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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: October 2021

This is a Summary of Material Modifications ("SMM") regarding the Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund (the "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. 14: COBRA Continuation Coverage and Medicare Eligibility

Effective October 14, 2020, the Plan has been amended to incorporate the Department of Labor's proposed notice to Participants and Beneficiaries regarding the interaction between COBRA continuation coverage and Medicare eligibility, which is summarized below.

You may have other options available to you other than COBRA continuation coverage if you lose group health coverage through the Plan. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees. There may also be other coverage options for you and your family through Medicare, Medicaid, Children's Health Insurance Program ("CHIP"), or other group health plan coverage options. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at https://www.healthcare.gov.

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period you have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

A. The month after your employment ends; or

B. The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A

or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. For more information, see https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information, visit https://www.medicare.gov/medicare-and-you.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator, whose contact information is below. For more information about your rights under the Employee Retirement Income Security Act ("ERISA"), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit https://www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Amendment No. 15: Tolling Period Updates

Effective April 9, 2021, in response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes relating to certain notification, payment, and claims-related deadlines for Plan participants and beneficiaries.

Starting on March 1, 2020, the timeframes for you to request special enrollment, elect COBRA coverage, make COBRA self-payments, notify the Plan of a qualifying event or determination of disability, file a claim, appeal an adverse benefit determination, or request an external review were suspended during a "Tolling Period," which ends on the earlier of:

- Sixty days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

- One year from the date you were first eligible for relief from the deadline or timeframe for a circumstance listed above. The earliest date that you were first eligible for relief from a deadline or timeframe for a circumstance listed above was either:

    - March 1, 2020 for events occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline or timeframe must have been on or after March 1, 2020; or

    - Upon the occurrence of an event initiating a deadline or timeframe occurring after March 1, 2020, but before March 1, 2021.

The following timeframes are disregarded during a Tolling Period:

- The 60-day window (or 30-day window in the case of acquiring a new Dependent) in which you must request special enrollment under the Plan;
- The 60-day window in which the Fund Office must be notified of a COBRA Qualifying Event;
- The 60-day window in which you may elect for COBRA continuation coverage;
- The 45-day deadline to make the initial COBRA self-payment and the 30-day grace period for making subsequent self-payments;
- The 60-day window in which the Qualified Beneficiary must notify the Plan Administrator of a Social Security Disability Determination;
- The 90-day deadline for filing a post-service claim;
- The 180-day window in which you may file an appeal of a denial of benefits; and
- The four-month window in which you may file a request for an external review.

Amendment No. 16: COBRA Subsidies and Extended Election Period

Effective April 1, 2021, the Plan was amended to provide subsidized COBRA continuation coverage and extended election opportunities as provided by federal law.

During the period from April 1, 2021 through September 30, 2021 (the "Subsidy Period"), any "Assistance Eligible Individual" is not required to make self-payments for COBRA continuation coverage. An "Assistance Eligible Individual" is an individual who is enrolled in COBRA continuation coverage during the Subsidy Period if he or she became eligible for COBRA continuation coverage due to a loss of coverage under the Plan resulting from the Employee's involuntary termination of employment (other than termination for gross misconduct) or a reduction of hours.

In addition, any individual who could be an Assistance Eligible Individual during the Subsidy Period except for the fact that he or she stopped making the required COBRA continuation coverage self-payments or never enrolled in COBRA continuation coverage is allowed another opportunity to elect (or re-elect) COBRA continuation coverage during the 60-day period following the date that he or she received the initial notice from the Plan Administrator about the special COBRA continuation coverage election opportunity. If an individual becomes an Assistance Eligible Individual enrolled in COBRA continuation coverage under this extended election period, the maximum COBRA continuation coverage period will not extend beyond the last day that the Assistance Eligible Individual would have been eligible for COBRA continuation coverage had he or she not stopped making self-payments or had enrolled in COBRA continuation coverage when it was first offered.

Subsidized COBRA continuation coverage will end if an Assistance Eligible Individual becomes eligible for coverage under another group health plan or Medicare. If this is the case, an Assistance Eligible Individual is required to notify the Plan Administrator about the group health plan or Medicare eligibility.

