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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: August 2018

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 Summary Plan Description and Plan Document (amended and restated September 1, 2017) as indicated below.

Amendment No. 2: Coverage exclusion for out-of-network non-emergency inpatient treatment and services

Effective October 1, 2018, the Plan has been amended to exclude coverage for charges related to out-of-network inpatient services unless it is a "Medical Emergency." For purposes of this coverage exclusion, the term "Medical Emergency" means a condition that starts suddenly and requires immediate care (within forty-eight (48) hours) to prevent serious harm to a major organ, life, or limb.

Please update your Summary Plan Description and Plan Document booklet (dated September 1, 2017) to reflect these changes by inserting replacement pages 16, 16A, 20, 21, 44, 49, 70 and 73 into your booklet to replace existing pages.

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

SECTION 2 SCHEDULE OF BENEFITS

2.1. COMPREHENSIVE MAJOR MEDICAL BENEFITS

Below is the schedule of benefits for "Comprehensive Major Medical Benefits."

PLEASE NOTE: Out-of-network non-emergency inpatient services are excluded from coverage (see Section 6).

Deductible amount per Calendar Year	
Per Eligible Person	$750
Per Family	$2,250
Copayment	$25 per office visit $50 per specialist visit $250 per emergency room visit
Plan's Coinsurance (including In-Hospital and Physician's Services and Out-of-Hospital Major Medical Services)	Plan pays 80%
Out-of-pocket maximum per Calendar Year (including the deductible)	
Per Eligible Person	$3,000
Per Family	$6,000
The Plan generally pays 100% of covered expenses in excess of the out-of-pocket maximum for remainder of that Calendar Year	
Preventive Care (including routine immunizations that are Preventive Care)	Plan pays 100%
Routine Physical Examinations that are not Preventive Care per Eligible Person per Calendar Year	Plan pays 100%
Doctor on Demand	Plan pays 100%

The following are specific maximum amounts applicable to certain services and supplies covered under the Plan's Comprehensive Major Medical Benefits provisions.

Organ Transplants (other than Essential Health Benefits) Maximum for professional services per transplant per donor Maximum for private nursing care per transplant per donor	 $10,000 $10,000
Skilled Nursing Home Care Maximum number of days per Eligible Person per confinement	 30
Chiropractic Care Maximum number of visits per Eligible Person per Calendar Year	 20
Genetic Testing and Counseling (other than amniocentesis, Preventive Care, and Essential Health Benefits) Maximum per Eligible Person per calendar year	$2,000
Hearing Aid Appliances Maximum per ear per benefit period	$500
Wigs and Toupees Maximum per lifetime per Eligible Person	$300

SECTION 3 PREFERRED PROVIDER NETWORKS

3.1. PREFERRED PROVIDER PRESCRIPTION DRUG PROGRAM

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

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

3.1.1. 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.

3.2.1. Payment of Benefits

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

For charges incurred with PPO Providers, the Plan will pay a discounted amount. Such providers have agreed to accept payment from the Plan as payment in full, except for applicable deductibles, coinsurance, copayments, maximum benefit limitations or other similar limitations under the Plan.

For charges incurred with Non-PPO Providers within the geographic area of the BlueCross BlueShield of Minnesota AWARE Network, the Plan will pay the Usual and Customary Charge or, if applicable, a separately negotiated amount to the Non-PPO Provider. Additionally, the Eligible Person will be responsible for applicable deductibles, coinsurance, copayments, maximum benefit limitations, and other similar limitations under the Plan and may be billed for the balance by the Non-PPO Provider.

Charges incurred with non-PPO Providers outside the geographic area of the BlueCross BlueShield of Minnesota AWARE Network will generally come through BlueCross' Blue Card Program. The Plan will pay the reasonable expense, as defined in the Blue Card Host Plan in the Blue Card System or, if applicable, an amount separately negotiated with the non-PPO Provider. The Eligible Person will be responsible for applicable deductibles, coinsurance, copayments, maximum benefit limitations, or other similar limitations under the Plan and may be billed for the balance by the non-PPO Provider.

3.2.2. BlueCross BlueShield Healthy Start Prenatal Support Program

Employees and Eligible Dependents have access to the Healthy Start Prenatal Support Program offered by BlueCross BlueShield of Minnesota. This program is designed to assess, educate, and support pregnant women to achieve an optimal childbirth outcome.

The Plan will pay for the cost of participation and a $50.00 gift card sent to those completing the program.

Additionally, if an Eligible Person enrolls in the Healthy Start Prenatal Support Program prior to the second trimester of pregnancy, the Plan will pay benefits for such pregnancy and delivery-related expenses at ninety percent (90%) instead of eighty percent (80%).

If an Eligible Person is expecting, she should call Healthy Start at 651-662-1818 or 866-489-6948 before the second trimester to enroll and obtain the maximum benefits possible.

3.3. ELIGIBLE PERSON'S CHOICE OF COVERED HEALTH CARE PROVIDER

Eligible Persons will have the sole right to select their own Physician, Dentist, Hospital, and other covered health care Providers.

PLEASE NOTE: Out-of-network non-emergency inpatient services are excluded from coverage (see Section 6).

as Injury, Illness, congenital defect, or premature birth) that requires treatment, no coverage will be provided for any expenses incurred by the newborn Dependent Child including charges for Hospital confinement.

2. Confinement in an Intensive Care Unit, including confinement in duration of twenty-four (24) or more consecutive hours in a recovery room of a Hospital if the Eligible Person receives the same care and services as those normally provided in the Intensive Care Unit of the Hospital.

