★★ SUMMARY OF MATERIAL MODIFICATIONS ★★

June 2016

To All Employees and Dependents:

This Summary of Material Modifications (SMM) is an amendment to your Plan Document/Summary Plan Description (SPD) booklet, which was effective January 1, 2012, to formalize language incorporating recent Trustee actions regarding your Plan. Some of the new or modified language, which will be added to or eliminated from your existing SPD, is shown in italics in this SMM.

ONLINE CARE

We notified you in a May 2014 SMM that, effective June 1, 2014, there was an option offered to you through BCBS of Minnesota called "Online Care Anywhere" which allows you to “see” a Physician online and all in real time.

As of January 1, 2016, "Doctor On Demand" replaced "Online Care Anywhere" as the preferred Blue Cross Blue Shield of Minnesota and Blue Plus provider for telehealth services. All references to "Online Care Anywhere" from the prior SMM will be eliminated and replaced to reference "Doctor On Demand" instead.

OUT-OF-NETWORK PREVENTIVE SERVICES CHANGE

The Plan is revised effective January 1, 2016, to incorporate the following language into your SPD:

> *If the Plan does not have an in-network provider who can provide a particular covered preventive service, then it will cover the item or service without cost-sharing when performed by an out-of-network provider acting within the scope of his/her license or certification.*

DURABLE MEDICAL EQUIPMENT CHANGE

The Plan currently covers 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. Benefits for Durable Medical Equipment are payable subject to the Plan's deductible and coinsurance provisions.

The following language will be added to your SPD to be effective July 1, 2016:

(over)

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 a Participant's owned Durable Medical Equipment only when the replacement is needed for one or more of the following reasons:

1. *due to a change in the Participant's medical or physical condition;*
2. *when the equipment is inoperative due to irreparable damage;*
3. *when the equipment is inoperative due to irreparable wear; or*
4. *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) 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 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.

ALTERNATIVE PLAN B

The Plan is establishing an alternative plan design called "Plan B." It will consist of Plan A benefits, but exclude the following ancillary benefits:

- dental;
- vision;
- death;
- accidental death and dismemberment; and
- short-term disability.

Plan B will become available beginning with coverage on August 1, 2016, for employees covered under the Fund on that date. Plan B will be available to employees who become covered after August 1, 2016, according to the terms of their respective collective bargaining agreement.

Your employer and the terms of your collective bargaining agreement (CBA) will determine which benefit Plan (A or B) you will be offered, including your eligibility for single versus family coverage, as specified under Eligibility Rule 1, "How an Employee Becomes Eligible for Benefits" and Eligibility Rule 2, "Dependent Special Enrollment Period."

If you are offered Plan B 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 only can elect family ancillary benefit coverage if you have family medical coverage.

You will be offered the opportunity to elect ancillary benefits coverage at any one of the following times:

- When you become initially eligible for coverage under Plan B in accordance with Eligibility Rule 1, "How an Employee Becomes Eligible for Benefits;"

- During the Plan's Ancillary Benefit Open Enrollment Period. For the purpose of this section, 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 benefits coverage; or

- When you have a special enrollment event, as described under Eligibility Rule 2, "Dependent Special Enrollment Period."

Once you have elected ancillary benefits 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.

Please note that the existing one-year waiting period for dental and vision 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 one-year waiting period begins on the first day of the month in which your ancillary coverage became effective.

ELIGIBILITY RULE OPT-IN/OPT-OUT PROVISIONS

The Plan will add the following provision to the Eligibility Rules retroactively effective to August 1, 2015:

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:

1. *You otherwise are eligible to enroll in coverage at the time you apply to opt back into coverage;*
2. *You had other coverage under any group health plan or health insurance coverage when you opted out of coverage under this Plan;*

3. *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;*
4. *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 30 days prior to the date you request to opt back into coverage under the Plan;*
5. *One of the following changes in status applies:*
    - *You no longer are eligible for the other coverage you had when you opted out of coverage under this Plan;*
    - *The employer no longer pays any portion of the premium for the other coverage;*
    - *You have exhausted COBRA continuation coverage; or*
    - *You have acquired a dependent child or a spouse; and*
6. *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 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.

VISION CARE BENEFITS CLARIFICATION

We had previously notified you in a December 2014 Summary of Material Modifications that eligible dependent children under age 18 were eligible for one set of frames each 12 months. This should have stated they are eligible for one set of frames each calendar year.

TRUSTEE LISTING - UPDATED

The following is an updated listing of the Board of Trustees:

Labor Trustees	**Management Trustees**
Jennifer Christensen	Bruce Anderson
Tom Cvar, Alternate	Courtney Anderson
Tamara Jones	Boyd Hanson, Alternate
Gary Morgan	Jerry Miner

Please keep this SMM with your Plan Document/Summary Plan Description (SPD) booklet for future reference. If you have any questions, please call the Fund Office at (218) 728-4231, or toll-free at 1-800-570-1012.

Yours very truly,

THE BOARD OF TRUSTEES

nmwf\not\2016\0616 SMM