Amendment No. 17: Dental Care Benefits Schedule

Effective January 1, 2021, the Plan was amended to change the schedule for certain covered diagnostic and preventive dental services from a rolling 12-month basis to a Calendar Year basis.

Please update your Plan Document and Summary Plan Description booklet (dated September 1, 2017) to reflect these changes by inserting the attached replacement/supplemental pages 24, 24A, 25, 25A, 27, 27A, 27B, 27C, 30, 30A, 30B, 33, 33A, 33B, 57, 71, 71A, 76, 76A, 78, and 78A.

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

Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within thirty (30) days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Once you submit your enrollment request, your employer will again begin to make contributions to the Plan on your behalf.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within thirty (30) days after the date of marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at (844) 468-5917.

Notwithstanding any other provision of the Plan to the contrary, an Eligible Employee or Dependent is entitled to special enrollment rights under the Plan as required by applicable law under the following circumstances:

1. An Employee or 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 the Employee or Dependent requests coverage under the Plan not later than sixty (60) days after the date of termination of such coverage.

2. An Employee or 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 and the Employee or Dependent requests coverage under the Plan not later than sixty (60) days after the date the Employee or Dependent is determined to be eligible for the assistance.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes in which you must request special enrollment under the Plan for the circumstances listed above.

Starting on March 1, 2020, the deadline for you to request special enrollment under the Plan for the circumstances listed above was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date you were first eligible for relief from the deadline to request special enrollment under the Plan for the circumstances listed above. The earliest date that you were first eligible for relief from a deadline to request special enrollment under the Plan for the circumstances listed above was either:

1. March 1, 2020 for special enrollment events occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. Upon the occurrence of a special enrollment event occurring after March 1, 2020, but before March 1, 2021.

The calculation of your Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to you specifically. The Tolling Period may not exceed one (1) year. If your eligibility to request special enrollment under the Plan began prior to March 1, 2020, the number of days by which you are required to take action after the Tolling Period is shortened by the number of days between the date your eligibility to request special enrollment under the Plan began and March 1, 2020 (the "Proration Rule").

CAUTION – in order to be able to re-enroll or enroll a Dependent in the Plan after having opted-out, you must be eligible for coverage. If, during the time you were in opt-out status, you lost eligibility because your Employer had stopped making contributions on your behalf, you will be required to again meet the Plan's rules for eligibility before being allowed to resume coverage. For part-time Employees who have not had a break in service and full-time Employees, this means earning at least eight (8) weeks of contributions in twelve (12) consecutive weeks of employment. A part-time Employee who goes six (6) consecutive months with no Employer contributions will suffer a break in service. When that happens, the part-time Employee must re-qualify as a new Eligible Employee by working twelve (12) months during which at least one Employer contribution is made. These rules are further stated in Section 4.6.

4.3 CONTINUATION OF ELIGIBILITY THROUGH EMPLOYMENT

An Employee's continued eligibility is determined weekly. Once an Employee has established eligibility, it will continue so long as required Employer contributions to the Plan are made on the Employee's behalf for each subsequent week.

The amount of the Employer contribution is based on the number of hours worked per week, the Employee classification and the weekly rate specified by the collective bargaining agreement in effect at the time the contributions are earned. The collective bargaining agreement requires Employer contributions to be paid when an Employee meets the criteria for a specified employment classification (full-time Employee or modified part-time Employee) and works a specified amount of required hours. Generally, the amount of the Employer contribution determines whether the Employee is covered under as a full-time Eligible Employee or a part-time Eligible Employee.

If, in any week, an Employer does not make either the modified part-time or full-time contribution, as applicable, on an Employee's behalf because the Employee has not worked the required number of hours, the Employee may pay that weekly contribution himself to continue coverage, but only if actively working or scheduled to work.

In the event the minimum hourly requirements are not satisfied and all grace weeks have been used, the Employee will lose eligibility unless the Employee makes self-payments as provided in Section 4.5.

Continued eligibility will be given to Employees who are absent from active work due to work-related Injury up to a total of twenty-six (26) weeks inclusive of any Family and Medical Leave contribution requirement under Section 4.13.

