Minneapolis Retail Meat Cutters & Food Handlers Health and Welfare Fund

UFCW Local 663 Preparing today for a *secure* future.

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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: February 2020

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

Amendment No. 4: Children's Vision and Dental Coverage Limits

Effective March 1, 2019, the Plan has been amended to remove certain limits on pediatric vision and dental services. In the vision section of the Schedule of Benefits, the revised language provides that the Plan will pay 100% of the cost of lenses for Eligible Persons or Dependent Children under the age of 19. In the dental section of the Schedule of Benefits, the revised language provides that the maximum annual dollar limit of $1,250 does not apply to certain dental care benefits for Eligible Employees or Eligible Dependents under the age of 19.

Amendment No. 5: Prior Authorization and Step Therapy

Effective August 1, 2019, the Plan has been amended to require that certain prescription drugs will be subject to the Plan's Step Therapy, quantity level limits and prior authorization programs.

The Step Therapy program is a "step" approach to providing the medications that treat your condition. If your doctor prescribes you a new medication that is subject to the Plan's Step Therapy program, the Plan will initially only cover the least expensive "step" in that drug class, typically a generic drug. If the first step medication does not safely and effectively treat your condition, the Plan will cover the next "step," typically a formulary brand medication.

If your doctor recommends prescription drugs or quantities that do not comply with the prior authorization and/or Step Therapy protocols, your doctor will need to submit a prior authorization (PA) request that will include the medical reasons supporting that request to Prime Therapeutics.

Amendment 6: Part-Time Self Pay for Ancillary Benefits

Effective April 26, 2019, the Plan has been amended to allow all regular part-time, Group 3 part-time, and modified part-time Eligible Employees to self-pay for Ancillary Benefits if allowed by the applicable collective bargaining agreement.

"Ancillary Benefits" includes Dental Care, Vision Care, Life Insurance, Accidental Death and Dismemberment, and Employee Assistance Program benefits.

Amendment 7: Coverage for Conditions Related to Gender Dysphoria

Effective August 1, 2019, the Plan has been amended to provide coverage for conditions related to Gender Dysphoria.

Amendment 8: Accidental Death and Dismemberment and Life Insurance Updates

Effective August 1, 2019, the Plan has been amended to update the accidental death and dismemberment benefits and life insurance benefits to Symetra Life Insurance Company.

Amendment 9: Removal of Walgreens Pharmacy Exclusion

Effective January 1, 2020, the Plan has been amended to replace the Walgreens pharmacy exclusion with CVS pharmacy.

Please update your Plan Document and Summary Plan Description booklet (dated September 1, 2017) to reflect these changes by inserting the attached introduction page and replacement pages 10, 17, 17a, 18, 19, 20, 23, 48, 48a, 48b, 61, 62, 63, 64, 68 and 90.

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

MINNEAPOLIS RETAIL MEAT CUTTERS AND FOOD HANDLERS HEALTH AND WELFARE FUND

INTRODUCTION

To All Participants:

The Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund ("Plan") is developed and maintained pursuant to the Restated Agreement and Declaration of Trust of the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund ("Trust Agreement"). Benefits originally were provided according to a mini-premium arrangement with BlueCross BlueShield.

Effective April 1, 1985, the Board of Trustees ("Trustees") cancelled BlueCross BlueShield Master Insurance Policy No. AS314 and began providing health care benefits directly from Plan assets according to the Plan Document and Summary Plan Description, which has been amended from time to time. The benefits and other provisions were continued without modification or change. Life Insurance and Accidental Death and Dismemberment Benefits are insured through Symetra Life Insurance Company, 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004 (the "Life Insurance Company") subject to Master Insurance Policy No. is 01-018038-00.

Effective May 1, 2008, the Trustees restated the entire Plan Document. The Trustees have decided to restate the Plan Document as a Plan Document and Summary Plan Description, effective September 1, 2017. The restated Plan Document and Summary Plan Description incorporates all amendments adopted through August 28, 2017. This Plan continues in force until amended by the Trustees or terminated pursuant to the terms of the Trust Agreement. As future changes to the Plan are adopted by the Trustees, amendments will be incorporated into this Plan Document and Summary Plan Description, which then will constitute a continuously updated restatement of the Plan Document and Summary Plan Description.