3. Drugs, medicines, diagnostic x-rays, and laboratory tests, and other miscellaneous Hospital services and supplies not included in the room charges (including the anesthetist's fee when charged by the Hospital), if used while confined in the Hospital as a resident patient or while in the outpatient department of the Hospital when outpatient surgery is performed (see paragraph (h) (vi) for coverage of pre-admission testing).

4. Services for confinement in a Hospital and services provided in an intensive day treatment program that are related to treatment of mental Illness or nervous disorders. These services are payable the same as for any other disability.

5. Services provided for treatment during confinement in a Hospital or Residential Treatment Program for the treatment of alcoholism, chemical dependency, and substance abuse are payable the same as for any other disability.

   Inpatient charges incurred at a detoxification center are not covered unless the center is located within a Hospital or Residential Treatment Program and appropriate medical or psychiatric care is being provided. Confinement strictly for custodial care and out-of-network non-emergency inpatient services or treatment are not covered.

Under federal law, The Plan generally may not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a Provider obtain authorization from the Plan for prescribing a Hospital length of stay not in excess of these periods. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) or ninety-six (96) hours, as applicable.

Successive Hospital confinements will be considered one (1) confinement unless they are due to entirely unrelated causes or:

1. If the Eligible Person is an active Eligible Employee, the Eligible Person has returned to active work for at least one (1) full working day before the subsequent confinement begins; or

6. Outpatient pre-admission tests and exams provided that:

   (a) The surgery for which the tests or exams are furnished is performed within seventy-two (72) hours of the date on which they were given; and

   (b) The Eligible Person is confined as an inpatient in the in-network Hospital immediately following the surgery.

7. Emergency room treatment for accidental Injury or acute medical emergency. Diagnoses that generally would not qualify as acute medical emergencies include:

   (a) Scheduled diagnostic procedures;

   (b) Follow-up visits for further injections, such as antibiotics;

   (c) Suture removal; and

   (d) Urgent but not life-threatening conditions that are normally treated in a Physician's office, such as, but not limited to, ear ache, sore throat, upper respiratory infections, flu syndrome, and migraine headaches.

8. Services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for private duty nursing, other than a nurse who ordinarily resides in the Eligible Employee's home or is a member of the Employee's immediate family.

9. Artificial limbs or eyes to replace natural limbs or eyes, provided that replacement occurs promptly following the loss and in no event longer than twelve (12) months from the date of the loss, and repair or replacement of artificial limbs or eyes when Medically Necessary.

10. Casts, splints, trusses, braces, crutches, surgical dressings, and prosthetic appliances used only for medical treatment.

11. Rental of Hospital-type bed, wheelchair, iron lung, or other durable medical equipment. (The purchase of such device is covered if the rental would exceed the purchase price. However, the Fund Office must approve the purchase of any durable medical equipment.)

12. X-ray, radium, or cobalt treatment, including the services of a radiologist and the rental, but not the purchase, of such radioactive materials.

13. Outpatient radiation and chemotherapy treatment services.

14. Oxygen and the rental of equipment for its administration. (The purchase of such equipment is covered if the rental would exceed

2. Either:

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

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

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

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

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

2. Has recovered from a third party; or

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

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

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

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

NN. Charges for out-of-network inpatient services unless it is a "Medical Emergency." For purposes of this coverage exclusion, the term "Medical Emergency" means a condition that starts suddenly and requires immediate care (within forty-eight (48) hours) to prevent serious harm to a major organ, life, or limb.

charged an improper dollar copayment or percentage coinsurance (for example through the Preferred Provider Prescription Drug Program), he or she may submit a formal appeal to have his or her claim reviewed according to the claims review and appeal procedure. The appeal must be submitted to the Fund Office in writing within one hundred eighty (180) days of being charged the coinsurance or copayment.

7.1.3. Determination of Eligibility

On receipt of the completed claim form, the Fund Office will determine, based upon Trust Plan records, whether the claimant was eligible for benefits at the time the charges were incurred. The Fund Office also will assist Eligible Persons in obtaining benefits to which they are entitled.

7.1.4. Determination of and Amount of Benefits Payable

The determination of benefits payable will be based upon the claimant's eligibility and the provisions of the Plan. The amount of benefits payable will be based on the Schedule of Benefits in effect for the applicable class of Eligible Person when the covered charges were incurred.

The determination of the type of benefits payable, if any, and the amount of benefits payable will be the function and responsibility of the claims agent named by the Trustees.

7.1.5. Distribution of Benefits Payments

Generally, benefits the Fund Office determines are payable are automatically paid directly to the provider of service if: (i) the charges were incurred with PPO Providers or Non-PPO Providers outside the geographic area of the Blue Cross Blue Shield of Minnesota Aware Network (subject to the exclusions and limitations provided in Section 6); and (ii) the Fund Office accepts a request to pay the claims directly to the Providers. The Eligible Person will be sent a copy of the processed claim payment for the Eligible Person's records. If the Fund Office does not accept a request to pay the providers directly, or the charges were incurred with Non-PPO Providers within the geographic area of the Blue Cross Blue Shield of Minnesota Aware Network, benefits will be paid directly to the Eligible Person upon proper submission of the claim and proof of payment.

Although the Plan may make payments directly to providers, such payments do not make a provider an assignee for any purposes or otherwise confer on the provider any rights under the Plan or ERISA. Any attempt to assign any rights, claims or causes of action to any person or entity will be null and void absent written consent by the Plan.

7.2 CLAIMS REVIEW PROCEDURE

When a claim for benefits is submitted to the Fund Office, the Fund Office will determine eligibility and calculate the amount of benefit payable, if any.

If the claimant feels that the action taken on his eligibility or claim is incorrect, the claimant immediately must ask the Fund Office to review the claim with him. In some cases, the Fund Office may request additional information that might enable the Fund Office to reevaluate its decision.