4.4. EFFECTIVE DATE OF CHANGE IN COVERAGE

The amount and type of benefits payable are determined by the Plan under which the Employee is covered when the claim is incurred.

4.4.1. Full-Time Employees

If a full-time Eligible Employee works only the number of hours that require the Employer to make modified part-time contributions on the Employee's behalf, the plan of benefits that covers the Employee will change. In that event, the change in benefits will become effective on the first day following the end of the Employee's eight (8) week grace period (reduced by the number of grace weeks previously used).

If the full-time Eligible Employee continues to work part-time under the terms of the collective bargaining agreement with modified part-time contributions made on the Employee's behalf, the Eligible Employee will be eligible for modified part-time Eligible Employee benefits.

When the full-time Eligible Employee becomes eligible for modified part-time Eligible Employee benefits, he or she may purchase coverage for their Dependent Children only.

4.4.2. Part-Time Employees

In the event that a modified part-time Eligible Employee works the number of hours that require the Employee's Employer to make full-time contributions on the Employee's behalf, the Eligible Employee and the Employee's Dependents will become eligible for full-time benefits if the Eligible Employee is reclassified by the Employer as full-time and has eight (8) weeks of full-time contributions within a twelve (12) week period. Full-time coverage will become effective on the first day of the first month following the month in which the Employer paid contributions for eight (8) full-time weeks in a consecutive twelve (12)-week period.

4.5. CONTINUATION OF ELIGIBILITY THROUGH SELF-PAYMENTS AND COBRA CONTINUATION RIGHTS

When circumstances described in this Section cause a reduction in, or a loss of, coverage, some of the coverages in effect at the time can be continued by making self-payments. The following terms incorporate COBRA and HIPAA requirements as amended in all respects. Any future IRS guidance will be incorporated even if it conflicts with existing Plan provisions.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly

premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty (30) day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees. There may also be other coverage options for you and your family through Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight (8) month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

A. The month after your employment ends; or

B. The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. For more information, see https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information:

Minneapolis Retail Meat Cutters and Food Handlers Health and Welfare Fund
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Phone: (952) 851-5797

Employees and Dependents may, as Plan Participants or as Qualified Beneficiaries, continue coverage and eligibility for certain benefits subject to the following conditions:

Office within sixty (60) days of the Qualifying Event will cause a person to lose the opportunity to continue coverage.

Employers notify the Trustees of Qualifying Events, such as a reduction in an Employee's hours and an Employee ceasing active work, through the Employer Reports. Notices explaining the right to continue coverage will be furnished to Employees and Dependents when such a Qualifying Event occurs.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to notifying the Fund of a COBRA Qualifying Event.

Starting on March 1, 2020, the deadline to notify the Fund Office of a COBRA Qualifying Event was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the Qualified Beneficiary was first eligible for relief from a deadline related to notification of the Fund Office of a COBRA continuation coverage Qualifying Event. The earliest date that a Qualified Beneficiary was first eligible for relief from a deadline related to notification of the Fund Office of a COBRA continuation coverage Qualifying Event was either:

1. March 1, 2020 for a COBRA continuation coverage Qualifying Event occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. Upon the occurrence of a COBRA continuation coverage Qualifying Event after March 1, 2020, but before March 1, 2021.

The calculation of a Qualified Beneficiary's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each Qualified Beneficiary. The Tolling Period may not exceed one (1) year. If a COBRA continuation coverage Qualifying Event occurred prior to March 1, 2020, the number of days by which the Qualified Beneficiary is required to take action after the Tolling Period is shortened by the number of days between the date the Qualified Beneficiary was first required to notify the Fund Office of a COBRA continuation coverage Qualifying Event and March 1, 2020 (the "Proration Rule").

B. <u>The Trustees' Responsibility to Notify a Qualified Beneficiary When the Qualifying Event is Loss of Coverage Due to the Employee's Death, Divorce, or Legal Separation or a Dependent Child No Longer Meets the Definition</u>

of Dependent. Not later than fourteen (14) days after receipt of notice from an Employee or Dependent, the Fund Office will advise the Qualified Beneficiary of the coverages, options, costs, self-payment due dates, and duration of self-payment privileges.