Yours sincerely,

THE BOARD OF TRUSTEES

chiropractor, osteopath, podiatrist, optometrist, doctor of dental surgery, Nurse Anesthetist providing anesthesia services, and Nurse Midwife providing obstetrical services. The Physician must be duly licensed and qualified under the laws of the state in which the eligible Health Services are performed.

1.30. PLAN YEAR

"Plan Year" means the twelve (12)-month period beginning March 1 and ending February 28.

1.31. PREDETERMINATION

"Predetermination" means the pretreatment review that is used to determine the eligibility of the individual and the amount of coverage for services in accordance with the Schedule of Benefits.

1.32. PREFERRED PROVIDERS

A "Preferred Provider" means any of the following who alone or as part of a group enter into a contract with the Trustees agreeing to be compensated for their services and supplies that are covered under this Plan in accordance with the terms of such contract:

A. Physician, Dentist, R.N., physical therapist, or other licensed health care Provider;

B. Hospital;

C. Alcohol and substance abuse treatment facility;

D. Hospice facility or Program;

E. Laboratory;

F. Outpatient surgical facility;

G. Pharmacy;

H. Business establishment selling or renting durable medical equipment; or

I. Any other source for services or supplies covered under this Plan.

Current types of Preferred Providers include the following:

A. Preferred Provider Prescription Drug Program. Preferred Providers under the Preferred Provider Prescription Drug Program include Pharmacies in the Prime Therapeutics Classic Network.

B. Preferred Provider Network. The Preferred Provider Network includes only those Hospitals, Physicians, and other health care professionals in the BlueCross BlueShield of Minnesota Network.

C. Delta Dental Network. The Delta Dental Network includes the Preferred Providers of Dental Care Benefits.

2.2. PRESCRIPTION DRUG BENEFITS

Only Prescription Medication purchased through the Prime Therapeutics Classic Network will be covered. Prescription Medication filled at CVS, Walmart, Target, Hy-Vee, Sam's Club, Costco, and Coborn's 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%

Certain drugs will be subject to a prior authorization and some will also be subject to "Step Therapy", split fills (i.e. a 30-day prescription will be filled in two 15-day increments to determine whether the drug is tolerated by participant to reduce waste) and quantity level limits (dispensing only quantities that will actually be used).

The Step Therapy program is a "step" approach to providing the medications that treat your condition. This means that you may first need to try a more clinically appropriate or cost-effective medication before certain higher-cost medications will be approved. Step Therapy programs can help both you and the Plan save money. A medication meets the Plan's Step Therapy requirements if it is the most cost-effective medication available to treat a disease or condition. This means that if your doctor prescribes you a new medication that is subject to the Plan's Step Therapy program, the Plan will initially only cover the least expensive "step" in that drug class, typically a generic drug. If the first step medication does not safely and effectively treat your condition, the Plan will cover the next "step", typically a formulary brand medication.

If your doctor recommends prescription drugs or quantities that do not comply with the prior authorization and/or Step Therapy protocols, your doctor will need to submit a prior authorization (PA) request that will include the medical reasons supporting that request to Prime Therapeutics. Your doctor can visit MyPrime.com to download the PA form. If, as of August 1, 2019, you have started use of a prescription under the Plan's schedule in a manner that does not follow the above rules, you will be grandfathered with regard to that prescription and with regard to the above rules for Step Therapy and prior authorization. To obtain a current list of these prescriptions, please call the Plan Administrator at (952) 851-5797.

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
One set per Eligible Person or Dependent Child under age 19 per Calendar year	100%
Frames	
One set per Eligible Person per Calendar Year Maximum payment per set	$70

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.

2.4. DENTAL CARE BENEFITS

"Dental Care Benefits" are payable for full-time Eligible Employees and their Eligible Dependents and part-time Eligible Employees (and their Dependent Children, if applicable). The maximum annual dollar limit of $1,250 described below in this Section does not apply to the following Dental Care Benefits for Eligible Employees or Eligible Dependents under age nineteen (19):

A. Routine dental examinations;

B. Sealants;

C. Dental prophylaxis;

D. Topical fluoride treatments; and

E. X-rays.

Below is the schedule of benefits for Dental Care Benefits for Eligible Persons.

