MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS HEALTH AND WELFARE FUND

IMPORTANT NOTICE

Summary of Material Modifications

TO: Participants and Beneficiaries of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund

FROM: The Board of Trustees

DATE: April 2018

This is a Summary of Material Modifications (SMM) regarding the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (Fund). The Board of Trustees has amended the Summary Plan Description and Plan Document (amended and restated September 1, 2017) as indicated below.

Amendment No. 1: Mail-Order Prescription Medications, Generic Substitution and Disability Claims Procedures

Effective November 1, 2017, the Plan has been amended to remove all references to the mail-order prescription service that was eliminated.

Effective January 1, 2018, the Plan has been amended to remove the coverage exclusion for certain prescription medications. It has also been updated to include the Plan's generic substitution requirement. Generic Prescription Medication will be substituted in lieu of any prescribed brand name Prescription Medication if it is commercially available and if such substitution is consistent with the prescription, the dispensing pharmacist's professional judgement, and applicable law.

Effective April 1, 2018, the Plan's disability claims procedures have been updated to comply with the U.S. Department of Labor's final rule entitled "Claims Procedure for Plans Providing Disability Benefits." If a claim is denied, claimants will now be provided with a statement that the claimant has the right to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

If the claim for benefits is denied based upon a disability determination, the notice will provide an explanation of the basis for agreeing or disagreeing with the following:

1. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

2. The review of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

3. A disability determination regarding the claimant made by the Social Security Administration if such determination is presented by the claimant to the Plan.

The procedure for claim appeal reviews have been amended to state that the review will not afford deference to the initial adverse benefit determination and will be conducted by individuals who were neither the individuals who made the initial adverse benefit determination that is the subject of the appeal, not the subordinates of such individuals. Before the Plan issues an adverse benefit determination, the Plan will provide the claimant, free of charge and sufficiently in advance of the date on which the notice of benefit determination is required to be provided, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan or those involved with the Plan or the claim, to give the claimant a reasonable opportunity to respond prior to the benefit determination date.

If an adverse benefit determination is made, the following will now be required as part of the notice provided to the claimant:

- The statement, "You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."; and

- If the claim is denied based upon a disability determination, the notice will provide an explanation of the basis for agreeing or disagreeing with the following:

  (a) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

  (b) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

  (c) A disability determination regarding the claimant made by the Social Security Administration if such determination is presented by the claimant to the Plan.

Please update your Summary Plan Description and Plan Document booklet (dated September 1, 2017) to reflect these changes by inserting replacement pages 17, 20, 47, 70, 75, 76, 77, and 77A into your booklet to replace existing pages.

If you have any questions about these changes to the Plan, please contact the Plan Administrator at (952) 851-5797 or (844) 468-5917.

2.2. PRESCRIPTION DRUG BENEFITS

Only Prescription Medication purchased through the Prime Therapeutics Select Care Network will be covered. Prescription Medication filled at Walgreens, Walmart, Target, Hy-Vee, Sam's Club, Costco, and Coburns will not be covered or reimbursed. Below is the schedule of benefits for "Prescription Drug Benefits."

Out-of-pocket maximum per Calendar Year	
Per Eligible Person	$3,600
Per Family	$7,200
Prescription	**Plan's Coinsurance**
Prescriptions purchased at a retail pharmacy, except as otherwise specifically stated	Plan pays 80%
OTC Prilosec and OTC Loratadine upon a Physician's written prescription	Plan pays 100%
Prescriptions purchased through the Specialty Drug Program	Plan pays 80%

2.3. VISION CARE BENEFITS

Below is the schedule of benefits for "Vision Care Benefits."

Services and Supplies	Maximum Plan Payment
Examination	
One per Eligible Person over age 19 per Calendar year	$50
One per Dependent Child under age 19 per Calendar year	100%
Lenses	
One set per Eligible Person per Calendar Year	
Single, each lens	$37
Bifocal, each lens	$64
Trifocal, each lens	$78
Lenticular, each lens	$140
Contacts, per set (or disposable contacts)**	$87
Frames	
One set per Eligible Person per Calendar Year	$70
Maximum payment per set	

The amounts in the Maximum Plan Payment column show what the Plan will pay toward the listed services and supplies. The Eligible Person is responsible for all additional amounts and other charges.

** The contact lens benefit is in lieu of all other lens and frame benefits for the Calendar Year.

SECTION 3 PREFERRED PROVIDER NETWORKS

3.1. PREFERRED PROVIDER PRESCRIPTION DRUG PROGRAM

When a full-time Eligible Employee or Eligible Dependent or a part-time Eligible Employee (and their Dependent Children, if applicable) opts to purchase Prescription Medications through the Preferred Provider Prescription Drug Program, benefits are payable subject to the following terms and conditions.

The Preferred Provider for the Prescription Drug Program is Prime Therapeutics ("Select Care Network"). Only prescriptions that are purchased through this network will be covered.