C. The Trustees' Responsibility to Notify a Qualified Beneficiary When Other Qualifying Events Occur. Not later than thirty (30) days after receipt of notice of an Employee's loss of coverage from the Employer or by examining monthly contribution reports, the Fund Office will advise the Qualified Beneficiary of the coverages, options, costs, self-payment due dates, and duration of self-payment privileges.

D. Due Date for Qualified Beneficiaries' Response. A Qualified Beneficiary has sixty (60) days from the date of coverage termination or the receipt of the COBRA notice, whichever is later, to elect whether to continue coverage. The election must be communicated to the Fund Office in writing on an Election Form. Each Employee, Spouse, and Dependent Child has the right to make an individual election; however, covered Employees may elect to continue coverage on behalf of their Spouses, and parents may elect to continue coverage on behalf of their Children. Failure to state the election to the Fund Office within sixty (60) days from the date of coverage termination or the receipt of the COBRA notice, whichever is later, terminates rights to continued coverage.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to electing COBRA continuation coverage.

Starting on March 1, 2020, the deadline for a Qualified Beneficiary to elect COBRA continuation coverage was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the Qualified Beneficiary was first eligible for relief from a deadline to elect COBRA continuation coverage. The earliest date that a Qualified Beneficiary was first eligible for relief from a deadline to elect COBRA continuation coverage was either:

1. March 1, 2020 for COBRA continuation coverage election triggering events occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. Upon the occurrence of a COBRA continuation coverage election triggering event after March 1, 2020, but before March 1, 2021.

The calculation of a Qualified Beneficiary's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is

analyzed as to each Qualified Beneficiary. The Tolling Period may not exceed one (1) year. If the COBRA continuation coverage election triggering event occurred prior to March 1, 2020, the number of days by which a Qualified Beneficiary is required to take action after the Tolling Period is shortened by the number of days between the COBRA continuation coverage election triggering event and March 1, 2020 (the "Proration Rule").

A Qualified Beneficiary may elect COBRA continuation coverage up until sixty (60) days after the end of the Tolling Period, subject to the Proration Rule. The Plan must still provide a Qualified Beneficiary with COBRA continuation coverage election notices within the normal timeframe.

Under the Proration Rule, if a COBRA continuation coverage election triggering event occurred prior to March 1, 2020, the extension periods are shortened by the number of days between the event and March 1, 2020.

E. Due Dates for Self-Payments.

1. The required initial self-payment must be made to the Fund Office not later than forty-five (45) days following the election to continue coverage (which is the post-mark date, if mailed). Failure to do so will cause eligibility and coverage to terminate retroactively to the later of the Qualifying Event or loss of eligibility and will cause loss of all continuation coverage rights under the Plan. The amount of the first self-payment is for the time period beginning with the date of the Qualifying Event and extending through the month in which payment is made.

2. Subsequent monthly self-payments must be made to the Fund Office by the first day of the month for that month of coverage. The Plan allows a thirty (30) day grace period for making self-payments.

3. In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor guidance providing extended timeframes related to COBRA Continuation Coverage.

   Starting on March 1, 2020, the deadline to make the first COBRA continuation coverage payment was suspended during a "Tolling Period" which ends on the earlier of:

   Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the COBRA continuation coverage Qualified Beneficiary was first eligible for relief from the deadline to make the first COBRA continuation coverage payment. The earliest date that a COBRA continuation coverage Qualified Beneficiary was first eligible for relief from a deadline related to making the first COBRA continuation coverage payment was either:

1. March 1, 2020 for COBRA continuation coverage payment grace periods ending on or before March 1, 2020. To be in this window, the last day of the grace period must have been on or after March 1, 2020; or

2. The last date of a COBRA continuation coverage payment grace period after March 1, 2020, but before March 1, 2021.

The calculation of a Qualified Beneficiary's Tolling Period and relief from deadlines and suspension of certain requirements is fact specific and is analyzed as to each Qualified Beneficiary. The Tolling Period may not exceed one (1) year. If the COBRA continuation coverage payment grace period began but did not end prior to March 1, 2020, the number of days by which a COBRA continuation coverage payment grace period ends after the Tolling Period is shortened by the number of days by which the payment due date preceded March 1, 2020 (the "Proration Rule").

