Northern Minnesota-Wisconsin Area Retail Clerks
Fringe Benefit Funds

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

IMPORTANT NOTICE TO PLAN PARTICIPANTS AND BENEFICIARIES

The Board of Trustees has amended the Plan Document and Summary Plan Description ("SPD"). This notice summarizes the changes in Amendments No. 10, 11, and 12 to the SPD and the effective dates of the changes.

Amendment No. 10, Effective Date January 1, 2022.

The Plan was amended to implement provisions that are required by the Consolidated Appropriations Act, 2021 (the "Act") and regulations issued pursuant to the Act.

Specifically, the Plan was amended to state that the Plan does not cover inpatient out-of-network services, except that the Plan will cover out-of-network Emergency Services, services furnished to you by a non-Preferred Provider at a Participating Health Care Facility to which you did not provide written consent, and out-of-network Air Ambulance Services in accordance with the Act. Your cost-sharing requirements for these specific out-of-network services will be no greater than the Plan would apply if the services were provided by Preferred Providers. Cost-sharing paid by you for these specific services will apply to your Deductible and Out-of-Pocket Maximum.

The Plan was amended to state that the Plan covers Medically Necessary local professional ground ambulance service to the nearest health care facility qualified to provide Medically Necessary treatment for an Emergency or acute illness, or a provider initiated inter-health care facility transfer to the nearest health care facility qualified to provide the Medically Necessary treatment.

The Plan was amended to state that the Plan covers Medically Necessary Air Ambulance Services to the nearest facility qualified to provide the Medically Necessary treatment of an Emergency or acute illness, or a provider initiated inter-health care facility transfer to the nearest health care facility qualified to provide the Medically Necessary treatment. The Plan will cover the cost of Air Ambulance Services only as Medically Necessary:

- Due to inaccessibility by ground transport, and/or
- If the use of ground transport would result in a serious adverse impact on the Eligible Person's health status.

Expenses incurred for transportation and/or ambulance services, including Air Ambulance Services, are not covered if such services are incurred for the convenience of the Eligible Person, the Eligible Person's health care provider, or the Eligible Person's family or other individual involved in the Eligible Person's care. Expenses for any transportation and/or ambulance services

are not covered if the Plan determines the transportation and/or ambulance services are not Medically Necessary. After you have satisfied the required Deductible, eligible transportation and/or ambulance services will be subject to a 20% Coinsurance payment by you until your Out-of-Pocket Maximum is met.

The Plan was amended to state that all Emergency Services are covered at the in-network level of benefits, subject to the Plan's standard cost-sharing provisions, even if services are obtained at an out-of-network provider. Coverage for Emergency Services will be provided without the need for any prior authorization. The Plan will not impose any administrative requirement or limitation to coverage for Emergency Services from out-of-network providers that is more restrictive than for Emergency Services from Preferred Providers. Emergency Services for Sickness are subject to a $100 Deductible per visit. This Deductible is waived if Hospital confinement occurs within 24 hours of your visit to a Hospital for Emergency Services. There is no separate Emergency Services Deductible if you suffer an Injury for which you seek Emergency Services, but the Plan's general Deductible for Comprehensive Major Medical Benefits will apply.

The Plan was amended to define or revise the definition of the terms "Air Ambulance Services," "Emergency," "Emergency Services," "Independent Freestanding Emergency Department," and "Participating Health Care Facility."

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

- "Emergency" means a medical condition including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

    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.

- "Emergency Services" means, with respect to an Emergency medical condition:

    A. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department and ancillary services routinely available to the emergency department to evaluate such Emergency medical condition; and

    B. Such further medical examination and treatment to stabilize the patient as are within the capabilities of the staff and facilities available at the Hospital or the

Independent Freestanding Emergency Department (regardless of the department of the Hospital in which such further examination or treatment is furnished).

- "Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct and licensed separately from a Hospital under applicable State law to provide Emergency Services.

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

Amendment No. 11, Effective Date January 26, 2022.

The Plan was amended to state that whether a covered item or service is Medically Necessary will be determined in accordance with Blue Cross Blue Shield of Minnesota's medical policy.

Amendment No. 12, Effective Date January 15, 2022.

The United States government is providing free at-home COVID-19 test kits. Please visit www.covidtests.gov or call 1-800-232-0233 (TTY 1-888-720-7489) to order up to two sets of four free tests per household. The test kits will ship through the USPS and are expected to ship out seven to 12 days after the order date to most residential addresses.