Deductible amount per Eligible Person per Calendar Year for restorative and prosthetic services, including oral surgery	$25
Plan's Coinsurance Diagnostic and Preventive Services Restorative Services Prosthetic Services	 Plan pays 100% Plan pays 80% Plan pays 80%
Calendar Year maximum aggregate amount payable per Eligible Person for diagnostic and preventive, restorative, and prosthetic services	$1,250
Orthodontics Deductible Amount Plan's Coinsurance Orthodontic Lifetime maximum amount payable per Eligible Person Orthodontics services are available only for Eligible Dependents who are ages 8 through 18.	 No Deductible Plan pays 50% $1,500

2.5. WEEKLY DISABILITY INCOME BENEFITS

"Weekly Disability Income Benefits" are only available for full-time Eligible Employees.

Percentage of Average Weekly Wage	Plan pays 60%
Maximum weekly amount	$300
Maximum number of weeks	26

2.6. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

"Accidental Death and Dismemberment Benefits" are available for part-time Eligible Employees only and are insured through the Life Insurance Company.

F. Principal sum	G. $1,000

2.7. LIFE INSURANCE BENEFITS

"Life Insurance Benefits" are available for full-time Eligible Employees and their Dependents and part-time Eligible Employees (and their Dependent Children, if applicable) and are insured through the Life Insurance Company.

Full-time Eligible Employee	$25,000
Full-time Eligible Employee's Spouse	$2,000
Full-time Eligible Employee's Dependent Children:	
Fifteen (15) days to nineteen (19) years or twenty-five (25) years if full-time student	$2,000
Part-time Eligible Employee	$10,000

SECTION 3 PREFERRED PROVIDER NETWORKS

3.1. PREFERRED PROVIDER PRESCRIPTION DRUG PROGRAM

H. 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 ("Classic Network"). Only prescriptions that are purchased through this network will be covered.

3.1.1. 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 certain 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.

A modified part-time Employee will become eligible as a part-time Eligible Employee even if an occasional full-time contribution is made on behalf of such Employee.

Effective April 26, 2019, all regular part-time, Group 3 part-time, and modified part-time Eligible Employees may self-pay for Ancillary Benefits (Dental Care, Vision Care, Life Insurance, Accidental Death and Dismemberment, and Employee Assistance Program benefits) prior to the Effective Date of Eligibility referenced in Section 4.2, if allowed by the applicable collective bargaining agreement.

4.2. EFFECTIVE DATE OF ELIGIBILITY

A. An Employee becomes eligible under the Plan on the first day of the first month following satisfaction of the provisions in Section 4.1.C or 4.1.D.

B. Coverage for Dependents is provided for full-time Eligible Employees only. Dependents become eligible under the Plan on the first day of the first month following the month the Employee satisfies the provisions in Section 4.1.C. If an Employee acquires a Dependent after his or her effective date, the new Dependent will be covered on the date he or she becomes such a Dependent.

Part-time Eligible Employees may purchase coverage for their Dependent Children only. If a part-time Eligible Employee purchases coverage for a Dependent Child, the Dependent Child will be covered under the Plan on the first day of the first month following receipt of the part-time Eligible Employee's payment for such coverage. Parents and other relatives are not eligible for Dependent coverage even if they are supported by the Eligible Employee.

C. Opt-Out. An Eligible Employee may choose to "opt out" of coverage under the Plan for the Eligible Employee and his or her Dependents by completing and submitting the form designated by the Trustees to the Plan Administrator if both of the following circumstances are met:

1. The Eligible Employee has satisfied the initial eligibility provisions under the Plan; and
2. The terms of the collective bargaining agreement requiring contributions on behalf of the employee provide an "opt out of coverage" option.

If an Eligible Employee opts out of Plan coverage for himself or herself and his or her Dependents due to enrollment in other health insurance or group health insurance coverage, the Eligible Employee must state in writing that the Plan coverage is being declined due to enrollment in other health coverage at the time the Eligible Employee exercises his or her right to opt out of coverage under the Plan.

