Pipe Trades Services MN Welfare Fund

Plan Document and
Summary Plan Description

Restated January 1, 2024

PIPE TRADES SERVICES MN
HEALTH & PENSION FUNDS
Serving the pipe trades industry in Minnesota

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Pipe Trades Services MN Welfare Fund

Dear Participant:

This document is the Pipe Trades Services MN Welfare Fund's restated Plan Document and Summary Plan Description effective as of January 1, 2024 ("**SPD**"). This SPD replaces and supersedes the **Benefits Booklets** that collectively served as the Welfare Fund's Plan Document and SPD prior to the effective date of this SPD, and all other prior restatements of the Welfare Fund.

The Welfare Fund strives to provide you and your Dependents with high-quality benefits while being mindful of the ever increasing costs for healthcare services. Please review this document carefully to understand the health and welfare benefits made available to you and your Dependents through the Welfare Fund.

Please note that the SPD's format has changed. Previously, you only received the Benefits Booklet that described the benefits available to you from the Welfare Fund based on your employee classification under a CBA or eligibility for Medicare. For example, Journeymen Employees and Pre-Medicare Retirees used different Benefits Booklets and each Benefit Booklet only described the benefits applicable to that respective group. This SPD describes the benefits available for all groups and classifications and notes when a certain benefit or coverage is not available to all Welfare Fund Participants.

We have attempted to describe all of the available benefits as completely as possible in easy to understand everyday language. If you have any questions, you can find the appropriate contact in Section 3 ("Important Contact Information") or contact the Fund Office.

This SPD contains a summary of your rights and benefits under the Welfare Fund in English. If you have difficulty understanding any part of this SPD, contact the Fund Office, the Welfare Fund's administrator, at Pipe Trades Services MN, Inc., 4461 White Bear Parkway, Suite 1, White Bear Lake, MN 55110. Office hours are from 7:30 a.m. to 5:00 p.m., Monday-Friday. You may also call the Fund Office at (651) 645-4540 for assistance.

Sincerely,

The Welfare Fund's Board of Trustees

Important Notice

The Welfare Fund is generally not subject to state laws that regulate insured health plans because it is a self-funded ERISA plan. The Trustees may exercise discretion when interpreting the terms of the Welfare Fund and may modify, amend, or terminate any of the Welfare Fund's benefits or coverage.

See Section 17H ("Amending and Terminating the Welfare Fund") and Section 17I ("Discretion to Interpret Welfare Fund and Fact Finding") for more information.

The Welfare Fund's Board of Trustees

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Section 2

Summary of Coverage

The following summarizes the various coverages made available to you through the Welfare Fund's Plans. Each Plan is described in greater detail in Sections 7-15 of this SPD. A list of the Welfare Fund's benefits available to you is provided in Section 5 ("Benefits").

You have $0 Copayment for the services you receive at the Wellness Centers.
See Section 8 ("Pipe Trades Services MN Family Health & Wellness Centers") for more information.

Summary of Medical Benefits
Pipe Trades Services MN Health Plan (Section 7)

Journeymen, Pre-Medicare Retirees, Support Workers, and NBU Employees
(Dependent coverage)

Maximum OOP: $2,000/individual; $6,000/family (excludes Deductible)
Deductible: See your ***Annual Coverage Update*** or the ***Deductible Election Form*** (if applicable)
Annual Limit: None

Helpers and Pre-Apprentices (no Dependent coverage)

Maximum OOP: $2,850 (excludes Deductible)
Deductible: See your ***Annual Coverage Update*** or the ***Deductible Election Form*** (if applicable)
Annual Limit: None

Type of Benefit	In-Network	Out-of-Network
Covered Expenses (this general rule applies to any Covered Expense that is not subject to one of the specific rules below) Examples of Covered Expenses subject to specific rules include: hospital expenses, durable medical equipment, Prescription Drugs, etc.	10% Coinsurance Deductible applies	20% Coinsurance, Deductible applies
Emergency Services	10% Coinsurance Deductible applies	
Urgent Care at a Hospital	10% Coinsurance Deductible applies	20% Coinsurance Deductible applies
Urgent Care at an Office	$25 Copayment Deductible does not apply	20% Coinsurance Deductible applies

Type of Benefit	In-Network	Out –of-Network
Office Visits (this rule applies to items and services provided during an Office Visit except durable medical equipment)	$25 Copayment Deductible does not apply	20% Coinsurance Deductible applies
Laboratory Services (preventive)	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance Deductible applies
Laboratory Services (non-preventive) in conjunction with an Office Visit or outpatient services	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance Deductible applies
Laboratory Services (non-preventive) in conjunction with a hospital or emergency room visit	10% Coinsurance Deductible applies	20% Coinsurance Deductible applies
Diagnostic imaging in conjunction with an Office Visit	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance Deductible applies
Diagnostic imaging in conjunction with a non-Office Visit	10% Coinsurance Deductible applies	20% Coinsurance Deductible applies
Preventive Care	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance Deductible applies
Prescription Drugs[1]	20% Coinsurance Deductible does not apply Helpers and Pre-Apprentices: 30% Coinsurance Deductible does not apply	Not covered
Treatment at Minute Clinics	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance Deductible applies
Treatment via Virtuwell (online clinic)[2]	You pay $0 (0% Coinsurance) Deductible does not apply	Not applicable

[1] Certain Prescription Drugs are available to you at no cost from the Wellness Centers. For a list of the Prescription Drugs available from the Wellness Centers, contact your local Wellness Center. See Section 3 ("Important Contact Information").

[2] Virtual Primary Care services are also available to you at no cost from the Wellness Centers. Get started by calling (888) 535-4980.

Type of Benefit	In-Network	Out-of-Network
Chiropractic Services[3]	20% Coinsurance Deductible applies	20% Coinsurance up to Annual Limit of 20 visits Deductible applies
Acupuncture	20% Coinsurance up to Annual Limit of $300 Deductible applies	
Hearing Aids	10% Coinsurance up to one hearing aid for each ear every three years Deductible applies	20% Coinsurance up to one hearing aid for each ear every three years Deductible applies
Telephone visits (this coverage does not apply to virtual visits through Virtuwell or the Wellness Centers)	$25 Copayment Deductible does not apply	20% Coinsurance Deductible applies
In-home sleep studies	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance Deductible applies

Summary of Wellness Center Services
Pipe Trades Services MN Family Health & Wellness Centers (Section 8)

The Wellness Centers operated by Premise Health offer the primary care services you would expect from a family physician or general practitioner/Provider at no cost to you. There is no Copayment or Coinsurance for a visit to the Wellness Center and your Deductible does not apply.

The primary care services offered at the Wellness Centers include:

- Primary care for common conditions such as colds, flu, asthma, diabetes, etc.;
- Care for acute conditions, chronic disease, and cardiovascular care;
- Preventive care including immunizations, physicals, etc.;
- Physical therapy and chiropractic care;
- Behavioral and mental health care;
- Women's healthcare services;
- Provider dispensing of 200+ Prescription Drugs at no cost to you;
- Patient education;
- Full-service vision center (White Bear Lake Wellness Center only); and
- Certain lab tests can also be completed at the Wellness Centers.

The Wellness Centers are located in Eagan, Maple Grove, Rochester, and White Bear Lake.

You also have 24/7 access to **Virtual Primary Care** services. Get started by calling (888) 535-4980.

[3] Chiropractic services are available to you at no cost from the Wellness Centers. See Section 8 ("PTSMN Family Health & Wellness Centers").

Summary of Dental Benefits Pipe Trades Services MN Dental Plan (Section 9) Summary of Dental Benefits for Eligible Employees and their Dependents		
Maximum OOP: None Deductible: None Annual Limit: $2,500/individual[4]		
Dental Benefit	**Cost Sharing**	
	In-Network	**Out-of-Network**
Preventive Dental Care	You pay $0 (0% Coinsurance)	You pay $0 (0% Coinsurance) for Allowed Amount[5]
Basic Dental Care	You pay $0 (0% Coinsurance)	You pay $0 (0% Coinsurance) for Allowed Amount
Endodontics	40% Coinsurance	40% Coinsurance
Periodontics	40% Coinsurance	40% Coinsurance
Oral Surgery	40% Coinsurance	40% Coinsurance
Major Restorative Dental Care	20% Coinsurance	40% Coinsurance
Prosthetic Repairs and Adjustment	40% Coinsurance	40% Coinsurance
Prosthetics	40% Coinsurance	40% Coinsurance
Orthodontia (Subject to $2,000/individual Lifetime Limit)	You pay $0 (0% Coinsurance)	You pay $0 (0% Coinsurance) for Allowed Amount
Summary of Dental Benefits for Retirees and their Dependents (if elected)		
Retirees must elect the Welfare Fund's dental coverage at the time of retirement or during an open enrollment period (every other year).		

[4] Benefit maximums may not be carried over to future coverage years. Also, the benefit maximum does not apply to Preventive Dental Care for eligible Dependent Children up to age 18.

[5] Review Appendix B ("Delta Dental SPD for Employees") for more on the Allowed Amount.

Plan Services	Cost Sharing In-Network		Out-of-Network
	Delta PPO	Delta Premier	
Diagnostic & Preventive	You pay $0 (0% Coinsurance)	20% Coinsurance	20% Coinsurance
Basic Restorative	You pay $0 (0% Coinsurance)	50% Coinsurance	50% Coinsurance
Oral Surgery-Simple Extractions	You pay $0 (0% Coinsurance)	50% Coinsurance	50% Coinsurance
Endodontics	10% Coinsurance	50% Coinsurance	50% Coinsurance
Periodontics-Non Surgical	20% Coinsurance	50% Coinsurance	50% Coinsurance
Periodontics-Surgical	20% Coinsurance	50% Coinsurance	50% Coinsurance
Oral Surgery-All Other Extractions	20% Coinsurance	20% Coinsurance	20% Coinsurance
Crowns	40% Coinsurance	50% Coinsurance	50% Coinsurance
Crown Repairs	40% Coinsurance	50% Coinsurance	50% Coinsurance
Fixed Prosthetic Repairs	40% Coinsurance	50% Coinsurance	50% Coinsurance
Removable Prosthetic Repairs	40% Coinsurance	50% Coinsurance	50% Coinsurance
Prosthetics, Removable & Fixed	40% Coinsurance	50% Coinsurance	50% Coinsurance
Annual Deductible	**None**	**$25.00**	**$25.00**
Annual Limit	**$2,000.00**	**$2,000.00**	**$2,000.00**

Summary of Vision Benefits
Pipe Trades Services MN Vision Plan (Section 10)

Maximum OOP: None
Deductible: None
Annual Limit: $250/individual for Out-of-Network Covered Expenses (no In-Network Annual Limit)

The White Bear Lake Wellness Center has a VSP Vision Center which may provide additional benefits to you and your Dependents.

Type of Benefit	In-Network	Out-of-Network
Eye Exam	You pay $0 (0% Coinsurance) Limit one per calendar year	0% Coinsurance up to Annual Limit of $250, then 100% Coinsurance. Annual limit applies to all vision benefits.

Frames or Contact Lenses	You pay $0 for frames or contact lenses up to $175. You pay 100% of the cost above $175. $95 frame Allowance at Costco, limit one per year.	0% Coinsurance up to Annual Limit of $250, then 100% Coinsurance. Annual limit applies to all vision benefits.
Lenses (single, bifocal, trifocal, lenticular, blended, polycarbonate and progressive)	You pay $0 (0% Coinsurance), limit one pair of lenses per year	0% Coinsurance up to Annual Limit of $250, then 100% Coinsurance. Annual limit applies to all vision benefits.
Safety Lenses (if your work requires safety eyewear)	VSP's ProTec Safety® Plan provides discounts on safety eyewear and examinations. These Vision Benefits are only available to active Employees, not Retirees or Dependents. See Section 10C(4) ("ProTec Safety® Plan") for more information.	

Summary of Disability Benefits
Pipe Trades Services MN Weekly Injury And Illness Disability Program (Section 11)

If you become temporarily unable to work due to a non-occupational related Injury or Illness, you will receive $500 per week ($100 per day) and your Dollar Bank will be credited with 37.5 hours per week (7.5 per day) up to a maximum of 975 hours. Benefits cease when you return to work or after 26 weeks, whichever comes first. You may also be eligible for this benefit if you are unable to work while pregnant or following the delivery of your new Child. If your Injury or Illness arises out of a motor vehicle accident, benefits will not be payable until the $20,000 no-fault benefit is exhausted. Your Dependents cannot participate in this Program and you cannot participate in this Program when you are on Extended Eligibility.

Summary of Death Benefits
Pipe Trades Services MN Death Benefits Program (Section 12)

For eligible Employees, your Beneficiary will be paid $7,000 upon your death. For Retirees, your Beneficiary will be paid $3,500 upon your death. Dependents cannot participate in this Plan.

Summary of AD&D Benefits
Pipe Trades Services MN Accidental Death and Dismemberment Program (Section 13)

If you die or suffer a loss of limb or vision due to an accidental Injury, you or your Beneficiary (Loss of Life only) will be paid as follows:

- Loss of Life: $7,000
- Loss of two limbs or loss of sight in both eyes: $7,000
- Loss of one limb or loss of sight in one eye: $3,500

Your Dependents cannot participate in this Plan.

Summary of Jury Duty Benefits
Pipe Trades Services MN Jury Duty Program (Section 14)

If you are unable to work due to jury duty, you will receive $90 per day and your Dollar Bank will be credited with an amount equal to eight Hours of Work per day. Benefits cease when you return to work. Your Dependents cannot participate in this Plan and you cannot participate in this Plan when you are on Extended Eligibility.

Summary of Bereavement Pay
Pipe Trades Services MN Bereavement Benefits Program (Section 15)

In the event of the death of a qualifying family member, you will receive $300. Your Dependents cannot participate in this Plan.

Section 3

Important Contact Information

For Information About	Contact	Contact Information
Eligibility (Section 5) Disability Benefits (Section 11) AD&D Benefits (Section 13) Death Benefits (Section 12) Jury Duty Benefits Section 14) Bereavement Benefits (Section 15) Claims and appeals for the above (Section 16)	**Fund Office**	Pipe Trades Services MN, Inc. (800) 515-2818 or (651) 645-4540 www.ptsmn.org Submit claims and appeals for all benefits* to: Pipe Trades Services MN Welfare Fund 4461 White Bear Parkway, Suite 1 White Bear Lake, MN 55110 * Certain benefits may require a first-level appeal to a third party. See Section 16 ("Claims and Appeals") for additional information.
PTSMN Wellness Centers (Section 8) Virtual Primary Care	**Premise Health**	(651) 683-2507 (Eagan) (651) 683-2434 (Maple Grove) (651) 287-0185 (Rochester) (651) 348-8851 (White Bear Lake) www.members.premisehealth.com/pipe-trades/ Get started by calling (888) 535-4980
Health Benefits (Section 7) Questions About Health Benefits and Claims Provider Directory(ies) Medical Coverage Criteria	**HealthPartners**	Member Services (877) 822-6706 or (952) 967-7080 www.healthpartners.com Provider directories are available once you log into your authenticated account. Coverage Policies www.healthpartners.com/public/coverage-criteria/

For Information About	Contact	Contact Information
Fitness Discount Programs (Section 7F))	**HealthPartners**	Go to Living Well once you log in to your authenticated HealthPartners member account at www.healthpartners.com to navigate to the available discount programs.
Medical Benefit Claims and Appeals		Submit medical benefit Claims and first-level appeals to: HealthPartners Appeals PO Box 1309 Minneapolis, MN 55440-1309 Submit second-level medical benefit appeals to the Fund Office. Also see www.healthpartners.com/hp/legal-notices/disclosures/complaints/index.html
Evidence of Coverage for Medicare-Eligible Retirees		Visit www.healthpartners.com and log into your authenticated web account.
Enrolled Medicare-Eligible Retiree Claim and Benefit Questions		Journey Group Plan (PPO) (952) 883-6655 or (866) 233-8734 Retiree National Choice (PDP) (952) 883-7373 or (877) 816-9539 Claims and Appeals Contact Riverview Member Services at (952) 883-7979 or (800) 233-9645
Prescription Drug Benefits (Section 7E)) Prescription Drug Benefit Questions Locating a Network Pharmacy	**Optum**	Pharmacy Helpdesk: (844) 368-8732 Member Helpdesk: (866) 328-2005 www.optumrx.com
Prescription Drug Claims and Appeals		Submit Prescription Drug Claims and first-level appeals to: OptumRx Claims Department PO Box 650629 Dallas, TX 75265-0629 Submit second-level Prescription Drug appeals to the Fund Office.

For Information About	Contact	Contact Information
Specialty Drug Benefits (Section 7E))	**Optum Specialty Pharmacy**	(855) 427-4682
Obtaining Specialty Drugs Specialty Drug Claims and Appeals		Submit Specialty Drug Claims and first-level appeals to: Optum Specialty Pharmacy 4100 South Saginaw Street Flint, MI 48507 Fax: (844) 262-8479 Submit second-level Specialty Drug appeals to the Fund Office.
Dental Benefits (Section 9) Finding a Dentist	**Delta Dental**	Delta Dental of Minnesota P.O. Box 9124 Farmington Hills, MI 48333-9124 (800) 448-3815 or (651) 406-5901 www.deltadentalmn.org
Dental Benefit Claims		Employees-send Dental Benefit Claims to: Delta Group #50865 Delta Dental of Minnesota PO Box 9120 Farmington Hills, MI 48333-9120 Retirees-send Dental Benefit Claims to: Delta Group #04059 Delta Dental of Minnesota PO Box 9120 Farmington Hills, MI 48333-9120
Dental Benefit Appeals		Submit first-level Dental Benefit appeals to: Delta Dental of Minnesota Attn: Professional Services Appeals and Grievances PO Box 30416 Lansing, MI 48909 Submit second-level Dental Benefit appeals to the Fund Office.

For Information About	Contact	Contact Information
Vision Benefits (Section 10) Vision Services Vision Benefit Claims Vision Benefit Appeals	**Vision Service Plan ("VSP")**	(800) 877-7195 www.vsp.com Submit Vision Benefit Claims to: Vision Service Plan Attn: Out-of-Network Claims PO Box 495918 Cincinnati, OH 45249-5918 (must use ID# with 0000 preceding it) Submit first-level Vision Benefit Appeals to: Vision Service Plan Attn: Appeals Dept. PO Box 2350 Rancho Cordova, CA 95741 Submit second-level Vision Benefit appeals to the Fund Office.
EAP Benefits (Section 7G)) Employee Assistance Program	**HealthPartners**	(866) 326-7194 www.hpeap.com A password is required when calling or accessing website. Contact the Fund Office for your password. See Section 7G ("Employee Assistance Program ("EAP")) for information about using the mobile app to access the EAP.
Minute Clinic Claims and appeals	**Minute Clinic**	(866) 389-ASAP (2727) www.cvs.com/minuteclinic/ (located in select CVS Pharmacy stores) Submit Minute Clinic Claims and appeals to HealthPartners
Online Clinic Claims and appeals	**Virtuwell**	www.virtuwell.com Submit Virtuwell Claims and appeals to HealthPartners

Section 4
Background Information

A. How to Use This Booklet

The Welfare Fund provides benefits through its various component benefit plans and programs (each a "**Plan**"), each of which is subject to its own rules. This SPD is your guide to those benefits and describes your rights and obligations under each Plan. You should review this SPD in its entirety and keep a copy for your reference. An up-to-date copy of the SPD is also available at www.ptsmn.org once you log into your account. Contact the Fund Office if you have not registered your account.

Share the SPD with your Spouse (if applicable) and other eligible Dependents or Beneficiaries so they are aware of the benefits provided by the Welfare Fund and the notices and disclosures provided in the SPD (i.e., COBRA continuation coverage, Death Benefits, etc.). If you have difficulty understanding any part of this SPD for any reason, please contact the Fund Office.

There are a variety of forms described in this Section 4 and throughout the SPD that you may be required to complete in connection with your or your Dependent's coverage (e.g., ***Enrollment Form***). Other forms can be completed by you at any time (e.g., ***Beneficiary Designation Form***). The Welfare Fund's forms are available from the Fund Office and www.ptsmn.org.

Capitalized terms used and not defined throughout the SPD have the meanings provided in Section 20 ("Definitions") unless indicated otherwise. Please review these terms because how they are defined affects your eligibility for benefits. "You" and "your" generally refer to Participants, including Spouses and other Dependents, as the readers unless the context indicates otherwise.

B. Your Responsibilities

1. **Annual Notice of Premium and Deductibles**. On an annual basis (usually October-November), you will receive the ***Annual Coverage Update*** form which provides you with notice of the Premium for the following calendar year. If you will be given the option to elect a Deductible (and Premium) for the following calendar year, you will receive a ***Deductible Election Form*** from the Fund Office.

   If you do not return the ***Deductible Election Form*** by the deadline stated on the form, your election (if one was available) from the prior year will generally apply unless it is no longer available. If your Deductible for the prior year is not available and you do not return the form, you will be deemed to have elected the default Deductible.