Coverage of At-Home COVID-19 Tests On and After April 1, 2022[1]

The Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund ("Plan") will provide Plan participants and covered family members with coverage for at-home over-the-counter ("OTC") COVID-19 test kits. This section discusses the Plan's coverage of at-home OTC COVID-19 test kits purchased at a pharmacy or other retailer or ordered through the Elixir Mail Order Pharmacy on and after April 1, 2022 through the end of the COVID-19 Public Health Emergency declared by the Department of Health and Human Services.

- ***The Plan will only cover COVID-19 test kits available "over the counter" that have been approved by the FDA for use at home or elsewhere without involvement of a health care provider.*** Please go to www.fda.gov to learn which tests are currently FDA approved or check the packaging on the test kit before purchasing.

- If purchased through the Elixir Mail Order Pharmacy or at an in-network pharmacy, the Plan will cover 100% of the cost (no Deductible or Copayment) for up to eight at-home OTC COVID-19 test kits per covered Eligible Person under the Plan per calendar month.

- Elixir Mail Order Pharmacy:

    - You can order eight at-home COVID-19 test kits per Eligible Person per calendar month from the Elixir Mail Order Pharmacy at no cost to you. A minimum of eight tests is required per order. To order at-home COVID-19 test kits from the Elixir Mail Order Pharmacy, have your Plan Prescription card ready and call (866) 909-5170.

[1] See below for information regarding coverage of at-home OTC COVID-19 test kits during the period from January 15, 2022 to March 31, 2022.

- In-Network Pharmacies:

    - You must purchase the OTC COVID-19 test kits at the pharmacy counter of a pharmacy in Elixir's network and present your Plan Prescription card at the time of purchase. If the in-network pharmacy is set up to process test kits in the same manner as a prescription, you will not pay any amount for the OTC COVID-19 test kits at the time of purchase.

    - Some pharmacies in the Elixir network are not set up to process at-home OTC COVID-19 test kits in the same manner as a prescription. You must pay 100% of the cost for at-home OTC COVID-19 test kits you purchase at one of these pharmacies. The Plan will reimburse you for the entire cost of these at-home OTC COVID-19 test kits if you save your receipt of purchase and submit a request for reimbursement to Elixir, following the reimbursement instructions at elixir.info/otc-guide.

- Out-of-Network Pharmacies and Other Retailers:

    - Plan reimbursement for at-home OTC COVID-19 test kits that you do not purchase at an Elixir in-network pharmacy will be limited to the cost of the test kit or $12, whichever is less. You are responsible for any amount that you pay in excess of $12 for an at-home OTC COVID-19 test kit purchased at a pharmacy that is not in the Elixir pharmacy network or from any other retailer or supplier. For reimbursement (subject to these limitations), save your receipt of purchase and submit a request for reimbursement to Elixir, following the reimbursement instructions at elixir.info/otc guide.

- The Plan will cover only OTC COVID-19 test kits for at-home medical use by you. Tests for employment purposes or resale will not be covered or reimbursed under this program.

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

Coverage of At-Home COVID Tests Purchased Between January 15, 2022 and March 31, 2022

The Plan covered 100% of the cost (no Deductible or Copayment) for up to eight at-home OTC COVID-19 test kits per Eligible Person under the Plan per calendar month that were purchased during the period from January 15, 2022 through March 31, 2022 subject to the following.

- ***The Plan will only cover COVID-19 test kits available "over the counter" that have been approved by the FDA for use at home or elsewhere without involvement of a health care provider.*** Please go to www.fda.gov to learn which tests are currently FDA approved or check the packaging on the test.

- At-home OTC COVID-19 test kits purchased during this period are covered in full regardless of whether the test kit was purchased at an in-network pharmacy or an out-of-network pharmacy or other retailer.

- If you paid out-of-pocket for at-home OTC COVID-19 test kits during this period, the Plan will reimburse you for the entire cost of the at-home OTC COVID-19 test kits already purchased. In order to be reimbursed, submit your receipt and a separate claim form for each covered person to the Fund Office at the address listed on the form.

- The Plan will cover only OTC COVID-19 test kits for at-home medical use by you. Tests for employment purposes or resale will not be covered or reimbursed under this program.

The above provisions only apply to at-home OTC COVID-19 test kits purchased without the involvement of a health care provider and do not affect existing Plan provisions regarding coverage of OTC COVID-19 tests ordered by an attending health care provider.