Except as provided in Section 4.2.D below, an Eligible Employee that opts out of Plan coverage for himself or herself and his or her Dependents will not be entitled to re-enroll in the Plan's coverage.

D. Special Enrollment Rights.

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your

4. Physical, occupational, speech, and respiratory therapy; and

5. Drugs and supplies prescribed by a Physician.

G. Genetic testing and counseling, provided services are rendered for one (1) or more of the following reasons:

1. The Eligible Employee and/or the Employee's Dependents suffer from a disease that is known to have a genetic cause;

2. A strong family history of a disease that is known to have a genetic cause is present even though neither the Eligible Employee, nor the Employee's Spouse has the disease. A strong family history means at least one (1) first-degree relative or at least two (2) second-degree relatives of the Employee or Spouse has been diagnosed with a disease that is known to have a genetic cause;

3. The Eligible Employee and/or Spouse has produced a Child with mental retardation, a disease known to have a genetic cause, or a birth defect; or

4. The Eligible Employee and/or a Spouse has had two (2) or more miscarriages or babies who died in infancy.

Genetic testing, except for amniocentesis and genetic testing that qualifies as Preventive Care, is subject to the separate annual maximum stated in the Schedule of Benefits.

H. Conditions related to Gender Dysphoria, including supportive mental health counseling and treatment of any additional comorbid mental health conditions, appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, or genital reconstructive surgery where those interventions and treatments comply with all other provisions of the Plan. Any limitations on mental health counseling will be consistent with corresponding limitations on medical/surgical benefits under the Mental Health Parity and Addiction Equity Act ("MHPAEA"). Appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, and genital reconstructive surgery will be provided only if:

1. The Eligible Employee and/or the Employee's Dependents have undergone evaluation by a Qualified Mental Health Professional ("QMHP") experienced in the evaluation and treatment of patients with a variety of mental health issues and has the requisite skill and experience in evaluation of patients with Gender Dysphoria and all relevant comorbid mental health conditions, including familiarity in

the application of the Diagnostic Statistical Manual of Mental Disorders ("DSM V"), or the then current version of the DSM.

A Provider will be considered a QMHP if the Provider is a board-certified psychiatrist, psychologist, or an in-network master's level Provider with a degree in a clinical behavioral science field from a nationally-accredited credentialing board and appropriately licensed in the jurisdiction in which the Provider practices and is qualified to evaluate and treat patients as noted above.

2. The Eligible Employee and/or the Employee's Dependent must satisfy all criteria in the current version of the DSM.

3. The Eligible Employee and/or the Employee's Dependent must have no confounding comorbid mental health conditions, which would be contraindications to treatment.

4. Treatment must have been recommended by a QMHP. The approval of the QMHP is to be administered so it does not constitute a prohibited non-quantitative treatment limitation ("NQTL") under the MHPAEA and the Plan imposes corresponding approval requirements for medical/surgical benefits.

5. Related surgical expenses are covered for an Eligible Employee and/or the Employee's Dependent, subject to the following conditions:

   (a) Well documented and persistent Gender Dysphoria;

   (b) The Eligible Employee and/or the Employee's Dependent must be age 18 or over;

   (c) Two referral letters from QMHPs as described above; one of which must be the Eligible Employee's and/or the Employee's Dependents treating mental health professional and second from an additional QMHP who has performed an appropriate evaluation of the Participant;

   (d) Documented control of any comorbid medical or mental health conditions that would render the Eligible Employee and/or the Employee's Dependents incapable of making a fully informed decision or interfere with the diagnosis of Gender Dysphoria and substantially diminish the likelihood of a reasonable treatment outcome;

(e) In the absence of a medical contraindication, complete twelve (12) months of continuous hormone therapy appropriate to the Eligible Employee's and/or the Employee's Dependents' gender goals and complete twelve (12) months of living in a congruent gender role;

(f) Obtain treatment from a Provider and facility with appropriate experience in the provision of the requested services; and

(g) Obtain precertification prior to surgical procedure.

