Employees:

We are happy to provide you with this new Plan Document and Summary Plan Description ("SPD" or "Summary") incorporating all changes to the Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund (the "Plan") adopted through January 1, 2019.

In easy-to-understand language, this SPD tells you how to become and remain eligible for benefits, explains the benefits available, and gives you instructions on how to apply for benefits. The Trustees have the right to change, add, or delete benefits, self-payment rates, the "Eligibility Rules," or any other provisions relating to the operation of the Plan in an effort to best serve all Plan Participants.

The benefits described in this SPD are self-funded. Self-funded benefits are limited to Plan assets available for such purposes. This updated SPD incorporates Plan changes, most of which you were informed of previously in the respective Summaries of Material Modifications.

The Plan's "Eligibility Rules" (Section 11) and benefits are maintained at levels in line with the Trust Fund's income and assets and they are reviewed regularly. The Eligibility Rules and other Plan provisions have been updated as necessary to comply with legal requirements, including the Patient Protection and Affordable Care Act and the Mental Health Parity and Addiction Equity Act.

We suggest you familiarize yourself with the information in this SPD and keep it handy for reference. If you have any questions at any time regarding the Plan, please contact the Fund Office.

Yours sincerely,

THE BOARD OF TRUSTEES

The names and addresses of the Trustees are found in Section 20.5.

Fund Office
Northern Minnesota-Wisconsin Area
Retail Food Health and Welfare Fund
2002 London Road, Suite 300
Duluth, MN 55812

Telephone: (218) 728-4231 locally, or call toll-free at (877) 752-3863.

Office Hours: Monday-Friday 8:00 a.m. to 5:00 p.m.

Website: www.ufcw1189benefits.com

IMPORTANT NOTICE REGARDING GRANDFATHERED STATUS

This Plan will be considered a non-grandfathered plan under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). Questions concerning this status change can be directed to the Fund Office at (218) 728-4231 or (877) 752-3863. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which consumer protections do and do not apply to non-grandfathered health plans.

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

Treatment of Mental Health Conditions	
Mental Health Professionals and Physician visits	$35 Copayment, 100% thereafter; no Deductible
Hospital confinement	80%
Outpatient treatment	80%
Treatment of Substance Use Disorders	
Mental Health Professionals and Physician visits	$35 Copayment, 100% thereafter; no Deductible
Hospital confinement	80%
Outpatient treatment	80%
Medical-related dental services for Dependent children	80%
Extended post-Hospital care - maximum following one period of Hospital confinement	30 days; 80%
Surgeon's services	
Preferred Provider	80%
Non-Preferred Provider	Limited to percentage of R&C Charge for surgeon and 20% of surgical allowance for assistant surgeon
Physician Office/Hospital visits	$35 Copayment, 100% thereafter; no Deductible
Retail clinic visits	$10 Copayment, 100% thereafter; no Deductible
Doctor on Demand visits	$10 Copayment, 100% thereafter; no Deductible
(Does not include visits for optometry, chiropractic and dental services.)	
Chiropractic	
Maximum per Eligible Person per Calendar Year	16 visits; 80%
Routine care from birth through age 25 see Section 2.9 (“Coverage for Preventive Health Services”)	100% - No Deductible
Routine annual physical exam, including related office visits, for Employee and Spouse see Section 2.9 (“Coverage for Preventive Health Services”)	100% - No 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%

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	 $50 $100
Prescriptions filled at non-participating pharmacies, Sam's Club, or Wal-Mart pharmacies are not covered under this Plan.	

Retail	
Generic: Up to a 90-day supply	10%; minimum Copayment: $15
Brand: 30-day supply	
Preferred	20%; maximum Copayment:$75
Non-Preferred	20%; minimum Copayment: $35; maximum Copayment: $150
Mail	
Generic: 90-day supply	10%; minimum Copayment: $15
Brand: 90-day supply	
Preferred	20%; minimum Copayment: $25; maximum Copayment: $150
Non-Preferred	20%; minimum Copayment: $70; maximum Copayment: $300
Specialty medications through EnvisionRx Managed Copay Program: Eligible Person must opt in to the EnvisionRx Managed Copay Program to receive discounts on Copayments for certain specialty drugs. Each 30-day supply must be filled through EnvisionRx Specialty Network.	
Specialty medications through EnvisionPharmacies Specialty Pharmacy	
Preferred Generic and Brand: 30-day supply	20%; maximum Copayment: $100
Non-Preferred Generic and Brand: 30-day supply	20%; maximum Copayment: $350
Out-of-Pocket Maximum	
Per Eligible Person per Calendar Year	$2,000
Per Family per Calendar Year	$4,000

Plan pays 100% of covered expenses in excess of such Preferred Provider Pharmacy ("PPRx") Out-of-Pocket Maximums for the remainder of that Calendar Year.

The PPRx Out-of-Pocket Maximum includes all Deductibles, Copayments, and Eligible Person's Coinsurance for PPRx covered expenses. These Out-of-Pocket Maximums are separate from and do not apply to the Out-of-Pocket Maximums for Comprehensive Major Medical Benefits.

1.3 Vision Care Benefits

Plan A Coverage Only (see Section 6). Vision care expenses incurred at Sam's Club or Wal-Mart are not covered under this Plan.	
Eligible Persons age 18 years and older:	
Vision examination (one per Eligible Person each Calendar Year); Lenses (one set per Eligible Person each Calendar Year); Frames (one set per Eligible Person each Calendar Year); and Lasik surgery	80% to a maximum payment of $250 each Calendar Year; no Deductible.
Eligible Dependent children under age 18:	
Vision examination (one per Eligible Person each Calendar Year)	80%; no Deductible, no maximum dollar limit
Lenses (one set per Eligible Person each Calendar Year)	50%; no Deductible
Frames (one set per Eligible Person each Calendar Year)	50%; no Deductible

Benefit Waiting Period: Eligible Persons who are age 18 and older on the date in which they become eligible for benefits under this Plan will not be eligible for "Vision Care Benefits" (Section 6) until the first day of the month following twelve (12) months of coverage under this Plan. For the purpose of this Benefit Waiting Period, the twelve (12) month coverage period may not be continuous coverage.

1.4 Dental Care Benefits

Plan A Coverage Only (see Section 7).	
Routine exams and cleanings, basic dental care, and full denture replacement benefits[1]	
Deductible	None
Plan's Coinsurance	90% of R&C Charge
Maximum benefit per Eligible Person per Calendar Year[2]	$1,000

[1] Benefits are payable for one routine exam and one prophylaxis (cleaning) every six (6) months, four (4) bite-wing x-rays every twelve (12) months, panoramic or full-mouth x-rays once every three (3) years, topical fluoride applications once every twelve (12) months for Dependent children, and sealants on permanent teeth for Dependent children.

[2] Preventive dental care for Eligible Persons under age eighteen (18) is not subject to the maximum dollar amount.

Temporomandibular Joint Dysfunction (TMJ)	
Deductible	None
Plan's Coinsurance	50% of R&C Charge
Maximum TMJ Lifetime benefit per Eligible Person	$900
Orthodontic – Dependent child under age 18 only	
Deductible	None
Plan's Coinsurance	50% of R&C Charge
Maximum orthodontic Lifetime benefit	$900

Benefit Waiting Period: Eligible Persons who are age 18 and older on the date in which they become eligible for benefits under this Plan will not be eligible for "Dental Care Benefits" (Section 7) until the first day of the month following twelve (12) months of coverage under this Plan. For the purpose of this Benefit Waiting Period, the twelve (12) month coverage period may not be continuous coverage.

1.5 Other Benefits (Plan A Coverage Only)

"Death Benefits"-Active Employees Only (see Section 8)	
Amount of Death Benefit	$10,000
Accidental Death and Dismemberment Benefits-Active Employees Only (see Section 9)	
Principal sum	$5,000
Weekly Disability Benefits-Active Employees Only(Short-Term Total Disability) (see Section 10)	
Weekly rate	50% of your average gross weekly earnings, up to $325
Maximum per period of disability	26 weeks[3]

[3] See Section 10 ("Weekly Disability Benefits") for specific limits for disabilities certified by a chiropractor.

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 treatment of an Emergency medical condition.

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 treatment of an Emergency medical condition.

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

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.

B. **Extended post-Hospital care** when the attending Physician determines that an Eligible Person no longer requires confinement in a Hospital, but does require Medically Necessary continuing care, the following will be covered when prescribed immediately upon Hospital discharge:

1. Care at home by a registered nurse, licensed practical nurse, or nurse's aide; and

2. Skilled Nursing Home care.

Extended post-Hospital care benefits are payable up to the maximum stated in the Schedule of Benefits (Section 1.1) following one period of Hospital confinement. Benefits are payable at the Coinsurance stated in the Schedule of Benefits (Section 1.1) and do not count toward the out-of-pocket maximum.

C. **Physicians' services** include charges for:

1. Surgery by a Physician, including outpatient surgery. Surgeons' services through Blue Cross Blue Shield of Minnesota network providers are covered at the Coinsurance stated in the Schedule of Benefits (Section 1.1). If you use a provider that is not in the network, benefits are limited to the percentage of the R&C Charge for the surgeon and twenty (20%) percent of the surgical allowance for the assistant surgeon.

   Organ transplants and all related expenses (including pre- and post-operative care and immunosuppressant drugs) for Eligible Persons may be covered by the Plan. Covered transplants include, but are not limited to: heart, heart/lung, lung, liver, pancreas, kidney, bone marrow, cornea, and stem cell. Animal organs and/or mechanical devices are not covered.

   For individuals receiving mastectomy-related benefits, coverage will be provided on the same basis as other medical and Surgical Procedures covered by the Plan and in a manner determined in consultation with the attending Physician and the patient for all stages of reconstruction of the breast and nipple of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance; prostheses; and treatment of the physical complications of the mastectomy, including lymphedemas;

2. Anesthetic and its administration by a professional anesthetist when the charge for those services is not included in the Hospital's charges;

3. Medical services rendered during in-Hospital, outpatient, office, and home visits by a Physician. Second surgical opinions and routine exams are covered.

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 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 or Outpatient Psychiatric Facility, except that a Physician can render such treatment at any location. Outpatient treatment does include collateral interviews with the Eligible Person's family.

   Benefits are payable for outpatient treatment of Mental Health Conditions subject to the Coinsurance stated in the Schedule of Benefits (Section 1.1).

   Benefits are payable for outpatient treatment of Substance Use Disorders subject to the coinsurance stated in the Schedule of Benefits (Section 1.1).

   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.

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.

G. Other covered charges include the following:

1. Other Hospital charges incurred as an outpatient;

2. Charges of a qualified physical therapist, occupational therapist, speech therapist, registered nurse (R.N.) or licensed practical nurse (L.P.N.) if the services are ordered and monitored by a Physician pursuant to a written treatment plan for an identifiable clinical condition and submitted to and approved by the Plan. Progress reports must be submitted by the monitoring Physician to demonstrate that the therapy services ordered continue to be Medically Necessary and that the treatment plan has a reasonable expectation to produce measurable and sustainable progress toward improving the clinical condition in a reasonable and predictable period of time. Services provided by a person who ordinarily resides in your home or is a member of your immediate family (comprised of your spouse and your and your spouse's children, brothers, sisters, and parents) are not covered expenses. Benefits for rehabilitative therapy (including physical, occupational, and speech therapy) are payable at the Coinsurance and up to the applicable maximum number of visits per Eligible Person per disability as stated in the Schedule of Benefits (Section 1.1);

3. Medically Necessary local professional ground ambulance service to the nearest Hospital equipped to provide the necessary treatment. If an Injury or Sickness requires special and unique Medically Necessary Hospital treatment that is not available in a local area Hospital, the Plan covers Medically Necessary professional ambulance service by air or helicopter ambulance service to the Hospital selected by the treating Physician providing services related to a medical Emergency, provided that the Hospital is the nearest Hospital equipped to furnish the treatment. Charges are payable for Medically Necessary emergency transport by air and helicopter ambulance subject to the Plan's Deductible and Coinsurance, as stated in the Schedule of Benefits (Section 1.1), and the reimbursement terms available to the Plan through the Preferred Provider's contract or in the case of a non-Preferred Provider, the R&C Charge allowed by the Plan. Charges for ambulance service by railroad, ship, bus, or other common carrier are not covered expenses. Benefits are not payable for transportation or transfer based solely on your or your Health Care Professional's convenience, your personal preference, or any reason other than being Medically Necessary;

4. Charges for the following additional services and supplies: oxygen and the rental of equipment for its administration; x-ray, radium, or cobalt treatment, including the services of a radiologist and the rental (but not the purchase) of such radioactive materials, provided that treatment is rendered in the radiologist's office or in the outpatient department of the Hospital making the charge; blood or blood plasma (if not replaced) and its administration; surgical dressings and casts; dental services rendered by a Physician, Dentist, or dental surgeon for treatment of a fractured jaw or Injury to natural teeth, including replacement of such teeth within six (6) months after the date of the accident; and intra-uterine devices (IUDs) for birth

control;

5. Infertility treatment, payable at the Plan's Coinsurance after satisfaction of the Deductible, up to the maximum per Eligible Person per Calendar Year stated in the Schedule of Benefits (Section 1.1). Benefits for infertility treatment do not count toward the Out-of-Pocket Maximum and do not include infertility drugs;

6. Artificial life support systems for the first five (5) days after a medical determination that death has occurred, up to a maximum of $5,000, when an Eligible Person is determined to be legally or clinically dead;

7. Durable Medical Equipment, including but not limited to, splints, braces, trusses, and crutches; rental of Hospital-type bed, wheelchair, or iron lung (or the purchase of such device if the rental would exceed the purchase price); artificial limbs and eyes; and breast prostheses following a mastectomy. After satisfaction of the Deductible, benefits for Durable Medical Equipment are payable at the Plan's Coinsurance.

   The Plan may purchase equipment if it determines the purchase is more economical than rental. A purchase may be made even if rental payments already have been made. The Plan will cover the replacement of Participant-owned Durable Medical Equipment only when the replacement is needed for one or more of the following reasons:

   a. Due to a change in the Participant's medical or physical condition;

   b. When the equipment is inoperative due to irreparable damage;

   c. When the equipment is inoperative due to irreparable wear; or

   d. When the repair cost is equal to or greater than the cost of rental or replacement.

   "Replacement" refers to the provision of an identical or near identical item. Situations involving the provision of a different item because of a change in a Participant's medical or physical condition does not meet the definition of "replacement" under this provision.

   "Irreparable damage" refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.) that rendered the equipment unusable. "Irreparable wear" refers to deterioration of the equipment sustained from day-to-day usage over a period of at least five (5) consecutive years, but does not include deterioration or damage caused in part or in whole from abuse or neglect.

   Repairs to equipment which a Participant owns are covered when necessary to make the equipment serviceable, unless such repairs are covered under any manufacturer's warranty. Routine periodic servicing, such as, but not limited to, testing, cleaning, or regulating the Participant's equipment, is not covered. The Plan will pay the reasonable cost of rental

equipment during the time the Participant's equipment is being repaired;

8. The following specified routine screenings: mammograms, PSA tests, and Pap tests. Benefits are payable at 100% with no Deductible requirement. These screenings are covered under this Section only if performed on a routine basis; and

9. The following smoking cessation services:

    a. Over-the-counter nicotine replacement therapy;

    b. Prescription drugs to help you quit smoking. Coverage for these prescription medications will be subject to the Preferred Provider Pharmacy Prescription Drug Benefits outlined in the Schedule of Benefits (Section 1.2); and

    c. Coaching support.

    These smoking cessation services are available at a reduced cost to you through the "Enhanced Stop Smoking" program sponsored by Blue Cross Blue Shield of Minnesota. More information on the Enhanced Stop Smoking Program is available in Section 3.2 ("Smoking Cessation Program"). If you enroll in the Enhanced Stop Smoking Program, the Plan will cover the entire cost of over-the-counter nicotine replacement therapy and coaching support provided through the program.

H. Bariatric Surgery, subject to the following conditions:

To ensure that your "Bariatric Surgery" and any related surgeries subsequent to an approved Bariatric Surgery procedure, such as Panniculectomy (removal of loose skin), will be covered, you must first contact the Fund Office in advance of your surgery to learn if you meet the requirements for coverage under the Plan and if your procedure will be approved.

Approval of Bariatric Surgery will be based upon a number of factors including body mass index ("BMI"), morbid obesity, history of failure to sustain weight loss, the results of a mental health evaluation, patient expectations for the surgery, the patient's understanding of the risks, benefits and uncertainties of Bariatric Surgery and the patient's treatment plan, including pre- and post-operative dietary evaluations. These factors are subject to modification as technology changes.

You also must use a Blue Distinction Center for Bariatric Surgery for benefits to be payable. These are designated facilities within participating Blue Cross and/or Blue Shield companies that have been selected after a rigorous evaluation of clinical data measurers established in collaboration with leading doctors, medical societies, and professional organizations. You can contact the Fund Office for a listing of the Blue Distinction Centers for Bariatric Surgery.

