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 change and its effective date.

Amendment No. 4, Effective Date May 4, 2020.

The Plan was amended to extend the timeframes for special enrollment, COBRA coverage, COBRA payments, notification of a qualifying event or determination of disability, filing a claim, appealing an adverse benefit determination, and requesting an external review. These timeframes are extended during the Outbreak Period, defined as the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury.

Amendment No. 5, Effective Date June 1, 2020.

The Plan was amended to exclude certain drugs categorized as non-essential drugs by EnvisionRx.

Please retain this notice with your current copy of the Plan Document and Summary Plan Description and insert the attached slip pages 24, 24A, 36, 37, 37A, 41, 42, 43, 43A, 73, 73A, 87, 87A, 89, and 89A 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.

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;

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

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

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

4.4 Contraceptive Coverage

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

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

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

A. 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

B. 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.

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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.

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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

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.

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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.

During the Outbreak Period, as defined in Section 11.10(B)(1), the sixty (60) day window in which a Qualified Beneficiary may elect for continuation coverage is disregarded and resumes at the end of the Outbreak Period.

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.

During the Outbreak Period, as defined in Section 11.10(B)(1), the forty-five (45) day deadline to make the initial self-payment is disregarded and resumes at the end of the Outbreak Period.

6. Due Date for Subsequent Self-Payments

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

During the Outbreak Period, as defined in Section 11.10(B)(1), the thirty (30) day grace period for making subsequent self-payments is disregarded and resumes at the end of the Outbreak Period.

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.

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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

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.

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14.2 Compliance With Claim Rules

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

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

14.3 Pre-Service Claims

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

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

14.4 Post-Service Claims

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

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

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

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

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

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

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

the decision and request a review of the claim. The Plan will provide for a full and fair review of a claim and adverse benefit determination, pursuant to the following:

A. You will have one hundred eighty (180) days after you receive the notice of an adverse benefit determination to file your appeal in writing to the Fund Office and it must include the specific reasons you feel denial was improper.

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B. You will be allowed the opportunity to submit written issues and comments, documents, records, and other information relating to the claim for benefits which may have been requested in the notice of denial or which you may consider desirable or necessary.

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

D. Your review will take into account all comments, documents, records, and other information submitted by you relating to the claim, whether or not such information was submitted or considered in the initial benefit determination.

E. The Board of Trustees, as an appropriate named fiduciary for the Plan, will be the assigned decision maker on appealed claims.

F. The Plan will consult with appropriate Health Care Professionals in deciding appealed claims that are based in whole or in part on medical judgment, including determination of Experimental or investigational treatments and medical necessity. Such Health Care Professional will have appropriate training and experience in the field of medicine involved in the medical judgment. The Health Care Professional consulted for the appeal of an adverse benefit determination will be someone who was not consulted in the initial adverse benefit determination nor the subordinate of such individual.

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

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

I. The Plan must ensure that all claims and appeals are adjudicated with the utmost

impartiality and avoid conflicts of interest. The claims or appeals adjudicator must be independent from and impartial to the Plan.

J. For appeals of pre-service claims, the Plan will notify you of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receiving the appeal request.

K. The Board of Trustees will review post-service and disability claim appeals at their

A. Standard External Review

1. Request for External Review

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

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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.

During the Outbreak Period, as defined in Section 18.8(A)(1), the four (4) month filing period (or forty-eight (48) hour window after receipt of the notice, whichever is later) is disregarded and resumes at the end of the Outbreak Period.

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