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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 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. 11: COVID-19 Coverage Revised

Effective April 1, 2020, the Plan has been amended to remove the end date of April 30, 2020 for coverage of diagnostic testing and diagnosis for COVID-19 and to provide coverage for the duration of the national emergency surrounding COVID-19. The Plan also removed the exclusion for telehealth visits and provides coverage for telehealth visits, other than through Doctor on Demand, at the regular cost sharing amounts, unless the visit is for COVID-19, in which case the visit is covered at 100% (no member cost share).

Amendment No. 12: Extension of Coverage for Cancelled Procedures

Effective March 1, 2020, the Plan has been amended to extend coverage through December 31, 2020 for a medical or dental procedure for Participants or any Dependents who had the procedure scheduled prior to the declaration of the national emergency concerning COVID-19 but the procedure was then canceled due to COVID-19 and who lost coverage prior to the procedure being completed.

Amendment No. 13: Extension of Timeframes for Outbreak Period

Effective May 4, 2020 the Plan has been amended to adopt the Department of Labor's regulations regarding extending timeframes for special enrollment, COBRA coverage, COBRA payments, notification of a qualifying event or determination of disability, filing a claim, appealing an adverse benefit determination, and requesting an external review.

The Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known

as the “Outbreak Period.” During the Outbreak Period, the following timeframes are disregarded and will resume at the end of the “Outbreak Period.”

- The sixty (60) day window (or thirty (30) day window in the case of acquiring a new Dependent) in which you must request special enrollment under the Plan;
- The sixty (60) day window in which the Fund Office must be notified of a COBRA Qualifying Event;
- The sixty (60) day window in which you may elect for COBRA continuation coverage;
- The forty-five (45) day deadline to make the initial Self Payment, and the thirty (30) day grace period for making subsequent self-payments;
- The sixty (60) day window in which the Qualified Beneficiary must notify the Fund Office of a Social Security Disability Determination;
- The ninety (90) day deadline for filing a post-service claim;
- The one hundred eighty (180) day window in which a claimant may file an appeal of a denial of benefits; and
- The four (4) month window in which you may file a request for an external review

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 16, 24, 24A, 27, 27A, 30, 30A, 51, 51A, 60, 60A, 69, 70, 71, 76, 76A and 78.

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%
Telehealth visits other than through Doctor on Demand	Plan pays 80%, unless the visit is for COVID-19, in which case the Plan pays 100%

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.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the sixty (60) day window (or thirty (30) day window in the case of acquiring a new Dependent) in which you must request special enrollment under the Plan for the circumstances listed above is disregarded and resumes at the end of the Outbreak Period.

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 determine 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.

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.

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B. 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 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.

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continuation coverage is disregarded and resumes at the end of the Outbreak Period.

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. Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the forty-five (45) day deadline to make the initial Self Payment, and the thirty (30) day grace period for making subsequent self-payments, are disregarded and resume at the end of the Outbreak Period.

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.

F. 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.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the “Outbreak Period.” During the Outbreak Period, the sixty (60) day window in which the Qualified Beneficiary must notify the Fund Office of a Social Security Disability Determination is disregarded and resumes at the end of the Outbreak Period.

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]

24. Mastectomy bras, up to two (2) per Eligible Person per Calendar Year.

25. Jobst stockings, up to two (2) pair per Eligible Person per Calendar Year.

26. Discounted charges for walk-in clinics in retail settings.

27. For the duration of the national emergency concerning COVID-19, the Plan will cover at 100% (no member cost share) claims for COVID-19 diagnostic testing and diagnosis as well as the related office (urgent care, emergency room) visit during which the treating health care provider determined such testing was medically necessary and appropriate according to the accepted guidelines of the Federal Food and Drug Administration ("FDA") and/or the respective state Department of Health.

28. Effective March 1, 2020, the Plan will pay claims for a medical or dental procedure for a Participant or Participant's Dependent(s) that was scheduled to occur prior to the declaration of the national emergency concerning COVID-19 on March 13, 2020 ("National Emergency") and was canceled by the health care or service provider due to the National Emergency, and who subsequently had his or her coverage terminated under the Plan before the procedure could be completed. To be eligible for coverage for such procedure, Participants and/or Dependent(s) must provide documentation to the Fund Office demonstrating that (1) the procedure was originally scheduled prior to the National Emergency for a date after such declaration; (2) the procedure was canceled by the health care or service provider after the commencement of the National Emergency; and (3) and the procedure was rescheduled and performed no later than December 31, 2020.

2.1.2. Preventive Care and Other Routine Care

The deductible is waived for covered expenses related to the routine services described below. The Plan pays one hundred percent (100%) of the Usual and Customary Charges for products and services that meet the definition of Preventive Care. There is no cost-sharing for Preventive Care.

A. Routine physical examinations including charges for an examination, x-rays, and laboratory tests performed by a Physician or surgeon in a Hospital, clinic, or Physician's office. Covered expenses include:

1. For Eligible Dependents of an Eligible Employee, only routine office visits for the ongoing care of a well-baby and routine well child care, including professional services or supplies related to routine immunizations of Dependent Children. With respect to childhood immunizations, the Plan will cover those recommended by the

American Academy of Pediatrics and those that satisfy the definition of Preventive Care.

2. Examinations required by third parties, including, but not necessarily limited to, schools, employers, insurance companies, camps, and adoption agencies.