As technology changes, the Bariatric Surgery procedures, including related subsequent procedures, covered by the Plan will be subject to modifications in the form of additions or deletions as the Trustees deem appropriate. You can contact

the Fund Office to learn of the current medical policy for the Plan in approving surgery and which Bariatric Surgery procedures are covered under the Plan.

If you are considering Bariatric Surgery, you must contact the Fund Office to determine the appropriate steps you must follow and the requirements that you must meet in order to have your Bariatric Surgery procedure covered by the Plan.

2.5 Prohibition on Pre-Existing Condition Exclusions

The Affordable Care Act prohibits pre-existing condition exclusions for all Eligible Persons.

2.6 Emergency Services

The Affordable Care Act requires that all Emergency services are covered at the in-network level of benefits even if services are obtained at an out-of-network provider.

2.7 Coverage for Routine Patient Costs Incurred by Qualified Individuals Eligible to Participate in an Approved Clinical Trial

To the extent required by the Affordable Care Act, the Plan will not deny any “Qualified Individual” the right to participate in an “Approved Clinical Trial”; deny, limit, or impose additional conditions on the coverage of “Routine Patient Costs” for items and services furnished in connection with participation in the Approved Clinical Trial; and will not discriminate against any Qualified Individual who participates in an Approved Clinical Trial. Qualified Individuals must use a PPO Provider if a PPO Provider is participating in an Approved Clinical Trial and the PPO Provider will accept the Qualified Individual as a participant in the Approved Clinical Trial.

There are specific guidelines as to who is a "Qualified Individual," what is an "Approved Clinical Trial," and what are "Routine Patient Costs," as defined below. The Plan's utilization review provider will review all services related to participation in a clinical trial to determine whether related services are payable by the Plan under these guidelines.

"Routine Patient Costs" include items and services typically provided under the Plan for an Eligible Person not enrolled in an Approved Clinical Trial. However, such items and services do not include:

A. The investigational item, device, or service itself;

B. Items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or

C. A service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

A "Qualified Individual" is an Eligible Person who is eligible, according to the trial protocol, to participate in an Approved Clinical Trial for the treatment of cancer or other “Life-Threatening Condition” and either:

A. The referring Health Care Professional is a participating provider and has concluded that the Eligible Person's participation in the Approved Clinical Trial

would be appropriate; or

B. The Eligible Person provides medical and scientific information establishing that participation in the Approved Clinical Trial would be appropriate.

An "Approved Clinical Trial" is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition and is:

A. Approved or funded by one of the following:

1. The National Institutes of Health;

2. The Centers for Disease Control and Prevention;

3. The Agency for Health Care Research and Quality;

4. A cooperative group or center of any of the preceding entities or the Departments of Defense or Veterans Affairs;

5. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

6. The Departments of Veterans Affairs, Defense, or Energy if certain conditions are met.

B. Conducted under an investigational new drug application reviewed by the FDA; or

C. A drug trial that is exempt from having such an investigational new drug application.

"Life-Threatening Condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

If you are recommended for participation in a clinical trial, please contact the Fund Office to determine if you satisfy the parameters for this coverage.

2.8 Nondiscrimination Provisions Against Any Health Care Provider Acting Within the Scope of His or Her License or Certification

To the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques specified under the Plan with respect to the frequency, method, treatment, or setting for an item or service, the Plan will not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law.

2.9 Coverage for Preventive Health Services

The Affordable Care Act requires coverage for certain “Preventive Health Services” with no cost-sharing on your part when rendered by an in-network PPO Provider. Current non-PPO Provider Plan provisions will continue to apply when such services are rendered by a non-PPO Provider.

But if the Plan does not have an in-network PPO Provider who can provide a particular covered Preventive Health Service, then it will cover the item or service without cost-sharing when performed by a non-PPO Provider acting within the scope of his or her license or certification. No cost-sharing means that the Plan will pay 100% with no Deductible, Copayment, or Coinsurance requirement.

The list of recommended Preventive Health Services under the Affordable Care Act is subject to change and may have varying effective dates for specific services. The Plan will continue to cover all the Preventive Health Services and immunizations it currently does at the current benefit design until the required effective dates. For information on whether a specific Preventive Health Service or immunization is covered at 100%, you can contact the Fund Office or visit the federal government's website at https://www.healthcare.gov/preventive-care-benefits/.

The Plan may apply reasonable medical management techniques to determine coverage limitations, if any, in cases where the recommendations or guidelines for a recommended Preventive Health Service do not specify the frequency, method, treatment, or setting for the provision of that service.

Preventive Health Services include the following:

A. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (the "USPSTF");

B. Immunizations for routine use that have in effect, a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

C. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

D. With respect to women, additional preventive care and screenings will be covered as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, to the extent not already included in certain recommendations of the USPSTF.

The current recommendations of the USPSTF will be considered "current" and will be followed until new guidelines are issued for breast cancer screening, mammography, and prevention. For more information about the current USPSTF recommendations, please visit https://www.uspreventiveservicestaskforce.org/.

2.10 Exceptions and Limitations

In addition to the Plan's coverage exclusions provided in Section 12.8 ("General Exclusions") and other limits that apply to specific benefit provisions as described in those applicable sections, Comprehensive Major Medical Benefits do not cover:

A. Dental treatment or dental x-rays, except as specifically provided; and

B. Examination for the correction of vision or fitting of glasses or contact lenses,

except as specifically provided. Lasik surgery is covered only under the provisions of Section 6 (“Vision Care Benefits”).

SECTION 3
PREFERRED PROVIDER NETWORK

As part of the Trustees' ongoing effort to manage health care costs, the Plan participates in a number of preferred arrangements which offer cost savings to both you and the Plan and may include financial incentives for network providers. The Plan has agreements with participating providers where the providers agree to accept a negotiated amount as full payment for covered services at the time your claim is processed. The amount the Plan pays to providers and the amount you pay in the form of Deductibles, Copayments, and Coinsurance will be based on the negotiated payment amount the Plan has established with the provider. The negotiated amount of payment with participating providers for certain covered services may not be based on a specific charge for each service, and the Plan uses a reasonable allowance to establish a per service allowed amount for such covered service. Where there is no specific charge for a covered service, your Coinsurance will be based on a reasonable allowance for the covered service established by the Plan.

The Trustees have entered into a "Preferred Provider arrangement" with Blue Cross Blue Shield of Minnesota AWARE Network ("BCBSM"). BCBSM provides a network of Hospitals, Physicians, Mental Health Professionals, and other Health Care Professionals who provide high quality medical care while helping you and the Plan to manage costs. These Hospitals, Physicians, Mental Health Professionals, and other Health Care Professionals ("PPO Providers") have agreed to offer you and the Plan "preferred" rates. You have the option of choosing a PPO Provider or a non-PPO Provider each time you need services. Your current Hospital, Physician, or Mental Health Professional already may be a member of this network.

You can request a current listing of PPO Providers from BCBSM at no charge. It is recommended that you contact BCBSM prior to incurring covered expenses to make sure the Hospital, Physician, Mental Health Professional, or other Health Care Professional you choose is a PPO Provider. Call BCBSM at (800) 810-BLUE (2583) (select option 2) or visit their website at: www.bluecrossmn.com. PPO Providers automatically will file your claim for you if you present your identification card and sign the appropriate form.

For charges incurred with PPO Providers, the Plan will pay a discounted amount. These 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 BCBSM, the Plan will pay the R&C Charge or, if applicable, a separately negotiated amount to the non-PPO Provider. The rules applicable to the network provide that the Plan is not permitted to accept an assignment for these charges. Rather, the Plan is supposed to pay you directly and you then will be responsible for paying the non-PPO Provider for the charges and the Plan will make no further payment. Additionally, you 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. The Plan does not cover inpatient out-of-network services, except for treatment of an Emergency medical condition.

Charges incurred with non-PPO Providers outside the geographic area of the BCBSM will come through Blue Cross' Blue Card program. The Plan will pay the R&C Charge as provided by the Blue Card Host Plan in the Blue Card system or, if applicable, an amount separately negotiated

with the non-PPO Provider. The Plan may accept an assignment of these claims to make payment directly to the non-PPO Provider. You 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.

BCBSM also provides case management services for any Injury or Sickness covered under your Plan. If a catastrophic or other suitable case is referred to them, BCBSM will review the case to determine if case management is appropriate. If so, BCBSM will contact you, your Physician and/or Mental Health Professional, and the Fund Office to discuss treatment options and to identify available community resources. If you and your Physician and/or Mental Health Professional approve, they will coordinate the necessary services. It is often hard to make decisions about ongoing care. Case management allows you to discuss your concerns openly and makes you aware of all your options. Also, both you and the Plan may save money if a less costly setting is appropriate and you choose to use it. But remember, the choice is yours. The case manager will offer you alternatives, but you and your Physician and/or Mental Health Professional have the final decision.

3.1 Prenatal Support Program

You and your eligible Dependents have access to the “Healthy Start” prenatal support program offered by Blue Cross Blue Shield of Minnesota. This program is designed to assess, educate, and support pregnant women to achieve an optimal childbirth outcome.

If you or one of your eligible Dependents is expecting a baby, please call the Healthy Start Program at (866) 489-6948 or (651) 662-1818 to enroll in the program.

3.2 Smoking Cessation Program

The “Enhanced Stop Smoking Program” sponsored by Blue Cross Blue Shield of Minnesota also is available. If you or your eligible Dependents smoke and desire to quit, enrollment in this program will provide you access to a “Quit Coach” who will guide and support your efforts and supply you with over-the-counter nicotine replacement therapy (“OTC NRT”) products, such as nicotine patches, nicotine gum or lozenges. The Plan will cover the entire cost for these quit aids if you are enrolled in this program.

In addition, while you are enrolled in the Enhanced Stop Smoking Program, the Plan will cover prescription medications which are developed specifically to assist you in your efforts to quit smoking. Upon a Physician’s written prescription, these prescription medications will be covered at a $0 copayment through the Preferred Provider Pharmacy Prescription Drug Benefit program (Envision) at both retail network pharmacies and the mail-service pharmacy. To enroll in the Enhanced Stop Smoking Program, call (888) 662-BLUE (2583).

3.3 Doctor on Demand

Doctor on Demand allows you to “see” a Physician online and all in real time. Doctor on Demand provides live face-to-face visits using video or secure chat text with licensed Physicians who can discuss your immediate health issues and provide a diagnosis. The most common reasons someone might call are if they think they have sinusitis, an upper respiratory infection, a cough, sore throat, conjunctivitis, urinary tract infection, or a fever. The Physician will diagnose your condition and prescribe the medications you need. The most common prescriptions are: Amoxicillin, Augmentin, Cipro, Medrol Pak, and Zithromax. Please note that Doctor on Demand

Physicians cannot prescribe narcotics.

You can use Doctor on Demand from anywhere to address your symptoms quickly and conveniently without ever having to leave your home. The program is available twenty-four (24) hours a day, seven (7) days a week, including holidays, and no appointment is necessary. Visit www.doctorondemand.com.

Please Note: In the case of a medical Emergency, call 911. The services provided by Doctor on Demand are in no way meant to replace the emergency room when Medically Necessary.

SECTION 4
PREFERRED PROVIDER PHARMACY

Active Employees and Dependents

Envision Pharmaceutical Services, Inc. ("Envision") provides full management of the Plan's prescription drug card program. It offers a nationwide network of pharmacies where you can use your identification card to purchase your prescription drugs at reduced rates. The network includes most major chain stores and many independent pharmacies. To locate a participating pharmacy, you can call Envision at (800) 361-4542 or visit their website at: www.envisionrx.com.

Benefits are payable for the following upon a written prescription executed by a Physician and dispensed by a licensed pharmacist:

A. Federal legend drugs;

B. Compound medications for eligible "'pediatric" Dependents (meaning birth to age eighteen (18)), covered without prior authorization;

C. Insulin;

D. Insulin syringes/needles and other diabetic supplies, such as lancets, lancet pens, blood sugar and acetone test strips, and test-tape;

E. Injectable medications;

F. Oral contraceptives;

G. Migraine medications;

H. Nail fungal treatment; and

I. Smoking cessation.

For each prescription purchased at a PPRx, you will pay the Copayment or Coinsurance per prescription as stated in the Schedule of Benefits (Section 1.2) for either generic drugs (up to a ninety (90) day supply) or brand name (up to a thirty (30) day supply).

Diabetic supplies and insulin purchased at a participating retail pharmacy are payable at eighty (80%) percent through Envision.

If you obtain a prescription at a retail pharmacy which does not participate in the Envision network, you will have to pay the full cost up front and then submit the drug claim to the Fund Office. You will be reimbursed at fifty (50%) percent (including injectables) of the cost after the minimum Coinsurance stated in the Schedule of Benefits (Section 1.2). **However, prescription drugs obtained at a Sam's Club or Wal-Mart Pharmacy are not covered under the Plan.**

Envision offers a mail service program. You can order maintenance prescriptions through the mail service program in a ninety (90) day supply, and pay the Copayment or Coinsurance per prescription as stated in the Schedule of Benefits (Section 1.2). The first time you order through

the mail service program, you will need to send in an original prescription from your Physician along with a medical profile. Refills can be processed by phone at (800) 361-4542 or online at www.envisionrx.com.

For purposes of benefit payment calculation by the Plan, the use of generic equivalent substitution is required for all prescriptions, regardless of whether the prescription indicates "dispense as written." If a generic equivalent is available for a prescription and you elect to purchase the brand name drug, you must pay the difference between the cost of the generic and the brand name drug in addition to the brand name Copayment. If a generic equivalent is not available, or if a generic equivalent is determined to be ineffective in your particular case based on competent medical evidence satisfactory to the Plan, you will pay the brand name Copayment or Coinsurance. To be eligible for payment of a brand name prescription drug when a generic substitute is available, you must establish Medical Necessity through the drug exception appeal procedure established by the Plan.

If you use the PPRx while ineligible according to the Plan's Eligibility Rules (Section 11), the Plan will recover the ineligible payments from you according to the right of recoupment provisions stated in Section 12.6 ("Right of Recoupment").

Claims related to prescription drug expenses should be filed with the patient's primary source of coverage and then submitted to the Plan for coordination of benefits. If this Plan makes payments and later determines it is not the primary source of coverage, overpayments will be recouped from you.

4.1 Specialty Drugs

You must purchase specialty medications through EnvisionPharmacies Specialty Pharmacy as stated in the Schedule of Benefits (Section 1.2). "Specialty drugs" are prescription medications that require special handling, administration, or monitoring. These drugs are used to treat complex, chronic, and often costly conditions such as cancer, hepatitis C, HIV/AIDS, multiple sclerosis, psoriasis, and rheumatoid arthritis. EnvisionPharmacies Specialty Pharmacy not only provides access to high-cost injectable and oral specialty medications, it ensures that you receive the most appropriate treatment for your condition and/or prescribed therapy.

You may receive reduced Copayments for certain specialty drugs through the EnvisionRx Managed Copay Program. You must opt in to the EnvisionRx Managed Copay Program and fill each prescription for your specialty drug through EnvisionPharmacies Specialty Pharmacy to receive reduced Copayments. Only the amount you actually pay will count toward your maximum annual Copayment on specialty drugs as stated in the Schedule of Benefits (Section 1.2). The drugs covered by the EnvisionRx Managed Copay Program may change from time to time, as determined by Envision. You may contact Envision to determine if a drug is covered by the EnvisionRx Managed Copay Program. Alternatively, Envision may contact you to ask if you want to participate in the EnvisionRx Managed Copay Program as part of the care management for your condition. Medications covered under the EnvisionRx Managed Copay Program are limited to a thirty (30) day supply per prescription fill.

If you have not opted in to the EnvisionRx Managed Copay Program, you can purchase one thirty (30) day supply of a specialty drug at a network retail pharmacy (except for hepatitis C drugs); then each thirty (30) day supply must be filled through EnvisionPharmacies Specialty Pharmacy. **If you have opted in to the EnvisionRx Managed Copay Program, you must purchase your**

thirty (30) day supply of a specialty medication at an EnvisionPharmacies Specialty Pharmacy.

EnvisionPharmacies Specialty Pharmacy provides the convenience of receiving your specialty drugs through express delivery to the location of your choice. You can choose to have your medication delivered to your home or Physician's office. To receive a specialty drug through EnvisionPharmacies Specialty Pharmacy, please call (877) 437-9012 **at least fourteen (14) calendar days** before your current prescription is due to run out to enroll.

4.2 Step Therapy Program

A "step therapy" program is designed specifically for patients with certain conditions that require them to take medications regularly. It is the practice of beginning medication therapy for a medical condition with the most cost-effective medication and progressing to other more costly therapy(s) should the initial medication not provide an adequate therapeutic benefit.

In step therapy, medications are grouped into categories:

1st Step: "First Line" medications – These medications should be tried first. They are mostly generic medications that have been proven safe, effective, and affordable.

2nd Step: "Second Line" medications – These are mostly higher costing brand name medications.