3.3.1. Payment of Benefits

An Eligible Person must show his or her I.D. card at the network retail pharmacy to receive discounts through the Preferred Provider Prescription Drug Program and pay the required coinsurance at the time of purchase. Benefits are payable at the coinsurance stated in the Schedule of Benefits.

The Plan will provide coverage for specialty Prescription Medications through the specialty drug network. Benefits are payable at the coinsurance stated in the Schedule of Benefits.

3.1.2. Eligible Expenses

The expenses for Prescription Medications that are provided in Comprehensive Major Medical Benefits are also covered under the Preferred Provider Prescription Drug Program, except that injections and injectables are covered through the Specialty Drug Program.

3.1.3. Generic Substitution Requirement

Generic Prescription Medication will be substituted in lieu of any prescribed brand name Prescription Medication if it is commercially available and if such substitution is consistent with the prescription, the dispensing pharmacist's professional judgement, and applicable law.

3.2. PREFERRED PROVIDER NETWORK

The Plan uses BlueCross BlueShield of Minnesota as its Preferred Provider Network. Although the Plan covers services at in-network and out-of-network Hospitals and services provided by Preferred Providers ("PPO Provider") and non-participating providers ("Non-PPO Provider"), you will generally pay less if you use an in-network or PPO Provider.

3.2.1. Payment of Benefits

Benefits will be payable for Hospital and Physician services and supplies at the Plan's coinsurance, applied to the Hospital's or Physician's negotiated charge according to the contract in effect at the time charges are incurred. The PPO network also offers a smoking cessation program and a Healthy Start Prenatal Support Program.

For charges incurred with PPO Providers, the Plan will pay a discounted amount. Such providers have agreed to accept payment from the Plan as payment in full, except for

Prescription Medication services do not include the following:

1. Supplies or appliances that are not Prescription Medication, even if obtained with a Prescription Order, such as devices, bandages, heat lamps, braces, splints, artificial appliances, diaphragms, and syringes for use with insulin;

2. Drugs and medications that can be obtained without a Prescription Order, except insulin and smoking cessation medications obtained through the Preferred Provider's Smoking Cessation Program (and OTC Prilosec and Loratadine upon a Physician's written prescription through the Preferred Provider Prescription Drug Program);

3. Cost of administering a Prescription Medication;

4. Cost of Prescription Medications for use while the Eligible Person is confined in a Hospital;

5. Any Prescription Medication that is not approved for sale by the United States Government;

6. Cosmetic drugs;

7. Health and beauty aids, cosmetics, and dietary supplements;

8. State-restricted drugs;

9. Impotence medications; and

10. Injections and injectables, except insulin when prescribed by a Physician and prescriptions obtained through the Preferred Provider's Specialty Drug Program.

F. Hospice care for terminally ill Eligible Persons who otherwise, upon the recommendation of their Physician, would be required to be Hospital-confined. Benefits are payable for home care administered under an approved Hospice Program or Home Health Care Agency at the patient's home, for care in a hospice unit of a Hospital, or for care in a separate hospice facility.

The following hospice care services are covered during the period the Eligible Person otherwise would have to be Hospital-confined:

1. Physicians' visits;

2. Care provided by an R.N. and home health care aides;

3. Assessment visit by a Hospice program staff member;

2. Either:

   a. A recovery subject to the Plan's subrogation and reimbursement rights has been received (whether before or after the submission of or payment of claims by the Plan); or

   b. The Plan deems it likely that recovery will be received.

   At the discretion of the Trustees, losses, expenses, and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement. As used in this Section, the term "third party" includes any individual, insurer, entity, or federal, state or local government agency who is or may be in any way legally obligated to reimburse, compensate, or pay for an Eligible Person's loss, damages, Injuries or claims relating in any way to the Injury, occurrence, condition, or circumstance giving rise to the Plan's provision of medical, dental, or disability benefits, including but not limited to, insurers providing liability, medical expense, wage loss, uninsured motorist, or under-insured motorist coverages.

JJ. Any loss, expense, or charge incurred as the result of any Injury, occurrence, conditions or circumstance for which the injured Eligible Person:

1. Has the right to recover payment from a third party (at the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement);

2. Has recovered from a third party; or

3. Has not submitted a claim for the loss, expense, or charge prior to resolution of the third party claim.

KK. Charges for Injury or Illness resulting from the Eligible Person's participation in a riot or the Eligible Person's commission of any act that may be charged as a felony or gross misdemeanor offense, except in circumstances involving domestic violence or when the commission of the gross misdemeanor or felony is caused by a mental health condition.

LL. Charges for any Injury or Illness that results from an incident occurring on any property where the lessee or lessor or owner of the property is responsible for Injury or Illness or what otherwise is covered under homeowner's insurance. However, the Plan will consider the charges if: no insurance or other form of compensation is available to the Eligible Person; and the Eligible Employee signs a subrogation agreement in the form designated by the Trustees with the Plan.

MM. Charges for PCSK9 drugs and drugs containing bulk powders unless the Eligible Person receives preauthorization by the Plan for such drugs.