1. The Employee has remained continuously employed by the same Employer; and

2. The Employee is ready, willing, and able to return to full-time employment when it becomes available.

B. Cessation of Active Work.

1. If an Employee ceases active work due to lay-off, work stoppage, resignation, or dismissal, coverage may be continued for up to eighteen (18) months from the time coverage ceases.

2. If an Employee ceases active work due to a disability or sick leave:

(a) The Employee may continue coverage for of eighteen (18) months; or

(b) The Employee (or any other Qualified Beneficiary) may continue coverage for him or herself and his or her Dependents for up to twenty-nine (29) months of disability if:

i. The Social Security Administration (SSA) determines that any of the Qualified Beneficiaries are disabled under the Social Security Act either: (i) at the time employment terminated or hours were reduced; or (ii) at any time within sixty (60) days of the Qualifying Event;

ii. The disability lasts at least until the end of the eighteen (18) month period of continuation coverage; and

iii. The Qualified Beneficiary notifies the Fund Office in writing 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 Social Security Disability Determination to the Fund Office.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to the sixty (60) day window in which the Qualified Beneficiary must notify the Fund Office of a Social Security Disability Determination.

Starting on March 1, 2020, the sixty (60) day window in which the Qualified Beneficiary must notify the Fund Office of a Social Security Disability

Determination was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the Qualified Beneficiary was first eligible for relief from a deadline to request extended COBRA continuation coverage due to Social Security disability. The earliest date that a Qualified Beneficiary was first eligible for relief from a deadline to request extended COBRA continuation coverage due to Social Security disability was either:

1. March 1, 2020 for Social Security disability determinations occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. Upon the occurrence of a Social Security disability determination after March 1, 2020, but before March 1, 2021.

The calculation of a Qualified Beneficiary's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each Qualified Beneficiary. The Tolling Period may not exceed one (1) year. If the Social Security disability determination occurred prior to March 1, 2020, the number of days by which a Qualified Beneficiary is required to take action after the Tolling Period is shortened by the number of days between the Social Security disability determination and March 1, 2020 (the "Proration Rule").

A Qualified Beneficiary's obligation to notify the Plan of a disability qualifying for a disability extension of COBRA Continuation Coverage is extended to sixty (60) days after the end of the Tolling Period, subject to the Proration Rule.

Under the Proration Rule, if a disability occurred prior to March 1, 2020, the extension periods are shortened by the number of days between the event and March 1, 2020.

Each Qualified Beneficiary who has elected continuation coverage will be entitled to the eleven (11) month disability extension if one (1) of them qualifies. If the Qualified Beneficiary is determined by SSA to no longer be disabled, the Qualified Beneficiary must notify the Fund Office within thirty (30) days after the SSA determination.

Failure to provide notice of a disability may affect the right to extend the period of continuation coverage.

[SECTION CONTINUES ON NEXT PAGE]

I. For a Qualified Beneficiary who was entitled to the additional eleven (11) months continuation coverage based on a disability extension, eligibility for continuing the disability extension will terminate when there has been a final determination that the disability no longer exists.

Continuation coverage also may be terminated for any reason the Plan could terminate coverage of a Participant or Dependent not receiving continuation coverage (such as fraud).

4.5.8. Temporary Waiver of COBRA Continuation Coverage Self-Payments

An Assistance Eligible Individual is not required to make any required self-payments for COBRA continuation coverage for any period of coverage during the period from April 1, 2021 through September 30, 2021 (the "Subsidy Period") and is treated as having made such self-payments for all purposes.