"Step therapy" is a process to ensure you are receiving a cost-effective therapy. You will first try a recognized First Line medication (1st Step) before approval of a more costly and complex therapy is approved (2nd Step). If the 1st Step therapy does not provide you with the therapeutic benefit desired, your Physician may write a prescription for a Second Line medication. Generally, Second Line medications require the usage and failure of a First Line medication before coverage is approved. The step therapy approach to care is a way to provide you with savings without compromising your quality of care.

Always talk to your Physician before discontinuing or changing any medication. Ask your pharmacist or Physician about First Line medications and discuss the step therapy medications on your benefit plan.

A higher cost does not automatically mean a medication is better. For example, a brand name medication may have a less expensive generic or brand name alternative that might be an option for you. Generic and brand name medications must meet the same standards set by the U.S. Food and Drug Administration for safety and effectiveness. We encourage you to work with your Physician to determine which medication options are best for you.

4.3 Preferred Provider Pharmacy Exceptions and Limitations

Benefits are not payable under the Preferred Provider Pharmacy Program for the following:

A. Non-legend over-the-counter ("OTC") drugs other than insulin and diabetic supplies;

B. Drugs purchased at the Hospital pharmacy for you at the time of discharge;

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;

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; and

P. Smoking cessation drugs, except as provided elsewhere.

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. Accordingly, the Plan will continue to use a "cost-sharing" benefit design for brand name contraception drugs if a generic version is available and just as effective and safe for patient use. Generic contraceptives and contraceptives for which there is no generic alternative will be covered at a $0 copayment upon a Physician's written prescription.

Contraceptive medications and devices that are obtainable at the pharmacy and require a Physician's written prescription will be covered under the Preferred Provider Pharmacy Prescription Drug Benefit. This includes oral and transdermal contraceptives (patch), diaphragms, and vaginal hormone rings. In addition, emergency contraceptives (for example, Plan B) will be covered.

Coverage for contraceptives that are administered or inserted by a Physician, including contraceptive injections, implant systems and devices, intrauterine devices, injectable hormones, and sterilization will be covered at 100% under Comprehensive Major Medical Benefits (Section 1.2).

4.5 Other Preventive Care Prescriptions

Upon a Physician's written prescription, certain prescription medications meeting the USPSTF guidelines for Preventive Health Services (described in Section 2.9), will be covered at a $0 Copayment through the Preferred Provider Pharmacy Prescription Drug Benefits (Envision) at both retail network pharmacies and the mail-service pharmacy. For current USPSTF guidelines, please visit https://www.uspreventiveservicestaskforce.org/.

SECTION 5
EMPLOYEE ASSISTANCE PROGRAM

Active Employees and Dependents

The Employee Assistance Program ("EAP") is a confidential resource that helps address various kinds of personal concerns. The program offers consultation, support, information, and planning as well as referrals to, professional resources in your community. Services include face-to-face counseling, telephone consultations, and support and educational materials for issues such as:

- Marital conflicts;
- Legal issues;
- Financial issues;
- Family and relationship concerns;
- Alcohol and/or chemical dependency;
- Emotional and psychological issues;
- Job-related difficulties;
- Grief and loss; and
- Depression and anxiety.

The EAP is administered by TEAM Corporation. Several key points about this program include:

A. All counseling by TEAM Corporation has been prepaid by the Plan. However, when a referral is made to another care provider, the cost will be handled according to Plan provisions;

B. Every consultation is confidential. No information will be given to either your Employer or the Union unless you specifically request it; and

C. This counseling is available to you and your eligible Dependents.

There is a TEAM Corporation office in the Duluth area located at: 2002 London Road, Suite 95, Duluth, MN 55812. Confidential assistance is available twenty-four (24) hours a day by calling (800) 634-7710 or (218) 727-8589.

You are not required to use the EAP to receive treatment for a Mental Health Condition or Substance Use Disorder, but the EAP may be able to help you obtain needed services more quickly or at a lower cost to you.

SECTION 6
VISION CARE BENEFITS

Active Employees and Dependents Plan A Coverage Only

"Vision Care Benefits" are payable at the Coinsurance and up to the maximum amount stated in the Schedule of Benefits (Section 1.3) for R&C Charges related to vision exams, lenses, frames, and Lasik surgery. Services and supplies must be furnished by an Optician, Optometrist, or Ophthalmologist acting within the scope of such practice.

Vision Care Benefits are payable for the following, up to the maximum amount:

A. One vision examination each Calendar Year (vision exams for Eligible Persons under age eighteen (18) are not subject to, and do not count toward, the maximum amount);

B. One set of lenses (including contact lenses) each Calendar Year;

C. One set of frames each Calendar Year. Related professional services for fitting and adjusting are included in such coverage; and

D. Lasik surgery.

Benefit Waiting Period

Eligible Persons who are age eighteen (18) and older on the date in which they become eligible for benefits under this Plan will not be eligible for Vision Care Benefits until the first day of the month following twelve (12) months of coverage under this Plan. For the purpose of this Benefit Waiting Period, the twelve (12) month coverage period may not be continuous coverage.

Limitations

In addition to the coverage exclusions in Section 12.8 ("General Exclusions"), Vision Care Benefits do not cover expenses incurred for services performed or supplies furnished by anyone other than an Optician, Optometrist, or Ophthalmologist. Vision care expenses incurred at a Sam's Club or Wal-Mart are not covered under the Plan.

SECTION 7
DENTAL CARE BENEFITS

Active Employees and Dependents Plan A Coverage Only

You are free to use the Dentist of your choice. However, we encourage you to use a Dentist who participates in the Delta Dental of Minnesota's "Delta Dental PPO" or "Delta Dental Premier" networks. To confirm whether your Dentist is a participating provider, you can visit Delta Dental's website at: www.deltadentalmn.org or call (800) 553-9536.

Participating Dentists have agreed to accept Delta Dental's allowable charge as payment in full for covered dental care. These savings are passed on to you through reduced dental service fees and lower out-of-pocket expenses. In addition, participating Dentists will file claims directly with the Fund Office on your behalf.

"Dental Care Benefits" are payable at the percentage and up to the applicable maximum amount stated in the Schedule of Benefits (Section 1.4) for the following R&C Charge related to preventing dental disease, restoring teeth, furnishing dentures, and straightening teeth (orthodontia). Preventive dental care for Eligible Persons under age eighteen (18) is not subject to, and does not count toward, the maximum amount.

Benefit Waiting Period

Eligible Persons who are age eighteen (18) and older on the date in which they become eligible for benefits under this Plan will not be eligible for Dental Care Benefits until the first day of the month following twelve (12) months of coverage under this Plan. For the purpose of this Benefit Waiting Period, the twelve (12) month coverage period may not be continuous coverage.

7.1 Routine Oral Examinations

A routine oral examination includes services performed by a Dentist for one or any combination of the following:

A. Prophylaxis, which also may be performed by a Dental Hygienist under the direction and supervision of a Dentist;

B. Oral examination, including dental x-rays if professionally indicated; and/or

C. Diagnosis.

You and each of your eligible Dependents are entitled to: one routine oral examination and one prophylaxis every six (6) months; four (4) bitewing x-rays every twelve (12) months; and panoramic or full-mouth x-rays once every three (3) years.

7.2 Basic Dental Care

Basic dental care includes services performed by a Dentist for an actual or suspected dental disease, defect, or Injury. These benefits include, but are not necessarily limited to:

A. Topical fluoride applications, for Dependent children once each twelve (12)

months;

B. Sealants for Dependent children on permanent teeth only;

C. Emergency treatment;

D. Treatment of periodontal disease;

E. Extractions, including removal of multiple unimpacted teeth;

F. Root canal therapy;

G. Crowns, fillings, and inlays;

H. Bridgework and repair of bridgework;

I. Space maintainers and related services;

J. Initial installation or repair of a full or partial denture;

K. Replacement of a partial denture;

L. Examination and treatment by a Dentist in connection with an actual or suspected dental disease, defect, or Injury; and

M. Treatment of temporomandibular joint dysfunction (TMJ), payable at the Coinsurance and up to the separate Lifetime maximum per Eligible Person stated in the Schedule of Benefits (Section 1.4).

7.3 Full Denture Replacement

A full denture replacement includes services of a Dentist for replacement of an existing full upper or lower denture or full dentures. One replacement of one upper denture or one lower denture or one full set of dentures is provided to you and each of your eligible Dependents each five (5) consecutive years, as Medically Necessary.

7.4 Orthodontic Benefits

Benefits are payable for the R&C Charge incurred during a period of orthodontic treatment for Dependent children under age eighteen (18). Benefits payable for orthodontic treatment are subject to the Lifetime maximum orthodontic benefit stated in the Schedule of Benefits (Section 1.4), which means the aggregate amount payable for all orthodontia expenses per each Dependent child's Lifetime.

Eligible dental expense for this provision is an expense incurred as the result of the initial and subsequent installation of orthodontic appliances, including all orthodontic treatment rendered by an orthodontist preceding and subsequent to the installation.

7.5 Limitations

Dental Care Benefits do not cover the following:

A. Services or treatment rendered or supplies furnished primarily for cosmetic purposes, except as may be specifically provided;

B. Expenses incurred for services performed or supplies furnished by anyone other than a Dentist, except for prophylaxis which may be performed by a Dental Hygienist under the direction and supervision of a Dentist;

C. Procedures, appliances, or restorations (including orthodontic treatment) to correct congenital or developmental malformations, other than those malformations which will respond to dental treatments covered under this Plan;

D. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including, but not limited to:

1. Increasing vertical dimension;

2. Periodontal splinting;

3. Gnathologic recordings;

4. Realignment of teeth; or

5. Replacing or stabilizing tooth structure loss due to attrition.

E. Services of an anesthesiologist;

F. Implants (artificial materials implanted or grafted into or onto bone or soft tissue) or surgical removal of implants;

G. Veneers (bonding of coverings to the teeth); and

H. Pre-operative visits by a Dentist.

In all cases in which you select a more expensive service than is customarily provided, or for which a valid need is not shown, the Plan will pay the applicable percentage of the fee for the service which is adequate to restore the tooth or dental arch to contour and function. You are responsible for the entire remainder of the Dentist's fee.

SECTION 8
DEATH BENEFITS

Active Employees Plan A Coverage Only

Immediately upon receipt of acceptable proof of your death on forms provided by the Trustees, the Plan will pay to your Beneficiary of record the "Death Benefit" stated in the Schedule of Benefits (Section 1.5) in a lump sum amount.

At the time of enrollment, you must complete a form provided by the Trustees naming one or more primary Beneficiaries or alternative Beneficiaries.[4] A Beneficiary designation will not be effective unless the designation includes the name, Social Security number, and address of the Beneficiary as well as a description of the Beneficiary's relationship to you. If you name two (2) or more individuals as primary Beneficiaries, the Death Benefit will be shared equally by any of them that survive you, unless otherwise specified. The Death Benefit only will be paid to your designated alternate Beneficiaries if, at the time of your death, no primary Beneficiaries are living. You may change any Beneficiary designation from time to time without providing notice to any Beneficiary or getting the consent of any Beneficiary.

It is important to keep your Beneficiary information up to date. If, for example, there is a change in your marital status or the birth of a child, you may wish to complete a new Beneficiary designation form. Also keep in mind that a Beneficiary designation becomes immediately ineffective if the indicated relationship ends because of a judgment and decree of marital dissolution. For example, the designation of a Beneficiary labeled as your "spouse" becomes ineffective upon divorce.

If you fail to designate a Beneficiary, or you revoke a Beneficiary designation without naming another Beneficiary, or none of your designated Beneficiaries survive you, this Death Benefit will be payable to individuals in the following order:

A. Your surviving spouse;

B. Your surviving children (provided as follows);

C. Your surviving parents; or

D. The executor or administrator of your estate.

The term "children" includes legally adopted children and illegitimate children. If the Death Benefit is payable to your children, they split the benefit equally. If one of your children has died before you do, that child's surviving children, if any, will equally split the portion of the Death Benefit that would have gone to the deceased child had the deceased child survived you.

If you designate a minor child as your Beneficiary, you must provide the Plan's Administrative Manager with information regarding the child's guardian or about the trust from which the payment of benefits will be made.

[4] If you are married and intend to designate someone other than your spouse as your Beneficiary, you should consult your lawyer.

SECTION 9
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Active Employees Plan A Coverage Only

"Accidental Death and Dismemberment Benefits" are payable if, while your coverage is in force under the Plan, you suffer bodily Injury caused solely by accidental means and occurring within ninety (90) days of the date of the accident. For the loss of both hands, both feet, both eyes, or the loss of any two (2) of these, benefits are payable for the "Principal Sum" stated in the Schedule of Benefits (Section 1.5). For the loss of one hand, one foot, or one eye, benefits are payable for one-half the Principal Sum.

These payments will be made directly to you, if living, otherwise to your Beneficiary.

"Loss" with reference to hand or foot means complete severance through or above the wrist or ankle joint and with reference to the eye means the irrecoverable loss of its entire sight. If you suffer more than one loss in an accident, benefits will be paid only for the one loss for which the larger amount is payable.

SECTION 10
WEEKLY DISABILITY BENEFITS
(Short-Term Total Disability)

Active Employees Plan A Coverage Only

When you are Totally Disabled due to an Injury or Sickness that prevents you from working in any occupation for wage or profit and while under the care of a Physician, "Weekly Disability Benefits" will be paid to you at the weekly rate stated in the Schedule of Benefits (Section 1.5). However, if you are disabled due to Injury or Sickness on the date of your initial eligibility for benefits, you will not be eligible for Weekly Disability Benefits until the date the disability ends and you resume your regular occupation.

Weekly Disability Benefits begin with the:

A. First (1st) day of disability due to an Injury;

B. Fourth (4th) day of disability due to Sickness (except for Substance Use Disorders); and

C. Eighth (8th) day of disability due to Substance Use Disorders.

Benefits will continue for a maximum of twenty-six (26) weeks for any one period of disability. Disability certified by a chiropractor is limited to four (4) consecutive weeks; benefits considered beyond the four (4) weeks must be certified by a licensed M.D.

Reminder: This benefit is subject to federal Social Security (FICA) taxes.

Limitations

Two (2) or more periods of disability are considered as one unless you have returned to your regular occupation for two (2) months or more between periods of disability or unless the disabilities are due to entirely unrelated causes.

Weekly Disability Benefits are not provided for any loss caused by:

A. Injury that arises out of or occurs in the course of any occupation or employment for wage or profit; or

B. Sickness for which you are entitled to benefits under any Worker's Compensation or Occupational Disease Law.

Weekly Disability Benefits cease as of the date eligibility is lost.

SECTION 11
ELIGIBILITY RULES

11.1 How an Employee Becomes Eligible for Benefits

You will become covered under the Plan (as may be modified from time to time by the Trustees) on the first day after you meet the Plan's general substantive eligibility conditions and the Plan's general waiting period has elapsed, or the first day after you meet the Plan's alternative substantive eligibility conditions and the Plan's alternative waiting period has elapsed, whichever comes first.

A. General Eligibility

You meet the Plan's general substantive eligibility conditions on the day the Plan receives the total number of contributions that your collective bargaining agreement says are required for you to become covered.

The Plan's general waiting period begins on the day you meet the Plan's general substantive eligibility conditions and ends on the last day of the month in which the waiting period begins. If you need a copy of your collective bargaining agreement, you can obtain one by contacting the offices of the United Food and Commercial Workers Union Local 1189 at (218) 728-5174.

B. Alternative Eligibility

You meet the Plan's alternative substantive eligibility conditions on the day that the Plan receives from you an application for coverage (on a form acceptable to the Plan) demonstrating to the satisfaction of the Trustees that:

1. You are currently employed by a contributing Employer in a classification under which you could receive coverage from the Plan under its general eligibility conditions;

2. You have accumulated 1,200 hours of service with your current Employer (excluding hours of service accumulated prior to a period of twenty-six (26) weeks or more during which you were not employed by your current Employer); and

3. You have paid the total amount that the Plan would require to commence coverage under its general eligibility provisions.

To determine the amount you must pay to satisfy the Plan's alternative eligibility conditions, contact the Fund Office.

The Plan's alternative waiting period begins on the day you meet the Plan's alternative substantive eligibility conditions and ends on the last day of the second month after the month in which the waiting period begins. For instance, if you meet the Plan's alternative substantive eligibility conditions on June 15, the alternative waiting period ends on August 31.

Coverage under the Plan's alternative eligibility provisions is the same as that which you

would receive if you were eligible under the Plan's general eligibility provisions, except that to continue coverage you must make monthly payments of the amount that your Employer would be required to make to continue coverage if you were eligible for coverage under the Plan's general eligibility provisions. Additionally, you may only continue coverage under alternative eligibility while you remain employed by the Employer for whom you worked when you became eligible. If you receive coverage under the Plan's alternative eligibility conditions and subsequently meet the requirements for coverage under the general eligibility conditions, the terms of your coverage will be governed by the Plan's general eligibility conditions beginning at the time that coverage would have commenced under the general eligibility conditions.