6. Hormone therapy is covered for an Eligible Employees and/or Employee's Dependent under the Prescription Drug Benefit under the following conditions:

(a) Completion of evaluations as outlined and have a diagnosis of Gender Dysphoria with no contraindications to treatment;

(b) Treatment must be ordered and supervised by a Provider experienced in the treatment of individuals with Gender Dysphoria;

(c) The Eligible Employee and/or the Employee's Dependent must obtain precertification prior to beginning therapy; and

(d) The Eligible Employee and/or the Employee's Dependent must be age 18 or over.

I. Other covered expenses for:

1. Maternity and obstetrical services performed by a Nurse Midwife.

2. Local ground and air ambulance services to the nearest Hospital equipped to furnish the Medically Necessary treatment in a medical emergency, not for family convenience.

3. Blood and blood plasma.

4. Health Services provided for the treatment of a full-time Employee's emotionally handicapped Dependent Children and furnished by a Residential Treatment Facility (included in the inpatient maximum stated in the Schedule of Benefits).

5. Outpatient surgery performed in the outpatient department of a Hospital.

5.4.2. Successive Periods of Disability

Successive periods of disability separated by less than fourteen (14) days of continuous active employment will be considered one (1) period of disability unless they are due to separate and unrelated causes, in which case, the periods of disability will be deemed separate if the Employee returns to active work for at least one (1) day.

5.4.3. Maximum Payment Amount

Once the maximum benefit has been paid and the Eligible Employee has returned to work, the Employee will not be eligible for any further Weekly Disability Income Benefits until twelve (12) months from the date the Employee was paid the maximum benefit.

5.4.4. Limitations

Weekly Disability Income Benefits are not payable when the:

Eligible Employee is not under the care of a Physician;

Disability is due to a self-inflicted Injury, except when caused by or resulting from a physical or mental condition of the Eligible Employee;

Injury or illness arises out of, and in the course of, any occupation or employment for wage or profit; or

Eligible Employee has applied for pension benefits.

NOTE: Weekly Disability Income Benefits cannot be continued through self payments. However, an Employee may continue to self pay for all other coverage while collecting Weekly Disability Income Benefits.

5.5. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

I. Accidental Death and Dismemberment Benefits are available for part-time Eligible Employees only and are insured through the Life Insurance Company. In cases of conflict between this Summary Plan Description and the group policy, the group policy will govern.

5.5.1. Determination of Benefit Amount

If you suffer bodily injury caused by accidental means while you are a part-time Eligible Employee and the injury causes your death or any of the following specified losses within ninety (90) days of the date of the accident, the following benefits are payable based on the principal sum stated in the Schedule of Benefits:

(A) The principal sum for loss of life;

The principal sum for loss of two (2) limbs, sight of both eyes, or one limb and sight of one eye;

One-half of the principal sum for loss of one hand by severance at or above the wrist, loss of one foot by severance at or above the ankle, or irrecoverable loss of the entire sight of one eye; or

D. One-quarter of the principal sum for loss of thumb and index finger of either hand.

If you suffer more than one (1) loss in an accident, payment will be made only for the loss for which the larger amount is payable. The Trustees may, at their own expense, require a physical examination while considering your claim or, if you die, an autopsy where law permits.

5.5.2. Limitations

Accidental Death and Dismemberment Benefits do not cover losses from:

(A) Intentionally self-inflicted injury or suicide, except when caused by or resulting from a physical or mental condition of the Eligible Employee;

(B) Insurrection, war, or any act of war;

(C) Participation in a riot;

(D) Commission of an assault or felony;

(E) Disease of the body, mental infirmity, bacterial infection (unless the infection is a result of accidental injury), or the taking of poison.

5.6. LIFE INSURANCE BENEFITS

Life Insurance Benefits are available for full-time Eligible Employees and their Dependents and part-time Eligible Employees (and their Dependent Children, if applicable) and are insured through the Life Insurance Company. In cases of conflict between this Summary Plan Description and the group policy, the group policy will govern.

If you die from any cause, on or off the job, your Beneficiary will be paid the amount of insurance stated in the Schedule of Benefits. The benefit will be paid in full according to the terms of the policy upon receipt of your claim form, death certificate, and any other required supporting documentation.

