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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 change and its effective date.

Amendment No. 3, Effective Date March 19, 2020.

The Plan was amended to provide coverage for diagnostic testing products used for the detection or the diagnosis of COVID-19 that are approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act, and the administration of such diagnostic testing products, at 100% (no member cost share). Also covered at 100% (no member cost share) are items and services supplied 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 testing product as described above, to the extent such items and services relate to the supplying or administration of COVID-19 testing product or to your evaluation for purposes of determining your need for the COVID-19 testing product. These changes are effective for such items and services provided on or after March 19, 2020.

The Plan was also amended to provide coverage for telemedicine visits in addition to Doctor on Demand.

Please retain this notice with your current copy of the Plan Document and Summary Plan Description and insert the attached slip pages 2, 2A, 14, 14A, and 60 to replace the current page of the same number. If you have any questions about the Plan, contact the Fund Office at (218) 728-4231 or (877) 752-3863.

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.

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.)	$10 Copayment, 100% thereafter; no Deductible
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 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

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), 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.

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

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

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

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

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

JJ. Charges for or related to fetal tissue transplants;

KK. Maintenance and custodial therapy;

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

MM. Aquatic therapy;

NN. Orthotics prescribed by a chiropractor;

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

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

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

RR. Wigs;

SS. Reversals of sterilizations;

TT. Diet consultations, except when related to diabetes;

UU. Surgery for obesity, except as specifically provided;

VV. Charges for transplant donor-related services;

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