Your eligibility for single versus family coverage for your eligible Dependents also is determined by your collective bargaining agreement. If family coverage is not provided automatically under your collective bargaining agreement, you do have the opportunity to purchase family coverage by notifying your Employer or the Fund Office of your desire for this benefit. You will be personally responsible for paying the difference between the single and family coverage contribution. You may elect to purchase family coverage within two (2) months of the date on which you become eligible for coverage under the Plan. The Plan's Dependent waiting period begins on the day the Plan receives notice of your election and your payment, if applicable, and ends on the last day of the month that follows the month in which the waiting period begins.

11.2 Spousal Eligibility

A Dependent spouse will not be eligible for coverage under the Plan if the Dependent spouse is eligible to enroll in group health plan coverage sponsored by his or her employer. If a Dependent spouse is offered group health plan coverage by his or her employer, but the spouse does not enroll, then the Plan will not cover the Dependent spouse.

This rule does not affect a Dependent spouse if:

A. The Dependent spouse is not employed;

B. The Dependent spouse's employer does not offer any group health plan coverage; or

C. The Dependent spouse is required to make an employee contribution of an amount established by the Trustees per month for employee-only coverage under the lowest cost of coverage available under the Dependent spouse's employer-sponsored coverage.

If one of the circumstances described above is applicable, this Plan will continue to cover the Dependent spouse.

11.3 Dependent Special Enrollment Period

Special enrollment periods are available to add family benefits if you have a change in status which meets one of the following criteria:

A. You become married. Election of family coverage must be made within thirty (30) days from the date of marriage. Eligibility is effective the date of your marriage if

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.

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.

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

the following times:

1. When you become initially eligible for coverage under Plan B in accordance with Section 11.1 ("How an Employee Becomes Eligible for Benefits");

2. During the Plan's "Ancillary Benefit Open Enrollment Period." For purposes of this Section, the "Ancillary Benefit Open Enrollment Period" means a period, once each Calendar Year, as specified by the Plan, when you may make or change an enrollment election for ancillary benefit coverage; or

3. When you have a special enrollment event, as described in Section 11.3 ("Dependent Special Enrollment Period").

Once you have elected ancillary benefit coverage, you are required to continue coverage and pay the applicable self-payment through payroll deduction for the entire Calendar Year that your coverage became effective.

***Important Note*.** The existing one (1) year Benefit Waiting Period for Dental Care Benefits and Vision Care Benefits that applies to newly Eligible Employees will continue to apply to Plan A and to those Employees in Plan B that elect to purchase the ancillary benefits. This Benefit Waiting Period begins on the first day of the month in which your ancillary coverage became effective.

11.6 How Eligibility Is Continued

Your eligibility will be continued based on work months, contribution months, and coverage months as follows:

Work Month	Contribution Month	Coverage Month
January	February	March
February	March	April
March	April	May
April	May	June
May	June	July
June	July	August
July	August	September
August	September	October
September	October	November
October	November	December
November	December	January
December	January	February
January	February	March

Your Employer will make contributions on your behalf in the contribution month for hours you work during the work month. Contributions made during the contribution month will determine eligibility for the coverage month. In no event will your coverage continue beyond the end of the month in which you leave employment with a contributing Employer.

Transitional Rule: The Plan will provide continuous coverage if you migrate from one contributing Employer to another, provided the gap in employment is less than thirty (30) days.

11.7 How Eligibility Is Continued for Surviving Spouses

The surviving spouse of an active Employee may continue eligibility for benefits under the Plan's COBRA rules following the death of the Employee by paying the COBRA self-payment amount established by the Trustees from time to time.

11.8 How to Opt Into Coverage After You Have Opted Out of Coverage

If your collective bargaining agreement allows you to opt out of coverage and you choose to opt out of coverage when it is initially offered to you, you must state in writing whether coverage is being declined due to other health coverage. If you fail to provide this written statement or opt out of coverage for a reason other than having other health coverage, the Plan is not required to provide special enrollment to you or any of your Dependents.

If you opt out of coverage pursuant to the terms of your collective bargaining agreement, you may opt back into coverage only if all of the following requirements are satisfied:

A. You otherwise are eligible to enroll in coverage at the time you apply to opt back into coverage;

B. You had other coverage under any group health plan or health insurance coverage when you opted out of coverage under this Plan;

C. At the time you opted out of coverage under this Plan, you provided the Plan with a written statement that you were opting out of coverage because you had other health coverage;

D. You provide the Plan with documentation that you had continuous coverage from the date you opted out of coverage under the Plan to at least thirty (30) days prior to the date you request to opt back into coverage under the Plan;

E. One of the following changes in status applies:

   1. You no longer are eligible for the other coverage you had when you opted out of coverage under this Plan;

   2. The employer no longer pays any portion of the premium for the other coverage;

   3. You have exhausted COBRA continuation coverage; or

   4. You have acquired a Dependent child or a spouse; and

F. You submit an application specifying the change in status (i.e., loss of eligibility, change in employer share of premium, exhaustion of COBRA coverage, or acquisition of Dependent or spouse) within thirty (30) days of the change in status.

The application to opt back into coverage must include a copy of the document demonstrating the change in status and any additional information the Trustees may require.

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.

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.

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.

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.

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-day (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 (19th) through the twenty-ninth (29th) 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.

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

and a child loses Dependent status, that child may continue coverage for up to thirty-six (36) months from the date of the original Qualifying Event (i.e., the Employee's termination of employment) by making his own separate self-payments.

If a second Qualifying Event occurs (e.g., a divorce or legal separation, a Dependent losing Dependent status under the Plan, or the death of a covered Employee) the Qualified Beneficiary must notify the Trustees directly within sixty (60) days of the second Qualifying Event so the Trustees may provide proper notices and explanations to Qualified Beneficiaries about extended eligibility. When providing notice to the Plan, the Qualified Beneficiary must provide documentation to support the occurrence of the second Qualifying Event. In the 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. In the case of the death of a covered Employee, a copy of the death certificate or similar document will be required. If the Trustees are not notified in writing within sixty (60) days of the second Qualifying Event, the person will not be entitled to the extension of COBRA coverage.

G. Termination of Self-Payment Provisions for Qualified Beneficiaries

Self-payments no longer are accepted and continued eligibility under this provision terminates on behalf of all Qualified Beneficiaries (unless specifically stated otherwise) when:

1. The Plan no longer provides group health care coverage to any Eligible Employee;

2. The required notice of a Qualifying Event is not provided by the Qualified Beneficiary within sixty (60) days of its occurrence;

3. The election for continuation is not made within sixty (60) days following the date of coverage termination or receipt of the Fund Office explanation, whichever is later;

4. The initial self-payment is not paid by the due date explained in Section 11.10(B)(5) ("Due Date for Initial Self-Payment");

5. The subsequent self-payments are not paid as explained in Section 11.10(B)(6) ("Due Date for Subsequent Self-Payments");

6. The person continuing coverage becomes covered under another group health care plan as an employee or dependent after such person's COBRA election date and waiting periods and/or pre-existing condition limitations, if any, under such other group health care plan have been satisfied with previous coverage credits;

7. The maximum continuation coverage period is reached;

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.

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

such work is available) within the applicable time limits stated in the following Section 11.11(C) ("Status Upon Return from Military Service"), provided you otherwise satisfy the reemployment requirements necessary to qualify for reemployment rights under USERRA (e.g., provide evidence of honorable discharge, cumulative military service of no longer than five years) and make any applicable self-payments required to be immediately reinstated in the Plan.

B. Continuation of Coverage

1. If you fail to provide advance notice of your military service, your coverage will terminate on the date your eligibility has been exhausted and you will not be eligible to continue coverage under this Section unless your failure to provide advance notice is excused. The Trustees will, in their sole discretion, determine if your failure to provide advance notice is excusable under the circumstances and may require that you provide documentation to support the excuse. If the Trustees determine that your failure to provide advance notice is excused, you may elect to continue coverage, in accordance with this Section, retroactive to the date you left employment for the purpose of performing services with the uniformed services of the United States, provided that you elect such coverage and pay all amounts required for the continuation coverage.

2. When the Fund Office has been notified that you are entering the military service, you will be given the option of continuing your same class of coverage under the Plan. Continuation coverage under this Section is very similar to the continuation coverage described under COBRA continuation coverage. The rules for election of and payment for continuation coverage are the same as the COBRA election and payment rules, provided the COBRA rules do not conflict with USERRA. If you do not elect continuation coverage and do not submit payment for all amounts required to continue coverage within the applicable COBRA timeframe, you will lose your right to continue coverage under this Section and such right will not be reinstated.

3. You are required to make timely self-payments at the COBRA rate to be determined by the Trustees from time to time to purchase COBRA continuation coverage.

4. The COBRA continuation coverage rules apply to payment for continuation coverage under this Section provided that the COBRA payment rules do not conflict with USERRA. You must make all required self-payments within the COBRA timeframe described under COBRA continuation coverage in this SPD to continue coverage under this Section unless the COBRA payment rules conflict with USERRA.

5. You and your eligible Dependents may continue coverage for a period ending the earlier of:

    a. The date that the Plan no longer provides group health care coverage to any Employees;

b. The day after the date you fail to elect continuation coverage as required by the COBRA continuation coverage election rules;

c. The first day of the month for which a timely self-payment has not been received;

d. Twenty-four (24) months from the first date of absence due to military service; or

e. The day after the date you fail to apply for re-employment with a contributing Employer within the applicable time period allowed under the following Section 11.11(C) ("Status Upon Return from Military Service") or otherwise cease to have USERRA reemployment rights.

The right to freeze eligibility and make self-payments under this provision ceases when you provide notice that you do not intend to return to work for a contributing Employer after uniformed service.

C. Status Upon Return from Military Service

If you are eligible for benefits when you enter the military service and you make timely self-payments to maintain coverage upon your return to work, you and your eligible Dependents again will be eligible for benefits on the date of your return to work for a contributing Employer within the following time periods, provided you satisfy the other re-employment requirements of USERRA:

1. For periods of military service of fewer than thirty-one (31) days, you must report to the Employer not later than the beginning of the first full regularly scheduled work period on the first full calendar day following completion of the period of military service plus eight (8) hours, after a period allowing for safe transportation from place of military service to place of your residence;

2. For periods of military service of more than thirty (30) days but fewer than 181 days, you must apply for re-employment not later than fourteen (14) days after military service is completed; and

3. For periods of military service of more than one hundred eighty (180) days, you must apply for re-employment not later than ninety (90) days after military service is completed.

Such time periods may be extended up to two (2) years for Injuries or Sicknesses, as determined by the Secretary of Veteran Affairs, to have been incurred or aggravated during your service in the uniformed services.

If you satisfy the USERRA re-employment requirements, you will be eligible for benefits on the date of your return to work within the required time periods, provided you make any applicable self-payments required to continue eligibility. If you fail to make self-payments as required upon reinstatement in the Plan, your eligibility for coverage will terminate as of the last date of the period for which a

timely payment was received and you then will be treated as a new Employee.

These rules are intended to comply with the requirements of USERRA. The USERRA provisions will control in the event there are any inconsistencies between the Act and the Plan.

The Plan will provide continuation coverage and reinstatement rights to the extent required by USERRA. You also may have continuation coverage rights under COBRA. Although the COBRA and USERRA provisions are similar, COBRA continuation coverage and USERRA continuation coverage are not identical. If you are eligible simultaneously for both COBRA and USERRA continuation coverage, you will receive the more generous benefit rights that apply under these statutes.

COBRA and USERRA continuation periods will run concurrently.

11.12 Coverage While on Family and Medical Leave

If you become eligible for leave according to the Family and Medical Leave Act of 1993 ("FMLA"), your coverage under the Plan may be continued for up to the number of weeks required by law, provided your Employer:

A. Is subject to FMLA;

B. Makes the required contribution (or you do so); and

C. Files the appropriate notification and certification forms with the Fund Office.

If your leave is eligible under the FMLA, and you do not return to work after the leave, then for COBRA continuation coverage purposes, the date of the Qualifying Event will be the last day of your FMLA leave. This provision will apply whether or not you elect to continue coverage under the Plan during the leave.

To be subject to FMLA, an Employer must have at least fifty (50) Employees within seventy-five (75) miles.

For additional information regarding your rights under FMLA, see Section 15 ("Your Rights Under the Family and Medical Leave Act of 1993").

11.13 Termination of Individual Coverage

Coverage will terminate under this Plan at midnight on the last day of the month in which any of the following occur:

A. The Trust Fund or the collective bargaining agreement is terminated;

B. The date you cease to be eligible for coverage according to the Eligibility Rules adopted by the Trustees or the collective bargaining agreement because any required contributions are not made or your employment with a contributing Employer is terminated. In no event will your coverage continue beyond the end of the month in which you leave employment with a contributing Employer.

For example, if you leave employment with a contributing Employer in June, your coverage under the Plan will terminate on June 30; or

C. The date your Dependent ceases to be an eligible Dependent as defined in Section 13 ("General Definitions").

Certificate of Creditable Coverage: In accordance with HIPAA, the Plan will issue a certificate of creditable coverage to you and your Dependents when your regular health care benefits coverage or COBRA continuation coverage terminates (and also upon request, within twenty-four (24) months thereafter). The certificate provides information on the period of your coverage under the Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund that may be credited on your behalf to satisfy any applicable pre-existing condition limitations of a new health plan in which you enroll.

11.14 Rescission of Coverage

An Eligible Person and persons seeking coverage on behalf of an Eligible Person may not engage in any fraudulent act, practice, or omission in connection with coverage under the Plan or make an intentional misrepresentation of material fact in connection with coverage under the Plan. If an Eligible Person or a person seeking coverage on behalf of an Eligible Person engages in such act, practice, omission, or misrepresentation, the Eligible Person's coverage (including the coverage of any Dependents in the case of an Eligible Employee and the coverage of the Eligible Employee in the case of a Dependent) may be retroactively terminated or cancelled.

Retroactive termination or cancellation includes, but is not necessarily limited to, the following:

A. Any loss, expense, or charge incurred as a result of such act, practice, omission, or misrepresentation will not be covered;

B. The Eligible Person (including any Dependents in the case of an Eligible Employee and the Eligible Employee in the case of a Dependent) will be required to reimburse the Plan for any claim erroneously paid by the Plan because of such act, practice, omission, or misrepresentation; and

C. The Trustees of the Plan may treat the Eligible Person's coverage (including the coverage of any Dependents in the case of an Eligible Employee and the coverage of the Eligible Employee in the case of a Dependent) as void from the time the act, practice, omission, or misrepresentation occurred.

The following are examples of fraudulent acts, practices, or omissions or intentional misrepresentations of material fact that may result in the retroactive termination or cancellation of an Eligible Person's coverage. Intentionally or fraudulently failing to:

A. Timely update his or her enrollment status;

B. Report to the Plan:

1. His or her divorce;

2. His or her legal separation;

3. The death of a Dependent;

4. His or her loss of custody of a Dependent child; or

5. A Dependent child's eligibility to enroll in an employer-sponsored health plan other than the group health plan of a parent.

C. Satisfy his or her notification obligations under the Plan as specified in Section 11.15 ("Notification Obligations"); or

D. Honor the Plan's right of subrogation and reimbursement or otherwise failing to cooperate with the Plan, as specified in Section 12 ("General Provisions").

This is not a complete list of acts, practices, and omissions that are considered fraudulent or a complete list of intentional misrepresentations of fact considered material. The requirements of this Eligibility Rule do not limit the Plan's ability to prospectively terminate your coverage.

11.15 Notification Obligations

Eligible Persons must notify the Fund Office of any event or change in circumstances that affects:

A. Any Eligible Person's eligibility for coverage under the Plan; or

B. Any Eligible Person's eligibility for payment of any specific claim for benefits.

Notification must be given to the Fund Office in writing within twenty (20) days of any such event or change in circumstances.

11.16 How Eligibility Is Reinstated

If your eligibility under the Plan ends, you can become eligible for benefits again by satisfying the requirements of initial eligibility specified in Section 11.1 ("How an Employee Becomes Eligible for Benefits"). However, if your coverage is rescinded pursuant to Section 11.14 ("Rescission of Coverage"), reinstatement will be at the sole discretion of the Trustees.

11.17 Conformity with Law

Any provisions of this Section 11 ("Eligibility Rules") held to be unlawful or inconsistent with the requirements for tax-exempt status of this Plan under Section 501(c)(9) of the Internal Revenue Code will be void.

SECTION 12
GENERAL PROVISIONS

12.1 Coordination of Benefits

If you or your eligible Dependents are entitled to benefits under any other group health care plan, the amount of benefits payable by this Plan will be coordinated so that the total amount paid will not exceed one hundred (100%) percent of the medical expenses incurred. In no event will this Plan's payment exceed the amount which 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 actually was filed.

When another plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an allowable expense and a benefit paid.

12.2 Order of Benefit Calculation

If the other group plan does not contain a coordination of benefits or similar provision, then that plan will always calculate and pay its benefits first. When duplicate coverage arises and both plans contain a coordination of benefits or similar provision, the Eligible Employee must report such duplicate group health care coverage on the claim form which is submitted to secure reimbursement of allowable expenses incurred. This Plan has established the following rules to decide which group plan will calculate and pay its benefits first.