An Assistance Eligible Individual is not eligible for relief from the requirement to make self-payments for COBRA continuation coverage during the Subsidy Period described in this section for any month of coverage that begins on or after the earlier of:

A. The first date that the Assistance Eligible Individual is eligible for coverage under any other group health plan (other than a group health plan that consists of only excepted benefits), a flexible spending arrangement, a qualified small employer health reimbursement arrangement, or Medicare; or

B. The earlier of:

1. The date following the expiration of the Assistance Eligible Individual's maximum period of COBRA continuation coverage; or

2. The date following the expiration of the period of COBRA continuation coverage as extended by Section 4.5.9.

For periods of COBRA continuation coverage following the Subsidy Period, Assistance Eligible Individuals who remain eligible for and continue COBRA continuation coverage must make the applicable required self-payment in accordance with the Plan's regular COBRA self-payment rules.

4.5.9. Temporary Extension of COBRA Election Period

Any individual who, as of April 1, 2021, would be an Assistance Eligible Individual except for the fact that he or she does not have a COBRA continuation coverage election in effect or has discontinued COBRA continuation coverage before April 1, 2021 prior to the expiration of his or her initial COBRA continuation coverage period, is eligible to elect (or re-elect, as the case may be) COBRA continuation coverage during the period from April 1, 2021 through the date that is 60 days after the date that the Plan Administrator provides the individual with the notice required by Section 4.5.10.

If a Qualified Beneficiary elects (or re-elects) COBRA continuation coverage pursuant to the extended election period described in this section, such COBRA continuation coverage will become effective on the first date of the coverage period that begins on or after April 1, 2021, but such COBRA continuation coverage will not extend beyond the last date

that such Assistance Eligible Individual would have been eligible for COBRA continuation coverage in the absence of the temporary extended election period described in this section.

4.5.10. Notice to Assistance Eligible Individuals

The Plan Administrator is required to provide Assistance Eligible Individuals and individuals described in Section 4.5.9 who became entitled to elect COBRA continuation coverage before April 1, 2021 with notice of the availability of and information about COBRA continuation coverage self-payment assistance, along with the forms required to establish eligibility for self-payment assistance, no later than 60 days after April 1, 2021.

4.5.11. Requirement to Report Notice of Eligibility for Another Group Health Plan or Medicare

Any Assistance Eligible Individual who becomes ineligible for the temporary waiver of the requirement to make COBRA continuation coverage self-payments during the Subsidy Period under Section 4.5.8(A), due to eligibility for another group health plan or Medicare must notify the Plan in accordance with rules established by the Plan Administrator.

4.5.12. Assistance Eligible Individual

An Assistance Eligible Individual is, with respect to any period of COBRA continuation coverage during the period beginning on April 1, 2021 and ending on September 30, 2021, a COBRA Qualified Beneficiary who elects COBRA continuation coverage and became eligible for COBRA continuation coverage due to a loss of coverage resulting from either the Employee's termination of employment (other than the Employee's voluntary termination of employment or involuntary termination of employment due to the Employee's gross misconduct) or a reduction in the Employee's hours of employment.

4.6. REINSTATEMENT OF COVERAGE

4.6.1. Full-Time Eligible Employees

If a full-time Eligible Employee's coverage terminates, the Employee may be reinstated on the first of the month following the date when eight (8) weeks of Employer full-time contributions have been paid to the Fund on the Employee's behalf during a consecutive twelve (12) week period.

4.6.2. Part-Time Eligible Employees

If a part-time Eligible Employee loses eligibility, but does not incur a break in service (as defined below), he may regain eligibility by completing twelve (12) consecutive weeks of employment during which at least eight (8) weeks of part-time contributions are made to the Plan.

A break in service is the longer of: (A) a period of six (6) consecutive months during which no Employer contributions are made on an Employee's behalf; or (B) the length of an approved leave of absence. If an Employee loses eligibility after having incurred a break in service, he may regain eligibility by once again satisfying the requirements for initial eligibility. Part-time eligibility credit for months preceding a break in service is forfeited and does not count for purposes of obtaining eligibility.

These rules apply when an Employee who has opted-out of Plan coverage seeks to opt-in (and again become and Eligible Employee) under the Special Enrollment Rights stated in Section 4.2.D.