Your Beneficiary designation and any change in Beneficiary must be filed in writing with the Fund Office on a properly completed form. It will become effective on the date the request is signed, provided the Life Insurance Benefit had not been paid already before the request is received. Your Beneficiary designation will be made available to you upon request at the Fund Office.

If you become disabled and subsequently die, and if anyone has paid expenses incurred because of your disability and death, the Plan may reimburse the amount paid, up to $500, from the Life Insurance Benefit. A satisfactory receipt will be proof of expense. The balance of the Life Insurance Benefit will be paid to your Beneficiary.

5.6.1. Designation of Beneficiary

If you do not designate a Beneficiary or if your Beneficiary does not outlive you, the life insurance amount will be paid in a single sum to the first of the following classes that survives you:

(A) Spouse;

Children;

Parents;

Brothers and sisters; or

Executors or administrators of your estate.

5.6.2. Coverage During Total Disability

If you become Totally Disabled before age sixty (60) and remain disabled, your Life Insurance Benefits may be continued with no additional cost to you as long as the disability continues. You must provide the Fund Office with written proof of your Total Disability within one (1) year of the date the disability begins, or as soon as reasonably possible. After the first two (2) years of disability, written proof of disability may be requested annually by Physicians chosen by the Life Insurance Company. The Life Insurance Company will pay for all such exams. Contact the Fund Office for details and appropriate forms to apply for waiver of premiums.

If you die within one (1) year after the date of termination of your insurance under the group life policy, but before written proof of your Total Disability has been received, then written proof that your Total Disability continued uninterrupted until the date of your death must be furnished within one year after your death occurs.

If an individual policy of life insurance has become effective for a Totally Disabled person according to the provisions of the conversion privilege set forth in the group life policy, the Total Disability benefits will apply to that person only if the individual policy is surrendered to the Company without claim thereunder other than for return of the premiums paid, less any indebtedness.

All rights under the Total Disability provisions listed in the group life policy will automatically and immediately cease on the earliest of the following dates:

(B) The date your Total Disability no longer exists;

The date you fail to submit to the required medical examination; or

The date you fail to submit any required proof of the uninterrupted existence of your Total Disability.

If a death benefit is paid under the Total Disability section of the group policy, it will be in lieu of all other life insurance benefits provided by the group life insurance.

5.6.3. Employee Continuance of Life Insurance

If your coverage for Life Insurance Benefits under the Plan ends because you are laid off, your employment ends, or you no longer satisfy the requirements for hours worked, you may continue life insurance for yourself and your Dependents for as long as eighteen (18) months by paying the required premium. You may not continue life insurance if your employment ends because you are discharged for gross misconduct or the policy is discontinued. The life insurance continued is the amount in force on the day insurance otherwise would have ended.

To continue life insurance, you must send the Fund Office written notice that you wish to continue life insurance along with the first monthly premium, payable at the Plan's full cost. You must do so within sixty (60) days of written notification from the Fund Office of your right to continue, including the premium amount and due date.

Continued life insurance ends on the earliest of:

(A) The day insurance has been continued for eighteen (18) months;

The day a conversion policy is obtained;

The day you obtain coverage under another group policy, contract, or plan; or

The day insurance otherwise would end according to policy provisions.

See the following section regarding conversion privilege when continued life insurance ends.

5.6.4. Conversion Privilege

If your life insurance terminates as a result of termination of employment, transfer to a class of employees not eligible under the policy, or your disability, you may convert your insurance (and insurance on your Spouse and Children if you are a full-time Employee) to any form of individual policy of life insurance (without double indemnity or disability riders) then customarily issued by the Life Insurance Company, except a policy of term insurance.

If the Master Policy terminates or is amended so as to terminate your insurance, and you have been insured under the policy for at least five (5) years, you may convert your insurance (and your Dependents' insurance if you are a full-time Employee) for an amount not in excess of the smaller of:

(B) $5,000 for Employees and $2,000 for Dependents; or

The amount of your terminated insurance, less any amount of life insurance for which you may be eligible under any other group policy that replaces it within thirty-one (31) days.