A. If a patient is eligible as an employee in one plan and as a dependent in another, the plan covering the patient as an employee will determine its benefits first.

B. If a patient is eligible as a dependent child in two plans, the plan covering the patient as the dependent of that parent whose date of birth, excluding year of birth, occurs earlier in a Calendar Year will determine its benefits first.

C. When parents are divorced or separated, the order of benefit determination is:

1. The plan of the parent having custody pays first.

2. If the parent having custody has re-married, the order is:

   a. The plan of the parent having custody;

   b. The plan of the spouse of the parent having custody;

   c. The plan of the parent not having custody; then

   d. The plan of the spouse of the parent not having custody.

   However, when a Qualified Medical Child Support Order names and directs one of the parents to be responsible for the child's health care expenses, the plan of that parent will pay first and will supersede any order given here.

   Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility

for the child's health care expenses OR if the court decree states that both parents will be responsible for the health care needs of the child but gives physical custody of the child to one parent (and the entities obligated to pay or provide the benefits of the respective parent's plans have actual knowledge of those terms), benefits for the dependent child will be determined according to the prior Section 12.2(B).

D. If the rules of paragraphs A, B, and C above do not determine which plan will calculate and pay its benefits first, then the plan that has covered the patient for the longer period of time will determine its benefits before a plan that has covered the patient for a shorter time.

There is one (1) exception to this rule: A plan that covers a person other than as a laid-off or retired employee, or a dependent of such person, will determine its benefits first, even if it has covered the person for the shorter time.

In addition, if a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the benefits of the plan which covers the person as an employee will be determined before the benefits under the continuation coverage.

If any plan has a provision which results in lower benefits being paid because of the existence of this Plan, this Plan will pay benefits as if the other plan had paid its benefits based upon the customary coordination of benefit provisions and without regard to the existence of this Plan.

If you or your eligible Dependent are covered under another plan that has primary responsibility for expenses, you must follow all required procedures to obtain treatment and to qualify for all benefits available under your other plan. If, for any reason, you do not follow your primary plan's procedures, this Plan limits coverage to expenses, if any, which would have been payable had the necessary procedures been followed. No expenses will be payable under this Plan that should have been payable under you or your eligible Dependent's primary plan.

12.3 Order of Benefit Calculation If Entitled to Medicare

Eligible Persons who are retired or disabled and become entitled to Part A and Part B of Title XVIII of the Social Security Amendments of 1965 (more commonly known and described as "Medicare") by reason of attained age, qualifying disability, or ESRD are required to enroll in Medicare. The Plan will coordinate its benefits with Medicare as described in this Section.

A. For Persons Initially Entitled to Medicare by Reason of Attained Age or Qualifying Disability (other than ESRD) and Eligible Due to Employer Contributions

Plan benefits are not reduced for persons eligible through Employer contributions even though they also may become initially entitled to Part A or Part B of Medicare due to attained age or a qualifying disability (other than ESRD). In the event such person subsequently becomes entitled to Medicare due to ESRD, the Plan will continue to be the primary source of coverage for the full thirty (30) month coordination period.

This Plan may pay before Medicare pays for Eligible Persons entitled to Medicare due to ESRD if that person is eligible under the Plan through either self-payments

or Employer contributions. In the event an Eligible Person is required to enroll in Part A and Part B of Medicare solely because of ESRD, benefits payable under the Plan will be limited to the covered charges incurred during the initial thirty (30) consecutive months of treatment, beginning with either:

1. The first month in which renal dialysis treatment is initiated; or

2. In the case of a transplant, the first month in which the individual could become entitled to Medicare, providing a timely application was filed.

B. Private Physician Contracts in Lieu of Medicare

For Eligible Persons who are enrolled, or eligible for enrollment, in Medicare and for whom Medicare is or would have been the primary source of coverage, the benefits payable under this Plan for services otherwise covered by Medicare, but which are privately contracted with a provider, will be limited to the amount that would have been payable by the Plan had the services been payable by Medicare.

12.4 Coordination of Benefits With Automobile, Motorcycle, Watercraft, or Other Recreational Vehicle Insurance

This Plan will coordinate benefits with automobile, motorcycle, watercraft, or other recreational vehicle insurance carriers as described in this Section:

A. Benefits payable under the Plan are not in lieu of those that would be payable under no-fault automobile, motorcycle, watercraft, or other recreational vehicle insurance and do not affect any legal requirement that an individual maintain the minimum no-fault insurance coverage within the jurisdiction in which that individual resides.

B. For any expenses arising from the maintenance or use of a motor vehicle, motorcycle, watercraft, or other recreational vehicle, no-fault insurance will calculate and pay its benefits first and this Plan will calculate and pay benefits second. The amount of benefits payable by this Plan will be coordinated so that the total amount paid will not exceed one hundred (100%) percent of the expenses incurred.

C. Benefits that otherwise might be payable under no-fault insurance will not be payable by the Plan merely because no claim for no-fault benefits was filed. If you or an eligible Dependent fails to maintain the legally required amount of no-fault insurance within the jurisdiction where you or your Dependent resides, Plan benefits will not be payable for amounts which the legally required no-fault insurance otherwise would have paid.

D. An individual injured in an automobile, motorcycle, watercraft, or other recreational vehicle accident which is or should be covered by no-fault insurance must timely protest any denial or notice of discontinuance of no-fault insurance. Benefits for those Injuries will not be payable under this Plan until such time as the individual exhausts all his arbitration and appeal rights relating to the denial or the discontinuance and provides to the Fund Office documentation, such as an “Award on Arbitration,” establishing to the Trustees’ satisfaction that all such rights have

been exhausted.

12.5 Subrogation and Reimbursement

The Plan has first priority subrogation and reimbursement rights if it provides benefits resulting from or related to an Injury, occurrence, or condition for which the Eligible Person has a right of redress against any third party.

This means that if the Plan pays benefits which are, in any way compensated by a third party, such as an insurance company, the Eligible Person agrees that when a recovery is made from that third party, the Plan is fully reimbursed out of that recovery for the benefits the Plan previously paid. If the Eligible Person does not agree to the Plan's subrogation and reimbursement rules, benefits will not be paid. For example, the subrogation and reimbursement rights may apply if an Eligible Person is injured at work, in an automobile accident, at a home or business, in an assault, or in any other way for which a third party has or may have responsibility. If a recovery is obtained from a third party, such as an insurance company, the Plan will be paid first and to the full extent of the benefits it paid. The Eligible Person receives payment only after the Plan is fully reimbursed.

The following are the rules that apply to the Plan's right of subrogation and reimbursement:

A. Subrogation and Reimbursement Rights in Return for Benefits

In return for the receipt of benefits from the Plan, the Eligible Person agrees that the Plan has the subrogation and reimbursement rights as described in this Section. Further, the Eligible Person will sign a form acknowledging the Plan's subrogation and reimbursement rights prior to payment, or further payment, of benefits. Benefits may not be paid if an acknowledgment form is not on file for the Eligible Person. Benefits may not be paid if the Eligible Person refuses to sign the acknowledgment. The Plan's subrogation and reimbursement rights to benefits paid prior to Plan notice of a subrogation and reimbursement right are not impacted if the Eligible Person refuses to sign the acknowledgment. The Plan has the sole discretion to determine, calculate, and/or itemize which benefits paid by the Plan are subject to the Plan’s subrogation and reimbursement rights.

B. Constructive Trust or Equitable Lien

The Plan's subrogation and reimbursement rights grant the Plan an equitable lien on the proceeds of any recovery obtained by the Eligible Person from a third party, whether by settlement, judgment, or otherwise. The Plan’s recovery operates on every dollar received by the Eligible Person from a third party. When a recovery is obtained, the recovery proceeds are held in trust for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovery proceeds and is paid to the full extent of its equitable subrogation and reimbursement rights. If the Eligible Person fails to hold the recovery proceeds in trust or in any other way prejudices or adversely impacts the Plan's subrogation and reimbursement rights, the Plan reserves the right to, among other things, pursue all available equitable actions and offset any future benefits payable to the Employee, Dependent, or Beneficiary under the Plan. If the Plan initiates an equitable action for reimbursement, the Plan is seeking to enforce an equitable lien by agreement.

C. Plan Paid First

Amounts recovered or recoverable by or on the Employee's, Dependent's, or Participant's behalf are paid to the Plan first, to the full extent of its subrogation and reimbursement rights, and the remaining balance, if any, to the Eligible Person. The Plan's subrogation and reimbursement right comes first even if the Eligible Person is not paid for all of his or her claims for damages. If the Plan's subrogation and reimbursement rights are not fully satisfied directly by a third party, the Plan's right to reimbursement may be enforced to the full extent of any recovery that the Eligible Person may have received or may be entitled to receive from the third party.

D. Right to Take Action

The Plan's right of subrogation and reimbursement is an equitable one and applies to all categories of benefits paid by the Plan. The Plan and any other Plan member can bring an action (including in the Eligible Person's name) for specific performance, injunction, to enforce an equitable lien by agreement, or any other equitable action necessary to protect its rights in the cause of action, right of recovery, or recovery by an Eligible Person. The Plan will commence any action it deems appropriate against an Eligible Person, an attorney, or any third party to protect its subrogation and reimbursement rights. The subrogation and reimbursement right applies to claims of Eligible Dependents covered by the Plan regardless of whether such Dependent is legally obligated for expenses of treatment.

E. Applies to All Rights of Recovery or Causes of Action

The Plan's subrogation and reimbursement rights apply to any and all rights of recovery or causes of action the Eligible Person has or may have against any third party.

F. No Assignment

The Eligible Person cannot assign any rights or causes of action he or she may have against a third party to recover medical expenses without the express written consent of the Plan.

G. Full Cooperation

The Eligible Person will cooperate fully with the Plan and do nothing to prejudice or adversely affect the Plan's subrogation and reimbursement rights. The Eligible Person, whether personally or through an attorney, must periodically update the Plan on the status of any action against a third party. The time period between updates must not exceed forty-five (45) days. The Eligible Person must notify the Plan before executing any settlement agreement with a third party, regardless of whether the settlement agreement purports to include or exclude the Plan’s subrogation or reimbursement interest. Benefits may be denied if the Eligible Person does not cooperate with the Plan.

H. Notification to the Plan

The Eligible Person must promptly advise the Plan Administrator, in writing, of any claim being made against any person or entity to pay the Eligible Person for his or her Injuries, Illness, or death. Further, the Eligible Person must periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of his or her claims.

I. Third Party

A “third party” includes, but is not limited to, all individuals, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, worker's compensation, premises liability, no-fault, uninsured or underinsured motorist insurers), who reimburse, compensate, or pay for an Eligible Person's losses, damages, Injuries, or claims relating in any way to the Injury, occurrence, conditions, or circumstances leading to the Plan's payment of benefits. This right of subrogation and reimbursement exists regardless of whether the policy of insurance is owned by the Eligible Person.

J. Apportionment, Comparative Fault, Contributory Negligence, Make-Whole, and Common-Fund Doctrines Do Not Apply

The Plan's subrogation and reimbursement rights include all portions of the Eligible Person’s claims regardless of any allocation or apportionment that purports to dispose of any portion of the claims not otherwise subject to subrogation, including, but not limited to, any apportionment for pain and suffering, wage loss, partial or total disability, or to a spouse for loss of consortium. The Plan's subrogation and reimbursement rights are not affected, reduced, or eliminated by comparative fault, contributory negligence, the double-recovery rule, the make-whole or common-fund doctrines, or any other equitable defenses.

K. Attorney’s Fees

The Plan shall not be responsible for any attorney’s fees or costs incurred by the Eligible Person in any legal proceeding or claim for recovery, under the common-fund doctrine or any other legal theory, unless prior to incurring such fees or costs, the Trustees agree in writing to pay all or some portion of attorney's fees or costs.

L. Course and Scope of Employment

If the Plan has paid benefits for any Injury which arises out of and in the course and scope of employment, the Plan's right of subrogation and reimbursement will apply to all awards or settlements received by the Eligible Person regardless of how the award or settlement is characterized and regardless of whether the Plan has intervened in the action. If attorney's fees are awarded to the Eligible Person’s attorney from the Plan's recovery, the Eligible Person will reimburse the Plan for the attorney's fees.

12.6 Right of Recoupment

Whenever the Plan has made unauthorized or erroneous payments or overpayments, the Trustees have the right to recover such unauthorized or erroneous payments or overpayments from one or more of the following sources:

A. Any person to whom or on whose behalf such payments were made, including by making deductions from benefits which may be payable to or on behalf of such person in the future; or

B. Any service provider, insurance company, or other entity to whom such unauthorized or erroneous payment or overpayment was made.

12.7 Physical Examinations

The Trustees, through a Physician they may designate, have the right and opportunity to have medically examined any individual whose Injury or Sickness is the basis for a claim when and as often as they reasonably may require during the pendency of a claim under the Plan.

12.8 General Exclusions

The Plan does not cover:

A. Injury or Sickness which arises out of or occurs in the course of any occupation or employment for wage or profit (except for Death and Accidental Death and Dismemberment Benefits);

B. Injury or Sickness for which the Eligible Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law;

C. Care for armed service-connected disabilities furnished within any facility of, or provided by, the United States Department of Veterans Affairs or Department of Defense;

D. Care for non-service-connected disabilities furnished within any facility of, or provided by, the United States Department of Veterans Affairs or Department of Defense for which there has not been furnished to the Fund Office required details and supporting papers;

E. Loss due to non-therapeutic release of nuclear energy;

F. Any loss or services to treat Injuries or Sicknesses incurred in, or aggravated during, performance of service in the uniformed services;

G. Loss incurred while engaged in military service (including naval or air service) for any country;

H. Aesthetic cosmetic surgery, treatment, or supplies, except for repair of damage due to Injury within one year after the date of the accident as otherwise expressly

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. Charges, expenses, or losses for sex transformations or any treatment related to sexual dysfunction;

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;

Q. Charges resulting from confinement, treatment, or Surgical Procedures in a Hospital owned and operated by the United States Government or agency thereof, or in a Hospital that makes charges that an Eligible Person is not obligated to pay, or any other supplies or services for which an Eligible Person is not legally required to pay;

R. Expenses incurred as a result of an accident if a third party is legally responsible for the expenses;

S. Charges incurred in excess of specified limitations provided in this Plan;

T. Charges for therapeutic acupuncture, Experimental surgery and treatments, services of clergy, and homeopathic remedies;

U. Charges for rehabilitation services such as physical, occupational, and speech therapy that are not expected to make measurable or sustainable improvement within a reasonable period of time;

V. Recreational or educational therapy or forms of non-medical self-care or self-help training, including health club memberships;

W. Charges for hypnosis or biofeedback;

X. Purchase of radioactive materials for x-rays, radium, or cobalt treatment;

Y. Repair or replacement of Durable Medical Equipment, except as specifically provided, and in no event will payment exceed the purchase price (e.g., wheelchairs, Hospital beds, side rails, iron lungs, and prosthetic devices);

Z. Purchase of nondurable medical supplies that are not Medically Necessary for the treatment or diagnosis of an Injury or Sickness or to improve the functioning of a malformed body member (e.g., alcohol swabs, cotton balls, incontinence liners/pads, cotton swabs, adhesives, and informational material);

AA. Charges for personal services or supplies such as television, slippers, lotion, facial tissue, breast pump, food supplements, or oral and other hygiene products;

BB. Any bodily Injury, Sickness, or disease that is intentionally self-inflicted, unless due to the physical or Mental Health Condition of the Eligible Person;

CC. Expenses incurred for rest cures, domiciliary care, or for the convenience of the household;

DD. Expenses incurred for procedures or treatment of any nature not generally recognized by the American Medical Association or the United States Department of Health;

EE. Drugs that can be purchased over the counter, including, but not limited to, vitamins, whether prescribed or not prescribed, except as specifically provided;

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 telephone consultations and televideo consultations by Health Care Professionals, except as specifically provided;

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

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

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

KK. Charges for or related to fetal tissue transplants;

LL. Maintenance and custodial therapy;

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

NN. Aquatic therapy;

OO. Orthotics prescribed by a chiropractor;

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

QQ. 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;

RR. 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;

SS. Wigs;

TT. Reversals of sterilizations;

UU. Diet consultations, except when related to diabetes;

VV. Surgery for obesity, except as specifically provided;

WW. Charges for transplant donor-related services;

XX. 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

constituting the felony or gross misdemeanor. Subject to the other limitations and exclusions provided in this document, coverage may be provided for any loss, expense, or charge related to an act of domestic violence committed against the Eligible Person, or if the illegal act is related to a physical or Mental Health Condition of the Eligible Person;

YY. Any Injury or Sickness that results from an incident occurring on any property where the lessee or lessor or owner of the property is responsible for the Injury or Sickness or which is otherwise covered under homeowner's insurance or premises liability insurance. However, at the sole discretion of the Trustees, the Plan will consider advancing payment of the charges only if:

1. No insurance or other form of compensation is available to the Eligible Person; and

2. The Eligible Person (who incurred the expenses) and any other person the Trustees deem necessary signs an acknowledgment of the Plan's first priority right to subrogation and reimbursement.