4.7. TERMINATION OF EMPLOYMENT

In the event an Eligible Employee's employment is terminated, the Employee's eligibility will continue under the Plan for the number of grace weeks the Employee has accrued (as provided below).

Each Eligible Employee who has qualified for health care benefits, for either full-time or modified part-time coverage, will accumulate a total of eight (8) grace period weeks. The Fund Office will use one (1) grace week whenever a current weekly contribution is not received for the coverage in effect. When all of the grace weeks have been used and there are no current contributions, the Employee's full-time or modified part-time coverage, whichever applies, will be terminated. However, the Employee still has, the option of continuing coverage.

It is each Employee's responsibility to keep track of any grace weeks used. An Employee may make contributions on his or her behalf in lieu of using any grace weeks OR may buy back any grace weeks used. However, such option must be exercised within sixty (60) days of the date the Eligible Employee is notified of either the Employee's termination of coverage or the Employee's reduction to modified part-time Employee status. Employees who are currently working or

5.3.7. Description of Services

Dental Care Benefits are subject to the maximums stated in the Schedule of Benefits in Section 2.4, the limitations described within each coverage category, and the exclusions specified in Section 5.3.8.

A. Diagnostic and Preventive Services. The below diagnostic and preventive services are covered.

1. Examinations, no more frequently than two (2) in a Calendar Year. Coverage will be provided for two (2) additional oral examinations each Calendar Year, provided such services are Medically Necessary due to a systemic disorder. Such services will require Predetermination.

2. Full mouth x-rays once each three (3) years.

3. Two (2) bitewing x-rays, no more frequently than twice in a Calendar Year.

4. Panagraphic x-rays once each three (3) years unless special need is indicated.

5. Dental prophylaxis (teeth cleaning), limited to two (2) in a Calendar Year. Coverage will be provided for two (2) additional prophylaxes each Calendar Year, provided such services are Medically Necessary due to a systemic disorder. Such services will require Predetermination.

6. Topical fluoride treatments for Eligible Persons under age nineteen (19), limited to once in a Calendar Year.

7. Oral hygiene instruction when prescribed by a Dentist but limited to once in a Calendar Year.

8. Sealants for Eligible Persons under age nineteen (19). No charges for dental fillings or reapplications of sealants will be payable within three (3) years after the initial sealant has been applied.

B. Restorative Services. The below restorative services are covered.

1. Emergency treatment for the relief of pain.

2. Space maintainers.

3. Restorations of amalgam, silicate, synthetic porcelain, acrylic, plastic, resin (white), or composite type filling material. Gold foil

SECTION 7 CLAIMS, REVIEW, AND APPEAL PROCEDURES

7.1. CLAIMS PROCEDURE

The following procedures have been established by the Trustees for processing claims. For claims involving Plan benefits that are insured, the terms of the insurance policy will govern in the event of a conflict.

7.1.1. Notice of Claim

A. Pre-Service Claims. An Eligible Person must obtain:

1. Prior authorization for prophylactic mastectomies;

2. Certification of Medical Necessity for chiropractic visits exceeding twenty (20) per Eligible Person per Calendar Year;

3. Prior approval for the purchase of certain durable medical equipment specified in Subsection **Error! Reference source not found.**; and

4. Predetermination for certain dental services as specified in Section **Error! Reference source not found.**.

The claims listed above are called "pre-service claims," which are claims that require approval of the benefit in advance of obtaining medical care. Claims requiring prior authorization must be submitted in writing to the Fund Office.

There are special provisions in the Claims Procedure Regulations for "urgent care claims" (referred to under the Plan as "emergencies"), but, by definition, these provisions do not apply because the Plan does not require prior authorization of emergency admissions.

B. Post-Service Claims. Any Claim for benefits that is not a pre-service claim is considered a "post-service claim." An Eligible Person must submit all post-service claims in writing within ninety (90) days of the occurrence of the accident or Illness or as soon as reasonably possible. In no event (except in the absence of legal capacity) can a claim be submitted later than fifteen (15) months from the date of service.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing a post-service claim.