You have thirty-one (31) days to make application for conversion and pay the required premium following termination of your insurance. If you should die during this thirty-one (31)-day period, the amount of insurance that you would have had under the conversion

I. Surrogate maternity services.

J. Services for which the Eligible Person is not required to pay.

K. Transportation, except local emergency ambulance services.

L. Abortions.

M. Reversal or attempted reversal of a previous sterilization procedure.

N. Any services and supplies for, or related to, artificial insemination, invitro fertilization services, or other treatment in an attempt to achieve pregnancy.

O. Services to the clergy during normal duty when a charge usually would not be made.

P. Reversal of genital surgery; hair replacement or removal; voice therapy or lessons; liposuction; rhinoplasty; breast augmentation; lip reduction; lip augmentation; laryngeal or thyroid cartilage shaving or contouring; abdominoplasty; chest wall contouring; body contouring; facial contouring; skin resurfacing; collagen injections; reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or Gender Dysphoria surgery; cryopreservation of fertilized embryos; oocyte preservation; surrogate parenting; donor eggs; donor sperm and host uterus; or any other service considered to be cosmetic or not Medically Necessary under the Plan.

Q. Any diagnostic Hospital admission that can be performed on an outpatient basis.

R. The first $20,000 of charges incurred as a result of any automobile accident if:

   1. The Eligible Person fails to maintain the statutory minimum level of no fault automobile medical insurance protection, provided that the Eligible Person is required by applicable state law to maintain the protection;

   2. There is applicable no fault coverage but the Eligible Person has failed to apply for coverage;

   3. A no fault insurer has determined charges not to be Medically Necessary or Usual and Customary; or

   4. In states without a no fault statute, the Eligible Person does not first exhaust medical payment coverage on the vehicle(s) involved in the accident.

   In cases where a no fault carrier disputes coverage of the Eligible Person, the Plan may subrogate its interest in the payment of charges.

S. Costs associated with the removal of organs from a transplant donor who is a living Eligible Person or who was an Eligible Person prior to his or her death.

T. Services privately contracted with a provider that otherwise would be covered by Medicare that are incurred by an Eligible Person for whom Medicare is the primary source of coverage.

U. Charges incurred for obtaining additional medical records.

V. Claims submitted later that fifteen (15) months from the date incurred.

C. Apply the Trust Fund to pay for any and all obligations of the Trust and distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Trust and the requirements of law; and

D. Give any notices and prepare any reports that may be required.

9.7. FUNDING OF BENEFITS

Contribution payments are received and accepted by the Trustees from Employers party to collective bargaining agreements requiring the payment of contributions to this Plan in the amounts specified in the collective bargaining agreements. Self-payments from Eligible Employees with insufficient Employer contribution hours to maintain eligibility, former Employees, and retirees are received and accepted by the Trustees in amounts established by the Trustees from time to time. Investment earnings are used exclusively for providing benefits to Eligible Persons.

Benefits are provided directly from Plan assets, except that Life Insurance and Accidental Death and Dismemberment Benefits are provided through an insurance contract with the Life Insurance Company. Benefits eligible under the life insurance and accidental death and dismemberment policy are submitted to and paid by the Life Insurance Company.

All assets of the Plan are held by a custodian selected by the Trustees. A portion of Plan assets are allocated as reserves to provide future benefits under the Plan. The Trustees may, in their discretion, hire investment managers to invest any assets not needed for the immediate payment of benefits and other Plan expenses.

9.8. FUND RESERVES

The Trustees maintain a reserve that, in their sole judgment, is adequate to maintain the Plan. The Trustees' determination regarding the level of reserves considers the length of the collective bargaining agreements, total Plan costs including claims paid and payable, extended eligibility as provided in the Eligibility Rules, extensions of coverage for benefits if provided in the Plan, and any other data the Trustees may consider necessary.

9.9. LIMIT OF FUND LIABILITY

The Trustees maintain an excess Risk Indemnification Agreement that limits Plan liability for claims to an annual individual maximum. The individual maximum and other provisions are determined in accordance with the agreement, which is a part of the contract in effect between the Trustees and the contracting insurance carrier.

9.10. LIMITATION OF BENEFITS PAYABLE

Benefits otherwise payable under this Plan will be limited by the Plan's assets, regardless of accumulated eligibility.