ZZ. Any automobile, motorcycle, watercraft, or other recreational vehicle accident:

1. Where the Eligible Person fails to maintain the statutory minimum level of no-fault automobile, motorcycle, watercraft, or other recreational vehicle medical insurance protection required by the state in which the Eligible Person resides, provided that the Eligible Person is required by the state law to maintain the protection. (This exclusion will apply only up to the amount of no-fault medical insurance so required);

2. Where there is applicable no-fault coverage but the Eligible Person has failed to apply for the coverage;

3. Where the no-fault carrier determined the charges are not Medically Necessary or a R&C Charge;

4. In states without a no-fault statute, where the Eligible Person does not first exhaust medical payment coverage on the vehicle(s) involved in the accident; and

5. Where the Eligible Person, whether or not a minor, has a right to recover or claim a right to recover or have already recovered from a third-party, in which event the provisions of General Exclusions (CCC) through (EEE) will apply.

In cases where a no-fault carrier disputes coverage of the Eligible Person, the Plan may subrogate its interest in the payment of charges. Please also refer to Section 12.4 ("Coordination of Benefits With Automobile, Motorcycle, Watercraft, or Other Recreational Vehicle Insurance") of this Plan regarding when an individual injured in an accident must arbitrate before the Plan will pay benefits related to the accident.

AAA. Any loss, expense, or charge for which a third party may be liable for which the

individual on whose behalf the claim was filed did not submit the required subrogation acknowledgment form to the Plan. The term "third party," as used in Section 12.8 ("General Exclusions"), will include 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 individual's losses, damages, Injuries, or claims relating in any way to the Injury or Sickness 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 underinsured motorist coverages;

BBB. Any loss, expense, or charge incurred at any time as the result of an Injury or Sickness that is or would be subject to the Plan's right of subrogation and reimbursement and either:

1. As to which the Plan has agreed to a settlement of that right;

2. The Eligible Person has recovered payment from a third party;

3. The Eligible Person has received a recovery from a third party; or

4. Would otherwise, in the sole discretion of the Trustees, be considered a future related medical expense, even if incurred but not paid before the settlement, unless the Trustees have explicitly agreed in writing that the Plan will pay for such a loss, expense, or charge. This means that claims submitted after the settlement or recovery that are, in the sole discretion of the Trustees, related to the Sickness or Injury giving rise to the settlement or recovery will be excluded from coverage under this Plan. This exclusion applies to any settlement or recovery received by the Eligible Person regardless of how it is characterized, including but not limited to, any apportionment to a spouse for loss of consortium.

CCC. Any loss, expense, or charge incurred as the result of any Injury or Sickness for which the 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 first priority right of subrogation and reimbursement and the provisions of Section 12.5 ("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.

DDD. Any loss, expense, or charge for which a third party may be liable and for which either:

1. 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

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; and

GGG. Inpatient out-of-network services, except for the treatment of an Emergency medical condition.

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

of Plan assets will be made only for the benefit of Eligible Persons who were covered under the Plan at the time of the Plan termination; and

D. Give any notices and prepare and file any reports which may be required by law.

12.10 Genetic Information Nondiscrimination Act

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

12.11 Mental Health Parity and Addiction Equity Act

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Although the Plan has been amended to comply with the MHPAEA, the law continues to change and some ambiguity in its provisions remains. By keeping the preceding language, the Plan is protecting itself against such ambiguity should a Plan provision subsequently be found to conflict with the MHPAEA.

12.12 Discretionary Authority

The Trustees have the discretionary authority to interpret and administer the Plan and all Plan documents, rules, and procedures. Their interpretation is binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the Trustees that the decisions are to be upheld unless it is determined to be arbitrary or capricious.

The Trustees have the discretionary authority to change the Plan's Eligibility Rules (Section 11) and any other provisions of the Plan and to amend, increase, decrease, or eliminate benefits, and to terminate the Plan, in whole or in part. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them. The Trustees may adopt rules as they feel are necessary, desirable, or appropriate in the exercise of their fiduciary duty, and they may change these rules and procedures at any time.

The right to add, change or eliminate any and all aspects of benefits provided to retirees is a right specifically reserved to the Trustees. Retirees are not covered under the Plan and retiree coverage is not an "accrued" or "vested" benefit. If retiree coverage is added as a Plan benefit in the future, the Trustees reserve the right to reduce retiree benefits, increase self-payment rates, or completely terminate the benefits at any time. Such a change will be effective even though an Employee has already become a retiree.

SECTION 13
GENERAL DEFINITIONS

Wherever used in this SPD, the following terms are understood to have the meanings described as follows.

Calendar Year means that period commencing at 12:01 a.m. Central Standard Time ("CST") on the date the Eligible Person first becomes eligible and continuing until 12:01 a.m. CST on the next following January 1st. Each subsequent Calendar Year will be the period from 12:01 a.m. CST on January 1st to 12:01 a.m. CST on the next following January 1st. The time will be that time at the address of the Trustees.

Dental Hygienist means any person who is currently licensed (if licensing is required in 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 of a Dentist.

Dentist means any person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry, and who is acting within the usual scope of such practice.

Dependent means the Eligible Employee's:

A. Spouse. "Spouse" means an individual who is the legally recognized spouse of an Employee under the laws of the state in which the marriage or civil union was established. For this purpose, a legal civil union is considered a legal marriage. A certified copy of your marriage certificate or other documentation substantiating status as a spouse may be required to be on file at the Fund Office before claims for your spouse will be processed.

B. Child who is under age twenty-six (26).

The term "child" or "children" includes the following:

1. Any biological child of an Eligible Employee.

2. Any child legally adopted by an Eligible Employee or placed for adoption with an Eligible Employee. Placement for adoption means the assumption and retention by an Eligible Employee of a legal obligation for total or partial support of a child in anticipation of the legal adoption of such child by the Eligible Employee. Placement for adoption will terminate upon the termination of such legal obligation.

3. Any stepchild of an Eligible Employee, meaning any child of an Eligible Employee's current spouse from whom the Eligible Employee is not divorced or legally separated who:

   a. Was born to such spouse;

   b. Was legally adopted by such spouse;

   c. Has been placed for adoption with such spouse; or

d. Is a foster child placed with such spouse by an authorized placement agency or a court.

4. Any foster child placed with an Eligible Employee by an authorized placement agency or a court.

5. Any unmarried child who is named in a Qualified Medical Child Support Order with which you and the Plan are obligated to comply.

6. Grandchildren who reside with the Eligible Employee and for whom the Eligible Employee:

a. Provides at least fifty (50%) percent support;

b. Claims as a Dependent on his taxes; and

c. Has been awarded custody (permanent or temporary) by a court order.

C. Child who is incapable of self-sustaining employment by reason of developmental cognitive disability or physical handicap, provided that:

1. Such incapacity began prior to attainment of age twenty-six (26); and

2. The child is primarily financially dependent upon the Eligible Employee. Proof of the incapacity must be submitted to the Trustees within thirty-one (31) days after the child first becomes eligible under this Section.

Durable Medical Equipment means equipment that:

A. Is prescribed by the attending Physician;

B. Is Medically Necessary;

C. Is primarily and customarily used only for a medical purpose; and

D. Serves a specific therapeutic purpose in the treatment of an Injury or Sickness and is used only by the patient who is sick.

Durable Medical Equipment does not include services or supplies of a common household use, such as vehicle lifts, waterbeds, air conditioners, heat appliances, dehumidifiers, exercycles, air purifiers, water purifiers, allergenic mattresses, blood pressure kits, computer equipment and related devices, or supplies of a similar nature, whether or not prescribed by a Physician.

Eligible Employee means any Employee or former Employee of an Employer, which Employee is eligible for benefits in accordance with the Eligibility Rules (Section 11) of the Plan.

Eligible Person means either the Eligible Employee or the Eligible Employee's Dependent.

Emergency means a medical condition 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:

A. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;

B. Serious dysfunction of any bodily organ or part;

C. Serious impairment of bodily functions; or

D. 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.

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" means at a minimum, any medical services that are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and Substance Use Disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; and oral and vision care for Eligible Persons under age eighteen (18).

Experimental means any procedure that is investigative and limited to research rather than applied to accepted, general clinical practice. Experimental also means any technique that is restricted to use at those centers which are capable of carrying out disciplined clinical efforts and scientific studies. Any procedure that has a lack of objective evidence which suggests therapeutic benefit and proven value, or whose efficacy is medically questionable also is considered Experimental.

Fiscal Year means the twelve (12) months beginning any January 1st and ending the following December 31st.

Health Care Professional means a person 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 and includes, but is not limited to, the services of a Physician, Mental Health Professional, podiatrist, chiropractor, Optometrist, Optician, Dentist, and Dental Hygienist, provided such individual is licensed and acting within the usual scope of such practice.

Hospital means an establishment which meets all of the following requirements:

A. Holds a license as a Hospital (if licensing is required in the state);

B. Operates primarily for the reception, care, and treatment of injured or sick persons as inpatients;

C. Provides twenty-four (24) hour-per-day nursing service by registered nurses;

D. Has a staff of one or more licensed Physicians available at all times;

E. Provides organized facilities for diagnostic and major Surgical Procedures; and

F. Is not primarily a clinic, nursing, rest, or convalescent home or similar establishment.

However, "Hospital" also will include an establishment or institution specializing in the care, treatment, and rehabilitation of alcoholics or substance addicts provided such establishment is licensed by the appropriate governmental authority, if licensing is required.

Injury means accidental bodily damage including all related conditions and recurrent symptoms that require treatment by a Health Care Professional and which result in loss independent of Sickness and other causes.

Intensive Care Unit means a special area of a Hospital exclusively reserved for critically ill patients requiring constant observation which, in its normal course of operation, provides:

A. Personal care by specialized registered nurses and other nursing care on a twenty-four (24) hour-per-day basis;

B. Special equipment and supplies which are available immediately on a stand-by basis; and

C. Care required but not rendered in the general surgical or medical nursing units of the Hospital.

The term "Intensive Care Unit" also includes an area of the Hospital designated and operated exclusively as a coronary care unit, cardiac care unit, or neonatal Intensive Care Unit.

Lifetime, with reference to benefit maximums and limitations, means aggregate covered expenses incurred while an Eligible Person is both alive and covered under the Plan. Under no circumstances will "Lifetime" include any expenses incurred during any period of time during which the person is not covered under the Plan.

Medically Necessary means a service or supply which is appropriate and consistent with the diagnosis of an Injury or Sickness in accordance with accepted standards of community practice and which could not have been omitted without adversely affecting the person's condition or the quality of medical care.

Mental Health Condition means a mental or behavioral disorder as defined in the International Classification of Diseases, other than a mental or behavioral disorder due to psychoactive substance use. It does not include an intellectual disability or disorders of psychological development.

Mental Health Professional means a person providing clinical services in the treatment of Mental Health Conditions and/or Substance Use Disorders and who holds and provides services consistent with all of the prerequisite licenses and/or certifications required by law to provide clinical services and/or meets the certification requirements of the applicable state or national

professional governing body necessary to work in at least one of the following disciplines:

A. Psychiatric nursing;

B. Clinical social work;

C. Psychology;

D. Psychiatry;

E. Marriage and family therapy;

F. Licensed professional clinical counseling;

G. Allied fields (persons holding a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness); or

H. Certified drug and alcohol counseling.

Non-Durable Medical Supplies means supplies that are Medically Necessary for the treatment or diagnosis of an Injury or Sickness and are prescribed by a Health Care Professional, but are not reusable.

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

Outpatient Psychiatric Facility means a Hospital, community mental health center, day care center, or night care center associated with a Hospital and licensed as required by applicable law. It does not include institutions or facilities primarily engaged in providing services which are custodial, recreational, social, or educational in nature. An approved Outpatient Psychiatric Facility will be recognized only if there is either a psychiatric Physician or a licensed psychologist present in the facility on a regularly scheduled basis who assumes the overall responsibility for coordinating the care of all patients. Services must be available through Mental Health Professionals staffed by the facility, as needed. Emergency medical care must be accessible through formal agreement with a Hospital.

Physician means a person 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 and includes the services of a doctor of medicine and osteopathy, provided such individual is licensed and acting within the usual scope of such practice.

Plan means this document adopted by the Trustees, as amended from time to time, which incorporates the provisions, terms, and conditions under which benefits are paid and the schedules of benefits which are in effect.

Plan Year means the twelve (12) months beginning any January 1st and ending the following December 31st.

Preferred Provider means a:

A. Physician, Dentist, registered nurse, physical therapist, or other licensed health care provider;

B. Hospital;

C. Mental Health Professional;

D. Hospice;

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;

who/which alone, or as part of a group, enter into a contract with the Trustees and who/which agree to be compensated for their services and supplies as are covered under this Plan according to the terms of the contract. Such parties are Preferred Providers while such contract is in effect.

Current types of Preferred Providers include the following:

A. **Preferred Provider Network** means any of the Hospitals, Health Care Professionals, or other health care providers that contract with the Trustees directly or through their agents from time to time. The agent is Blue Cross Blue Shield of Minnesota. A current list of network providers is maintained at the Fund Office.

B. **Preferred Provider Pharmacy** or **PPRx** means the pharmacy that is party to a contract with the Trustees, currently Envision Pharmaceutical Services, Inc.

C. **Employee Assistance Program ("EAP") Manager** means the organization that contracts with the Trustees to provide specified Employee assistance services. The current EAP manager is TEAM Corporation.

D. **Preferred Provider Dental Program** means the organization that contracts with the Trustees from time to time to provide dental care services. The current Preferred Provider Dental Program is Delta Dental Plan of Minnesota.

Qualified Medical Child Support Order ("QMCSO") means any court judgment, decree, or order, including a court's approval of a domestic relations settlement agreement, or any judgment, decree, or order issued through an administrative process established under state law that has the force and effect of law under applicable state law, that:

A. Either:

1. Provides for child support payments related to health benefits with respect

to a child or requires health benefit coverage for such child by the Plan, and is ordered under state domestic relations law; or

2. Enforces a state law relating to medical child support payments with respect to the Plan; and

B. Creates or recognizes the right of a child as an alternate recipient who is recognized under the order as having a right to be enrolled under the Plan to receive benefits derived from such child's relationship to an Eligible Employee who is a participant in the Plan;

C. Includes the name and last known address of the Eligible Employee from whom such child's status as an alternate recipient under this Plan is derived and of each alternate recipient, a reasonable description of the type of coverage to be provided by the Plan, and the period for which coverage must be provided;

D. Does not require or purport to require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act; and

E. Has been determined to be a Qualified Medical Child Support Order under reasonable procedures adopted and uniformly applied by the Plan. A copy of the written procedures for determining whether or not an order is "qualified" is available from the Fund Office upon request at no charge.

Reasonable and Customary ("R&C") Charge(s) means the commonly charged or prevailing fees for health care services and supplies within a geographic area, which are Medically Necessary and recommended by a Health Care Professional or required for treatment. A fee is generally considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service or supply within the specific community in which the service or supply was provided.

Self-Funded Plan means a group health care plan in which the plan assumes the financial risk for providing health care benefits to its employees. Instead of paying a fixed premium to an insurance company to pay the claims, a Self-Funded Plan directs employer contributions, self-payments, and investment earnings into a trust fund that is overseen by strict federal government regulation. The Plan pays claims directly from accumulated trust fund assets.

Sickness means a disease, disorder, or condition, whether physical or mental in origin (including pregnancy and childbirth and any related conditions) and requires treatment by a Health Care Professional.

Skilled Nursing Home means an institution which fully meets every one of these requirements:

A. Is regularly engaged in providing skilled nursing care for injured and sick persons at the patient's expense;

B. Requires that patients be regularly attended by a Physician and that medications be given only on the order of the Physician;

C. Maintains a daily medical record of each patient;

D. Continuously provides nursing care under twenty-four (24) hour-a-day supervision by a registered nurse;

E. Is not, except incidentally, a facility for the aged, a rest home, or the like;

F. Is not, except incidentally, a place for treatment of substance addiction, alcoholism, or mental illness;

G. Is currently licensed as a Skilled Nursing Home, if licensing is required in the area where it is located, and is classified as a Skilled Nursing Home under Medicare;

H. Has permanent facilities for the care of six (6) or more resident inpatients; and

I. Requires a Physician's certification that confinement is Medically Necessary.

Substance Use Disorder means a mental or behavioral disorder due to psychoactive substance use, as defined in the International Classification of Diseases.

Surgical Procedure means performance of one or more Surgical Procedures during a single operation period, including all procedures performed during one continuous period of anesthetization.

Totally Disabled means you have a physical or mental condition occurring because of bodily Injury or Sickness that results in your complete inability to engage in any paid employment or work for which you are qualified by education, training, or experience. To be “Totally Disabled,” you must be wholly and continuously disabled, you must be under the care of a Physician, and you cannot be engaged in any occupation for wage or profit.

The terms **"Association," "Beneficiary," "Employee," "Employer," "Participant," "Trust Agreement," "Trust Fund," "Trustees,"** and **"Union"** have the same meaning in this Summary Plan Description as they do in the Restated Trust Agreement, which is incorporated by reference.