2. **Updates Upon Change in Status**. You must notify the Fund Office within 30 days (unless stated otherwise) of certain events or changes in your status which occur during the year. Notify the Fund Office when you:

   - Become eligible for Medicare;
   - Get married, legally separated, or divorced;

- When you gain or lose a Dependent;
- Have a Dependent Child who turns age 26;
- Change your contact information (e.g., address, telephone number, email address, etc.);
- Experience a change in coverage under a state Medicaid plan or a Children's Health Program ("**CHIP**"); or
- Gain or lose other coverage or insurance.

If you or your Dependents are eligible under the Welfare Fund, but are not enrolled in Welfare Fund coverage, you and your Dependents may have special enrollment rights if you lose your other coverage, acquire a new Dependent, or become eligible for a premium assistance subsidy under a state Medicaid plan or a CHIP. To exercise your special enrollment rights, you must notify the Fund Office within 30 days of the date you lose other group health coverage or you acquire a new Dependent. If you lost coverage under a state Medicaid plan or a CHIP, or become eligible for a premium assistance subsidy under a state Medicaid plan or a CHIP, you must notify the Fund Office within 60 days of such event. Once enrolled, an individual's eligibility for coverage is determined under the terms of Section 6 ("Eligibility").

Life events must be reported because they may affect your Welfare Fund coverage. Below is a list of life events and the corresponding documentation that you must provide to the Fund Office:
Marriage. A completed ***Enrollment Form*** and a copy of the official, state-issued marriage certificate.
Divorce. A copy of the recorded final divorce decree.[6]
Birth. A completed ***Enrollment Form*** and a copy of the official, state-issued birth certificate. You can also submit a copy of hospital-issued birth certificate if you are enrolling your Child within 120 days of the Child's birth.
Adoption or Placement for Adoption. A completed ***Enrollment Form*** and a copy of the adoption or placement papers issued by a court.
Legal Guardianship. A completed ***Enrollment Form*** and a copy of the guardianship papers issued by a court.
Disability Retirement. A completed ***Retirement Application.*** See the Pension Fund's SPD for the medical documentation and examination requirements related to a Disability Pension. See Section 6B(2)(d) ("Disability Retirement") for more information.
Disability Benefits. A completed ***Weekly Disability Benefits Application*** and supporting medical documentation as may be required by the Welfare Fund.
Death. A copy of the recorded death certificate.

[6] See Section 6E ("Notice of Continuation Coverage Rights Under COBRA") for more on a former Spouse's right to continue Welfare Fund coverage after the divorce.

Permanent Disability of Dependent Age 26 or Older. Contact the Fund Office for a list of the medical documentation and examination requirements required to demonstrate your Dependent's permanent disability.

3. **Updating Your Beneficiary.** Your Beneficiary for any benefits payable upon your death will be the Standard Beneficiary Designation unless you submit a completed ***Beneficiary Designation Form*** to the Fund Office.

4. **Dependent Verification Audits**. You may be selected for an audit to verify that your Dependents are eligible for Welfare Fund coverage. Failing to timely comply with a request for information about a Dependent can result in the suspension of your Dependent's coverage. The Welfare Fund may collect any overpayments from you as a result of the failure to return information about your Dependents.

   To verify Dependent eligibility, the Welfare Fund may perform audits of any Participant or Dependent information on record with the Fund Office. These audits help assure that only eligible individuals are benefitting from the Welfare Fund. You will be responsible for repaying the Welfare Fund for the healthcare expenses it paid on behalf of your ineligible Dependent.

5. **Other Required Updates**. You must also notify the Fund Office if you or your Dependent:

   - Are enrolled in another group health plan or maintain other insurance coverage;
   - Receive workers' compensation benefits or file a workers' compensation claim;
   - Receive benefits arising out of an automobile accident or other incident for which a third party may be liable;
   - Assert a Claim for benefits arising out of an automobile accident or other incident for which a third party may be liable;
   - Return to work after a disability ends;
   - Enter or are discharged from the military or other uniformed service; or
   - Plan to retire or are retiring.

C. How You Can Help Contain Costs

There are a number of things you can do to help contain costs for you and the Welfare Fund.

- **Visit one of the PTSMN Wellness Centers or access Virtual Primary Care** if you are seeking primary care services or one of the other healthcare services provided by Premise Health. See Section 8 ("Pipe Trades Services MN Family Health & Wellness Centers") for more information.
- **Visit healthcare Providers in the PPO network**. The Welfare Fund contracts with HealthPartners who negotiates discounted rates with Providers for nearly all types of medical services. Contact HealthPartners' Member Services or use HealthPartners' Provider Directory(ies) to locate an In-Network Provider. See Section 3 ("Important Contact Information") for more information.
- **Actively manage your Prescription Drugs and Specialty Drugs.** The Welfare Fund contracts with Optum, a pharmacy benefit manager ("**PBM**"), to provide you with access to its network of retail pharmacies and Optum Specialty Pharmacy. You also have access to certain

Prescription Drugs at no cost to you through the PTSMN Wellness Centers. See Section 8 ("Pipe Trades Services MN Family Health & Wellness Centers") for more information.

- **The Welfare Fund has contracted with VSP to provide you access to your vision benefits**. If you are eligible for Vision Plan coverage, have your vision supplies and services provided by an In-Network Provider with VSP. The White Bear Lake Health & Wellness Center also offers you with access to a full service VSP clinic. See Section 10 ("Pipe Trades Services MN Vision Plan") for more information.
- **The Welfare Fund has contracted with Delta Dental to help you obtain discounted dental services.** If you are eligible for Dental Plan coverage, have your dental needs provided by an In-Network Provider with Delta Dental. See Section 9 ("Pipe Trades Services MN Dental Plan") for more information.
- **Review your receipts and explanations of benefits carefully**. If you ever receive an explanation of benefits or bill from a hospital that is incorrect, notify the Provider, the applicable PPO, and the Fund Office. You may receive 25% of the amount recovered from the Fund Office (up to $500) if your efforts produce an adjusted claim. Contact the Fund Office for more information.
- **Whenever possible, use outpatient services** (including outpatient surgery) instead of receiving the same services on an inpatient basis.
- **Only use the emergency room if you have an actual emergency**. An emergency room is the most expensive place to obtain care and should generally not be used for minor Illnesses such as sore throats, ear infections, etc. Use urgent care facilities, Minute Clinics, Virtual Primary Care through the PTSMN Wellness Centers, Virtuwell, or your own Provider whenever possible for these situations.

Section 5
Benefits

The Welfare Fund provides various benefits through its different Plans. When you become eligible for benefits from the Welfare Fund, you and your Dependents (if applicable) become Participants in the Welfare Fund's coverage based on:

- Your employee classification under the CBA (e.g., Journeyman, Helper, NBU Employee, etc.);
- Your employment status (i.e., active, disabled, retired, etc.), and;
- Your eligibility for Medicare (once Retired).

You and your Dependents (if applicable) are eligible for the Welfare Fund's benefits as follows:

A. Journeymen, Apprentices, NBU Employees, and their Dependents

1. The PTSMN Health Plan (Section 7).

2. The PTSMN Wellness Centers (Section 8).

3. The PTSMN Dental Plan (Section 9).

4. The PTSMN Vision Plan (Section 10).

5. The PTSMN Weekly Disability Program (Section 11).

No Dependent participation.

6. The PTSMN Death Benefits Program (Section 12).

No Dependent participation.

7. The PTSMN Accidental Death and Dismemberment Program (Section 13).

No Dependent participation.

8. The PTSMN Jury Duty Program (Section 14).

No Dependent participation.

9. The PTSMN Bereavement Benefits Program (Section 15).

No Dependent participation.

B. Pre-Medicare Retirees and their Dependents.

1. The PTSMN Health Plan (Section 7).

2. The PTSMN Wellness Centers (Section 8).

3. The PTSMN Dental Plan—Retiree Coverage (Section 9).

This coverage is optional and must be elected.

4. The PTSMN Vision Plan—Retiree Coverage (Section 10).

5. The PTSMN Death Benefits Program (Section 12).

No Dependent participation.

C. Support Workers and their Dependents, Helpers and Pre-Apprentices.

1. The PTSMN Health Plan (Section 7).

2. The PTSMN Wellness Centers (Section 8).

D. Medicare-Eligible Retirees and their Dependents.

1. Health benefits available to Medicare-Eligible Retirees are described in the applicable Evidence of Coverage document(s) that is available for your review online once you log into your authenticated account. See Section 3 ("Important Contact Information") for information on accessing the Evidence of Coverage on the HealthPartners website.

2. The PTSMN Wellness Centers (Section 8).

3. The PTSMN Dental Plan—Retiree Coverage (Section 9).

This coverage is optional and must be elected.

4. The PTSMN Vision Plan—Retiree Coverage (Section 10).

5. The PTSMN Death Benefits Program (Section 12).

No Dependent participation.

Contact the Fund Office at (651) 645-4540 if you have questions about the Welfare Fund benefits that are available to you.

Section 6
Eligibility

A. Active Employee and Dependent Eligibility, Termination of Eligibility

1. Initial Eligibility for Active Employees. If you are working in Covered Employment, you will initially become eligible to receive benefits from the Welfare Fund as described in Section 5 ("Benefits") of this SPD on the first day of the second month following the month in which you perform enough Hours of Work as an Employee that the balance of your Dollar Bank equals or exceeds the Welfare Fund's monthly Premium for your employment classification under the CBA (i.e., Helper, Apprentice, Journeyman, etc.).

This eligibility rule applies if you are currently eligible for benefits from the Welfare Fund under a different employment classification in the CBA. For example, if you are eligible for benefits from the Welfare Fund as a Helper and then you become an Apprentice, you become eligible for the benefits available to Apprentices on the first day of the month following the month in which the balance of your Dollar Bank equals or exceeds the Welfare Fund's monthly Premium for Apprentices. During the period in which you are working as an Apprentice but have not accumulated a Dollar Bank balance that equals or exceeds the Premium for Apprentices, you are only eligible for the benefits available to Helpers.

Once you satisfy the eligibility requirements and begin participating in the Welfare Fund under a particular employment classification in the CBA, only the Welfare Fund's benefits available to that employment classification are available to you. You will remain eligible for Welfare Fund benefits until your eligibility is terminated.

See Section 5 ("Benefits") for a list of the Welfare Fund benefits that are available to you.

2. Termination of Active Employee Eligibility. You remain eligible for benefits from the Welfare Fund until your eligibility is terminated. Your eligibility terminates on the earliest of:

- The first day of the first month in which the balance of your Dollar Bank is less than the Welfare Fund's monthly Premium applicable to you;[7]
- The day you enter active military service, subject to the provisions of USERRA;
- The day your Union or district council ceases to require Contributions to the Welfare Fund on your behalf under a CBA;

[7] If the amount in your Dollar Bank ever falls below the amount necessary to cover at least two months of Premiums, the Fund Office will generally send you a notice called the ***Low Dollar Bank Notice***. However, you are responsible for ensuring that your Dollar Bank is sufficient to cover your Premium regardless of whether you receive a ***Low Dollar Bank Notice***. You may also check your individual Dollar Bank information at www.ptsmn.org. Go to the *Members* page and then click on the *Eligibility Information* tab to view your Dollar Bank balance.

- The day you work for an employer in the Pipe Trades Industry that is not signed to the CBA with a Union (you must notify the Fund Office immediately if you leave the Pipe Trades Industry or become self-employed);
- The day the Welfare Fund is terminated.

If your eligibility terminates and is not reinstated, you must meet the initial eligibility requirements to become eligible for benefits from the Welfare Fund again.

See Appendix A ("Eligibility Example") for an example of how the eligibility rules work.

3. **Eligible Dependents of Active Employees**. Your Dependents first become eligible for benefits on the same day that you first become eligible. If a person becomes your Dependent while you are eligible (by birth, marriage, adoption, or otherwise), that person becomes eligible on the day he or she becomes your Dependent provided that you submit a completed ***Enrollment Form*** to the Fund Office within 30 days of the individual becoming your Dependent. If you submit a completed ***Enrollment Form*** more than 30 days after the date the individual became your Dependent, your new Dependent will become eligible on the first day of the month following the month in which you submit a completed ***Enrollment Form*** to the Fund Office.

   This Subsection does not apply to Helpers or Pre-Apprentices because their Dependents are not eligible for coverage under the Welfare Fund.

4. **Termination of Eligibility for Active Employees' Dependents**. Once eligible, your Dependents will remain eligible until their eligibility is terminated. Each of your Dependents' eligibility will terminate on the earliest of the following:

   - The day your eligibility is terminated for any reason other than your death;
   - The last day of the month in which the Dependent ceases to qualify as your Dependent. See *Dependent* as defined in Section 20 ("Definitions");
   - If you die, the day that is six months after the day on which your Dependents would otherwise have ceased to be eligible due to an insufficient balance in your Dollar Bank.

   This Subsection does not apply to Helpers or Pre-Apprentices because their Dependents are not eligible for coverage under the Welfare Fund.

5. **Non-Bargaining Unit Employees**. NBU Employees are allowed to participate in the Welfare Fund upon the Board's approval. NBU Employees participate in the Welfare Fund under the terms and conditions of the Trustees' Policy for the Participation of Non-Bargaining Unit Employees and the applicable Participation Agreement approved by the Trustees. Generally, NBU Employees either:

   - Work in the office of a Union, a Contributing Employer, or the Fund Office ("**Office Employees**"); or
   - Are former members of a Union ("**Alumni Employees**").

   NBU Employees generally participate in the Welfare Fund on the same basis as Journeyman Employees and Apprentices except as otherwise provided herein.

6. **Continuation of Coverage During Leave**. Notify the Fund Office if you are taking leave from an Employer under any federal, state, or local law entitling you to certain benefit and employment rights (e.g., the Family and Medical Leave Act, Minnesota Pregnancy and Parental Leave Act, etc.). Generally, these rules require your Employer to approve the leave under the applicable law and maintain your Welfare Fund coverage.

   You will maintain your Welfare Fund coverage during your employer-approved leave, provided your Contributing Employer (or Union, if applicable) makes the required notification(s) to the Welfare Fund and continues to provide Contributions (if required by law).

   The Welfare Fund does not approve any applicable federal, state, or local leave and it does not determine whether you are eligible for the leave. If you and your Employer have a dispute, the Welfare Fund will not directly act to resolve the dispute and your benefits may be suspended until the dispute is resolved.

   Contact your Employer or the Fund Office if you believe that you are entitled to the leave and to maintain your Welfare Fund coverage during the leave period.

7. **Maintaining Eligibility with Short Dollars Premiums**. If your eligibility is terminated because the balance of your Dollar Bank is less than your monthly Premium but greater than $0, you will receive a ***Short Dollars Premium Invoice***. This is an invoice to you for the difference between the balance in your Dollar Bank and your monthly Premium (the "**Short Dollars Premium")**. If you pay the ***Short Dollars Premium Invoice*** by the deadline provided on the invoice, your eligibility will be retroactively reinstated to the beginning of the month in which your eligibility terminated. There is no limit on the number of consecutive months in which you may reinstate your eligibility by paying a Short Dollars Premium.

8. **Extending Your Eligibility**. If you work in Covered Employment and your eligibility is terminated because the balance of your Dollar Bank is less than the monthly Premium, you may receive an ***Application for Extended Eligibility***. You qualify for "**Extended Eligibility**" if:

   - You are not employed by a Contributing Employer;
   - You are seeking work with a Contributing Employer;
   - Contributions were made to the Welfare Fund on your behalf from a Contributing Employer for at least 1,500 hours in the past 12 months, 3,000 hours in the past 24 months, or 4,500 hours in the past 36 months;
   - You are not working for an employer in the Pipe Trades Industry that is not a Contributing Employer;
   - You are not covered under another health plan; and,
   - You submit a properly completed ***Application for Extended Eligibility*** form.

   If you qualify for Extended Eligibility, the Welfare Fund will credit your Dollar Bank the amount needed to reinstate and continue your eligibility for an extension period as follows:
   - Three months from the date of termination if you had 1,500 hours contributed on your behalf in the past 12 months;
   - Six months if you had 3,000 hours contributed on your behalf in the past 24 months; or
   - Nine months if you had 4,500 hours contributed on your behalf in the past 36 months.

While on Extended Eligibility, you are not eligible to participate in the following Plans:

- The Weekly Disability Program (Section 11);
- The Jury Duty Benefits Program (Section 14); and
- The Bereavement Benefit Program (Section 15).

You cease to qualify for Extended Eligibility at the end of the extension period or when Employer Contributions to your Dollar Bank are sufficient to pay your Premium, if earlier. If you reinstate your eligibility through Extended Eligibility, you are deemed to have exercised any COBRA rights you and your Dependents would otherwise have had. Extended Eligibility simply pays your COBRA Premium for a fixed period of time. When your Extended Eligibility ends, you may continue your COBRA continuation coverage by paying the COBRA Premium for the remainder of your COBRA coverage period. See Section 6E below for more about your COBRA rights.

Extended Eligibility is not available to Employees classified as Helpers or Pre-Apprentices in the CBA or Alumni Employees. Helpers, Pre-Apprentices, and Alumni Employees are not allowed to extend their eligibility for coverage under the terms of this Subsection.

9. Deferral of Eligibility. You may not defer your eligibility (or that of your Dependents) unless you meet the following criteria:

- Your employment with a Contributing Employer terminated while you were eligible;
- You are out of work but actively seeking employment with a Contributing Employer;
- You have employer-sponsored coverage through your Spouse or Minimum Value Coverage with a Deductible of no more than $3,500; and,
- You have submitted a completed ***Application to Defer Eligibility*** form to the Fund Office.

Alternatively, you may defer your eligibility (or that of your Dependents) if you:

- Terminate employment with a Contributing Employer;
- Immediately go to work as a government employee working with the tools of the trade;
- Remain a member of a Union; and
- Would otherwise be eligible for Retiree Coverage under the Welfare Fund upon your retirement from governmental employment.

If you are a Retiree, you may not defer your eligibility (or that of your Dependents) unless:

- You have employer-sponsored coverage through your Spouse or Minimum Value Coverage with a Deductible of no more than $3,500; and
- You have submitted a completed ***Application to Defer Eligibility*** form to the Fund Office.

If you meet the criteria for the deferral of your eligibility, your eligibility (and that of your Dependents) will be terminated on the first day of the month following the month in which you meet the criteria. Your Dollar Bank will not be forfeited upon your termination because your Dollar Bank will be frozen while you meet the criteria for a deferral of eligibility. Your eligibility will be reinstated on the first day of the first month following the month in which you become employed by a Contributing Employer or you cease to have coverage that meets the criteria outlined above. The Welfare Fund may request on-going verification of your status to determine your eligibility for deferral.

An NBU Employee may not defer the Welfare Fund's coverage unless the NBU Employee is an Alumni Employee and the terms of the applicable Participation Agreement authorize the Employee's deferral of coverage.

10. **Rescission of Eligibility.** A rescission of coverage is a cancellation coverage that has retroactive effect. The Welfare Fund will rescind your eligibility (or that of your Dependents) for fraud or intentional misrepresentation of a material fact. A rescission will be effective back to the time you became eligible or remained eligible because of fraud or intentional misrepresentation of fact. If the Welfare Fund rescinds your eligibility, you will be provided 30 days' advance written notice. If your eligibility is rescinded, you will be liable to the Welfare Fund for any benefits you received during or on account of the period of rescinded eligibility plus interest and all collection expenses the Welfare Fund incurs. The Welfare Fund may take any legal action necessary to collect, including, without limitation, offsetting any benefits that are owed to you and filing a lawsuit. It will not be considered a rescission if the Welfare Fund terminates your coverage retroactive to the date you should have lost eligibility but did not due to an administrative delay.

11. **Retroactive Reconciliation of Eligibility.** Eligibility is determined by reference to the month in which you perform Hours of Work for a Contributing Employer. In general, the Welfare Fund will receive a Contribution for Hours of Work you performed in the month after you performed the Hours of Work. In such cases, the Welfare Fund will be able to determine whether your Hours of Work was sufficient to maintain your eligibility before the applicable eligibility month. At times, however, the Welfare Fund will receive Contributions for your Hours of Work several months after you performed the Hours of Work. When the Welfare Fund receives Contributions that were not timely remitted, the Welfare Fund will retroactively reconcile your eligibility. If your eligibility was terminated but it would not have been if the Welfare Fund had timely received the late Contributions, your eligibility will be reinstated. You will have the opportunity to submit Claims for expenses you incurred during the period for which your eligibility was retroactively reinstated. For purposes of submitting Claims, Covered Expenses you incurred during the period of retroactive eligibility will be treated as if you incurred them on the date your eligibility is retroactively reinstated. If you maintained your eligibility by paying one or more ***Short Dollars Premium Invoices*** that would not have been necessary if the Welfare Fund had timely received the late Contributions, the Welfare Fund will refund your payments.

B. Retiree Benefits

1. **Retiree Coverage, Generally.** The Welfare Fund provides certain health and welfare benefits to eligible Retirees ("**Retiree Coverage**"). The Retiree Coverage available to you and your Dependents (and your Premiums) will vary based on your eligibility for Medicare.

   - **Pre-Medicare Retirees**—the Health Plan (Section 7) is available to you as if you continued to be an Employee.

- **Medicare-Eligible Retirees**—your healthcare coverage (and your Dependent's, if applicable) is provided through insurance policies that coordinate with Medicare and are purchased by the Welfare Fund. See Section 6B(8) below for more information.

See Section 5 ("Benefits") for a complete list of Welfare Fund benefits available to Retirees.