Starting on March 1, 2020, the deadline to file a post-service claim was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the Eligible Person was first eligible for relief from the deadline related to filing a post-service claim. The earliest date that an Eligible Individual was first eligible for relief from a deadline related to filing a post-service claim was either:

1. March 1, 2020 for medical services provided on or before March 1, 2020, including periods during which a claim was required or permitted to be filed that began before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. The date medical services were provided after March 1, 2020, but before March 1, 2021.

The calculation of an Eligible Person's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each Eligible Person. The Tolling Period may not exceed one (1) year. If the medical services were provided prior to March 1, 2020, the number of days by which an Eligible Person is required to take action after the Tolling Period is shortened by the number of days between the date that medical services were provided and March 1, 2020.

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

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.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing claim appeals.

Starting on March 1, 2020, the deadline to file a claim appeal was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the claimant was first eligible for relief from a deadline related to filing a claim appeal. The earliest date that a claimant was first eligible for relief from a deadline related to filing a claim appeal was either:

1. March 1, 2020 for claim denials or adverse benefit determinations occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. The date of a claim denial or adverse benefit determination was after March 1, 2020, but before March 1, 2021.

The calculation of a claimant's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each claimant. The Tolling Period may not exceed one (1) year. If the claim denial or adverse benefit determination occurred prior to March 1, 2020, the number of days by which a claimant is required to take action after the Tolling Period is shortened by the number of days between the date of the claim denial or adverse benefit determination and March 1, 2020.

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.

7.4. EXTERNAL REVIEW

The Plan will permit external review of benefit determinations in accordance with Section 2719 of the Public Health Service Act and its implementing regulations. If the Plan denies your claim and your appeal, you may seek external review of the Plan's decision. To seek external review, you must file a request with the Fund Office within four (4) months from the date your receive notice that the Plan denied your appeal. For more information on external review, contact the Fund Office.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing a request for an external review.

Starting on March 1, 2020, the deadline to file a request for an external review was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the claimant was first eligible for relief from the deadline related to filing a request for an external review. The earliest date that a claimant was first eligible for relief from a deadline related to filing a request for an external review was either:

1. March 1, 2020 for claim appeal denials occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. The date of a claim appeal denial after March 1, 2020, but before March 1, 2021.

The calculation of a claimant's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each claimant. The Tolling Period may not exceed one (1) year. If the claim appeal denial was provided to the claimant prior to March 1, 2020, the number of days by which the claimant is required to take action after the Tolling Period is shortened by the number of days between the date that the claim appeal denial was provided and March 1, 2020.

7.5. PHYSICAL EXAMINATIONS

The Plan, at its own expense, will have the right and opportunity to examine an Eligible Person whose Illness is the basis of a claim when, and as often as, it may reasonably require during pendency of a claim under the Plan.

7.6. RECORDS

Each Eligible Person authorizes and directs any provider that has attended, examined, or treated him to furnish the Fund, at any time upon its request, any and all information and records or copies of records relating to provided services. The Fund agrees that any information and records obtained pursuant to this Section will be considered confidential and will be protected in accordance with HIPAA requirements and Section 10.2.

7.7. ACTIONS AGAINST THE PLAN

No Eligible Person may bring an action at law or in equity, including proceedings before administrative agencies, to recover from the Plan until the Claims Review and Appeal Procedure stated in Section 7.2 has been exhausted. No action may be brought at all unless it is brought within two (2) years from the time the claim was required to be filed with the Plan.

7.8. ASSIGNMENT OF RIGHTS AND APPOINTING AN AUTHORIZED REPRESENTATIVE TO ACT ON YOUR BEHALF

An authorized or legal representative may act on behalf of a claimant in filing a claim or pursing an appeal of an adverse benefit determination. The claimant must first submit a signed letter to the Fund Office specifically identifying the person as the authorized or legal representative of the claimant. Neither the claimant nor any duly authorized representative will have the right to make a personal appearance before the Board of Trustees or any committee created by the Board of Trustees. Although a claimant may appoint an authorized representative to act on their behalf, under no circumstances may a claimant assign any rights under the Plan or ERISA, including any rights to appeal adverse benefit determinations or any causes of action that may arise after the denial of benefits.