3. Examinations for the purpose of contraceptive management, including a pelvic examination and pap-smear.

Benefits are not payable under this Routine Physical Examination Benefit for:

1. Routine immunizations or vaccinations, except as specifically stated;

2. Eye or dental examinations; or

3. Routine colonoscopy unless the colonoscopy is Preventive Care.

B. Routine immunizations. With respect to childhood immunizations, the Plan will cover those recommended by the American Academy of Pediatrics, including but not limited to, those to prevent diphtheria, pertussis, tetanus, polio, measles, mumps, and rubella, and those that satisfy the definition of Preventive Care.

G. Services performed before the effective date of the Eligible Person's coverage under this Plan.

H. Charges for dental services performed after the termination of the Eligible Person's coverage under this Plan, except for services performed within thirty (30) days after such termination, that are needed to complete a single procedure commencing on or before the termination date.

I. Charges for dental treatment in excess of the usual and customary charge or in excess of the maximum benefit payable as indicated in the Schedule of Benefits.

J. Charges for any dental procedures performed solely because the Eligible Person has changed Dentists.

K. Composite resin or acrylic restorations in occlusal and proximal surfaces of posterior teeth. An allowance will be made for amalgam restorations for those areas.

L. Crowns and dental implants when used as abutments for prosthetics.

M. Orthodontic services other than for eligible Dependent Children.

N. Restorations for identification purposes.

O. Repair or replacement of a retainer, even if lost or stolen.

P. Charges for dental procedures performed after the termination of the Eligible Person's coverage under this Plan, except for procedures that were scheduled to occur prior to the declaration of the national emergency concerning COVID-19 on March 13, 2020 ("National Emergency") and were canceled by the health care or service provider due to the National Emergency. To be eligible for extended coverage for such procedure, the Eligible Person must provide documentation to the Fund Office demonstrating that (1) the procedure was originally scheduled prior to the National Emergency for a date after such declaration; (2) the procedure was canceled by the health care or service provider after the commencement of the National Emergency; and (3) and the procedure was rescheduled and performed no later than December 31, 2020.

5.4 WEEKLY DISABILITY INCOME BENEFITS

Only full-time Eligible Employees are eligible for Weekly Disability Income Benefits, which are subject to the conditions of this Section.

5.4.1. Payment of Benefit

The Weekly Disability Income rate is stated in the Schedule of Benefits. The Weekly Disability Income Benefit is payable when a full-time Eligible Employee who is covered under the Plan becomes Totally Disabled because of a non-occupational Injury or Illness

that prevents the Employee from working. The Totally Disabled Employee must be under the care of a Physician to receive the benefit. The Schedule of Benefits states how the benefit is calculated, the maximum weekly amount, and the maximum number of weeks the benefit is payable for any one (1) period of disability.

Weekly Disability Income Benefits begin with:

A. The first (1st) day of disability due to an Injury; or

B. The eighth (8th) day of disability due to an Illness.

W. Medical Expenses a third party (such as the driver of a car that caused an accident for which medical expenses were incurred) was responsible for paying if the Eligible Employee or Dependent, whether or not a minor, did not comply with the subrogation provisions of this Plan stated in Section 8.7.

X. Charges incurred for any special education rendered to any Eligible Person, regardless of the type of education, except for education that qualifies as Preventive Care or as otherwise specifically stated.

Y. Charges for special home construction to accommodate a disabled Eligible Person.

Z. Charges incurred for completing claims forms (or forms required by the Plan for processing claims) by a Physician or other provider of medical services or supplies.

AA. Any losses incurred by an Eligible Person at a time the Eligible Person owes payment to the Plan because of benefit payments made in reliance upon incorrect, misleading, or fraudulent statements or representations by the Eligible Person, or where such person has failed to honor the Plan's right of subrogation or reimbursement or otherwise failed to cooperate with the Plan as specified.

BB. Radial keratotomy or Lasik surgery.

CC. State and local taxes (other than those mandated by law that the Plan must pay, such as MinnesotaCare tax) or shipping and handling charges incurred on covered expenses.

DD. Drugs or medicines prescribed by a Physician that are available as over-the-counter (OTC) purchases, including but not limited to, cough medicine, vitamin supplements, etc. (except as specifically provided through the Preferred Provider Pharmacy Program for OTC Prilosec and Loratadine), unless the prescription qualifies as Preventive Care.

EE. Charges incurred for travel, whether or not recommended by a Physician, except if specified as a covered expense under the Plan.

FF. Charges incurred for gambling addiction in a residential treatment program.

GG. Any loss caused by, or resulting from, mental deficiency, mental retardation, developmental deficiencies, genetics, or any treatment for learning disabilities, except as otherwise specifically stated.

HH. Any loss, expense, or charge for which:

1. A third party may be liable; and

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.

II. 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.

JJ. 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.

KK. 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.

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

MM. 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.

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.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the “Outbreak Period.” During the Outbreak Period, the ninety (90) day deadline for filing a post-service claim is disregarded and resumes at the end of the Outbreak Period.

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.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the "Outbreak Period." During the Outbreak Period, the one hundred eighty (180) day window in which a claimant may file an appeal of a denial of benefits is disregarded and resumes at the end of the Outbreak Period.

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.

Effective May 4, 2020, the Department of Labor declared the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency surrounding COVID-19, or other such date as announced by the Department of Labor, Internal Revenue Service, or Department of the Treasury, will be known as the “Outbreak Period.” During the Outbreak Period, the four (4) month window in which you may file a request for an external review is disregarded and resumes at the end of the Outbreak Period.

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.