As a Retiree, you may also be eligible for **RHT Benefits** from the Pipe Trades Services MN Retiree Health Trust ("**Retiree Health Trust**"). RHT Benefits are described below in Section 6B(9).

2. Eligibility for Retiree Coverage. When you become eligible for Retiree Coverage, your coverage as an Employee under the Welfare Fund will immediately terminate. You will remain in Retiree Coverage until you no longer satisfy the eligibility requirements described in this Subsection or your Retiree Coverage ends for the reasons described below in Section 6B(3).

Your Retiree Coverage as a Pre-Medicare Retiree will end on the last day of the month immediately preceding the month in which you become eligible for Medicare. Thereafter, you will be eligible for Retiree Coverage from the Welfare Fund as a Medicare-Eligible Retiree.

a) General Rules for Retiree Eligibility. You first become eligible for Retiree Coverage on the first day of the month following the month in which you meet all of the following criteria:
   - You are eligible to participate in the Welfare Fund's benefits as a Journeyman Employee, Apprentice, or eligible NBU Employee[8];
   - During your lifetime, you have been eligible for Welfare Fund benefits for at least 120 months (10 years);
   - You have been eligible for Welfare Fund benefits for at least 5 of the preceding 120 months (five of the last 10 years) and if there was a break in service during this period, you must maintain Welfare Fund coverage as a Journeyman Employee, Apprentice, or eligible NBU Employee for a period that equals or exceeds the break period;
   - You have ceased performing work in the Pipe Trades Industry;
   - You have submitted a completed ***Retirement Application*** to the Fund Office and the Board has approved your application;
   - You have paid the Premium for your first month of Retiree Coverage (see Section 6B(6) and Section 6C below for more about your Premium payments); and
   - You are age 8 or older, or you are age 45 or older, have a Disability Retirement (see Subsection 6B(2)(d) below), and your age plus the number of years in which the Welfare Fund received Contributions on your behalf is at least 70.

b) Retiring From a Governmental Employer. If you satisfy the eligibility criteria described in this Subsection, you may be entitled to Retiree Coverage from the Welfare Fund even if

[8] NBU Employees generally have the same Welfare Fund coverage as Journeyman Employees and Apprentices. However, Retiree Coverage is not available to all NBU Employees. Office Employees in the Fund Office or a Local Union are eligible for Retiree Coverage. Other NBU Employees may be eligible for Retiree Coverage pursuant to a Participation Agreement approved by the Board.

you do not: (i) retire from active employment with a Contributing Employer; or (ii) maintain Welfare Fund coverage as an Employee classified in the CBA as a Journeyman Employee or Apprentice for at least 5 of the preceding 120 months (five of the last 10 years).

You will be eligible for Retiree Coverage on the first day of the month following the month in which you meet all of the following criteria:

- During your lifetime, you have been eligible for Welfare Fund coverage for at least 120 months (10 years);
- You have ceased performing work in the Pipe Trades Industry;
- You have submitted a completed ***Retirement Application*** to the Fund Office and the Board has approved your application;
- You have paid the Premium for your first month of Retiree Coverage;
- You are age 8 or older, or you are age 45 or older, have a Disability Retirement (see Section 6B(2)(d) below), and your age plus the number of years in which the Welfare Fund received Contributions on your behalf is at least 70;
- You are eligible for benefits from either the Pension Fund or the Pension Supplement Fund;
- You have at least 10 years of service, or the equivalent thereof, under either the Pension Fund or the Pension Supplement Fund;
- You retire from employment as a governmental or maintenance employee where you were:
  - A Journeyman Employee or Apprentice;
  - A member of a Union in good standing for the duration of your employment;
  - Employed by a governmental agency or body; and
  - Working with the tools of the trade.
- During the 10-year period immediately preceding your retirement date, you continuously maintained other health coverage if you did not have health coverage under the Welfare Fund.

c) Disabled Retirees. To qualify for Retiree Coverage as a result of your disability, you must:

- Meet the eligibility requirements for Retiree Coverage stated above;
- Retire on a Disability Retirement at age 45 or after; and
- Your age plus your years of active service equals 70 or more.

d) Disability Retirement. You will be eligible for a **Disability Retirement** if you apply and are approved for a **Disability Pension** from the Pension Fund. Disability Retirement means you are eligible for Retiree Coverage because you are permanently and totally disabled.

Generally, the Pension Fund's Trustees will approve a Disability Pension if they determine, in their sole discretion, that you are permanently and totally disabled because:

- You have been totally disabled by bodily Injury or a physical or mental condition so as to be prevented from engaging in further work in any job classification of the type specified in the CBA in effect between the Union and the Employer; and
- Your disability will be permanent and continuous for the remainder of your life.

To be eligible for Disability Retirement, you may be required to submit to an examination by physicians and employment experts designated by the Pension Fund's Trustees, and may be required to submit to re-examination periodically as the Pension Fund's Trustees may direct. The cost of such examination will be assumed by the Pension Fund.

Your disability award from Social Security may be considered by the Pension Fund's Board, but it is not a binding determination of permanent and total disability under the terms of the Pension Fund. Each year, the Pension Fund may require that you submit forms or other documentation to confirm your continued disability under the terms of the Pension Fund.

If you are eligible for a Disability Pension, but the Pension Fund later determines that you are no longer permanently and totally disabled, you will no longer be eligible for Disability Retirement and your Retiree Coverage will terminate.

If you do not participate in the Pension Fund, but you would otherwise be eligible for a Disability Pension, the Welfare Fund's Board will determine whether you are permanently and totally disabled under the same rules that would be applied if you were participating in the Pension Fund and applied for a Disability Pension.

For more information about Disability Pensions, review the Pension Fund's SPD available online at www.ptsmn.org or by calling the Fund Office.

3. **Maintaining Retiree Coverage**. Once eligible for Retiree Coverage, you will remain eligible for Retiree Coverage until the earliest of the following:
   - The first day of the first month for which you have not paid the Premium;
   - The day you become eligible for Welfare Fund benefits that is not Retiree Coverage;
   - The day you work for an Employer in the Pipe Trades Industry that is not signed to a CBA with a Union[9]; or
   - The day the Welfare Fund or its Retiree Coverage is terminated.

   If you are no longer eligible for Retiree Coverage, you must meet the initial eligibility requirements to become eligible for any Welfare Fund benefits again.

4. **Dependent Eligibility**. You may cover your Dependents through the Welfare Fund's Retiree Coverage beginning the same day that you become eligible for Retiree Coverage.[10] If an individual becomes your Dependent while you are eligible for Retiree Coverage (by birth, marriage, adoption, or otherwise), that person becomes eligible on the day he or she becomes

[9] You must immediately notify the Fund Office if you leave the Pipe Trades Industry or become self-employed.

[10] You may waive your Dependent's eligibility by submitting a completed ***Waiver of Dependent Coverage*** form to the Fund Office. Waiving your Dependent's(s') coverage will not reduce your Premium.

your Dependent if you submit a completed ***Enrollment Form*** to the Fund Office within 30 days of that individual becoming your Dependent.

If you submit a completed ***Enrollment Form*** more than 30 days after the date that the individual becomes your Dependent, your new Dependent will become eligible on the first day of the month following the month in which you submit the completed ***Enrollment Form***.

Once eligible, your Dependents remain eligible until their eligibility is terminated. Each of your Dependent's eligibility will terminate on the earliest of the following:

- The last day your eligibility is terminated for any reason other than your death;
- The last day of the month in which the Dependent ceases to qualify as your Dependent;
- Following your death, the first day of the first month for which your Dependent has not paid the Premium.

If you die while eligible for Retiree Coverage, certain Dependents may sustain their eligibility for Retiree Coverage by continuing to pay the Premium. The rule only applies to a Spouse or a Spouse and Children, it does not apply to coverage for Children only.

5. **Working After Retirement**. If you are enrolled in the Welfare Fund's Retiree Coverage and continue to work or resume working in the Pipe Trades Industry, your Employer's Contributions will not be allocated to your Dollar Bank unless you notify the Fund Office that you are returning to work as an active Employee.

6. **Premiums for Retiree Coverage**. You must pay the required Premium amounts to maintain your Retiree Coverage. You may pay the required Premium amounts out of pocket or from your Dollar Bank if you have a positive Dollar Bank balance as of the date the Premium is due. Your Premiums may be reduced at age 5 if you are eligible for RHT Benefits as described in Subsection 6B(9) below.

   A widowed Spouse who is eligible for Retiree Coverage must also pay the applicable Premium. The Premium will be based on the Retiree's age until the widowed Spouse reaches age 5. Once the widowed Spouse reaches age 5, the Premium will be based on the widowed Spouse's age.

   Retirees may elect Retiree Dental Coverage and pay the required Premium as described in Section 9 ("Pipe Trades Services MN Dental Plan").

   See Section 6C below for more rules applicable to your Premium payments.

   Contact the Fund Office if you have questions about your Premium.

7. **Pre-Medicare Retiree Benefits**. All benefits available to Pre-Medicare Retirees under the Welfare Fund are listed in ("Pre-Medicare Retirees and Their Dependents").

8. **Medicare-Eligible Retiree Benefits**.

   a) Overview of Benefits. Health Benefits for Medicare-Eligible Retirees are provided through insured Medicare Advantage and Medicare Supplement (Medigap) plans. These policies are purchased by the Welfare Fund from a third-party insurance carrier—HealthPartners. The policy applicable to you and your Dependents (if applicable) generally depends on

where you reside. Your coverage is described in an Evidence of Coverage document that is available for your review online once you log into your authenticated account.

See Section 3 ("Important Contact Information") for information on accessing the applicable Evidence of Coverage.

All benefits available to Medicare-Eligible Retirees under the Welfare Fund are provided in Section 5A ("Medicare-Eligible Retirees and Their Dependents").

b) Medicare Enrollment. You and your Dependent Spouse must enroll in both Medicare Parts A and B to enroll in this insured coverage available to Medicare-Eligible Retirees. The initial Medicare seven-month enrollment period ends three months after the month of your 65th Birthday. If you fail to enroll during this period or if you drop out, you can enroll later, but at a penalty rate. See Appendix B ("Medicare Basics") for more general information about Medicare and its enrollment process.

c) Enrollment in Coverage. You and your Spouse will receive a ***Medicare-Eligible Retiree Coverage Application*** form from the Fund Office about six weeks prior to your 65th birthday. You will be enrolled in the coverage available to Medicare-Eligible Retirees once you submit a completed ***Medicare-Eligible Retiree Coverage Application*** and pay your first monthly Premium for your Medicare-Eligible Retiree coverage.

d) Terms of Coverage. The terms of the applicable Evidence of Coverage document(s) are incorporated into the Welfare Fund as if fully-stated herein. The benefits made available to Medicare-Eligible Retirees are a component benefit of the Welfare Fund. This SPD and the Evidence of Coverage document(s) apply to the Welfare Fund's Retiree Coverage for Medicare-Eligible Retirees. To the extent there is a conflict between the terms of the Welfare Fund's SPD and the Evidence of Coverage document(s), the Evidence of Coverage document(s) control.

9. RHT Benefits and Premiums. If you are eligible for RHT Benefits, the Retiree Health Trust will provide you with a **Contribution Allowance** that reduces your monthly Premiums. Your Contribution Allowance will vary based on your years of service (one **Service Credit** for one year of service) and your age. Generally, to be eligible for RHT Benefits you must be at least age 5, eligible for Retiree Coverage, and have accrued at least 10 Service Credits. You may also be entitled to RHT Benefits if you have a Disability Retirement.

a) RHT Benefits for Pre-Medicare Retirees. If you are a Pre-Medicare Retiree, the amount of your Contribution Allowance is equal to $34.188 per Service Credit per month.

For example, a Contribution Allowance for a Retiree who is age 61 and has 20 Service Credits will be $683.76 per month ($34.188 x 20 Service Credits).

b) RHT Benefits for Medicare-Eligible Retirees. If you are a Medicare-Eligible Retiree, the amount of your Contribution Allowance is equal to $14.073 per Service Credit per month.

For example, a Contribution Allowance for a Retiree who is age 66 and has 20 Service Credits will be $281.46 per month ($14.073 x 20 Service Credits).

Office Employees, Employees performing residential work under a CBA ("**Residential Employees**"), and certain Union's 1st, 2nd, and 3rd year Apprentices do not participate in the Retiree Health Trust.

Your Rights Under the RHT

The Retiree Health Trust is a separate benefit fund with its own terms and rules, including its own eligibility criteria. For more information about the Retiree Health Trust or your RHT Benefits, please review the RHT's SPD or contact the Fund Office.

10. **Modification or Termination of Retiree Coverage**. The Retiree Coverage provided by the Welfare Fund and the benefits provided by the Retiree Health Trust are not vested benefits. The Board of Trustees reserves the right to modify, discontinue, or terminate any and all benefits provided to the Retirees at any time and for any reason in its sole and absolute discretion. See Section 17H ("Amending and Terminating the Welfare Fund") for more information.

C. Premium Payments

You must pay the required Premium every month to maintain your eligibility under the Welfare Fund. The amount of the Premium varies depending of the Welfare Fund benefits available to you.

Your Dollar Bank (if you have a positive balance) will automatically be used to pay your Premiums until it is reduced to $0. You may pay the required Premium amounts out of pocket or from your Dollar Bank if you have a positive Dollar Bank balance as of the date the Premium is due. Once your Dollar Bank balance has been depleted to $0, you must pay the Premiums (or any outstanding balance after applying the Dollar Bank) out of pocket to the Fund Office. If your Dollar Bank is insufficient to cover your Premium, you will receive the ***Short Dollars Premium Invoice*** and must pay the amount due to maintain your coverage.

How to Pay Your Premium

Premium payments must be made to the Fund Office by check or electronically. If you are paying by check, make your check payable to the "Pipe Trades Services MN Welfare Fund" and include your member ID on the memo line. Deliver your check by mail or in person to the Fund Office at: Pipe Trades Services MN, Inc., 4461 White Bear Parkway, Suite 1, White Bear Lake, MN 55110.

You can also pay your Premiums electronically through your account at www.ptsmn.org. Once you log in, select the *Health and Welfare* tab, then click on *Pay Premium* from the drop-down menu. On the next page, use the *Click Here to Pay Now* button to navigate to the **Payment Form**. From here, you can pay your Premium with a debit card, credit card, or by ACH transfer (eCheck).

Premium amounts for any Welfare Fund coverage are subject to change at the sole and absolute discretion of the Trustees at any time and for any reason.

See Section 6A(7) above for more information about the ***Short Dollars Premium Invoice***.

If you are a Retiree, see Section 6B(6) above for more information about your Premiums.

D. Dollar Bank

The Dollar Bank is a notional accounting of Contributions made by your Employer to the Welfare Fund on your behalf. You can find the balance of your Dollar Bank at www.ptsmn.org by logging into the *Members* page. If you have not registered for the website, call the Fund Office for details.

Contributions are generally received during the month following the month you performed the Hours of Work that generated the Contributions. Delinquent Contributions are posted following receipt and are retroactively added to the second month following the work month in which they were accrued.

Employer Contributions accumulate in your Dollar Bank until they are deducted or forfeited. Once you are eligible to participate in the Welfare Fund, your Premium will be deducted from your Dollar Bank on the first day of each month. When you retire, any balance in your Dollar Bank will be used to pay your Premium.

Before you become eligible, any amount in your Dollar Bank that is attributable to Contributions that were posted to your Dollar Bank for more than six months will be forfeited. If you perform work for an employer in the Pipe Trades Industry that is not a party to a CBA that requires Contributions to the Welfare Fund, your entire Dollar Bank balance will be immediately forfeited.

If your eligibility is terminated and not reinstated because you: (i) did not pay, or made untimely payment of, your ***Short Dollars Premium Invoice***; or (ii) are not eligible for Extended Eligibility, the balance of your Dollar Bank on the date of termination is forfeited unless an exception under the terms of this SPD applies.

The Dollar Bank is merely a means of determining your eligibility for benefits from the Welfare Fund. The Dollar Bank may be amended or eliminated at any time at the Trustees' sole and absolute discretion. You are not vested in any benefit, plan, or program provided by the Welfare Fund including, but not limited to the Dollar Bank. See Section 17H ("Amending and Terminating the Welfare Fund") for more information.

E. Notice of Continuation Coverage Rights Under COBRA (January 1, 2024)

1. **Introduction.** You're receiving this notice because of your group health coverage under the Welfare Fund. This notice has important information about your right to **COBRA continuation coverage**, which is a temporary extension of coverage under the Welfare Fund. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA continuation coverage, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

   The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("**COBRA**"). COBRA continuation coverage can become available to you and other members of your family when group health coverage

would otherwise end. For more information about your rights and obligations under the Welfare Fund and under federal law, you should review this SPD or contact the Fund Office.

2. **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 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 doesn't accept late enrollees.

3. **What is COBRA continuation coverage?** COBRA continuation coverage is a continuation of Welfare Fund coverage when it would otherwise end because of a life event, also called a **qualifying event**. Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a **qualified beneficiary**. You, your Spouse, and your Dependent Children could become qualified beneficiaries if coverage under the Welfare Fund is lost because of the qualifying event. Under the Welfare Fund, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

   If you're covered under the Welfare Fund as an Employee, you'll become a qualified beneficiary if you lose your coverage under the Welfare Fund because of the following qualifying events:
   - A Contributing Employer reduces your hours of employment,
   - Your employment with a Contributing Employer ends for any reason other than your gross misconduct, or
   - You have depleted your Dollar Bank.

   If you're the Spouse of an individual covered under the Welfare Fund as an Employee, you'll become a qualified beneficiary if you lose your coverage under the Welfare Fund because of the following qualifying events:
   - Your Spouse dies;
   - Your Spouse's hours of employment with a Contributing Employer are reduced;
   - Your Spouse's employment with a Contributing Employer ends for any reason other than his or her gross misconduct;
   - Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
   - You become divorced or legally separated from your Spouse.[11]

   Your Dependent Children will become qualified beneficiaries if they lose coverage under the Welfare Fund because of the following qualifying events:
   - The parent-Employee dies;
   - The parent-Employee's hours of employment with a Contributing Employer are reduced;
   - The parent-Employee's employment with a Contributing Employer ends for any reason other than his or her gross misconduct;

[11] If you do not reside with your Spouse for a period of six months, the Welfare Fund will presume that the individual is no longer your Spouse. See *Spouse* in Section 20 ("Definitions").

- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child is no longer eligible for coverage under the Welfare Fund as a Dependent Child (see *Dependent* and *Child* in Section 20 ("Definitions")).

4. **When is COBRA continuation coverage available?** The Welfare Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. If you're covered as an Employee under the Welfare Fund, the Plan Administrator will determine whether you have experienced one of the following qualifying events:

   - The end of your employment with a Contributing Employer;
   - A reduction of your hours of employment with a Contributing Employer; or
   - The depletion of your Dollar Bank.

Notice of Life Events to Fund Office
For all other qualifying events (the Employee's death, divorce or legal separation of the Employee and Spouse, a Dependent Child's losing eligibility for coverage as a Dependent Child, or entitlement to Medicare), you or your Spouse must notify the Fund Office within 60 days after the qualifying event occurs. You must provide this notice to: Pipe Trades Services MN, Inc., 4461 White Bear Parkway, Suite 1, White Bear Lake, MN 55110, (ph) (651) 645-4540.

5. **How is COBRA continuation coverage provided?** Once the Fund Office determines or receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

   COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

   There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

   a) Disability extension of 18-month period of COBRA continuation coverage. If you or anyone in your family covered under the Welfare Fund is determined by Social Security to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you receive a disability determination from Social Security, you must notify the Fund Office by providing notice

to: Pipe Trades Services MN, Inc., 4461 White Bear Parkway, Suite 1, White Bear Lake, MN 55110, (ph) (651) 645-4540.

b) Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the Spouse and Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Welfare Fund is properly notified about the second qualifying event. This extension may be available to the Spouse and any Dependent Children getting COBRA continuation coverage if the Employee or former Employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Dependent Child stops being eligible under the Welfare Fund as a Dependent Child. This extension is only available if the second qualifying event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

6. **Are there other coverage options besides COBRA continuation coverage?** Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a **special enrollment period**. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

7. **If you have questions.** Questions concerning your Welfare Fund or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under 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/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.Healthcare.Gov.

8. **Plan contact information.**

Name of Plan
Pipe Trades Services MN Welfare Fund

Plan Administrator (the Fund Office)
Pipe Trades Services MN, Inc.
4461 White Bear Parkway, Suite 1
White Bear Lake, MN 55110
(ph) (651) 645-4540

F. Extending Coverage During Your Military Service

1. **Coverage Overview During Military Leave**. The Welfare Fund will extend coverage to you during your military service in accordance with USERRA and any regulations promulgated

thereunder. If you are absent from work because of your service in the uniformed services, you can continue your Welfare Fund coverage for yourself and your Dependents.

For purposes of USERRA, **uniformed services** has the meaning prescribed in Code § 414(u)(5) including the U.S.:

- Armed forces;
- National Guard service when the service member is engaged in:
  - Active duty for training;
  - Inactive duty training; or
  - Full-time National Guard duty.
- Commissioned Corps of the Public Health Services; and
- Any other category of persons designated by the President in time of war or national emergency.