7.2.5 Adverse Benefit Determination

The Plan will notify the claimant of an adverse benefit determination within a reasonable period of time, but not later than thirty (30) days after the Plan's receipt of a claim or fifteen (15) days after the Plan's receipt of claim in the case of a pre-service claim.

If, for any reason, a claim is denied, in whole or in part, the Fund Office will provide the Eligible Employee, Eligible Dependent, Beneficiary, or authorized or legal representatives ("claimant"), as may be appropriate, with written notice of adverse benefit determinations within the time frames previously stated. Notices will contain the following information stated in an easily understandable manner:

A. The date of service, the health care provider, the claim amount (if applicable), the diagnosis code, the treatment code, and the corresponding meanings of these codes;

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

C. Reference to specific Plan provisions on which the adverse benefit determination is based;

D. A description of additional information, if any, necessary to complete the claim and why the material or information is necessary;

E. A description of the Plan's internal and external review procedures, how to initiate an appeal, and the time limits applicable to the review procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;

F. A statement that the claimant has the right to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim;

G. If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, a description of such rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse benefit determination and a statement that a copy of such criterion will be provided free of charge to the claimant upon request;

H. If the adverse benefit determination was based on a Medical Necessity or Experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge to the claimant upon request;

I. If a medical or vocational expert's advice was obtained on behalf of the Plan in connection with a claim, a statement that the claimant may request the identity of the expert, regardless of whether the advice was relied upon;

J. Contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act; and

K. If the claim for benefits is denied based upon a disability determination, the notice will provide an explanation of the basis for agreeing or disagreeing with the following:

1. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

2. The review of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

3. A disability determination regarding the claimant made by the Social Security Administration if such determination is presented by the claimant to the Plan.

7.3 APPEAL PROCEDURE

If all or part of a claim is denied, if a claimant is otherwise dissatisfied with the determination made by the Plan, or if the claimant has not received the notice of denial of the claimant's claim within the applicable time limits after the Plan has received all necessary claim information, the claimant has the right to appeal the decision and request a review of the claim. The Plan will provide for a full and fair review of a claim and adverse benefit determination, pursuant to the following:

A. A claimant will have one hundred eighty (180) days after the claimant receives the notice of an adverse benefit determination to file the claimant's appeal in writing to the Fund Office, and it must include the specific reasons the claimant feels denial was improper.

B. A claimant will be allowed the opportunity to submit written issues and comments, documents, records, and other information relating to the claim for benefits that may have been requested in the notice of denial or that the Eligible Employee may consider desirable or necessary, but neither the claimant nor representative of the claimant will have the right to appear in person before the Board of Trustees.

C. A claimant or duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all designated, pertinent documents, records, and other information relevant to the Employee's claim for benefits.

D. The review will take into account all comments, documents, records, and other information related to the claim that are submitted by the claimant, 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 review will not afford deference to the initial adverse benefit determination and will be conducted by individuals who were neither the individuals who made the initial adverse benefit determination that is the subject of the appeal, not the subordinates of such individuals.

G. 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 professionals 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 or the subordinate of such individual.

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

I. Before the Plan issues an adverse benefit determination, the Plan will provide the claimant, free of charge and sufficiently in advance of the date on which the notice of benefit determination is required to be provided, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan or those involved with the Plan or the claim, to give the claimant a reasonable opportunity to respond prior to the benefit determination date.

J. For appeals of pre service claims, the Plan will notify the claimant 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 claim appeals at their next regularly scheduled Board of Trustees' meeting (at least quarterly) that follows the receipt of the request for review. However, if the request is filed within thirty (30) days of the date of the meeting, the determination may be made no later than the date of the second meeting following the receipt of the request for review. If special circumstances require a further extension, the appeal decision can be pushed back to the third meeting following the appeal request. However, prior to the extension, the Plan must notify the claimant of the extension, the special circumstances, and the date as of which the determination will be made.

The Plan will provide the claimant with written notice of an adverse benefit determination as soon as possible but within five (5) days of the decision being made. The notice will include the following information stated in an easily understandable manner:

1. The date of service, the health care provider, the claim amount (if applicable), the diagnosis code, the treatment code, and the corresponding meanings of these codes;

2. The specific reason or reasons the claim was denied, including (if applicable) the denial code and its corresponding meaning;

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

4. A statement that the claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his/her claim for benefits;

5. A description of the Plan's internal and external review procedures and the time limits applicable to the review procedures;

6. A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA after the claimant has exhausted the Plan's claims review and appeal procedure;

7. If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, a description of such rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse benefit determination and a statement that a copy of such criterion will be provided free of charge to the claimant upon request;

8. If the adverse benefit determination was based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific of clinical judgment of the Plan in applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge to the claimant upon request;

9. Contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act;

10. The statement, "You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."; and

11. If the claim is denied based upon a disability determination, the notice will provide an explanation of the basis for agreeing or disagreeing with the following:

    (a) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

    (b) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

    (c) A disability determination regarding the claimant made by the Social Security Administration if such determination is presented by the claimant to the Plan.