Personal Pronoun Usage. Words used in this document in the masculine or feminine gender will be considered as the feminine gender or masculine gender, respectively, where appropriate.

Words used in the singular or plural will be considered as the plural or singular, respectively, where appropriate.

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.

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.

Step 2: When you receive your claim form, be sure to fill out your part completely. If the claim is for an eligible Dependent, be sure to complete that portion of the claim form referring to your eligible Dependent. If the claim you are submitting is the result of an accident, be sure to complete the accident portion of the claim form.

Step 3: If you also are applying for Weekly Disability Benefits, you must have your Employer complete his portion of the claim form. During your Total Disability, you periodically will be asked to complete a form. This form also must be completed by your Physician.

Step 4: Have your Physician fill out his or her part of the claim form. If your Physician provides his or her own claim form, you may submit it in place of the form provided by this Plan. Be sure your Physician provides a diagnosis on the claim form.

Step 5: Attach all bills relating to the claim.

Step 6: Forward completed claim form and related bills to the Fund Office within ninety (90) days of the date a medical charge is incurred or a disability occurs. Mail directly to:

Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund
Wilson-McShane Corporation
2002 London Road, Suite 300
Duluth, MN 55812

Your cooperation in following these steps in sequence and accurately printing the answers to the questions on the claim form will allow the Fund Office to process your claim as quickly as possible. Then, we can make sure that claims are paid promptly to the provider of service. Incomplete claim forms submitted for payment will cause delays.

Claims should be complete. They should contain, at a minimum:

A. Plan name (Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund);

B. Employee's name and unique identification number;

C. Full name (including "Jr.," if applicable) and date of birth of the Eligible Person who incurred the covered expense;

D. Name and address of the service provider;

E. Federal tax identification number of provider;

F. Diagnosis of the condition;

G. Procedure or nature of the treatment;

H. Date of and place where the procedure or treatment has been provided;

I. Amount billed and the amount of the covered expense not paid through coverage other than this Plan, as appropriate; and

J. Evidence that substantiates the nature, amount, and timeliness of each covered expense that is in a reasonably understandable format and is in compliance with all applicable law.

Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address. A general request for an interpretation of Plan provisions will not be considered a claim for benefits. Pre-determined amounts you must pay, such as a prescription drug Copayment or amount required because of use of a network or non-network provider, will not be considered a claim for benefits subject to the claims procedures. However, if you feel you have been charged an improper dollar or percentage copayment (for example through the Preferred Provider Pharmacy Program), you may submit a formal appeal to the Fund Office in writing within one hundred eighty (180) days to have your claim reviewed according to the appeal procedures stated in Section 18 (“Benefit Claims Procedure”).

You or an authorized representative can pursue a claim. You may authorize a representative by submitting a written authorization to the Trustees.

Please Note: You must submit a copy of the explanation of benefits (“EOB”) form along with your claim if you or your eligible Dependent have primary coverage under any other group health care plan, including Medicare. This information is necessary to monitor the coordination of benefits provisions when claims are processed.

SECTION 15
YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

The federal Family and Medical Leave Act of 1993 ("FMLA") requires certain employers to provide a certain number of weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees of such employers are eligible if they have worked for the employer for at least twelve (12) months, and for 1,250 hours over the previous twelve (12) months. See Section 11.12 ("Coverage While on Family and Medical Leave") for an explanation of whether a particular Employer is subject to the FMLA.

15.1 Reasons for Taking Leave

Unpaid leave must be granted for up to twelve (12) weeks for any of the following reasons:

A. To care for the employee's child after birth, or placement of a child with the employee for adoption or foster care;

B. To care for the employee's spouse, son or daughter, or parent who has a serious health condition;

C. For a serious health condition that makes the employee unable to perform his job; or

D. Because of "any qualifying exigency" (as defined in the applicable regulations) arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.

An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to twenty-six (26) weeks of leave in a single twelve (12) month period to care for the service member. This military caregiver leave is available during "a single twelve (12) month period" during which an eligible employee is entitled to a combined total of twenty-six (26) weeks of all types of FMLA leave.

At the employee's or employer's option, certain kinds of paid leave may be substituted for unpaid leave.

15.2 Advance Notice and Medical Certification

An employee ordinarily must provide thirty (30) days advance notice when the leave is "foreseeable." An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work. Taking of leave may be denied if these requirements are not met.

15.3 Job Benefits and Protection

A. For the duration of FMLA leave, the employer must maintain an employee's health coverage under any "group health plan."

B. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

C. The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

15.4 Unlawful Acts by Employers

The FMLA makes it unlawful for any employer to:

A. Interfere with, restrain, or deny the exercise of any right provided under the FMLA; or

B. Discharge or discriminate against any person for opposing any practice made unlawful by the FMLA or for involvement in any proceeding under or relating to the FMLA.

15.5 Enforcement

A. The DOL is authorized to investigate and resolve complaints of violations.

B. An eligible employee may bring a civil action against an employer for violations.

C. The FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights. Certain states, including Minnesota, have laws providing additional rights concerning parental leave.

SECTION 16
MEDICAL DATA PRIVACY AND SECURITY

16.1 Introduction

The U.S. Department of Health and Human Services issued regulations governing the Plan's use and disclosure of your health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). While the Plan always has taken care to protect the privacy and security of your health information, these regulations require the Plan to adopt more formal procedures and to tell you about these procedures in this SPD. The following information discusses ways in which the Plan uses and discloses your health information.

Under HIPAA, the Plan is required by law to take reasonable steps to ensure the privacy and security of your personally identifiable health information and to tell you about:

A. The Plan's uses and disclosures of your Protected Health Information ("PHI");

B. Your privacy rights with respect to your PHI;

C. The Plan's duties with respect to your PHI;

D. Your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and

E. The person or office to contact for further information about the Plan's privacy practices.

16.2 The Plan's Use and Disclosure of PHI

The Plan may use PHI to the extent of and according to the uses and disclosures allowed by the Medical Data Privacy Regulations ("Privacy Regulations") and "Security Regulations" adopted under HIPAA, including for purposes related to "Health Care Treatment," "Payment," and "Health Care Operations" as those terms are defined in such regulations.

The Plan will enter into agreements with other entities known as "Business Associates" to perform some of these functions on behalf of the Plan. Each Business Associate will be allowed to use and disclose only the minimum amount of PHI needed to perform the Business Associate's duties on behalf of the Plan. The Plan's agreements with its Business Associates also will meet the other requirements of the Privacy and Security Regulations.

A. Use of PHI for Treatment Purposes

Treatment includes the activities relating to providing, coordinating, or managing health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. As a health plan, the Plan is generally not involved in treatment situations but may, from time-to-time, release PHI to assist providers in your treatment.

B. Use of PHI for Payment and Health Care Operations

"Payment" includes the Plan's activities to obtain premiums, contributions, self-payments, and other payments to determine or fulfill the Plan's responsibility for coverage and providing benefits under the Plan. It also includes the Plan obtaining reimbursement or providing reimbursement for providing health care that has been provided. These activities include but are not limited to the following:

1. Determine eligibility or coverage under the Plan;

2. Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);

3. Subrogation;

4. Coordination of Benefits;

5. Establishing self-payments by persons covered under the Plan;

6. Billing and collection activities;

7. Claims management and related health care data processing including auditing payments, investigating and resolving payment disputes, and responding to covered persons' inquiries about payments;

8. Obtaining payment under stop-loss or similar reinsurance;

9. Reviewing whether claims are payable under the Plan, including whether they are Medically Necessary, meet the criteria of a R&C Charge, or otherwise payable;

10. Reviewing coverage under the Plan, appropriateness of care, or justification of charges;

11. Utilization review, including precertification, preauthorization, concurrent review, and retrospective reviews;

12. Disclosing to consumer reporting agencies certain information related to collecting contributions or reimbursement (the information that may be released is: name and address, date of birth, Social Security number, payment history, account number, and name and address of the provider and/or health plan); and

13. Reimbursement to the Plan.

"Health Care Operations" can include any of the following activities. While the Plan does not currently use or release PHI for all of these activities, it may do so in the future to perform health care operations of the Plan:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines as long as

general knowledge is not the primary purpose of these studies; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

2. Reviewing the competency or qualifications of Health Care Professionals; evaluating provider performance; accreditation, certification, licensing or credentialing activities;

3. Underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract (or reinsurance) or health benefits under the Plan;

4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

5. Planning and development, such as conducting cost-management and planning related analyses related to managing and operating the Plan (including formulary development and administration, development or improvement of methods of payment or coverage policies); and

6. Management and general administrative activities of the Plan, including but not limited to:

    a. Managing activities related to implementing and complying with the Privacy Regulations;

    b. Resolving claim appeals and other internal grievances;

    c. Merging or consolidating the Plan with another plan, including related due diligence; and

    d. As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.

16.3 Other Uses and Disclosures of PHI

The Privacy Regulations permit certain other uses and disclosures of your PHI. These include, for example, releasing PHI to personal representatives of deceased covered persons, releasing PHI for public health activities, releasing PHI for court proceedings, and releasing PHI for law enforcement and similar purposes. If the Plan releases PHI in any of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

The Privacy Regulations also permit the Plan to release PHI if it receives a valid authorization from you. If the Plan receives a valid authorization, the Plan will disclose PHI to the person or organization you authorize to receive the information. This may include, for example, releasing information to your spouse, to the pension plan, other retirement plans, vacation plan or similar plan for the purposes related to administering those plans.

16.4 Release of PHI to the Board of Trustees

The Plan will disclose PHI to the Board of Trustees, which is considered the Plan Sponsor under the Privacy Regulations. The Plan has received a certificate from the Board of Trustees that the Plan documents, including this SPD, have been amended to incorporate the following provisions.

The Board of Trustees will receive and use PHI only for the Plan administration functions that the Trustees perform for the Plan. In addition, the Trustees will:

A. Not use or further disclose PHI other than as permitted or required by the SPD or as required by law;

B. Ensure that any agents (such as Union and Employer Association staff) and Business Associates, including subcontractors, to whom the Board of Trustees provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such PHI;

C. Not use or disclose PHI for employment-related actions and decisions unless authorized by the person who is the subject of the PHI;

D. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the person who is the subject of the PHI;

E. Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;

F. Make PHI available to a person who is the subject of the information according to the Privacy Regulations' requirements;

G. Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;

H. Make available the PHI required to provide an accounting of disclosures;

I. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Regulations;

J. If feasible, return or destroy all PHI received from the Plan that the Trustees maintain in any form, and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible subject to any state or federal document retention requirements); and

K. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI (other than enrollment/disenrollment information and "Summary Health Information," which are not subject to these restrictions) that they create, receive,

maintain, or transmit on behalf of the Plan. The Trustees will report to the Plan any security incident of which it becomes aware.

16.5 Trustee Access to PHI for Plan Administration Functions

As required under the Privacy Regulations, the Plan will give access to PHI only to the following persons:

A. The Board of Trustees (including alternate Trustees).

The Plan will release PHI to Trustees, and the Trustees will be able to use PHI, for purposes of hearing and determining claim appeals; making other determinations concerning claims payments; assisting covered persons with eligibility and benefit issues; Plan benefit design; amending, modifying and terminating the Plan; and Plan management issues.

B. The Trustees' agents, such as Union and Employer Association staff, only to the extent reasonable to assist the Trustees in fulfilling their duties consistent with the prior uses and disclosures of PHI.

The disclosure of electronic PHI is supported by reasonable and appropriate security measures to the extent that the previously-noted personnel may access electronic PHI.

16.6 Noncompliance Issues

If the persons previously described do not comply with this SPD, the Board of Trustees will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

16.7 Plan's Privacy Officer and Contact Person

As required by the Privacy Regulations, the Plan has named a Privacy Officer to oversee the Plan's compliance with the Privacy Regulations. The Plan also has named a Contact Person to help answer your questions concerning the Privacy Regulations and your PHI. You also can call the Contact Person if you have any complaints concerning the use or disclosure of your PHI. If you have any questions or complaints concerning your PHI, please contact the Plan's Administrative Manager and ask to speak with the Plan's Contact Person.

SECTION 17
PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the "Affordable Care Act"), imposes a number of requirements on group health plans, such as this Plan. The federal Departments of Health and Human Services, Treasury, and Labor have jointly issued regulations implementing some provisions of the Affordable Care Act. While the Board of Trustees has taken care to ensure that the terms of the Plan comply with the requirements of the Affordable Care Act, a significant amount of ambiguity remains as to the requirements of the Affordable Care Act.

The terms and provisions of the Plan will be construed, to the extent possible, to comply with the Affordable Care Act, or any amended version of the Affordable Care Act. If it is determined that any term or provision of the Plan cannot reasonably be construed to comply with the Affordable Care Act, or any amended version of 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.

SECTION 18
BENEFIT CLAIMS PROCEDURE

18.1 Pre-Service Claims

When you submit a pre-service claim, the Plan (meaning the Fund Office) will notify you whether or not the claim is approved within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after the Plan's receipt of the claim. If you fail to follow the Plan's procedures for filing a claim, you will be notified of the failure and the proper procedures as soon as possible, but no later than five (5) days following the failure. We will notify you verbally, unless you request us to notify you in writing.

18.2 Post-Service Claims

For post-service claims, the Plan will notify you 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.

18.3 Additional Time

For both pre- and post-service claims, if the Plan needs additional time to determine whether a claim is a covered expense for reasons beyond the Plan's control, the Plan may take one fifteen (15) day extension. The Plan will notify you prior to the expiration of the initial fifteen (15) or thirty (30) day notification period, as applicable, of the circumstances requiring the extension and the date by which the Plan expects to make a decision. If an extension is needed due to your failure to submit necessary information to decide the claim, the Plan, in the notice of extension, will specifically describe the required information needed. The time period for making the determination is suspended from the date on which the notice of the necessary information is sent to you until the date you respond. The notice will state the amount of time that you have to respond to the request for information, which will be at least forty-five (45) days from receipt of the notice. Once you respond, the Plan will decide the claim within the fifteen (15) day extension period. Your claim will be denied if you do not respond in a timely manner. The Plan may take only one extension for group health claims and may not further extend the time for making its decision unless you agree to a further extension.

18.4 Concurrent Care Claims

A concurrent care claim is a claim that is reconsidered after the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments and the reconsideration results in the reduction or termination of the treatment (other than by Plan amendment or termination) before the scheduled end of the treatment. Although this situation is rare, we are required by law to tell you that this provision exists. If the Plan reduces or terminates treatment before the end of the course of the treatment, the Plan will notify you far enough in advance of the termination or reduction of treatment to allow you to appeal the adverse benefit determination and obtain a determination on review before the termination or reduction takes effect.

18.5 Disability Claims

For disability claims, the Plan has a reasonable period of time, not in excess of forty-five (45) days, to provide written notice of an adverse benefit determination for any claim for disability benefits under the Plan. The Plan may extend the decision-making period for up to an

additional thirty (30) days for reasons beyond the Plan's control but the Plan will notify you in writing before the expiration of the forty-five (45) day period of the reason for the delay and when the decision will be made. A second thirty (30) day extension is allowable if the Plan still is unable to make the decision for reasons beyond its control. You will be provided, before the expiration of the first thirty (30) day extension period, a notice that details the reasons for the delay and the date as of which the Plan expects to render a decision. If an extension is needed because the Plan needs additional information from you, the extension notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and specify the additional information needed to resolve those issues, in which case you will have forty-five (45) days from receipt of the notification to provide the requested information. The Plan will issue its decision within thirty (30) days of the date you submit your information (subject to the thirty (30) day extension previously described). Your claim will be denied if you do not submit the requested information in a timely manner.

18.6 Adverse Benefit Determinations

A. The term "adverse benefit determination" is defined in the Claims Procedure Regulations to include a "rescission" of coverage, except in the case of fraud or intentional misrepresentation of a material fact. The Claims Procedure Regulations defines a "rescission" as a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance only has a prospective effect. The following are not considered rescissions under the Claims Procedure Regulations, even though retroactive:

1. The retroactive termination to the extent attributable to failure to timely pay a premium (self-payment) towards coverage;

2. The retroactive elimination of coverage back to the date of termination of employment, due to delays in administrative recordkeeping if the employee does not pay any premiums for coverage after termination of employment; and

3. The Plan's termination of coverage retroactive to the date of a divorce.

To clarify, this means that, in general, the Plan cannot terminate your coverage retroactively. However, the Plan may do so under the circumstances described and in other instances as may be prescribed in the Claims Procedure Regulations. The Plan is required to provide at least thirty (30) days advance written notice to each person who is affected by a rescission of coverage before the coverage may be rescinded.