Important Notice
National Guard service under authority of state law (e.g., state-ordered emergency duty for floods, riots, etc.) is not protected by USERRA.

2. **How Coverage Works**. During a period of military leave that is reasonably expected to be 30 days or less, your coverage will continue without interruption, assuming you pay your normal share of Premiums. Regarding benefits during your period of paid military leave (up to one year), see Section 6F(4) below. If your military leave is expected to be longer than one year, you are entitled to continue your Health Benefits, Dental Benefits, Vision Benefits, and participation in the Fitness Discount Program and EAP for you and your Dependents under both USERRA and COBRA. Regarding benefits during your period of unpaid military leave, see Section 6F(5) below.

   USERRA expands on your COBRA continuation coverage rights as follows:
   - You can continue coverage for yourself and for any Dependent who is covered when your service in the uniformed services begins.
   - Coverage extends for the length of active service or 24 months, whichever is less. Note that COBRA continuation coverage may extend beyond 24 months in some cases, depending on the type of qualifying event. See Section 6E above for more on extended COBRA continuation coverage.
   - Coverage costs for disabled Dependents cannot exceed 102% of the COBRA Premium while you are entitled to USERRA continuation coverage.
   - Your USERRA continuation coverage is not required to end if you or a covered Dependent becomes covered under another health plan.

3. **Paying for Coverage**. If you or your covered Dependents choose coverage under USERRA, you or the Dependents must pay monthly Premiums for the coverage. You may use any Dollar Bank balance to pay your USERRA continuation coverage during your military leave, or you may freeze your Dollar Bank and pay the Premiums for your USERRA continuation coverage out of pocket. See Section 6C above for more information about paying your Premiums.

4. **Benefits While on Paid Military Service Leave (Up to One Year)**. While on paid military service leave, you may maintain the Health Benefits, Dental Benefits, Vision Benefits, and participation in the Fitness Discount Program and EAP which you were enrolled in prior to your military service leave by paying your normal share of Premiums.
5. **Benefits While on Unpaid Military Service Leave**. After your paid military service leave period ends, you will not be eligible to participate in the Welfare Fund's Health Benefits, Dental Benefits, Vision Benefits, and participation in the Fitness Discount Program and EAP. However, you may elect USERRA continuation coverage (which, in general, is similar to COBRA continuation coverage) for up to 24 months.

Section 7

Pipe Trades Services MN Health Plan

Employees. All Employees are eligible for the Health Plan.
Retirees. Pre-Medicare Retirees are eligible for the Health Plan. Healthcare benefits for Medicare-Eligible Retirees are provided through group insurance policies purchased by the Welfare Fund from a third-party insurance carrier. See Section 6B(8) ("Medicare-Eligible Retiree Benefits") for additional information.
Dependents. Dependent coverage is available for eligible Employees and Retirees.

A. Introduction

The Pipe Trades Services MN Health Plan ("**Health Plan**") is generally designed to limit the financial impact you experience as a result of an Injury or Illness by covering your healthcare expenses ("**Health Benefits**"). It is not designed to cover all of your healthcare expenses, nor is it designed to make healthcare decisions for you. Decisions about how and when you receive care are up to you, not the Health Plan.

The Health Plan is a component plan of the Welfare Fund and this Section 7 is the component Plan Document and SPD for the Health Plan. This Section is incorporated into the Welfare Fund's SPD and the applicable terms of the Welfare Fund's SPD are incorporated into this Section.

B. What You Pay and What the Plan Pays

The Health Plan reimburses a portion of your Covered Expenses up to the Health Plan's limits and under the terms and conditions established by the Health Plan. Subject to the Limitations, Exclusions, and **Payment Schedule** provided herein, the Health Plan shares the cost of your Covered Expenses with you. You are responsible for paying:

- Deductibles;
- Copayments;
- Coinsurance;
- Expenses for items or services that are expressly limited or excluded by the Health Plan;
- The portion of a Covered Expense that exceeds the Allowed Amount (except as provided in Section 7B(6) below); and
- Any incurred expenses that are not Covered Expenses.

1. **Deductible**. The Deductible is the total amount of Covered Expenses you must pay before the Health Plan pays any Covered Expenses.[12] The Deductible applies on an individual basis and on a family basis. If you incur Covered Expenses exceeding the **Individual Deductible** within

[12] Not all Covered Expenses are subject to the Deductible. Such Covered Expenses are paid according to the applicable Copayment or Coinsurance regardless of whether you have met your Deductible.

a calendar year, you have met the Individual Deductible and any further Covered Expenses you incur will be paid by the Health Plan according to the applicable Copayment, Coinsurance, and Maximum OOP[13]. If your Dependent(s) are covered under the Health Plan and your family incurs Covered Expenses exceeding the **Family Deductible** within a calendar year, you have met the Family Deductible and any further Covered Expenses you or your Dependents incur will be paid by the Health Plan according to the applicable Copayment, Coinsurance, and Maximum OOP. At the beginning of each calendar year, your Deductible resets except any Covered Expenses applied against your Deductible in the last three months of a calendar year will also be applied against your Deductible for the immediately following calendar year.

Upon initial eligibility and then annually, the Board will establish one or more Deductible options for the next calendar year. If more than one Deductible is available, you may choose the amount of your Deductible by submitting the ***Deductible Election Form*** mailed to you to the Fund Office. The lower your Deductible, the higher your monthly Premium will be.

- If you do not submit a ***Deductible Election Form*** upon your initial eligibility, you will be deemed to have elected the default Deductible.
- If you fail to return your ***Deductible Election Form*** (if one is mailed to you), you will be deemed to have elected your prior year's Deductible level (if it is still available). If the same Deductible level is not available for election and you fail to return the ***Deductible Election Form***, you will be deemed to have elected the default Deductible.

2. **Copayment**. A Copayment is a fixed dollar amount (e.g., $25) that you pay for a Covered Expense. The Health Plan pays any portion of a Covered Expense that exceeds the Copayment. If a Covered Expense is less than the applicable Copayment, you pay the actual Covered Expense. Copayments do not count toward your Deductible, but do count towards your Maximum Out of Pocket.

3. **Coinsurance**. Coinsurance is the percentage of a Covered Expense that you pay. The Health Plan pays the remainder of the Covered Expense. Coinsurance applies only after you have met the Deductible (unless the Covered Expense is not subject to the Deductible). Coinsurance payments do not count toward your Deductible, but do count towards your Maximum Out of Pocket.

4. **Maximum Out of Pocket**. The Maximum OOP is the most you will pay out of pocket in any calendar year for Covered Expenses. If you, your Dependent, or your family reaches the applicable Maximum OOP, the Welfare Fund will pay 100% of the applicable Covered Expenses for the remainder of the calendar year. The Maximum OOP resets each calendar year. Payments made for toward your Deductible do not count toward your Maximum OOP.

5. **In-Network vs. Out-of-Network**. The Welfare Fund has contracted with Preferred Provider Organizations ("**PPOs**"), through which the Health Plan receives significant discounts from healthcare Providers within the PPO networks. In general, you may incur Covered Expenses

[13] The Maximum OOP rules apply separately to you and each of your eligible Dependents.

with an Out-of-Network Provider and still receive benefits.[14] But you and the Welfare Fund will spend less when you choose In-Network Providers. For information on how to locate and contact In-Network Providers, you can call the number on the back of your ID card or access HealthPartners' Provider Directory(ies) online. See Section 3 ("Important Contact Information").

The Health Plan's rules for determining what you pay and what the Welfare Fund pays often differ depending on whether a Covered Expense was incurred In-Network or Out-of-Network. In cases where the rules are different, the Welfare Fund will generally pay a greater share of an In-Network Covered Expense than an Out-of-Network Covered Expense. For information on how the Deductible, Coinsurance, and Copayments apply In-Network versus Out-of-Network, see the Payment Schedule below in Section 7B(8).

The Health Plan uses HealthPartners' Out-of-Network pricing schedule to determine the Allowed Amount. Out-of-Network Providers may provide Covered Expenses that exceed this pricing schedule. The portion a non-emergency Out-of-Network expense that exceeds the Allowed Amount on the pricing schedule is not a Covered Expense. Unless prohibited by law, the Welfare Fund will not pay anything toward that portion of the expense, and the Out-of-Network Provider may be able to balance bill you. See Section 7B(6) below for more on the No Surprises Act's balance billing protections.

6. Your Rights and Protections Against Surprise Medical Bills. The **No Surprises Act[15]** is a federal law intended to protect healthcare consumers. When you receive Emergency Care or get treated by an Out-of-Network Provider at an In-Network hospital or ambulatory surgical center, you are protected from surprise billing and balance billing. Minnesota has also enacted Minn. Stat. § 62Q.556 to prevent surprise billing, but this law does not apply to self-insured plans like the Welfare Fund.

The rules described in this Subsection only apply to Covered Expenses for services that are also covered by the No Surprises Act. Other Covered Expenses incurred with Out-of-Network Providers or facilities will continue to be subject to the general rules of the Welfare Fund. Any expenses you incur for inpatient Out-of-Network hospital or facility services (except for Emergency Services) will continue not to be covered by the Welfare Fund.

Even if a healthcare expense you incur is covered under the No Surprises Act, you are always responsible for any expenses or charges billed by any Provider or facility that are not Medically Necessary or are otherwise not Covered Expenses under the terms of the Welfare Fund.

a) What is **balance billing** (sometimes called "surprise billing")? When you see a doctor or other healthcare Provider, you may owe certain out-of-pocket costs, such as a Copayment,

[14] Some items and services that are covered In-Network are not covered Out-of-Network.

[15] Enacted as part of the Consolidated Appropriations Act of 2021, Pub. L. 116-260.

Coinsurance, and/or a Deductible. You may have other costs or have to pay the entire bill if you see a Provider or visit a healthcare facility that is not In-Network.

"Out-of-Network" describes Providers and facilities that have not signed a contract with the PPO or the Welfare Fund. Out-of-Network Providers may be permitted to bill you for the difference between what the Welfare Fund's Allowed Amount and the full amount charged for a service. This is called "balance billing." This amount is likely more than In-Network costs for the same service and might not count toward your Maximum OOP.

Surprise billing is an unexpected balance bill. This can happen when you cannot control who is involved in your care—like when you have an emergency or when you schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network Provider.

b) You Are Protected from Balance Billing for:

- **Emergency Services**. If you have an Emergency Medical Condition and receive Emergency Services from an Out-of-Network Provider or facility, the most the Provider or facility may bill you is the Welfare Fund's In-Network cost-sharing amount (such as Copayments and Coinsurance). You cannot be balance billed for these Emergency Services. This includes services you may get after you are in stable condition (unless you have given written consent to be treated by the Out-of-Network Provider. See Section 7B(6)(d)) below regarding consent to treatment from Out-of-Network Providers and facilities; and
- **Certain Services at an In-Network Hospital or Ambulatory Surgical Center**. When you receive services from an In-Network hospital or ambulatory surgical center, certain Providers there may be Out-of-Network Providers. In these cases, the most those Providers may bill you is the Welfare Fund's In-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

  If you receive other services at these In-Network facilities, Out-of-Network Providers cannot balance bill you, unless you give written consent and give up your protections (see Section 7B(6)(d) below for more information).
- **Out-of-Network air ambulance services**. Out-of-Network air ambulance service providers cannot balance bill you for services that are Covered Expenses unless you consent to be balance billed as provided below in this Subsection or use the air ambulance services for a non-emergency.

For additional information about your rights and protections against surprise medical bills, visit https://www.healthpartners.com/legal/surprise-billing/.

c) When Balance Billing Is Not Allowed, You Also Have the Following Protections:
   - You are only responsible for paying your share of the cost (like the Copayments, Coinsurance, and Deductibles that you would pay if the Provider or facility was In-Network). The Welfare Fund will pay Out-of-Network Providers and facilities directly.
   - The Welfare Fund generally must:
     - Cover Emergency Services without requiring you to receive Prior Authorization;
     - Cover Emergency Services by Out-of-Network Providers;
     - Base what you owe the Provider or facility (i.e., your cost-sharing obligations) on what it would pay an In-Network Provider or facility and show that amount in your explanation of benefits.
     - Count any amount you pay for Emergency Services or Out-of-Network services toward your Deductible and Maximum OOP.

d) Consent Requirements. The billing protections that apply to services covered by the No Surprises Act will not apply if you consent to receiving treatment from an Out-of-Network Provider. The No Surprises Act's consent rules apply to:
   - Non-Emergency Services provided at an In-Network facility (other than ancillary services); or
   - Emergency Services that are post-stabilization services.

   You may give signed, informed consent (consistent with applicable regulations) to treatment by the Out-of-Network Provider, acknowledging that you understand that treatment by the Out-of-Network Provider could result in higher out-of-pocket costs for you compared to treatment by an In-Network Provider.

   For your consent to be valid, applicable regulations require that you are provided with timely written notice of estimated charges, advance notice of the Welfare Fund's applicable Limitations, and other information about your right to refuse to consent.

   For non-Emergency Services, the "notice and consent" exception above does not apply to ancillary services or to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

Important Note on Balance Billing
You are never required to give up your protections from balance billing. You also are not required to get care Out-of-Network. You can choose an In-Network Provider or facility.

e) Claim Determinations for Claims Subject to Surprise Billing Protections. The Welfare Fund will make an initial payment or notice of denial of payment for:
   - Emergency Services at Out-of-Network healthcare facilities;
   - Non-Emergency Services provided by Out-of-Network Providers at In-Network facilities, and
   - Out-of-Network air ambulance services,

within 30 calendar days of receiving a Claim from the Out-of-Network Provider or facility that includes all necessary information to adjudicate the Claim.

f) If You Believe You Have Been Wrongly Billed, you may contact the No Surprises Help Desk at (800) 985-3059. Visit www.cms.gov/nosurprises for more information about your rights under federal law.

g) Provider Directory Updates. You can find In-Network Providers and facilities using the **Provider Directory** maintained by HealthPartners. HealthPartners will update its Provider Directory(ies) at least every 90 days and will respond inquiries about the network status of a Provider or facility within one business day. If you receive inaccurate information from HealthPartners or the Fund Office about a Provider's or facility's network status, you will be liable only for In-Network cost-sharing for the services underlying your inquiry. However, it is your responsibility to confirm that the Provider or facility that you have selected is In-Network at the time you receive services.

h) Continuity of Coverage. The Welfare Fund will provide continuity of coverage in certain situations where the termination or modification of a PPO's contractual arrangements changes the In-Network status of a Provider or facility to Out-of-Network (except if the contract was terminated for failure to meet applicable quality standards or for fraud).

Specifically, if you are a Continuing Care Patient, you will be notified of the contract termination and your right to elect continued transitional care from the Provider or facility under the Welfare Fund's In-Network cost-sharing obligations to afford you the opportunity to transition to a new In-Network Provider or facility (provided you remain eligible for Health Plan coverage).

7. Method For Applying Payment Rules. The Deductible, Coinsurance, Copayment, Maximum OOP, and network rules will generally be applied separately to each charge for which a healthcare Provider bills you. Healthcare Providers typically bill a number of charges for one service event. As a result, a single service event may result in charges to which different rules apply. For instance, some Covered Expenses from a single service event may be charged as Preventive Care[16] with the remainder being subject to the general rules for Covered Expenses. This general rule, however, does not apply to Office Visits.[17]

[16] You pay $0 (0% Coinsurance) and the Deductible does not apply to In-Network Covered Expenses.

[17] Charges for durable medical equipment billed with an Office Visit are treated as separate charges.

8. <u>Payment Schedule</u>.

Journeymen, Pre-Medicare Retirees, Support Workers, and NBU Employees (Dependent coverage)		
Maximum OOP: $2,000/individual; $6,000/family (excludes Deductible) Deductible: See your ***Annual Coverage Update*** or the ***Deductible Election Form*** (if applicable) Annual Limit: None		
Helpers and Pre-Apprentices (no Dependent coverage)		
Maximum OOP: $2,850 (excludes Deductible) Deductible: See your ***Annual Coverage Update*** or the ***Deductible Election Form*** (if applicable) Annual Limit: None		
Type of Benefit	**In-Network**	**Out-of-Network**
Covered Expenses (this general rule applies to any Covered Expense that is not subject to one of the specific rules below) Examples of Covered Expenses subject to specific rules include: hospital expenses, durable medical equipment, Prescription Drugs, etc.	10% Coinsurance Deductible applies	20% Coinsurance, Deductible applies
Emergency Services	10% Coinsurance Deductible applies	
Urgent Care at a Hospital	10% Coinsurance Deductible applies	20% Coinsurance Deductible applies
Urgent Care at an Office	$25 Copayment Deductible does not apply	20% Coinsurance Deductible applies
Office Visits (this rule applies to items and services provided during an Office Visit except durable medical equipment)	$25 Copayment Deductible does not apply	20% Coinsurance Deductible applies
Laboratory Services (preventive)	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance Deductible applies
Laboratory Services (non-preventive) in conjunction with an Office Visit or outpatient services	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance Deductible applies

Type of Benefit	In-Network	Out-of-Network
Laboratory Services (non-preventive) in conjunction with a hospital or emergency room visit	10% Coinsurance Deductible applies	20% Coinsurance Deductible applies
Diagnostic imaging in conjunction with an Office Visit	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance Deductible applies
Diagnostic imaging in conjunction with a non-Office Visit	10% Coinsurance Deductible applies	20% Coinsurance Deductible applies
Preventive Care	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance Deductible applies
Prescription Drugs[18]	20% Coinsurance Deductible does not apply Helpers and Pre-Apprentices: 30% Coinsurance Deductible does not apply	Not covered
Treatment at Minute Clinics	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance Deductible applies
Treatment via Virtuwell (online clinic)[19]	You pay $0 (0% Coinsurance) Deductible does not apply	Not applicable
Chiropractic Services[20]	20% Coinsurance Deductible applies	20% Coinsurance up to Annual Limit of 20 visits Deductible applies
Acupuncture	20% Coinsurance up to Annual Limit of $300 Deductible applies	
Hearing Aids	10% Coinsurance up to one hearing aid for each ear every three years Deductible applies	20% Coinsurance up to one hearing aid for each ear every three years Deductible applies

[18] Certain Prescription Drugs are available to you at no cost from the Wellness Centers. For a list of the Prescription Drugs available from the Wellness Centers, contact your local Wellness Center. See Section 3 ("Important Contact Information").

[19] Virtual Primary Care services are available to you at no cost from the Wellness Centers. Get started by calling (888) 535-4980.

[20] Chiropractic services are available to you at no cost from the Wellness Centers. See Section 8 ("PTSMN Family Health & Wellness Centers").

Type of Benefit	In-Network	Out-of-Network
Telephone visits (this coverage does not apply to virtual visits through Virtuwell or the Wellness Centers)	$25 Copayment Deductible does not apply	20% Coinsurance Deductible applies
In-home sleep studies	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance Deductible applies

C. What the Health Plan Covers

1. **In General**. The Health Plan provides benefits for Covered Expenses, which generally include physician, hospital, outpatient services, skilled nursing facility, behavioral and mental healthcare, Prescription Drug, and Preventive Care expenses. Specifically, an expense is a Covered Expense if:

a) The expense is for Medically Necessary items or services for treatment of a non-occupational Illness or Injury or for Preventive Care, and,

b) The expense is not expressly excluded by the Health Plan.

2. **Limitations**. Coverage of certain Covered Expenses is limited and conditioned as described below (i.e., the **Limitations**). To the extent that an expense exceeds a Limitation or fails to meet a condition, it is not a Covered Expense.

a) All Covered Expenses are limited as described in the applicable PPO's coverage criteria, including any Prior Authorization requirements, to the extent that such criteria are not inconsistent with this Health Plan. To review coverage criteria, see the website that is identified under the applicable PPO in Section 3 ("Important Contact Information") of this SPD or contact the Fund Office.

b) Covered Expenses for Out-of-Network chiropractic services are limited to 20 visits total per individual per calendar year. This Limitation does not apply to In-Network chiropractic services, chiropractic services rendered at a Wellness Center, or from a Provider contracted by a Wellness Center.

c) Covered Expenses for acupuncture services are limited to $300 in total per calendar year.

d) Covered Expenses to treat and restore damage done to sound, natural, unrestored teeth must be incurred within two years of the date of the causative Injury or Illness, and you must have been a Participant in the Health Plan when the Injury or Illness occurred. See the applicable PPO's coverage criteria for additional coverage information and Prior Authorization requirements for accidental dental services. This Limitation does not apply to certain expenses for dental work or oral surgery.

e) When applicable, Covered Expenses for durable medical equipment are limited to rental unless the cost of rental equals or exceeds the purchase price.

f) Covered Expenses for hearing aids are limited to one hearing aid for each ear (per individual) in any three-year period.

g) Prior Authorization is required and Covered Expenses for services provided at a skilled nursing facility are limited to 60 days per Injury or Illness.

h) Covered Expenses for nutritional supplements are limited in accordance with Centers for Medicare and Medicaid Services ("**CMS**") national coverage determinations.

i) Prior Authorization is required for participation in in-facility sleep studies.

j) Covered Expenses for infertility treatments are limited to $5,000 per calendar year (per family) and $20,000 per lifetime (per family).

k) Prior Authorization is required for organ transplants.

l) Prior Authorization is required for Specialty Drugs and certain other Prescription Drugs. See Section 7E(7) below for more information.

m) The PPOs' medical or dental directors, or their designees, make coverage determinations of Medical Necessity, restrictions on access and appropriateness of treatment; however, the Welfare Fund, or its designee, will make final determinations on whether an expense is a Covered Expense under the terms of the Welfare Fund.