Please retain this notice with your current copy of the Plan Document and Summary Plan Description and insert the attached slip pages ii, v, 1, 2, 2A, 3, 7, 8, 11, 11A, 14, 14A, 64, 65, 66, 67, 67A, 68, 69, 69A, 98, 99, 99A, and 100 to replace and supplement the current pages of the same number. If you have any questions about the Plan, contact the Fund Office at (218) 728 4231 or (877) 752-3863.

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, the Mental Health Parity and Addiction Equity Act, and the Consolidated Appropriations Act, 2021. The Plan will be administered consistently with these laws and other applicable laws.

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

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. Whether a covered item or service is Medically Necessary will be determined in accordance with Blue Cross Blue Shield of Minnesota's medical policy. 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 that the Plan will cover out-of-network Emergency Services, services furnished to you by a non-Preferred Provider at a Participating Health Care Facility, and out-of-network Air Ambulance Services in accordance with the Consolidated Appropriations Act, 2021. Your cost-sharing requirements for these specific out-of-network services will be no greater than would apply if the services were provided by Preferred Providers. Cost-sharing paid by you for these specific services will apply to your Deductible and Out-of-Pocket Maximum. The Plan will pay for these specific out-of-network services.	
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, telemedicine visits.	$35 Copayment, 100% thereafter; no Deductible
Retail clinic visits	$10 Copayment, 100% thereafter; no Deductible
Doctor on Demand visits (Does not include visits for optometry, chiropractic and dental services.) Effective March 19, 2020 and for the duration of the public health emergency related to COVID-19 as determined by the Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury, all office, emergency, urgent care, and	$10 Copayment, 100% thereafter; no Deductible

telemedicine visits related to the diagnosis of COVID-19 will be covered at 100% (no member cost share).	
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 Ambulance services that are Emergency Services will be covered as stated in Section 2.6 of this SPD. Air Ambulance Services will be covered as stated in Section 2.4(G) of this SPD. Cost-sharing requirements for ambulance benefits that are out-of-network Emergency Services or Air Ambulance Services will not be greater than the cost-sharing for ambulance services received through Preferred Providers.	80%
Infertility treatment Maximum benefit per Eligible Person per Calendar Year (does not count toward the Out-of-Pocket Maximum, is a Non-Essential Health Benefit)	80% $200
Durable Medical Equipment	80%
Acupuncture	$500 annual payment limit

1.2. Preferred Provider Pharmacy Prescription Drug Benefits

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

SECTION 2
COMPREHENSIVE MAJOR MEDICAL BENEFITS

Active Employees and Dependents

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

2.1 Deductible

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

2.2. Coinsurance

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

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

The Plan does not cover inpatient out-of-network services, except that the Plan will cover out-of-network Emergency Services, services furnished to you by a non-Preferred Provider at a Participating Health Care Facility, and out-of-network Air Ambulance Services, subject to the terms of this SPD. The cost-sharing requirements for these specific out-of-network services will be no greater than would apply if the services were provided by Preferred Providers. Cost-sharing paid by you for these specific services will apply to your Deductible and Out-of-Pocket Maximum. The Plan will pay for these specific out of-network services in accordance with the Consolidated Appropriations Act, 2021.

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.

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 the Plan will cover out-of-network Emergency Services, services furnished to you by a non-Preferred Provider at a Participating Health Care Facility, and out-of-network Air Ambulance Services, subject to the terms of this SPD. The cost-sharing requirements for these specific out-of-network services will be no greater than would apply if the services were provided by Preferred Providers. Cost-sharing paid by you for these specific services will apply to your Deductible and Out-of-Pocket Maximum. The Plan will pay for these specific out of-network services in accordance with the Consolidated Appropriations Act, 2021.

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

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 health care facility qualified to provide Medically Necessary treatment for an Emergency or acute illness, or a provider initiated inter-health care facility transfer to the nearest health care facility qualified to provide the Medically Necessary treatment.

   The Plan covers Medically Necessary Air Ambulance Services to the nearest facility qualified to provide the Medically Necessary treatment of an Emergency or acute illness, or a provider initiated inter-health care facility transfer to the nearest health care facility qualified to provide the Medically Necessary treatment. Charges are payable for Medically Necessary Air Ambulance Services 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. Air Ambulance Services will be provided only as Medically Necessary (i) due to inaccessibility by ground transport, and/or (ii) if the use of ground transport would result in a serious adverse impact on the Eligible Person's health status.