B. If your claim for benefits is denied in whole or in part, the Plan will provide you, your Dependent, Beneficiaries, or authorized or legal representatives, as may be appropriate (hereafter referred to as "you" or "your") with written or electronic notice of adverse benefit determinations within the time frames previously stated. Notices will include the following information stated in an easily understandable manner:

1. The specific reason or reasons for the adverse benefit determination;

2. References to specific Plan provision(s) on which the adverse benefit

determination is based;

3. A description of any additional material or information, if any, necessary for you to perfect your claim and an explanation of why the material or information is necessary;

4. A description of the Plan's benefit appeals procedure and time limits applicable to such appeals procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;

5. 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;

6. If the adverse benefit determination was based on a medical necessity, Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request;

7. 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;

8. If the adverse benefit determination for a disability claim differs from a disability determination made by the Social Security Administration that is presented with your claim, a discussion of the basis for disagreeing with the Social Security Administration's disability determination; and

9. A statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

If you feel that the action taken on your eligibility or claim is incorrect, you immediately should ask the Fund Office to review your claim with you. In some cases, the Fund Office may request additional information from you which might enable the Fund Office to re-evaluate its decision.

C. The Plan must provide all notices to Participants in a "culturally and linguistically appropriate" manner where ten (10%) percent or more Participants residing in a county speak the same non-English language (however, this provision does not apply to the Plan at this time).

18.7 Denial of Claim on Appeal

If all or part of a claim is denied, or if you are otherwise dissatisfied with the determination made by the Plan, or if you have not received the notice of denial of your claim within the applicable time limits after the Plan has received all necessary claim information, you have 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. 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.

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

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, but the Plan must notify you of this extension and of the special circumstances and the date as of which the determination will be made prior to the extension time. The Plan will provide you with written or electronic 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 specific reason or reasons for the adverse benefit determination;

2. References to specific Plan provision(s) on which the adverse benefit determination is based;

3. A statement that you will be provided, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits;

4. A statement of your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the Plan's benefit appeals procedure;

5. 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 determination;

6. If the adverse benefit determination for a disability claim differs from a disability determination made by the Social Security Administration that is presented with your appeal, a discussion of the basis for disagreeing with the Social Security Administration's disability determination; and

7. If the adverse benefit determination was based on a medical necessity or Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request.

18.8 Federal External Claims Review Process

The Plan must implement an external review process for health claims that meets the following standards and give you written notice of your rights to an external review. The Plan must provide benefits pursuant to an Independent Review Organization ("IRO") decision without delay and regardless of whether the Plan intends to seek a judicial review of the external review decision and unless or until there is a judicial review otherwise.

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.

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

among them. The IRO will be required to:

a. Timely notify you in writing concerning your request's eligibility and acceptance for external review, as well as information on submitting additional information;

b. Use legal experts, where appropriate, to make coverage determinations under the terms of the Plan;

c. Notify you of your right to submit additional information in writing for the IRO to consider in making its decision; and

d. Notify the Plan of and provide to the Plan, within one (1) day of receipt, any additional information you provide regarding your claim appeal. If the Plan reverses its denial and provides coverage or payment based on this additional information, then the external review can be terminated.

4. Timely Review All Information and Documentation

In reaching its decision, the IRO will review the claim *de novo* and not be bound by any prior decisions or conclusions reached during the Plan's internal claims review and appeals procedures. The IRO will consider the following in reaching a decision:

a. Your medical records;

b. The attending Health Care Professional's recommendation;

c. Reports from appropriate Health Care Professionals and other documents submitted by the Plan, you, and your treating provider;

d. The terms of the Plan to ensure that any decision reached is not contrary to the Plan's terms unless the terms are inconsistent with law;

e. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

f. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

g. The opinion of the IRO's clinical reviewer(s) after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

5. Written Notice of IRO's Final Decision

The IRO will provide written notice of its final external review decision to you and the Plan within forty-five (45) days after the IRO received the initial request for external review. The IRO's decision will contain:

a. A general description of the reason for the request for external review, including the date(s) of service, the health care provider, the claim amount, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial;

b. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision;

d. A discussion of the principal reason(s) for its decision, including rationale for its decision and any evidence-based standards that were relied on in making its decision;

e. If the adverse benefit determination for a disability claim differs from a disability determination made by the Social Security Administration that is presented with your appeal, a discussion of the basis for disagreeing with the Social Security Administration's disability determination;

f. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan;

g. A statement that judicial review may be available to the claimant; and

h. Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

6. Maintaining Records

After the IRO reaches its final external review decision, the IRO will maintain all records of all claims and notices associated with the external review process for six (6) years. The IRO must make all such records available for examination by you, the Plan, any state or federal oversight agency, upon request, except if such disclosure would violate state or federal privacy laws.

7. Reversal of Plan's Decision

The Plan, upon receipt of notice of a final external review decision reversing

the adverse benefit determination or final adverse benefit determination, immediately will provide coverage or payments for the claim.

B. Expedited External Review

1. Request for Expedited External Review

The Plan will allow you to make a request for an expedited external review at the time you receive:

a. An adverse benefit determination if it involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal;

b. A final internal adverse benefit determination if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; or

c. A final internal adverse benefit determination if it concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency service, but you have not been discharged from a facility.

2. Preliminary Review

Immediately upon receipt of a request for an expedited external review, the Plan will determine whether the request meets the reviewability requirements and send written notice to you regarding whether you are eligible for an expedited external review.

3. Referral to IRO

Upon determination that a request is eligible for external review, following the preliminary review, the Plan will assign an IRO and provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO as expeditiously as possible, including but not limited to e-mail, telephone, or fax.

4. Review of Documents

In reaching its decision, the IRO will consider your medical records and other documents to the extent appropriate.

5. Notice of Final External Review Decision

The IRO will provide notice of its final expedited external review decision as expeditiously as your medical condition or circumstances require, but in

no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review.

The decision of the IRO will be binding on the Plan as well as you, except to the extent other remedies are available under federal or state law.

18.9 Legal Action

You may not begin any legal action, including proceedings before administrative agencies, until you have followed the procedures and exhausted the review opportunities described here. You may, at your own expense, have legal representation at any stage of these review procedures. No legal action for any benefits under the Plan may begin later than twelve (12) months after the time the claim for benefits was required to be filed as specified in this Section. Benefits under this Plan will be paid only if the Board of Trustees (as the Plan Administrator) decides in its discretion that you are entitled to them. The Plan will be interpreted and applied in the sole discretion of the Board of Trustees (or its delegate, including but not limited to, its Administrative Manager). Such decision will be final and binding on all persons covered by the Plan or who are claiming any benefits under the Plan.

SECTION 19
STATEMENT OF PARTICIPANTS' RIGHTS UNDER ERISA

In 1974, Congress passed and the President signed the Employee Retirement Income Security Act, commonly referred to as "ERISA."

ERISA sets forth certain minimum standards for the design and operation of privately-sponsored welfare plans. The law also spells out certain rights and protections to which you are entitled as a Participant.

The Trustees of the Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund want you to be fully aware of your rights, and for this reason, a statement of your rights follows.

As a participant in the Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund:

A. You automatically will receive a Plan Document and Summary Plan Description (this booklet). The purpose of this booklet is to describe all pertinent information about the Plan.

B. If any substantial changes are made in the Plan, you will be notified within the time limits required by ERISA.

Federal regulations under HIPAA require that participants and beneficiaries receive a summary of material modifications of any modification or change that is a material reduction in covered services or benefits under a group health plan within sixty (60) days after the adoption of the modification or change, unless the plan sponsor regularly sends out summaries of the modifications or changes at regular intervals of ninety (90) or fewer days.

C. Each year you automatically will receive a summary of the Plan's latest annual financial report. A copy of the full report also is available upon written request.

D. You may examine, without charge, all documents relating to the operation of this Plan. These documents include: the SPD and any insurance contracts, collective bargaining agreements, and/or copies of all documents filed by the Plan with the U.S. Department of Labor ("DOL") or the Internal Revenue Service, such as annual reports (Form 5500 Series).

Such documents may be examined at the Fund Office (or at other required locations such as worksites or Union halls) during normal business hours.

In order to ensure that your request is handled promptly and that you are given the information you want, the Trustees have adopted certain procedures which you should follow:

1. Your request should be in writing;

2. It should specify what materials you wish to look at; and

3. It should be received at the Fund Office at least three (3) days before you want to review the materials at the Fund Office.

Although all pertinent Plan documents are on file at the Fund Office, arrangements can be made upon written request to make the documents you want available at any worksite or Union location at which fifty (50) or more participants report to work. Allow ten (10) days for delivery.

E. You may obtain copies of any Plan document governing the operation of the Plan, including any insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 series) and an updated SPD upon written request to the Trustees, addressed to the Fund Office.

F. You have the right to continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a "Qualifying Event." You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

G. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way or take any action which would prevent you from obtaining a welfare benefit to which you may be entitled or from exercising any of your rights under ERISA.

H. In accordance with Section 503 of ERISA and related regulations, the Trustees have adopted certain procedures to protect your rights if you are not satisfied with the action taken on your claim.

I. These procedures appear in Section 18 ("Benefit Claims Procedure") of this SPD. Basically, they provide that:

1. If your claim for a health care benefit is denied, in whole or in part, you will receive a written explanation of the reason(s) for the denial; and

2. Then, if you still are not satisfied with the action on your claim, you have the right to obtain copies of documents relating to the decision without charge and to have the Plan review and reconsider your claim in accordance with the Plan's benefit appeals procedures, all within certain time periods.

These procedures are designed to give you a full and fair review and to provide maximum opportunity for all the pertinent facts to be presented on your behalf.

J. In addition to creating rights for plan participants, ERISA also defines the obligations of people involved in operating employee benefit plans. These persons are known as "fiduciaries." They have the duty to operate your Plan with reasonable care and to look out for your best interests as a participant under the Plan.

K. Under ERISA, you may take certain actions to enforce the rights previously listed.

1. For instance, if you request a copy of certain Plan documents or the latest

annual report from the Plan and do not receive them within thirty (30) days, you may file suit in federal court.

Of course, before taking such action, you will no doubt want to check again with the Fund Office to make sure that:

a. The request was actually received;

b. The material was mailed to the right address; and

c. The failure to send the material was not due to circumstances beyond the Trustees' control.

If you still are not able to get the information you want, you may wish to take legal action. The court may require the Trustees to provide the materials promptly or pay a fine of up to $110 for each day's delay until you actually receive the materials (unless the delay was caused by reasons beyond the Trustees' control).

2. Although the Trustees will make every effort to settle any disputed claims with participants fairly and promptly, there always is the possibility that differences cannot be resolved satisfactorily.

   If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court if you feel that you have been improperly denied a benefit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

   However, before exercising this right, you must take advantage of all the benefit appeals procedures provided under the Plan at no cost. If you still are not satisfied, then you may wish to seek legal advice.

3. If it should happen, that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the DOL or you may file suit in federal court.

   a. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

   b. If you are not successful, the court may order you to pay these costs and fees. For example, if the court finds your claim is frivolous, you may be required to pay these legal costs and fees.

If you have any questions about your Plan, you should contact the Trustees by writing to:

The Board of Trustees of the
Northern Minnesota-Wisconsin Area Retail
Food Health and Welfare Fund
2002 London Road, Suite 300
Duluth, MN 55812

Phone: (218) 728-4231
Toll-free: (877) 752-3863

Or if you have questions about this statement or your rights under ERISA or if you need assistance in obtaining documents from the Trustees, you may contact the nearest office of the Employee Benefits Security Administration at U.S. Department of Labor, EBSA, Kansas City Regional Office, 2300 Main Street, Suite 1100, Kansas City, MO 64108, (816) 285-1800. Or, you may contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You also may find answers to your Plan questions, your rights and responsibilities under ERISA, and a list of EBSA field offices by contacting the EBSA by: calling (866) 444-3272; sending electronic inquiries to www.askebsa.dol.gov; or visiting the website of the EBSA at www.dol.gov/agencies/ebsa. You also may obtain certain publications about your rights and responsibilities under ERISA by visiting https://www/dol.gov/general/topic/retirement/participantrights or calling the publications hotline of the EBSA at: (866) 444-3272.

SECTION 20
OTHER ERISA INFORMATION

20.1 Name and Address of Plan Administrator

The Plan is administered and maintained by the Board of Trustees. The Fund Office is located at: Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund, 2002 London Road, Suite 300, Duluth, MN 55812.

20.2 Type of Plan

This Plan is a group health plan that is a Self-Funded Plan. It is maintained for the exclusive benefit of the Employees and provides Death, Accidental Death and Dismemberment, and Weekly Disability Benefits for Employees and health, vision, and dental benefits for Employees and Dependents. This Plan is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

20.3 Plan Sponsor

The Plan Sponsor is the Board of Trustees of the Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund. This Fund is maintained by several Employers and one or more Employee organizations, and is administered by a joint Board of Trustees. A complete list of the Employers and Employee organizations sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries at the Fund Office.

20.4 Type of Plan Administration

Although the Trustees are legally designated as the Plan Administrator, they have delegated certain administrative responsibilities to an Administrative Manager.

The Administrative Manager maintains the eligibility records, accounts for the Employer contributions, answers Participant inquiries about the benefit programs, files required government reports, handles other routine administrative functions, and is primarily responsible for the processing of claims and benefit payments.

20.5 Names and Addresses of the Trustees

Union Trustees

Gary Morgan, Secretary
UFCW Local 1189
2002 London Road, Suite 211
Duluth, MN 55812

Jennifer Christensen
UFCW Local 1189
266 Hardman Avenue
South St. Paul, MN 55075

Tom Cvar
UFCW Local 1189
2002 London Road, Suite 211
Duluth, MN 55812

Al Priolo, Alternate
UFCW Local 1189
2002 London Road, Suite 211
Duluth, MN 55812

Management Trustees

Boyd Hanson, Chairman
Miner's Inc.
5065 Miller Trunk Highway
Hermantown, MN 55811

Bruce Anderson, Alternate
Miner's Inc.
5065 Miller Trunk Highway
Hermantown, MN 55811

Courtney Anderson
Miner's Inc.
5065 Miller Trunk Highway
Hermantown, MN 55811

Greg Kremer
Miner's, Inc.
5065 Miller Trunk Highway
Hermantown, MN 55811

20.6 Parties to the Collective Bargaining Agreement

The Plan is maintained pursuant to one or more collective bargaining agreements between your Employer and Local No. 1189, chartered by the United Food and Commercial Workers International Union. A copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and their beneficiaries at the Fund Office during normal business hours.

20.7 Internal Revenue Service Employee and Plan Identification Numbers

The Employer Identification Number (EIN) issued to the Board of Trustees is 41-6175286 and the Plan Number (PN) is 501.

20.8 Name and Address of the Persons Designated as Agents for Service of Legal Process

Service of legal process may be made upon:

David S. Anderson, Esq.
Kutak Rock LLP
60 South Sixth Street, Suite 3400
Minneapolis, MN 55402

Service of legal process also may be made upon any Plan Trustee.

20.9 Eligibility Requirements

The Plan's requirements with respect to eligibility for benefits are shown in the Eligibility Rules (Section 11). Circumstances which may cause the Participant to lose eligibility are explained in the Eligibility Rules.

20.10 Sources of Trust Fund Income

Sources of Trust Fund income include Employer contributions, self-payments, and investment earnings.

All Employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining agreements between the Union and Employers. The labor agreements specify the amount of contribution, due date of Employer contributions, type of work for which contributions are payable, and the geographic area covered by the labor contract.

20.11 Method of Funding Benefits

All Plan benefits are self-funded from accumulated assets and are provided directly from the Trust Fund. A portion of Fund assets is maintained in reserve to cover unexpected or unusually high expenses which the Fund may experience from time to time, such as a catastrophic claim.

Contributions are accumulated and invested in insured depository accounts and high quality, marketable securities. Benefits are paid from Plan assets and income from investments.

20.12 Fiscal Year of the Plan

The Plan's Fiscal Year begins January 1st and ends the following December 31st.

20.13 Procedures To Be Followed in Presenting Claims for Benefits Under the Plan

The procedures for filing for benefits are described in Section 14 (“How to Apply for Benefits”).

If a Participant wishes to appeal a denial of a claim in whole or in part, certain procedures for this purpose are found in Section 18 (“Benefit Claims Procedure”).

20.14 Plan Service Provider Contact Information

Fund Administrative Manager **Wilson-McShane Corporation** 2002 London Road, Suite 300 Duluth, MN 55812	Fund Preferred Provider Network **Blue Cross Blue Shield of Minnesota** P.O. Box 64560 St. Paul, MN 55164-0560
Fund Legal Counsel **Kutak Rock LLP** 60 South Sixth Street, Suite 3400 Minneapolis, MN 55402	Fund Preferred Provider Pharmacy **Envision Pharmaceutical Services, Inc.** 2181 East Aurora Road, Suite 201 Twinsburg, OH 44087
Fund Consultant **Lee Jost and Associates** One Park Plaza 11270 West Park Place, Suite 950 Milwaukee, WI 53224	Fund Employee Assistance Program Manager **TEAM Corporation** 1970 Oakcrest Avenue, Suite 200 Roseville, MN 55113 2002 London Road, Suite 95 Duluth, MN 55812
Fund Certified Public Accountant **Legacy Professionals LLP** 6800 France Avenue South, Suite 550 Edina, MN 55435	Fund Preferred Provider Dental Program **Delta Dental of Minnesota** P.O. Box 9304 Minneapolis, MN 55440-9304