3. **Notice Regarding Coverage for Obstetric or Gynecological Care**. You do not need Prior Authorization from the Welfare Fund or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact HealthPartners or use the Provider Directory. See Section 3 ("Important Contact Information").

D. What the Health Plan Does Not Cover

Notwithstanding anything to the contrary, the following are not Covered Expenses and are excluded from coverage by this Health Plan (i.e., the **Exclusions**):

1. An expense for an item or service that is not Medically Necessary.

2. An expense to the extent that it exceeds the Allowed Amount.

3. An expense for an item or service that is Experimental or Investigative.

4. An expense that is not a Covered Expense, or to the extent that the expense is not a Covered Expense.

5. An expense for an item or service for which Prior Authorization was required and either Prior Authorization was not sought or Prior Authorization was denied.

6. An expense that is not described in Code § 213(d) (which defines tax-deductible medical care).

7. An expense you incurred more than one year before the date you (or another person on your behalf) submitted a Claim for coverage of the expense to the Health Plan in accordance with the Welfare Fund's claims procedures.

8. An expense you are not liable to pay, or with respect to which you have an arrangement or understanding that your liability will be reduced or eliminated if the Welfare Fund denies coverage.

9. An expense for which a person or entity other than you or the Welfare Fund is or may be liable to pay.[21]

10. An expense to the extent that a third party (i.e., a person or entity other than you or the Welfare Fund) pays the expense, reimburses you for the expense, or otherwise acts to relieve you of the economic burden of paying the expense.[22]

11. An expense for treatment of an Illness or Injury that results from or is related to your employment or occupation or that is covered (or claimed to be covered) under workers' compensation or employer liability laws.[23]

12. An expense for an item or service furnished or rendered by any federal or state governmental institution or facility, except to the extent that this Exclusion is prohibited by law.

13. An expense for an item or service furnished to or rendered to a person who is not a Participant in the Health Plan, including, without limitation, an expense related to surrogate pregnancy.

14. An expense for an item or service furnished to or rendered to you by a person who is your relative.

15. Post-partum in-home visits, unless the visit occurs during a declared state of emergency.

16. An expense related to complications resulting from, or reversal of, any treatment, procedure, or surgery, the expenses of which do not qualify as Covered Expenses.

17. An expense for an item or service that is for personal comfort or convenience, including, without limitation: air conditioners, air purifiers, humidifiers, de-humidifiers, allergy-free

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[21] See Section 17B) ("The Welfare Fund's Subrogation and Reimbursement Rights") for further information regarding expenses for which another person or entity besides you or the Welfare Fund is or may be liable to pay.

[22] See Section 17B) ("The Welfare Fund's Subrogation and Reimbursement Rights") for further information regarding expenses that may or may not be a third-party's responsibility.

[23] See Section 17B) ("The Welfare Fund's Subrogation and Reimbursement Rights") for further information regarding expenses that result from or are related to your employment or occupation or that are covered (or claimed to be covered) under workers' compensation or employer liability laws.

pillows, blankets, mattress covers, orthopedic mattresses, articles of clothing, shoes, whirlpools, swimming pools, elevators, or stair lifts.

18. An expense for non-durable medical equipment, including, without limitation, cervical pillows and blood pressure monitors. See the current PPO's website for a list of non-durable medical equipment.

19. An expense for treatment of an Injury or Illness that is connected to your commission, or attempted commission, of an act that the Board of Trustees determines in its sole discretion to be illegal.

20. An expense for educational, recreational, or milieu services.

21. An expense for diagnostic, radiology, or laboratory services that is not Medically Necessary for your diagnosis, except as specifically provided by the Health Plan.

22. A medical expense for nutritional support taken orally, except an expense for special medical foods for the treatment of phenylketonuria or maple syrup urine disease and except to the extent this Exclusion is prohibited by law.

23. A medical expense for a regular food product, including, without limitation: a food thickener; a regular grocery product that can be used with an enteral system (whether taken orally or parenterally); a special infant formula; a food supplement; and, a vitamin or mineral taken orally.

24. An expense for biomedical feedback treatment, except if the treatment is for migraine headaches or fecal incontinence.

25. An expense for a drug that is available over-the-counter (i.e., a drug that may be legally obtained without a prescription) except for certain classes of medications such as omeprazole. Contact Optum's Pharmacy Helpdesk for a list of those medications, see Section 3 ("Important Contact Information").

26. An expense for a drug that is prescribed for off-label use (i.e., use in a manner that is inconsistent with the drug's FDA-approved labeling, such as treatment of a disease that the FDA has not approved the drug to treat).

27. An expense for a Specialty Drug except if the Specialty Drug is obtained from Optum Specialty Pharmacy or as required by law. For a list of Specialty Drugs or other information from Optum Specialty Pharmacy, see Section 3 ("Important Contact Information").

28. Expenses for repetitive drug testing except to the extent that the Health Plan is prohibited by law from excluding the expense from coverage.

29. An expense related to an abortion or complications from an abortion, except if the abortion was Medically Necessary to treat an Illness or Injury.

30. An expense related to treatment for obesity (or a co-morbidity of obesity if there is also a diagnosis of obesity), except to the extent that the Health Plan is prohibited by law from

excluding the expense from coverage. Examples of expenses excluded under this paragraph include gastric bypass surgery, bariatric surgery, weight loss clinics, appetite suppressants, etc.

31. An expense related to mammoplasty or breast reduction surgery, except if the mammoplasty or breast reduction surgery is Medically Necessary to treat an Illness or Injury.

32. An expense for an item or service that is primarily for cosmetic purposes such as an expense related to cosmetic surgery. This Exclusion does not apply if the cosmetic surgery is for the treatment of an Illness or Injury and you incur the expense within two years of sustaining the Illness or Injury.

33. An expense related to participation in a program specializing in the treatment of chronic pain.

34. An expense related to radial keratotomy surgery, eximer laser surgery, lasik, or any other refractive surgery.

35. An expense related to artificial heart surgery.

36. An expense related to a thermogram or thermography.

37. An expense related to laboratory work performed by or ordered by a chiropractor.

38. Expenses for room and board and care provided in halfway houses, extended care facilities, or comparable facilities, and residential treatment services except for residential care for the treatment of eating and substance use disorders or other mental health treatment in a licensed residential primary treatment center.

39. An expense, to the extent that it is covered by no-fault auto insurance or, if you were required by law to have no-fault auto insurance and did not, to the extent that the expense would have been covered by no-fault auto insurance if you had carried the statutory minimum coverage.

40. An expense for treatment of an Injury that resulted from the use of a Motorized Vehicle to the extent that it is covered by Motorized Vehicle insurance.

41. An expense for treatment of an Injury that resulted from the use of your Motorized Vehicle when you did not have personal injury coverage, except to the extent that a portion of the expense, when aggregated with all other personal injury expenses you incurred as a result of Injury, exceeds $5,000 or the maximum personal injury coverage available in your state, if less.

42. An expense for services rendered by a massage therapist.

43. An expense for long-term care including, without limitation, an expense for room and board and an expense for treatment that is not expected to result in an improvement in diagnosis or prognosis.

44. An expense related to or for a wig.

45. An expense related to the ablation of the basivertebral nerve using the Intracept procedure, unless the patient has experienced chronic lower back pain for a period of at least six months despite conservative treatments (such as exercise, activity modification, or chiropractic care).

Patients meet these measures for coverage of the procedure if: (i) an MRI is performed on the patient's spine within six months from the date of receiving the Intracept procedure; and (ii) the patient's conservative treatments include at least four physical therapy visits over a course of six weeks or less, during the same six-month period of time.

E. Pharmacy Benefit Information

OptumRx administers the Welfare Fund's **Pharmacy Benefit** and offers several self-service tools for registered accounts on www.optumrx.com that allow Participants to get the most out of their Pharmacy Benefits. These online tools provide real-time account information; alerts on savings opportunities; important care information; and details about dosage, refills, shipping, and more. To ensure coverage, Participants must follow Optum's **Utilization Review** directives related to Formulary, Quantity Limits, Step Therapy, etc. Visit the OptumRx website for updated Prescription Drug lists. See Section 3 ("Important Contact Information").

1. **OptumRx App.** The OptumRx mobile application (the "**OptumRx App**") is a tool to help manage your Pharmacy Benefits. The OptumRx App makes the online pharmacy experience as simple as possible. Through the OptumRx App, Participants can easily:
   - Refill or renew a home delivery Prescription Drug;
   - Transfer a retail Prescription Drug to home delivery;
   - Find drug prices and lower-cost options;
   - View Prescription Drug claim history or order status; and
   - Locate a pharmacy.

   Participants can download the OptumRx App from the Apple App Store or Google Play.

2. **OptumRx Price Edge**. This program helps you pay the lesser of: (a) your out-of-pocket cost for a Prescription Drug under the Welfare Fund, and (b) the out-of-pocket cost available to you through discount card benefits and programs. For Prescription Drugs covered by the Welfare Fund, Price Edge selects the lower cost option between the discount card price and what your cost-sharing responsibility would be for the Welfare Fund. Your out-of-pocket costs for the covered Prescription Drug will count toward your Maximum OOP. For Prescription Drugs that are not covered by the Welfare Fund, Price Edge discounts can still help you save. When you present your member ID card at the pharmacy for a non-covered Prescription Drug, your claim will be denied but the pharmacist can tell you if a discounted price is available. Your out-of-pocket costs for a Prescription Drug not covered by the Welfare Fund do not count toward your Deductible or Maximum OOP.

3. **Home Delivery.** Home delivery is generally the most cost-effective and convenient way to obtain your routine medications. Participants must sign-up for OptumRx Home Delivery for **Maintenance Medications** (i.e., Prescription Drugs you take regularly). However, Participants may opt out of OptumRx Home Delivery but only by following the instructions provided below. Switch to home delivery on the website or through the OptumRx App.

Steps to Sign Up for Home Delivery of Your Prescription Drugs	
Through the OptumRx Website	
Step 1	Sign into the website, www.optumrx.com
Step 2	Under *Quick actions*, select *My Prescriptions*
Step 3	A list of retail Prescription Drugs that are eligible for home delivery will populate. From there, add Prescription Drugs to the cart for home delivery
Step 4	Select *Proceed to Checkout*. Optum will contact your physician and mail the Prescription Drugs to the address provided.

Through the OptumRx App	
Step 1	Sign into the OptumRx App
Step 2	If Prescription Drugs are eligible, tap *Switch your medications to home delivery* on the home page
Step 3	A list of retail Prescription Drugs that are eligible for home delivery will populate. From there, select your Prescription Drugs for home delivery and complete the *Proceed to checkout* process.

Participants can also **opt out** of OptumRx Home Delivery for all or only select Prescription Drugs by calling the Optum Member Helpdesk at (866) 328-2005. Participants must then transfer the Prescription Drug(s) to a preferred pharmacy by:

- Having the physician call in the Prescription Drug to a preferred retail pharmacy; or
- Having a preferred retail pharmacy call OptumRx ((800) 791-7658) to have the Prescription Drug information transferred back to that retail pharmacy.

Participants that affirmatively opt out of OptumRx Home Delivery may fill either a 30-day or 90-day supply of Maintenance Medications at a retail pharmacy. Home delivery will continue to be required for those Participants who do not opt out.

4. **Automatic Refill Program.** The automatic refill program is an easy way for Participants to regularly receive Prescription Drug refills. Participants have three options to sign up for automatic refills: (a) visit optumrx.com; (b) download the OptumRx App; or (c) call the number on your member ID card with your ID card and Prescription Drug bottles ready. Once enrolled, Optum automatically:
   - Sends reminders to order along with updates on shipping (in case changes are required);
   - Bills the amount due to your approved payment method on file; and
   - Sends a three-month supply of the Prescription Drug to the address provided.
5. **Quantity Limits.** The **Quantity Limits** program can help Participants get the best results from medication therapy. With safe doses, Quantity Limits can also keep Prescription Drug costs lower. Quantity Limits are meant to lower the risk of overuse by placing Quantity Limits on what is covered. Quantity Limit rules are based on:

- FDA approved uses;
- Prescription Drug instruction labels; and
- Accepted or published clinical recommendations.

Contact Optum for questions about Quantity Limits on your Prescription Drugs. See Section 3 ("Important Contact Information").

6. **Step Therapy.** Most medical conditions have many Prescription Drug treatment options. Although their clinical effectiveness may be the same, the costs can be very different. The **Step Therapy** program gives Participants the treatment needed, usually at a lower cost. With this program, Participants must try a "step 1" Prescription Drug, before a "step 2" Prescription Drug may be covered.

   When Participants bring a prescription to their pharmacy, the Optum system will check the Prescription Drug for Step Therapy requirements. If pharmacy claims show the Participant tried a step 1 Prescription Drug in the recent past, the step 2 Prescription Drug may be filled. If not, the pharmacist will contact the prescribing Provider to explain next steps. Participants are encouraged to call the number on the back of the member ID card to discuss whether current Prescription Drugs are part of the Step Therapy program.

7. **Prior Authorization.** Specialty Drugs and certain other Prescription Drugs require Prior Authorization from Optum. Prior Authorization requires a prescribing Provider to explain why a Participant is taking a Prescription Drug to determine if it will be covered. Some Prescription Drugs must be reviewed because they may:
   - Only be approved or effective for safely treating specific conditions; and/or
   - Cost more than other Prescription Drugs used to treat the same or similar conditions.

   If a Participant must take a Prescription Drug that requires Prior Authorization right away (i.e., before the Prior Authorization can be completed), there are two options:

   a) Ask the prescribing Provider if a sample is available; or

   b) Check with the pharmacy to request a short-term supply of five days or less.

   Keep in mind, Participants are responsible for the full cost of a short-term supply of a Prescription Drug before a Prior Authorization request is approved. If the Prior Authorization request is approved, then the pharmacist can fill the rest of the prescription and the Participant can submit a claim for reimbursement. See Section 3 ("Important Contact Information") for detail on where to submit your claims. Participants are encouraged to call the phone number on the back of the member ID card to discuss whether current Prescription Drugs require Prior Authorization.

8. **Preventive Care Medications.** Benefit plans must cover certain Preventive Care Prescription Drugs at 100%—without charging a Copayment, Coinsurance or Deductible. These products include:
   - U.S. Preventive Services Task Force A & B Recommendation Prescription Drugs;
   - FDA-approved prescription and over-the-counter birth control (contraceptives); and

- Flu shots and other vaccines (see Section 7E(9) below for more information).

Optum offers an updated list of no-cost preventive care Prescription Drugs if they are:

a) Prescribed by a healthcare Provider;

b) Age- and condition-appropriate; and

c) Filled at a network pharmacy.

For a list of Preventive Care Prescription Drugs, contact Optum's Member Helpdesk, see Section 3 ("Important Contact Information").

9. Formulary. A **Formulary** is a list of prescribed Prescription Drugs or other pharmacy care products, services or supplies chosen for their safety, cost, and effectiveness. Prescription Drugs are listed by categories or classes and are placed into cost levels known as tiers. The Formulary includes both brand and generic Prescription Drugs. To create the list, Optum is guided by Optum's Pharmacy and Therapeutics Committee. This group of doctors and pharmacists reviews and determines which Prescription Drugs will be covered, how well the Prescription Drugs work, and overall value. Optum also ensures there are safe and covered options.

The price of a Prescription Drug may change if it moves tiers. Prescription Drugs may move to a lower tier at any time. Prescription Drugs may move to a higher tier when a generic equal becomes available. Additionally, Prescription Drugs may move to a higher tier or be excluded from coverage on January 1 or July 1 of each year. A Participant, Participant's authorized representative, or Provider can ask for a coverage request for a Prescription Drug by calling the number on your member ID card.

10. Smart Fill Program. This Specialty Drug program consists of two components:

a) Split Fills. The monthly supply for select oral oncology medications will be split with a pro-rated Copayment.

b) 90-Day Fills. Participants can opt into this program and receive a 90-day supply of certain therapeutic medications for multiple sclerosis, HIV, inflammatory conditions, and transplants. Eligible Participants can conveniently receive a 90-day supply every three months.

11. No-Cost Immunizations. The following vaccines are covered at no cost to you if received at a network pharmacy:

- COVID-19;
- Diptheria, tetanus, pertussis;
- Hepatitis A and B;
- Herpes zoster (shingles);
- Human papillomavirus (HPV);
- Inactive poliovirus;
- Influenza (flu);

- Measles, mumps, rubella;
- Meningococcal;
- Pneumococcal (pneumonia);
- Rabies;
- Travel immunizations;
- Varicella (chickenpox); and
- Any immunizations required in the event of bioterrorism.

Contact your network pharmacy to ensure the vaccine is in stock and can be administered at that pharmacy's location.

Other Prescription Drug Options
Certain Prescriptions Drugs and vaccines are available at no cost to you from the Wellness Centers. See Section 8 ("PTSMN Family Health & Wellness Centers") for more information.

F. Fitness Discount Program

1. **Introduction**. The fitness discount program ("**Fitness Discount Program**") offers health and wellness discounts on memberships at fitness centers, weight loss programs, and wellness brands. Once you login to your authenticated HealthPartners account, go to the "Living Well" tab for links to the available programs and enrollment information.

2. **Participating in the Fitness Discount Program**.

   a) Employees. All Employee classifications are eligible to participate in the Fitness Discount Program.

   b) Retirees. Only Pre-Medicare Retirees are eligible for the Fitness Discount Program. The Fitness Discount Program is not available to Medicare-Eligible Retirees.

   c) Dependents. Only Dependent Spouses and Children over age 18 are eligible for the Fitness Discount Program. The Fitness Discount Program is not available to Dependent Children under age 18.

   If you are eligible, you become a Participant in the Fitness Discount Program when you become eligible for benefits from the Welfare Fund. You will cease to be a Participant in the Fitness Discount Program when your eligibility for benefits is terminated.

3. **Additional Savings**. Visit HealthPartners.com/discounts for a list of retailers and discounts available through HealthPartners Healthy Discounts℠ program, including discounts for:
   - Fitness centers and classes;
   - Parents and babies;
   - Exercise and sports equipment;
   - Wellness and recover;
   - Skin and body care;
   - Natural, sustainable products;
   - Food;

- Medical equipment and treatment; and
- Pet care.

G. Employee Assistance Program ("EAP")

1. Introduction. The employee assistance program ("**EAP**") is a professional counseling service made available to you to discuss a variety of personal issues ("**EAP Benefits**").

2. Participating in the EAP.

a) Employees. EAP Benefits are available to Employees classified as Journeymen, Apprentices, or Support Workers under the CBA and NBU Employees. Coverage under the EAP is not available to Employees classified as Helpers or Pre-Apprentices.

b) Retirees. Only Pre-Medicare Retirees are eligible for EAP coverage. EAP Benefits are not available to Medicare-Eligible Retirees.

c) Dependents. Dependent coverage is available to Employees classified in the CBA as Journeymen, Apprentices, and Support Workers. No Dependent coverage is available to Employees classified in the CBA as Helpers or Pre-Apprentices. Pre-Medicare Retirees also have Dependent coverage.

If you are eligible, you become a Participant in the EAP when you become eligible for benefits from the Welfare Fund. You will cease to be a Participant in the EAP when your eligibility for benefits is terminated.

3. EAP Benefits. Through the EAP, you can speak with a counselor to help you with a range of issues, such as:

- Life improvement
- Emotional well-being
- Difficulties in relationships (marital counseling is limited to six visits per lifetime)
- Financial planning and debt management
- Grief & loss
- Legal referrals
- Anxiety issues with work or family
- Alcohol and drug abuse/dependence
- Personal achievement
- Smoking cessation
- Marital counseling (lifetime maximum of six visits).

The EAP Benefits available to you are completely confidential and there is no charge for you to speak with professional counselors There may be a cost associated with the EAP Benefits if you accept a referral to non-EAP services. You are encouraged to contact the EAP when a situation first develops, including emergencies. You can reach a member advocate 24 hours a day, 365 days a year by calling the number in Section 3 ("Important Contact Information").

Alternatively, you can connect with the EAP directly from your mobile device by downloading the iConnectYou application. Contact the Fund Office for the password to get started.

4. **Referrals for Other Services**. If there is a need to refer you to other services for further treatment, the EAP staff will coordinate the referral with specialized treatment centers and hospitals in your area. If you are referred to a specialist, the cost associated with going to that specialist will be your responsibility. If the specialist is a healthcare Provider, the Welfare Fund will pay for any Covered Expenses you may have under the terms of the Health Plan.

Section 8

Pipe Trades Services MN Family Health & Wellness Centers

Employees. All Employees may use the Wellness Centers.
Retirees. All Retirees may use the Wellness Centers.
Dependents. All Dependents may use the Wellness Centers.

The Pipe Trades Services MN Family Health & Wellness Centers ("**Wellness Centers**") provide convenient access to healthcare services that emphasize prevention, disease management, and wellness. The Providers you will meet at the Wellness Centers are focused on early detection and treatment of chronic conditions and the promotion of health awareness. The Providers at the Wellness Centers can also coordinate your care with HealthPartners to ensure that you are receiving the right care for your medical needs.