   Out-of-network Air Ambulance Services will be covered in accordance with the Consolidated Appropriations Act, 2021, The cost-sharing requirements will be the same as Air Ambulance Services provided by a Preferred Provider. The cost-sharing amounts paid by you for out-of-network Air Ambulance Services will apply to your Deductible and Out-of-Pocket Maximum.

   Charges for ambulance service by railroad, ship, bus, or other common carrier are not covered expenses. Expenses incurred for transportation and/or ambulance services, including Air Ambulance Services, are not covered if such services are incurred for the convenience of the Eligible Person, the Eligible Person's health care provider, or the Eligible Person's family or other individual involved in the Eligible Person's care. Expenses for any transportation and/or

ambulance services are not covered if the Plan determines the transportation and/or ambulance services are not 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

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.

I. Diagnostic Products for the Detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act ("COVID-19 diagnostic products") when ordered by an attending health care provider, and the administration of such COVID-19 diagnostic products, will be covered at 100% (no member cost share). Also covered at 100% (no member cost share) are items and services furnished to you during health care provider office visits (including both in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of a COVID-19 diagnostic products as described above, to the extent such items and services relate to the furnishing or administration of such COVID-19 diagnostic product or to your evaluation for purposes of determining your need for the product.

Additionally, effective January 15, 2022, and for the duration of the public health emergency concerning COVID-19, the Plan will provide coverage for up to eight at-home over-the-counter ("OTC") COVID-19 diagnostic products per calendar month without the requirement for an order by an attending health care provider, subject to the following rules. These provisions only apply to at-home COVID-19 diagnostic products and do not affect the Plan provisions regarding coverage of non-at-home OTC COVID-19 diagnostic products as described in the paragraph above.

1. During the period from January 15, 2022 through March 31, 2022, the Plan will cover 100% of the cost of an at-home OTC COVID-19 diagnostic product purchased at any pharmacy or other retailer or supplier.

2. During the period from April 1, 2022 through the end of the public health emergency concerning COVID-19, the Plan will cover 100% of the cost of an at-home OTC COVID-19 diagnostic product purchased at a Preferred Provider pharmacy or ordered through the Elixir Mail Order Pharmacy. Plan reimbursement for at-home OTC COVID-19 test kits that are not purchased at a Preferred Provider pharmacy will be limited to the cost of the test or $12, whichever is less. The Eligible Person is responsible for any amount in excess of $12 for an at-home OTC COVID-19 test kit purchased at a non-Preferred Provider pharmacy or any other retailer or supplier.

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 and the Consolidated Appropriations Act, 2021 require that all Emergency Services are covered at the in-network level of benefits even if services are obtained at an out-of-network provider. Coverage for Emergency Services will be provided without the need for any prior authorization. The Plan will not impose any administrative requirement or limitation to coverage for Emergency Services from out-of-network providers that is more restrictive than for Emergency Services from Preferred Providers. Your cost-sharing requirements for out of network Emergency Services will be no greater than would apply if the Emergency Services were provided by a Preferred Provider. The cost sharing for Emergency Services from an out of network provider will be calculated as if the total amount paid by the Plan for such services were paid to a Preferred Provider. The cost sharing amounts paid by you for Emergency Services from an out-of-network provider will apply to your Deductible and Out of Pocket Maximum.

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

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 Consolidated Appropriations Act, 2021

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Consolidated Appropriations Act, 2021 (CAA). The Plan has been amended to comply with the requirements of the CAA as of the effective date of Amendment No. 10: January 1, 2022.

12.13 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.

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

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 including a mental health condition or substance use disorder,

manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

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.

Emergency Services means, with respect to an Emergency medical condition:

A. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department and ancillary services routinely available to the emergency department to evaluate such Emergency medical condition; and

B. Such further medical examination and treatment to stabilize the patient as are within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department (regardless of the department of the Hospital in which such further examination or treatment is furnished).

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.

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

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.

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

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.

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

James Gleb, Secretary
UFCW Local 1189
266 Hardman Avenue North
South St. Paul, MN 55075

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

Abe Wangnoo
UFCW Local 1189
266 Hardman Avenue North
South St. Paul, MN 55075

Bruce Bergh, Alternate
UFCW Local 1189
2002 London Road, Suite 211
Duluth, MN 55812

Stacy Spexet, 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

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

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

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

Amy Andrews, Alternate
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:

Cindy L. Davis, 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”).