The Wellness Centers are owned by the Welfare Fund, but operated by Premise Health Employer Solutions, LLC ("**Premise Health**") and the Providers it employs for the benefit of Participants and their Dependents.

A. Who Can Use the Wellness Centers?

As a Participant in the Health Plan, you and your Dependents may use the Wellness Centers. Medicare-Eligible Retirees and their Dependents are also eligible to use the Wellness Centers.

You may not use the Wellness Centers to treat an Injury or Illness that relates to work, an accident, or any other type of Injury or Illness for which another person or entity may be liable.

B. What Services are Offered at the Wellness Centers?

The Wellness Centers offer the primary care services you would expect from a family physician or general practitioner/Provider, including:

- Primary care for common conditions such as colds, flu, asthma, diabetes, etc.;
- Care for acute conditions, chronic disease, and cardiovascular care;
- Preventive care including immunizations, physicals, etc.;
- Physical therapy and chiropractic care*;
- Behavioral and mental healthcare;
- Women's healthcare services;
- Provider dispensing of 200+ Prescription Drugs at no cost to you;
- Patient education;
- Full-service vision center (White Bear Lake Wellness Center only); and
- Certain lab tests can also be completed at the Wellness Centers.

* Patients of the Rochester Wellness Center may receive chiropractic care with no out-of-pocket costs through contracted third-party Providers. Contact the Rochester Wellness Center for additional information.

Patients also have 24/7 access to **Virtual Primary Care** services. Get started by calling (888) 535-4980.

Care Consult and Care Navigation services are coming soon.

200+ Prescription Drugs are available to you at no cost from the Wellness Centers. You can even get up to a 90-day supply for ongoing prescriptions to reduce the number of times you need a refill. When you are about to run out, schedule a follow-up visit with your Provider. Your Provider will monitor your progress and offer ongoing support. For a list of the Prescription Drugs available from the Wellness Centers, contact your local Wellness Center.

For a complete list of available services visit www.members.premisehealth.com/pipe-trades/ or contact your Wellness Center:

- (651) 683-2507 (Eagan)
- (651) 683-2434 (Maple Grove)
- (651) 287-0185 (Rochester)
- (651) 348-8851 (White Bear Lake)

C. What Are the Advantages to Using the Wellness Centers?

The Providers at the Wellness Centers are not compensated based on the number of tests or procedures they perform; they also are not incentivized to see as many patients as possible. Their goal and the goal of the Wellness Centers is to spend the time necessary with Participants; to get to know you and your Dependents and to support you in any way they can to help you improve your health.

Participants can save on their out-of-pocket healthcare expenses by using the Wellness Centers because:

- There is no Deductible for Office Visits at the Wellness Centers; and
- There is no Office Visit Copayment for visits to the Wellness Centers.

Participants using the Wellness Centers should be ready and willing to make lifestyle changes and understand the key role that a patient has in partnership with a Provider to improve their own health and the health of their family members.

D. Your Employers and Union Do Not Have Access to Your Records.

The Wellness Centers strictly adhere to HIPAA and associated rules, which protects every patient's health and medical records and keeps the records secure. The Wellness Centers will not share your health and medical records with a Contributing Employer without your consent and will not otherwise share your information unless authorized under HIPAA.

Section 9

Pipe Trades Services MN Dental Plan

Employees. Dental Benefits are available to all Employees classified as Journeymen and Apprentices under the CBA and NBU Employees. Employees classified as Support Workers, Helpers, or Pre-Apprentices in the CBA are not eligible for the Dental Plan.

Retirees. Retirees must elect Dental Plan coverage.

Dependents. Dependent coverage is available to eligible Employees and Retirees (if elected).

A. Introduction

The Pipe Trades Services MN Dental Plan ("**Dental Plan**") provides certain benefits for dental care ("**Dental Benefits**"). In general, the terms of your coverage under the Dental Plan are described in one of the following **Delta Dental SPDs** depending on your employment status (i.e., whether you are actively employed or retired):

1. Delta Dental PPO Plus Premier—Comprehensive Enhanced Dental Benefits With Orthodontic Coverage Dental Benefit Plan Summary (the "**Delta Dental SPD for Employees**") which is attached as Appendix C ("Delta Dental SPD for Employees").
2. Delta Dental PPO Plus Premier—Comprehensive Standard Dental Benefit Plan Summary (the "**Delta Dental SPD for Retirees**") which is attached as Appendix D ("Delta Dental SPD for Retirees").

The terms of the Delta Dental SPDs are incorporated into the Dental Plan as if fully-stated herein. The Dental Plan is a component plan of the Welfare Fund and this Section 9 is the component Plan Document and SPD for the Dental Plan. This Section is incorporated into the Welfare Fund's SPD and the applicable terms of the Welfare Fund's SPD are incorporated into this Section. To the extent there is a conflict between the terms of the Welfare Fund's SPD and the Delta Dental SPDs, the Delta Dental SPDs control.

B. Participating in the Dental Plan

1. **Dental Coverage for Eligible Employees**. If you are eligible for Dental Plan coverage, you become a Participant in the Dental Plan when you become eligible for benefits from the Welfare Fund. You will cease to be a Participant in the Dental Plan when your eligibility for benefits under the Welfare Fund is terminated unless you extend your participation in the Dental Plan under COBRA continuation coverage as described in Section 6E ("Notice of Continuation of Coverage Rights Under COBRA").
2. **Dental Coverage for Retirees**. If you elect Dental Plan coverage and pay the additional Premium amount, you become a Participant in the Dental Plan when you become eligible for benefits from the Welfare Fund.

You will cease to be a Participant in the Dental Plan if either:

- Your eligibility for benefits under the Welfare Fund is terminated (unless you extend your participation in the Dental Plan under COBRA continuation coverage as described in Section 6E ("Notice of Continuation of Coverage Rights Under COBRA"); or
- You fail to pay the additional Premium for Dental Plan coverage.

You will be given the option to elect Dental Plan coverage when you retire or during the open enrollment period for the Dental Plan which occurs every other year. For example, if you do not elect Dental Plan coverage when you retire and the next open enrollment period is not until the following year, you will not be able to elect Dental Plan coverage until the next open enrollment period.

C. Dental Benefits

Summary of Dental Benefits for Eligible Employees and their Dependents		
Maximum OOP: None Deductible: None Annual Limit: $2,500/individual[24]		
Dental Benefit	**Cost Sharing**	
	In-Network	**Out-of-Network**
Preventive Dental Care	You pay $0 (0% Coinsurance)	You pay $0 (0% Coinsurance) for **Allowed Amount**[25]
Basic Dental Care	You pay $0 (0% Coinsurance)	You pay $0 (0% Coinsurance) for Allowed Amount
Endodontics	40% Coinsurance	40% Coinsurance
Periodontics	40% Coinsurance	40% Coinsurance
Oral Surgery	40% Coinsurance	40% Coinsurance
Major Restorative Dental Care	20% Coinsurance	40% Coinsurance
Prosthetic Repairs and Adjustment	40% Coinsurance	40% Coinsurance
Prosthetics	40% Coinsurance	40% Coinsurance
Orthodontia (Subject to $2,000/individual Lifetime Limit)	You pay $0 (0% Coinsurance)	You pay $0 (0% Coinsurance) for Allowed Amount

[24] Benefit maximums may not be carried over to future coverage years. Also, the benefit maximum does not apply to Preventive Dental Care for eligible Dependent Children up to age 18.

[25] Review Appendix C ("Delta Dental SPD for Employees") for more on the Allowed Amount.

Summary of Dental Benefits for Retirees and their Dependents (if elected)			
Retirees must elect the Dental Plan coverage at time of retirement or during an open enrollment period (every other year).			
Plan Services	**Cost Sharing In-Network**		**Out-of-Network**
	Delta PPO	**Delta Premier**	
Diagnostic & Preventive	You pay $0 (0% Coinsurance)	20% Coinsurance	20% Coinsurance
Basic Restorative	You pay $0 (0% Coinsurance)	50% Coinsurance	50% Coinsurance
Oral Surgery-Simple Extractions	You pay $0 (0% Coinsurance)	50% Coinsurance	50% Coinsurance
Endodontics	10% Coinsurance	50% Coinsurance	50% Coinsurance
Periodontics-Non Surgical	20% Coinsurance	50% Coinsurance	50% Coinsurance
Periodontics-Surgical	20% Coinsurance	50% Coinsurance	50% Coinsurance
Oral Surgery-All Other Extractions	20% Coinsurance	20% Coinsurance	20% Coinsurance
Crowns	40% Coinsurance	50% Coinsurance	50% Coinsurance
Crown Repairs	40% Coinsurance	50% Coinsurance	50% Coinsurance
Fixed Prosthetic Repairs	40% Coinsurance	50% Coinsurance	50% Coinsurance
Removable Prosthetic Repairs	40% Coinsurance	50% Coinsurance	50% Coinsurance
Prosthetics, Removable & Fixed	40% Coinsurance	50% Coinsurance	50% Coinsurance
Annual Deductible	**None**	**$25.00**	**$25.00**
Annual Limit	**$2,000.00**	**$2,000.00**	**$2,000.00**

Section 10

Pipe Trades Services MN Vision Plan

Employees. Vision Benefits are available to all Employees classified as Journeymen and Apprentices under the CBA and NBU Employees. Employees classified as Support Workers, Helpers, or Pre-Apprentices in the CBA are not eligible for the Vision Plan.
Retirees. Retirees are eligible for Vision Plan coverage.
Dependents. Dependent coverage is available to eligible Employees and Retirees.

A. Introduction

The Pipe Trades Services MN Vision Plan ("**Vision Plan**") provides certain benefits for vision care ("**Vision Benefits**") through its PPO—Vision Service Plan ("**VSP**"). VSP has contracted with various vision Providers and facilities to provide Vision Benefits to you at a discounted rate.

The Vision Plan is a component plan of the Welfare Fund and this Section 10 is the component Plan Document and SPD for the Vision Plan. This Section is incorporated into the Welfare Fund's SPD and the applicable terms of the Welfare Fund's SPD are incorporated into this Section.

The Welfare Fund contracts with VSP to grant eligible Participants access to its network of Providers. The Welfare Fund's contract with VSP dictates the Vision Benefits made available to you and is subject to change. In the event that there is a conflict between the Welfare Fund's contract with VSP and the Welfare Fund's SPD, the contract will control. Certain Vision Benefits may vary by location based on local laws.

The White Bear Lake Wellness Center has a VSP Vision Center which may provide additional benefits to you and your family.

B. Participating in the Vision Plan

If you are eligible, you become a Participant in the Pipe Trades Services MN Vision Plan when you become eligible for benefits from the Welfare Fund. You will cease to be a Participant in the Vision Plan when your eligibility for benefits is terminated unless you extend your participation under COBRA continuation coverage as described in Section 6E ("Notice of Continuation of Coverage Rights Under COBRA").

C. Vision Benefits

The Welfare Fund's contracted VSP Provider network is the "VSP Signature Network". The available Vision Benefits are described below.

You can also register online at www.vsp.com to review your Vision Benefits.

1. In-Network Benefits Per Calendar Year.

a) Exams. One eye exam is covered with 0% Coinsurance. You pay $0 for the exam.

b) Frames. A $175 frame Allowance at retail, $95 frame Allowance at Costco. You have 0% Coinsurance up to $175. After $175, you pay 100%.

c) Lenses. One pair of covered lenses at 0% Coinsurance. You pay $0 for covered lenses. Covered lenses include single vision, bifocal, trifocal, lenticular. It also includes the following lens options: blended, polycarbonate and progressive.

d) Contacts. In lieu of a pair of frames and lenses, the Vision Plan provides a $175 Allowance for regular contact lenses. You pay 0% Coinsurance up to $175. After the Vision Plan has paid $175, you pay 100%.

2. **Out-of-Network Benefits.** The Vision Plan provides you a $250 Allowance for vision benefits from an Out-of-Network Provider. You pay 0% Coinsurance up to $250. After $250, you pay 100%. If you use an In-Network Provider for your eye exam, the cost of an eye exam will be deducted from your $250 Allowance.

3. **Primary EyeCare Plan**. VSP's Primary EyeCare Plan allows you to receive additional follow-up medical eye care services from an In-Network Provider. This coverage includes:
   - 100% coverage for retinal screenings for Participants with diabetes who do not have diabetic eye disease. These retinal photographs help your Provider establish a baseline to monitor and track changes in your eyes over time;
   - Additional examinations and services that track and monitor diabetic eye disease progression;
   - Treatment for dry eye, pink eye, eye injury, and foreign body removal;
   - Exams and services to diagnose and monitor glaucoma and cataracts; and
   - Tests to diagnose sudden vision changes.

   Claims for these healthcare services are first billed under the Health Plan (or coverage for Medicare-Eligible Retirees) and are subject to the Health Plan's cost-sharing requirements. Once your Claim is processed by the Health Plan, it can be submitted to VSP for coverage, subject to a $20 Copayment.

4. **ProTec Safety® Plan**. The Vision Benefits available under VSP's ProTec Safety® Plan are only available to active Employees, not Retirees or Dependents.

Benefit	Description In-Network Coverage	Copayment
Safety Exam®	• Determines your needs for eye protection at work • Every 12 months	$0
Prescription Lenses	• Certified according to American National Standards Institute ("**ANSI**") requirements • Every 12 months	$0

ProTec Eyewear® Frame	• Fully covered when you choose a safety frame from your VSP Provider's ProTec Eyewear® collection • Certified according to ANSI requirements • Every 12 months	$0
Extra Savings	• **Additional Safety Glasses**. 20% savings on additional pairs of glasses or sunglasses, including lens enhancements, from same VSP Provider. • **Laser Vision Correction**. Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	
Out-of-Network Coverage		
Single Vision Lenses—up to $35		
Lined Bifocal Lenses—up to $45		
Lined Trifocal Lenses—up to $60		
Frame—up to $25		

D. Exclusions

The following items and services are not covered by the Vision Plan:

- Cosmetic materials
- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Laminated lenses
- Oversized lenses
- Ultraviolet protected lenses
- Medical or surgical treatment of the eyes
- Corrective vision treatment that is Experimental or Investigative

E. Claims Processing

VSP will generally process Claims within 30 days after VSP has received a completed Claim, unless special circumstances require additional time. In such cases, VSP may obtain an extension of 15 days of this time limit by providing notice to you and the reason for the extension.

Contact information for your Vision Benefits and your Claims and appeals under the Vision Plan are provided in Section 3 ("Important Contact Information").

Section 11

Pipe Trades Services MN Weekly Injury and Illness Disability Program

Employees. Disability Benefits are available to Employees classified as Journeymen and Apprentices under the CBA and NBU Employees. Coverage under the Weekly Disability Program is not available to Employees classified as Support Workers, Helpers, or Pre-Apprentices.

Retirees. Retirees are not eligible for the Weekly Disability Program.

Dependents. Dependents are not eligible for the Weekly Disability Program.

A. Introduction

The Pipe Trades Services MN Weekly Injury and Illness Disability Program ("**Weekly Disability Program**") provides you with short-term disability benefits. While you have a non-occupational total disability resulting from an Injury or Illness that prevents you from working, the Weekly Disability Program will pay you $500 per week (for a maximum of 26 weeks) and will credit your Dollar Bank with 37 ½ hours per week up to a maximum of 975 hours (the "**Disability Benefits**").

The Weekly Disability Program is a component plan of the Welfare Fund and this Section 11 is the component Plan Document and SPD for the Weekly Disability Program. This Section is incorporated into the Welfare Fund's SPD and the applicable terms of the Welfare Fund's SPD are incorporated into this Section.

B. Participating in the Weekly Disability Program

If you are eligible, you become a Participant in the Weekly Disability Program when you become eligible for benefits from the Welfare Fund. You will cease to be a Participant in the Weekly Disability Program when your eligibility for benefits is terminated.

You are not eligible for Disability Benefits if you are participating in the Welfare Fund under the Extended Eligibility provisions described in Section 6A(8) ("Extending Your Eligibility") or COBRA continuation coverage described in Section 6E ("Notice of Continuation of Coverage Rights Under COBRA").

C. Payment of Benefits

Disability Benefits become payable on either:

- The first day of disability due to an Injury
- The earlier of:
  - The eighth day of disability due to an Illness; or
  - The day you are hospitalized or have surgery due to an Illness.

If you are disabled for a partial week, you will receive 1/5 of the Weekly Disability Benefit for each day of the five-day work week that you are entitled to Disability Benefits. This is known as the **Daily Disability Benefit** where the Welfare Fund will pay you $100 per day (for an annual

maximum of 60 days) and will credit your Dollar Bank with 7 ½ hours per day (up to an annual maximum of 450 hours) for each day you are not working as a result of your disability.

Your Dollar Bank will be credited using a formula based on the then current Premium applicable to you the day prior to the first day of your disability. The formula is as follows:

(Premium amount/4 weeks)/37.5 hours = Hourly Contribution Rate for Disability Benefits

Payments of your Disability Benefit will be made to you once the Fund Office receives:

- Evidence of your entitlement to Disability Benefits; and
- A completed ***Weekly Disability Benefits Application***.

Contact the Fund Office for a copy of the ***Weekly Disability Benefits Application***.

D. Eligibility for Benefits

Your disability absence must begin while you are eligible for benefits from the Welfare Fund. It is not necessary that you be confined to your home to receive benefits, but benefits are only payable for those days on which you are under the care of a physician and unable to work. A period of care will be considered to have started when you are seen and treated personally by the physician. You will be deemed to not be under the care of a physician if you go six weeks or more without seeing a physician. In addition, benefits are not payable on any day that you are performing work for compensation or profit, or on which you are able to work. The Welfare Fund reserves the right to investigate all disability claims, including having you examined by a physician that is selected by the Welfare Fund.

Benefits will not be paid to you if you are entitled to:

- Unemployment compensation;
- Workers' compensation;
- No-fault auto disability;
- Other third-party liability coverage or payment by a third party;
- Retirement benefits;
- Coverage under the Extended Eligibility provisions; or
- COBRA continuation coverage.

Unless you have an Illness that qualifies as a "Chronic Condition" (described below), successive periods of disability separated by less than two weeks of continuous active employment will be considered one continuous period of disability unless the disabilities are from different and unrelated causes, and you return to full-time work for at least one day.

E. Benefits Payable for Intermittent Disability

If you have been diagnosed with a "Chronic Condition" (described below) and you are being continuously seen and treated by a physician for the Chronic Condition, or you are undergoing chemotherapy or other similar infusions or treatments that cause intermittent periods of disability, you will be entitled to be paid the Daily Disability Benefit. Your inability to work as a result of your intermittent disability must documented by your treating physician.

A **Chronic Condition** is an Illness or Injury that is persistent, recurring, or long-lasting in its effects.

- The term "chronic" is often applied if the course of the disease lasts for more than three months.
- Chronic Conditions include, but are not limited to, cancer, chronic obstructive pulmonary disease, inflammatory bowel disease, hepatitis C, acquired immunodeficiency syndrome, and autoimmune conditions.

F. Benefits Payable During Pregnancy and Post-Delivery

Disability Benefits will be payable for a physical pregnancy-related complication if you provide documentation from your treating physician that includes:

- The medical reason that your pregnancy-related complication is preventing, or will prevent you, from performing the duties of your full-time occupation; and
- The expected length of time that you will be medically unable to perform the duties of your full-time occupation.

Disability Benefits will also be payable to female Participants who provide documentation from their treating physician that they are unable to work following the birth of a new Child. Generally, a treating physician will determine that new mothers are unable to work:

- For a period of six weeks following a traditional delivery; and
- For a period of eight weeks following a Cesarean delivery.

G. Tax Consequences

IRS regulations require that FICA tax be deducted from your Disability Benefits.

Section 12

Pipe Trades Services MN Death Benefits Program

Employees. Death Benefits are provided for Employees classified as Journeymen and Apprentices under the CBA and NBU Employees. Coverage under the Death Benefit Program is not available to Employees classified as Support Workers, Helpers, or Pre-Apprentices.

Retirees. Retirees are eligible for the Death Benefits Program.

Dependents. Dependents are not eligible for the Death Benefits Program.

A. Introduction

The Pipe Trades Services MN Death Benefits Program ("**Death Benefits Program**") pays a **Death Benefit** to your Beneficiary in accordance with the Standard Beneficiary Designation if you die while you are eligible to participate in the Death Benefits Program.

The Death Benefits Program is a component plan of the Welfare Fund and this Section 13 is the component Plan Document and SPD for the Death Benefits Program. This Section is incorporated into the Welfare Fund's SPD and the applicable terms of the Welfare Fund's SPD are incorporated into this Section.

B. Participating in the Death Benefits Program

If you are eligible, you become a Participant in the Death Benefits Program when you become eligible for benefits from the Welfare Fund. You will cease to be a Participant in the Death Benefits Program when your eligibility for benefits is terminated.

C. Death Benefits

The amount of the Death Benefit payable to your Beneficiary is either:

- $7,000, if you die when you an active Employee; or
- $3,500 if you die when you are a Retiree.

Contact the Fund Office for a copy of the ***Beneficiary Designation Form*** if you wish to designate or modify your Beneficiary designation. If you do not complete the Beneficiary Designation Form, your Beneficiary for Death Benefits will be the Standard Beneficiary Designation.

Payment of the Death Benefit will be made promptly in a lump-sum to your Beneficiary once the Fund Office receives:

- Evidence of the Beneficiary's entitlement to payment; and
- A completed ***Death Benefits Application***.

Contact the Fund Office for a copy of the ***Death Benefits Application***.

Section 13

Pipe Trades Services MN Accidental Death and Dismemberment Benefits Program

Employees. AD&D Benefits are provided for Employees classified as Journeymen and Apprentices under the CBA and NBU Employees. Coverage under the AD&D Benefits Program is not available to Employees classified as Support Workers, Helpers, or Pre-Apprentices.

Retirees. Retirees are not eligible for the AD&D Benefits Program.

Dependents. Dependents are not eligible for the AD&D Benefits Program.

A. Introduction

The Pipe Trades Services MN Accidental Death and Dismemberment Benefits Program ("**AD&D Benefits Program**") pays **AD&D Benefits** to you or your Beneficiary in the event you sustain certain types of losses.

The AD&D Benefits Program is a component plan of the Welfare Fund and this Section 13 is the component Plan Document and SPD for the AD&D Benefits Program. This Section is incorporated into the Welfare Fund's SPD and the applicable terms of the Welfare Fund's SPD are incorporated into this Section.

B. Participating in the AD&D Benefits Program

If you are eligible, you become a Participant in the AD&D Benefits Program when you become eligible for benefits from the Welfare Fund. You will cease to be a Participant in the AD&D Benefits Program when your eligibility for benefits is terminated.

C. AD&D Benefits

In the event you sustain any of the following losses as a direct result of an accidental Injury, either on or off the job, the following AD&D Benefits will be payable to you or your Beneficiary (in addition to any Death Benefit that may also be payable under Section 12 ("PTSMN Death Benefits Program")):

- Loss of life: $7,000
- Loss of two limbs or loss of sight in both eyes: $7,000
- Loss of one limb or loss of sight in one eye: $3,500

The loss must occur within 90-days from the day of the Injury. For purposes of this Section, a **loss of limb** means severance at or above the wrist or ankle joint and the **loss of sight** means the total and irrecoverable loss of sight.

If more than one of the above losses is suffered as the result of any one Injury, not more than the full benefit amount shown will be payable. AD&D Benefits are only payable if the loss is suffered by an eligible Employee, not for losses suffered by a Dependent.

The purpose of the AD&D Benefits Program is to provide AD&D Benefits for losses due to accidental Injuries. No benefits are paid for any loss caused by or contributed by a:

- Bodily or mental infirmity
- Medical or surgical treatment, except a loss covered by the AD&D Benefits Program, which results directly from a surgical operation made necessary solely by an Injury not excluded by the AD&D Benefits Program and performed within 90-days after such Injury
- Suicide, attempted suicide or intentional self-inflicted injury, or
- War or any act of war (whether declared or undeclared).

Contact the Fund Office for a copy of the ***Beneficiary Designation Form*** if you wish to designate or modify your Beneficiary designation. If you do not complete the Beneficiary Designation Form, your Beneficiary for Death Benefits will be the Standard Beneficiary Designation.

To receive AD&D Benefits, you or your Beneficiary must:

- Provide evidence of your Injury to the satisfaction of the Trustees; and
- Submit a completed ***AD&D Benefits Application*** to the Fund Office.

Contact the Fund Office for a copy of the ***AD&D Benefits Application***.

Section 14

Pipe Trades Services MN Jury Duty Benefits Program

Employees. Jury Duty Benefits are available to Employees classified as Journeymen and Apprentices under the CBA and NBU Employees. Coverage under the Jury Duty Benefits Program is not available to Employees classified as Support Workers, Helpers, or Pre-Apprentices.

Retirees. Retirees are not eligible for the Jury Duty Benefits Program.

Dependents. Dependents are not eligible for the Jury Duty Benefits Program.

A. Introduction

The Pipe Trades Services MN Jury Duty Benefits Program ("**Jury Duty Benefits Program**") pays **Jury Duty Benefits** to Employees required to miss work because of jury duty.

The Jury Duty Benefits Program is a component plan of the Welfare Fund and this Section 14 is the component Plan Document and SPD for the Jury Duty Benefits Program. This Section is incorporated into the Welfare Fund's SPD and the applicable terms of the Welfare Fund's SPD are incorporated into this Section.

B. Participating in the Jury Duty Benefits Program

If you are eligible, you become a Participant in the Jury Duty Benefits Program when you become eligible for benefits from the Welfare Fund. You will cease to be a Participant in the Jury Duty Benefits Program when your eligibility for benefits is terminated.

You are not eligible for Jury Duty Benefits if you are receiving Disability Benefits under Section 11 ("PTSMN Weekly Injury and Illness Disability Program") or unemployment compensation. You are also not eligible for Jury Duty Benefits if you are participating in the Welfare Fund under the Extended Eligibility provisions described in Section 6A(8) ("Extending Your Eligibility") or COBRA continuation coverage described in Section 6E ("Notice of Continuation Coverage Rights Under COBRA").

C. Jury Duty Benefits

The Jury Duty Benefit is:

- A per diem payment of $90 for involuntary unemployment due to jury duty; and
- Your Dollar Bank is credited with eight hours for each day you complete jury duty.

Your Dollar Bank will be credited using a formula based on the then current Premium applicable to you for the days you served on a jury. The formula is as follows:

(Premium amount/4 weeks)/40 hours = hourly Contribution rate for Jury Duty Benefits

To receive the Jury Duty Benefit, you must submit a completed ***Jury Duty Benefits Application*** to the Fund Office, including evidence you served on a jury (i.e., jury duty voucher).

Contact the Fund Office for a copy of the ***Jury Duty Benefits Application***.

Section 15

Pipe Trades Services MN Bereavement Benefits Program

Employees. Bereavement Pay is available to Employees classified as Journeymen and Apprentices under the CBA and NBU Employees. Coverage under the Bereavement Benefit Program is not available to Employees classified as Support Workers, Helpers, or Pre-Apprentices.

Retirees. Retirees are not eligible for Bereavement Pay.

Dependents. Dependents are not eligible for Bereavement Pay.

A. Introduction

The Pipe Trades Services MN Bereavement Benefit Program ("**Bereavement Benefit Program**") provides "**Bereavement Pay**" to you upon the death of certain relatives.

The Bereavement Benefit Program is a component plan of the Welfare Fund and this Section 15 is the component Plan Document and SPD for the Bereavement Benefit Program. This Section is incorporated into the Welfare Fund's SPD and the applicable terms of the Welfare Fund's SPD are incorporated into this Section.

B. Participating in the Bereavement Benefit Program

If you are eligible, you become a Participant in the Bereavement Benefit Program when you become eligible for benefits from the Welfare Fund. You will cease to be a Participant in the Bereavement Benefit Program when your eligibility for benefits is terminated.

You are not eligible for Bereavement Pay if you are participating in the Welfare Fund under the Extended Eligibility provisions described in Section 6A(8) ("Extending Your Eligibility") or COBRA continuation coverage described in Section 6E ("Notice of Continuation Coverage Rights Under COBRA").

C. Bereavement Pay

The Welfare Fund will make a payment to you in the amount of $300 for the death of any of the following relatives:

- Spouse
- Son, stepson, son-in-law, step-son-in-law
- Daughter, stepdaughter, daughter-in-law, step-daughter-in-law
- Mother, stepmother, mother-in-law, step-mother-in-law
- Father, stepfather, father-in-law, step-father-in-law;
- Brother, stepbrother, brother-in-law (your sister's husband or your Spouse's brother)
- Sister, stepsister, sister-in-law (your brother's wife or Spouse's sister)
- Grandfather, step-grandfather, (grandfather of Spouse is not covered)
- Grandmother, step-grandmother, (grandmother of Spouse is not covered)
- Grandchildren

You are not required to provide proof that you missed work in order to receive Bereavement Pay. However, you must:

- Provide a copy of the obituary notice, death certificate, or other evidence as the Trustees may require to the Fund Office; and
- Submit a completed ***Bereavement Pay Application*** to the Fund Office.

Contact the Fund Office for a copy of the ***Bereavement Pay Application***.

Section 16
Claims and Appeals

The Claim and appeal forms and documents referenced in this Section are available on www.ptsmn.org or by contacting the Fund Office (see Section 3 ("Important Contact Information"):

- Claim and Appeal Form
- Authorization of Representative
- Claim Reimbursement Form

If you are a Medicare-Eligible Retiree, contact Riverview Member Services at (952) 883-7979 or (800) 233-9645 for procedures to request a coverage decision or appealing a coverage decision.

A. The Welfare Fund's Claims and Appeals Procedures Generally

Below are the Welfare Fund's standard Claims and appeals procedures for all of the Welfare Fund's Plans. However, if the Welfare Fund contracts with a PPO to provide Claims or appeal adjudication services, that PPO's Claims and appeals procedures will supplement the Welfare Fund's standard Claims and appeal procedures. To the extent that a PPO's Claims and appeals procedures are inconsistent with the Welfare Fund's standard Claims and appeal procedures, the Welfare Fund's standard Claims and appeals procedures will control. A PPO appeal procedure that calls for two levels of appeal will not be considered inconsistent with the Welfare Fund's standard Claims and appeals procedures.

See Section 3 ("Important Contact Information") for information on filing Claims and appeals with each PPO.

Notwithstanding anything to the contrary, the Welfare Fund's standard Claims and appeals procedures will be administered in accordance with the requirements applicable to the Welfare Fund as described in the U.S. Department of Labor's **Claims Procedure Regulations** (29 C.F.R. § 2560.503-1 and, to the extent applicable, § 2590.715–2719).

B. What is a Claim?

A **Claim** is a request that satisfies all of the following:

- The request is from you or on your behalf for payment by the Welfare Fund of an expense you incurred, or for Prior Authorization, or for payment of a benefit to which you believe you are entitled;
- The request is in writing to the Fund Office and on the ***Claim and Appeal Form*** available from the Fund Office, or the request is formatted and submitted in the manner required by the Claims procedures of the applicable PPO[26];

[26] If you are unsure which PPO is appropriate for your Claim, contact the Fund Office. See Section 3 ("Important Contact Information") for PPO appeal information.

- The request provides the information necessary to determine whether the benefit payable under the applicable Plan of the Welfare Fund, or whether Prior Authorization can be granted, or whether you are entitled to payment; and
- The request is received by the Welfare Fund within one year of the date you incurred the expense or became entitled to the benefit and the request does not pertain to an expense or benefit for which you have previously filed a Claim.

A Claim must be truthful and not misleading. If the Welfare Fund makes a payment to you or on your behalf based on a Claim and it is later determined that the Welfare Fund would have paid less or paid nothing had the Claim been truthful and not misleading, you will be liable to the Welfare Fund for the amount of the payments that should not have been made to you or on your behalf plus interest and all collection expenses the Welfare Fund incurs. The Welfare Fund may take any legal action necessary to collect, including, without limitation, offsetting any benefits that are owed to you and filing a lawsuit.

Occupational or Accident-Related Claims

If the Welfare Fund or a PPO receives a request for payment of expenses you incurred as a result of your employment or an accident, the request will not be considered a Claim until you have completed or submitted any form or request that may be required by the Fund Office or PPO as a condition to payment of expenses. See Section 17B ("The Welfare Fund's Subrogation and Reimbursement Rights") for more information.

C. How Benefits Are Paid and How to File a Claim

When you incur Covered Expenses and you file a Claim, the Welfare Fund will reimburse you for those Covered Expenses to extent provided by the applicable Plan. In many cases, your Provider will file a Claim on your behalf using the information on your ID card.[27] In such cases, you will not need to personally file a Claim.[28] If you wish, you may notify the Fund Office in writing that all reimbursements should be disbursed directly to you. If you have not elected to receive reimbursements directly and a Provider submits a Claim that is determined to be payable, you will be presumed to have directed the Welfare Fund to pay your reimbursement directly to the Provider on your behalf. The Welfare Fund will then pay your reimbursement to the Provider in full satisfaction of the Welfare Fund's obligation to reimburse you. If you incur Covered Expenses

[27] A Provider may file a Claim on your behalf, but you cannot assign your right to receive payment from the Welfare Fund (or any rights associated with your right to payment) to any person or entity. See Section 17N) ("Non-Assignability of Rights") for more information.

[28] You are responsible for ensuring that your Provider files a timely, complete, and accurate Claim. You may appoint authorized representative(s) to act on your behalf with respect to one or more Claims if you submit a completed written ***Authorization of Representative*** form, or other evidence of your representative's authority to act on your behalf, with the Fund Office.

and another person or entity does not file a Claim on your behalf, you must file the Claim by filing a completed ***Claim Reimbursement Form*** with the applicable PPO, including any required support documentation.

If the Welfare Fund attempts to pay a Provider on your behalf and the Provider does not cash the check within 180 days, the Welfare Fund will make the payment to you instead. If the Welfare Fund attempts to reimburse you and you do not cash the check within 180 days, the Welfare Fund will attempt to locate you in accordance with the Welfare Fund's Missing Participant and Uncashed Distribution Checks Policies and Procedures. If efforts to locate you fail, you will forfeit your right to reimbursement one year from the date that the Welfare Fund first attempted to reimburse you.

If you, or another person on your behalf, attempts to file a Claim but does not provide all information required to process your Claim, you will be notified. If your attempt to make a Claim relates to Prior Authorization, you will be notified within five days (or 24 hours, if the Prior Authorization is for an Urgent Care Claim).

If you (or another person on your behalf) do not file a Claim for reimbursement of a Covered Expense within one year of the date you incur the Covered Expense, you forfeit any right to reimbursement that you would have had if you had filed a timely Claim.

D. How the Welfare Fund Decides Whether to Pay Your Claim, and How You Can Appeal

When the Welfare Fund (or the applicable PPO) receives a Claim, a decision will be made regarding whether or to what extent the Claim is payable under the terms of the applicable Plan. You will be notified of the decision in writing. With respect to a Claim for Health Benefits, you will generally be notified using a form called an **explanation of benefits**. The explanation of benefits may be from the Fund Office or a PPO.

E. Denied Claims

If the decision is to deny your Claim in whole or in part, the notice will be provided in a culturally and linguistically appropriate manner and will provide the following (to the extent applicable):

- If the denied Claim is for Health Benefits, information sufficient to identify the Claim involved (including the date of service, the Provider, the Claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The specific reason or reasons for the denial;
- Reference to the specific provisions of the Plan on which the denial was based;
- If your Claim was denied because more information was needed to process your Claim, the notice will describe the information needed and the reasons it is needed;
- A description of the applicable appeal procedures, including, if the denied Claim was an Urgent Care Claim, a description of the expedited appeal procedure;

- A statement that you have a right to bring a civil action under ERISA § 502(a) after you have exhausted your appeal rights;
- If the denied Claim is for Health Benefits, contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act ("**PHSA**") to assist individuals with the internal Claims and appeals and external review processes;
- If the denied Claim is for Disability Benefits, a description of any rule, guideline, or protocol that was relied on in denying your Claim and, if the denial was based on Medical Necessity, an explanation of any scientific or clinical judgment relied on in denying your Claim; and,
- If the denied Claim is for Disability Benefits, a discussion of the decision with an explanation of the basis for disagreeing with or not following the views you presented to the healthcare or vocational professionals who treated or evaluated you, the views of medical or vocational experts whose advice was obtained by or on behalf of the Welfare Fund in connection with the decision to deny your Claim, without regard to whether the advice was relied upon, and any disability determination made by the Social Security Administration.

F. Appeals

If you disagree with the decision to deny your Claim, you have 180 days to appeal the denial in writing.[29]

For all appeals, your request for appeal must include the specific reasons you feel the determination or the Claim denial was improper. Your request must be provided to the Fund Office on a completed ***Claim and Appeal Form***. You may submit any documents, materials and information you feel appropriate or would like to be considered as part of the decision.

You may request copies of documents relevant to your Claim from the Fund Office or the applicable PPO (there is no charge for copies). The Welfare Fund will provide you free of charge any new or additional rationale or evidence considered, relied upon, or generated by or on behalf of the Welfare Fund in the appeal process as soon as possible. If you receive notice or such new or additional evidence or rationale, you will be provided a reasonable opportunity to respond before a final decision is made on your appeal. If the new evidence or rationale arises with insufficient time to give you a reasonable opportunity to respond before a decision on your appeal is due, the deadline for the decision will be will be tolled while you are given an opportunity to respond. You may not file a lawsuit or take other action until you have appealed and either the appeal has been decided or you have not received a decision within the required timeframe.

Generally, the Board of Trustees will decide appeals, but the Board may delegate the authority to decide appeals to another person or entity. Decisions regarding hiring, compensation,

[29] For an Urgent Care Claim, your request for appeal need not be in writing. In addition to a denial of a Claim, you may also appeal a rescission of coverage as described in Section 6A)(10) ("Rescission of Eligibility") under the same rules that apply to a Claim.

termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

If the Trustees decide your appeal, their decision will generally be made at the next regularly scheduled Board meeting that is more than 30 days from the receipt of the appeal request. The Trustees may defer a decision on your appeal until the subsequent regularly-scheduled Board meeting. If the Trustees defer your appeal to a subsequent meeting, you will be notified of this decision and the reason why your appeal was deferred until a later date. The Trustees may defer a decision on your appeal until the 2nd following regularly-scheduled Board meeting. If your appeal is deferred for a second time, you will again be provided notice of the decision and the reason why your appeal was deferred until a later date. You may request the right to appear in person before the Board.[30] If the Trustees consent to your personal appearance, you will be notified in advance of the meeting.

On appeal, the initial decision to deny your Claim or to determine your eligibility will not be afforded deference. Everything you submitted relating to your Claim will be taken into account regardless of whether anything you submitted was considered or submitted in the initial decision to deny your Claim or to determine your eligibility. You will be provided notice of the decision within five days after your appeal was considered.

G. Denied Appeals

If your appeal is denied (in whole or in part) the notice of the adverse decision on appeal will (to the extent applicable):

- If the appeal relates to a Health Benefit, provide information sufficient to identify the Claim involved (including the date of service, the Provider, the Claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- State the specific reason(s) for the decision;
- Reference the specific provisions of the applicable Plan on which the denial was based;
- State that you are entitled to receive reasonable access to and copies of all documents relevant to your Claim, upon request and free of charge;
- If the denied Claim is for a Disability Benefit, provide a description of any rule, guideline, or protocol that was relied on in denying your Claim and, if the denial was based on Medical Necessity, an explanation of any scientific or clinical judgment relied on in denying your Claim;

[30] The Trustees are under no obligation to permit an in-person appeal and may decline a request for any reason or no reason. In-person appearance does not affect your obligation to provide a written statement of your reasons for appeal.

- State that you have a right to bring a civil action under ERISA § 502(a) and that you have one year to bring such an action;
- Provide contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHSA § 2793 to assist individuals with the internal Claims and appeals and external review processes;
- State that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."; and,
- If the denied Claim is for Disability Benefits, provide a discussion of the decision with an explanation of the basis for disagreeing with or not following the views you presented to the healthcare or vocational professionals who treated or evaluated you, the views of medical or vocational experts whose advice was obtained by or on behalf of the Welfare Fund in connection with the decision to deny your Claim, without regard to whether the advice was relied upon, and any disability determination made by the Social Security Administration.

If applicable PPO procedures call for two levels of appeal, the first-level of appeal will be decided by the applicable PPO and the second-level appeal will be decided by the Board of Trustees. You have 180 days from the date you receive notice of the first-level decision to file a second-level appeal with the Fund Office. You will be notified of the decision on a first-level appeal of a post-service Claim (you already incurred the expense) for Health Benefits within 15 days of the date the applicable PPO receives your Claim.

The Trustees may defer a decision on your second-level appeal in the manner described above in Section 16F.

If you disagree with the Trustees' decision[31], you have one year to file a lawsuit in federal court under ERISA § 502, or you have one year to request binding arbitration with the Welfare Fund. If you request binding arbitration, you waive your right to file a lawsuit.

H. Independent External Review Procedures

1. **External Review**. The Welfare Fund gives you the opportunity to seek review of certain Claim denials by an independent external review organization. If you disagree with the Trustees' final determination on internal appeal, you can seek review within four months of the decision. Your Claim is eligible for external review if you have exhausted your internal claim appeal opportunities and your appeal relates to:

   a) A medical judgment (i.e., Medical Necessity; Experimental/Investigative);

[31] A decision on a first-level appeal that is not made by the Trustees is not final. The Trustees must deny your appeal before you may file a lawsuit.

b) An adverse determination under billing protections of the No Surprises Act (see Section 7B(6) ("Your Rights and Protections Against Surprise Medical Bills") for more information); or

c) Rescissions of coverage (see Section 6A(10) ("Rescission of Eligibility") for more information).

Claims based on: (a) legal or contractual disputes; or (b) issues regarding your eligibility, are not eligible for external review.

2. **Notice of Rights and Assignment to IRO**. If your final internal appeal is denied, you will be notified in writing that your Claim is eligible for external review and you will be informed of the steps necessary to request an external review.

   If you decide to seek external review, an independent external review organization ("**IRO**") will be assigned your Claim, and the IRO will work with a neutral, independent clinical reviewer with appropriate medical expertise. The ultimate decision of the IRO is binding on you, the Trustees, and the Welfare Fund.

3. **Preliminary Review**. After you request an external review, the Trustees[32] must, within five business days, make a preliminary assessment of your Claim, confirming that:
   - You had Welfare Fund coverage at the time the service was requested or provided;
   - The determination relates to a medical judgment or rescission of coverage;
   - You have exhausted the internal appeals process; and
   - You have provided all of the paperwork necessary to complete the external review.

   The Trustees must notify you in writing within one business day of completing the preliminary assessment. If your request is complete but not eligible for external review, the Trustee's notice will provide: (a) the reasons your request is ineligible; and (b) contact information for the Employee Benefits Security Administration (toll-free (866) 444-EBSA (3272)). If your request is not complete, the Trustee's notice will describe the missing information or materials. The Trustees will then allow you to complete the request for external review before the end of the original four-month filing period or within 48 hours, whichever is later.

4. **Referral to IRO**. Once your request is complete and determined to be eligible for external review, the Trustees will assign an accredited IRO and provide the IRO with the internal file and other materials considered during the internal appeals process. The IRO will timely notify you in writing to:

   a) Confirm your request's eligibility and acceptance for external review; and

[32] The Trustees may delegate authority for this review, or any other review or action described in this Section to a committee of the Trustees, the Fund Office, or any other agent of the Board of Trustees as the Board deems appropriate in its sole and absolute discretion.

b) Provide you an opportunity to submit in writing, within 10 business days following the date of receipt, additional information that the IRO should consider when conducting the external review.

The IRO will forward any additional information you provide to the Trustees, so that the Trustees may consider whether to approve your Claim based on the new information.

The IRO will review any information or documents you provide within the 10-day window. In reaching a decision, the IRO is not bound by any decisions or conclusions reached during the Welfare Fund's internal appeals process. The IRO will also consider, where appropriate:

- Your medical records;
- The attending healthcare Provider's recommendation;
- Reports from appropriate healthcare Providers and other documents submitted by the Welfare Fund, you, or your treating Provider;
- The terms of the Welfare Fund, to ensure that the IRO's decision is not contrary to the terms of the Welfare Fund (unless the terms are inconsistent with applicable law);
- Appropriate practice guidelines, including applicable evidence-based standards, and any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Trustees, unless the criteria are inconsistent with the terms of the Welfare Fund or with applicable law; and
- The opinion of the IRO's clinical reviewer.

The IRO will provide written notice of the final external review decision to you, the Trustees, and the Welfare Fund, within 45 days of the date it receives the Claim.

If the IRO overturns the Welfare Fund's denial of your Claim, the Welfare Fund will immediately provide coverage or payment for your Claim.

5. **Expedited External Review**. You may immediately request an expedited external review at the time you receive:

a) An initial internal Claim denial involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the normal claim procedure guidelines;

b) A final internal appeal denial involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the normal claim procedure guidelines; or

c) A final internal appeal denial involving an admission, availability of care, continued stay, or a healthcare item or service for which you received Emergency Services, but have not been discharged from a facility.

Immediately upon receipt of your request, the Trustees will determine whether the request is eligible for expedited external review. The Trustees will immediately send you a notice of its eligibility determination.

6. **Referral of Expedited Review to IRO**. Upon a determination that a request is eligible for expedited external review following preliminary review, the Trustees will assign an IRO. The IRO will render a decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, the assigned IRO will provide you, the Trustees, and the Welfare Fund with a written notification of its decision within 48 hours.

7. **Maintenance of Appeals Records**. The IRO will maintain records of all Claims and notices associated with the external review process for a six-year period. The records will be available for examination by you, the Welfare Fund, or any state or federal oversight agency upon request, except where disclosure would violate state or federal privacy laws.

I. Decision and Appeal Timing

The timeframes for each step in the Claim and appeal process depend on the type of Claim at issue. The timeframes are as described below.

<table>
<tr><th></th><th colspan="2">Post-Service</th><th>Prior Authorization</th><th>Urgent Care Claim</th></tr>
<tr><td>Notice of Initial Decision</td><td colspan="2">Within 30 days of Claim receipt</td><td></td><td>Within 72 hours of Claim receipt (24 hours if more information needed to process claim)[33]</td></tr>
<tr><td>Extension Period</td><td colspan="2">15 days</td><td></td><td>None</td></tr>
<tr><td>Appeal Request</td><td colspan="2">Within 180 days</td><td></td><td>Within 180 days</td></tr>
<tr><td>Notice of Appeal Decision</td><td>5 days after the first Board meeting that is more than 30 days from receipt of appeal request (or within 30 days for a first-level appeal).</td><td>Within 30 days (or 15 days if there are two levels of appeal)</td><td></td><td>Within 72 hours</td></tr>
<tr><td>Extension Period</td><td>2 extensions, each until the next Board meeting</td><td>None</td><td></td><td>None</td></tr>
<tr><td>Independent Review Request</td><td colspan="3">Within four months of receipt of appeal decision</td><td>Within 72 hours or sooner</td></tr>
</table>

[33] Only 24 hours if your Claim pertains to a cessation of coverage of an ongoing course of treatment.

	Post-Service	Prior Authorization	Urgent Care Claim
Request for Arbitration	Within one year of receipt of appeal decision		Within one year of receipt of appeal decision
File Lawsuit	Within one year of receipt of appeal decision		Within one year of receipt of appeal decision

Section 17
Miscellaneous

A. Coordination of Benefits with Other Plans

1. **Coordination of Benefits, Defined**. Participants in the Welfare Fund may maintain coverage under another health plan. For example, if you are married and your Spouse has employer-sponsored group health coverage, each of you can choose to cover the other under your respective plans.

   Most medical and dental plans have coordination of benefits rules to ensure that insurers do not overpay or duplicate payments for Covered Expenses when multiple insurers are involved. This Section addresses the coordination of benefit rules under the Welfare Fund.

2. **When Coordination is Necessary**. Coordination of benefits is needed when you and/or your Dependents have coverage under:
   - More than one employer-provided health plan;
   - An individually purchased plan and an employer-provided plan;
   - A university–sponsored student plan and an employer-provided plan; and
   - Medicare and an employer-provided plan.

   An individual may become eligible for Medicare based on age, disability, or End-Stage Renal Disease. It is your responsibility to know if and when you or a Dependent become eligible for Medicare and the steps, if any, required to enroll for Medicare benefits. **Your eligibility for Medicare benefits may affect your eligibility for Welfare Fund benefits**. If you have any questions regarding Medicare eligibility and the impact on your Welfare Fund benefits, contact the Fund Office. Detailed information regarding Medicare is available at www.medicare.gov.

3. **How Coordination of Benefit Rules Work**. If a healthcare expense is covered by two plans, one plan is the **primary plan** and has first responsibility for the expense. When the primary plan has paid its normal benefits, the other, or **secondary plan** may make an additional payment based on its provisions. The Welfare Fund may:
   - Release to or obtain from any other plan any necessary Claim information;
   - Recover any overpayment from any other person or plan; and
   - Pay any other plan any amount the Welfare Fund should have paid.

   When the Welfare Fund pays reduced benefits as the secondary plan, the amount of the reduction will be maintained as a credit for you for the remainder of the calendar year. This amount may be used for other Covered Expenses in excess of the amount the Welfare Fund would have otherwise paid, but for the credit. This credit is only maintained for a calendar year and a new record starts each January 1. Credits will not be maintained in Claims coordinated with no-fault auto insurance or workers' compensation. Credits are only for the individual, not for the family.

a) If the Welfare Fund Is Primary. When the Welfare Fund is primary, it pays full benefits according to its rules. After you have received an explanation of benefits from the Welfare Fund, you can submit any remaining expenses to the secondary plan for consideration.

b) If the Welfare Fund Is Secondary. When the Welfare Fund pays benefits as the secondary plan, the primary plan pays its benefits first. The Welfare Fund's claims administrator then determines whether any additional benefit is payable. The claims administrator compares the primary plan's benefit with the amount the Welfare Fund would have paid as your only source of coverage. The Welfare Fund makes up the difference, if any, between the amount you have already received and the amount the Welfare Fund would have paid had it been the primary plan. The Welfare Fund will not pay a benefit if the primary plan paid the amount the Welfare Fund would have paid had it been the primary plan.

   This type of coordination of benefits provision is often referred to as non-duplication.

c) If the Expense Is for You. The Welfare Fund is the primary plan for you (you are covered as an Employee) and pays benefits without regard to other coverage, except if you are an acquired employee who remains covered under another plan for a period of time.

d) If the Expense Is for a Dependent. If a covered Dependent is an employee of another employer and is covered by that employer's plan, the other employer's plan will be the primary plan.

   If a Child is covered under both parents' plans, the primary plan will be that of the parent who has the earlier birthday during the calendar year.

   If a Child is covered under both plans of parents who are divorced or separated and not remarried, the plan of the parent with custody of the Child is the primary plan. An exception applies if the court has decreed that financial responsibility for medical and dental care expenses belongs with the other parent.

   If the parent with custody has remarried and a stepparent's plan also covers the Child, the plan of the parent with custody pays first and then the plan of the stepparent pays. The plan of the parent without custody pays last.

e) If the Other Plan Has No Coordination Rules. If the other plan has no provision regarding coordination of benefits, that plan is the primary plan.

f) If You Are Eligible for Medicare as an Active Employee or Dependent. If you're eligible for both Medicare and active Employee coverage under the Welfare Fund, the Welfare Fund will be the primary plan for you and your covered Medicare-eligible Dependents, although certain Medicare exceptions may apply. For example, if you have End-Stage Renal Disease, Medicare is the secondary payer to the Welfare Fund for a specified coordination period. After the coordination period, Medicare becomes the primary payer and the Welfare Fund becomes the secondary payer. You must enroll in Medicare (for example, Medicare Parts A and B) before the end of the coordination period to prevent a gap in coverage. Detailed information regarding Medicare is available at www.medicare.gov.

g) When None of the Rules Apply. If none of the rules above determine the primary plan, the primary plan is the one that has covered the person for the longest period of time.

4. **Questions on Coordination of Benefits**. For detailed information regarding the coordination of your Welfare Fund benefits with other coverage (or Medicare eligibility), contact the Fund Office.

B. The Welfare Fund's Subrogation and Reimbursement Rights

1. **Overview of the Welfare Fund's Rights.** Benefits payable by the Welfare Fund for the treatment of an Illness or Injury will be limited as described in this Section when the Illness or Injury is the result of an act or omission of another (including a legal entity), when another person or legal entity may be legally obligated to pay benefits or other compensation related to the Illness or Injury, or when you or your Dependent pursues or has the right to pursue a recovery from the other person or legal entity responsible for the Illness or Injury.

   The Welfare Fund will pay benefits for Covered Expenses related to such Illness or Injury only to the extent not paid by the third party.

   By accepting benefits under the Welfare Fund related to such Illness or Injury, you agree:
   - That the Welfare Fund has established a lien on any recovery received by you (or your Dependent, authorized representative, or agent).
   - To notify any third party responsible for your Illness or Injury of the Welfare Fund's right to reimbursement for any claims related to your Illness or Injury.
   - To notify the Welfare Fund and obtain its consent before settling claims with any third party responsible for your Illness or Injury.
   - To hold any reimbursement or recovery received by you (or your Dependent, authorized representative, or agent) in trust on behalf of the Welfare Fund to cover all benefits paid by the Welfare Fund with respect to such Illness or Injury and to reimburse the Welfare Fund promptly for the benefits paid, even if you are not fully compensated or made whole for your loss. See Section 17B(5) below for a more detailed description on the constructive trust established on any amounts you recover from a third party.
   - That the Welfare Fund has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the Participant or Dependent is made whole) and that the Welfare Fund's claim has first priority over all other claims and rights.
   - To reimburse the Welfare Fund in full up to the total amount of all benefits paid by the Welfare Fund in connection with the Illness or Injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance, or otherwise, must be turned over to the Welfare Fund as reimbursement up to the full amount of the benefits paid. See Section 17B(3) below for a more detailed description of the Welfare Fund's first priority right of reimbursement.
   - That the Welfare Fund's claim is not subject to reduction for attorneys' fees, costs, or damages under the "common fund" doctrine or otherwise.

- That, in the event that you elect not to pursue your claim(s) against a third party, the Welfare Fund is equitably subrogated to your recovery rights and may pursue your claims. See Section 17B(2) below for a more detailed description of the Welfare Fund's first priority right of subrogation.
- To assign, upon the Welfare Fund's request, any right or cause of action to the Welfare Fund.
- Not to take or omit to take any action to prejudice the Welfare Fund's ability to recover the benefits paid.
- To cooperate in doing what is necessary to assist the Welfare Fund in recovering the benefits paid or in pursuing any recovery or reimbursement.
- To forward any recovery to the Welfare Fund within 10 days of disbursement by the third party or to notify the Welfare Fund as to why you are unable to do so.
- To the entry of judgment against you and, if applicable, your Dependent, in any court for the amount of benefits paid on your behalf regarding the Illness or Injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Welfare Funds' attorneys' fees, costs, or damages.

No benefits will be payable for charges and expenses that are excluded from coverage under any other Welfare Fund provision. The Welfare Fund may enforce its right to reimbursement for expenses it incurred on your behalf as a result of a third-party's liability by filing a lawsuit, recouping the amount owed from your (or a covered Dependent's) future benefit payments (regardless of whether benefits have been assigned by a Participant or covered Dependent to the doctor, hospital, or other healthcare Provider), or any other remedy available to the Welfare Fund.

The Welfare Fund may permit you to turn over less than the full amount of benefits paid and recovered as it determines in its sole discretion. Any reduction of the Welfare Fund's claim is subject to prior written approval by the Trustees or the Executive Administrator of the Fund Office.

2. First Priority Right of Subrogation. The Welfare Fund has a first priority subrogation right for all benefits paid on your behalf and all benefits paid to you arising out of or relating to an Injury or Illness for which any individual or entity may be responsible. This first priority right of subrogation includes claims you may have against any individual, entity, or employer, and claims against any insurance policy including but not limited to all first-party insurance coverage (e.g. no-fault, underinsured, uninsured), third-party insurance coverage, general liability, employment practices, premises insurance coverage, etc. The Welfare Fund's first priority right of subrogation includes all work-related claims you may have arising out of or relating to employment and employment related activities. The Welfare Fund's first priority right of subrogation includes all claims against any responsible or potentially responsible individual, entity, or insurer whether arising out of statute, regulation, contract or common law. The Welfare Fund may pursue a claim or cause of action in its own name or in your name against the liable or potentially liable individual, entity, or insurer. The Welfare Fund's

subrogation claim will be paid in full before any amounts are paid to you, your attorney, or any other party. The Welfare Fund's subrogation right will be paid in full before any amounts are paid to a trust on your behalf, including any trust established on behalf of a minor Dependent.

3. **First Priority Right of Reimbursement.** The Welfare Fund has a first priority right of reimbursement. The Welfare Fund's first priority right of reimbursement includes all amounts paid by the Welfare Fund to you or your Dependent or paid on your behalf as determined by the Trustees as set forth below. The Welfare Fund's reimbursement right extends to all amounts you or your Dependent receive or have the right to receive relating to or arising out of any Illness or Injury no matter how the recovery is characterized and regardless of whether the amount represents reimbursement for medical claims, lost wages, loss of consortium, future losses, pain and suffering, property loss, etc. You are required to reimburse the Welfare Fund in full before any amounts are paid to you, to your attorney or to any other individual, entity, including any trust. Any state law requiring you to be made whole before the Welfare Fund is preempted by ERISA.

4. **Scope of Rights**. The amount of the Welfare Fund's right to subrogation and reimbursement includes all amounts the Welfare Fund has paid to you or your Dependent and amounts paid on your or your Dependent's behalf. The amount of the Welfare Fund's right also includes all amounts the Welfare Fund incurs for attorneys' fees and costs enforcing its subrogation or reimbursement rights. The Welfare Fund's first priority right of subrogation and first priority right of reimbursement will not be reduced by any attorneys' fees or costs that you or your Dependent incur. The Welfare Fund will not pay any portion of your or your Dependent's attorneys' fees or costs. The Trustees have the sole discretion to determine which benefits the Welfare Fund has paid relate to or arise out of the Injury or Illness for which you are receiving or are entitled to receive a recovery.

5. **Establishment of a Constructive Trust.** A constructive trust is automatically established for the benefit of the Welfare Fund and the Participants in all amounts you or your Dependents receive or become entitled to receive, including all amounts whether the amount represents reimbursement for medical claims, lost wages, loss of consortium, future losses, pain and suffering, property loss, etc.

C. Medicare Part D Prescription Drug Creditable Coverage

If you or a covered Dependent are eligible for Prescription Drug coverage under the Welfare Fund and are also eligible for Medicare, a federal law called the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Welfare Fund to provide you with an annual notice addressing whether the Welfare Fund's Prescription Drug coverage is creditable or non-creditable. You should receive the ***Notice of Creditable Coverage*** each year by October 15.

Creditable means that the Welfare Fund's Prescription Drug coverage is expected to pay out, on average, as much or more as the standard Prescription Drug benefit under Medicare Part D will

pay. You don't need to enroll in coverage under Medicare Part D if your coverage under the Welfare Fund is creditable.

However, if your coverage under the Welfare Fund is non-creditable, you may pay higher Medicare Part D premiums if you have a break in creditable coverage of 63 days or more and then enroll in Medicare Part D Prescription Drug coverage.

Additional information about your Prescription Drug coverage under the Welfare Fund is available in the ***Notice of Creditable Coverage*** that you receive. The ***Notice of Creditable Coverage*** is intended to help you decide between Medicare Part D Prescription Drug coverage or the Welfare Fund's coverage, if available. You can also request a copy of the ***Notice of Creditable Coverage*** by contacting the Fund Office.

D. Privacy of Your Health Information

HIPAA is a federal law that requires group health plans to protect the privacy and security of your confidential health information. The Health Information Technology for Economic and Clinical Health ("**HITECH**") Act is a related federal law that expanded the HIPAA privacy and security rules to impose breach notification requirements.

As a group health plan subject to ERISA, the Welfare Fund will not use or disclose your protected health information ("**PHI**") without your authorization, except for purposes of treatment, payment, health care operations, plan administration, or as required or permitted by law. A description of how the Welfare Fund uses and discloses your PHI, and your rights and protections under HIPAA's privacy and security rules, is set forth in the Welfare Fund's notice attached as Appendix E ("Privacy Notice") and accessible at www.ptsmn.org.

The Welfare Fund will also comply with any applicable requirements under the HITECH Act, which include providing notice to affected individuals if the Welfare Fund or its business associates discover a breach involving unsecured PHI.

E. Privacy of Your Genetic Information

The Genetic Information Nondiscrimination Act of 2008 ("**GINA**") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with GINA, we are asking that you not provide any genetic information to when responding to Welfare Fund requests for medical information except as described below.

Genetic information, as defined by GINA, includes:

- An individual's family medical history;
- The results of an individual's or family member's genetic tests;
- The fact that an individual or an individual's family member sought or received genetic services; and
- Genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Family medical history may be provided, however, regarding your family member if you are requesting benefits or coverage (under federal, state, or local leave laws or the Welfare Fund) because of a family member's serious health condition.

Generally, the Welfare Fund will not require you or your family members to provide genetic information or undergo genetic testing. However, the Welfare Fund may condition coverage of certain items or services on whether you have the appropriate genetic makeup. If you request coverage of such items or services, the Welfare Fund will request the relevant genetic information. Any genetic information the Welfare Fund receives will only be used or disclosed by the Welfare Fund as described in Appendix E ("Privacy Notice") in compliance with GINA. If you decline to provide the requested information, the Welfare Fund may deny coverage.

F. Newborns' and Mothers' Health Protection Act

Under the Newborns' and Mothers' Health Protection Act, the Welfare Fund may not restrict a hospital stay for childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarian section delivery. However, federal law allows the mother's or newborn's attending Provider, after consulting with the mother, to discharge the mother or newborn earlier than 48 hours (or 96 hours for a cesarean section). The Welfare Fund may not require that a Provider obtain authorization from the Welfare Fund for prescribing a length of stay that is not in excess of 48 hours (or 96 hours for a cesarean section).

G. Women's Health and Cancer Rights Act

The Welfare Fund complies with the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage is provided in a manner determined in consultation with the attending physician and the patient for: (i) all stages of reconstruction of the breast on which the mastectomy is performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; (iii) prostheses; and (iv) treatment of physical complications of the mastectomy, including lymphedema. Plan limits, Deductibles, Copayments, and Coinsurance apply to these benefits.

H. Amending and Terminating the Welfare Fund

The Board intends to continue the operation of the Welfare Fund indefinitely. The Trustees retain the right to amend or modify any Plan, in whole or in part, in its sole and absolute discretion at any time and for any reason, prospectively or retrospectively to the extent permitted by law. Any amendment to the Welfare Fund will be binding on all Participants on the effective date of the amendment. You are not vested in any benefit or Plan made available to you from the Welfare Fund. The Board also retains the right to terminate any Plan of the Welfare Fund, in whole or in part, in its sole and absolute discretion including, but not limited to the elimination of Retiree Coverage as provided in Section 6B(10) ("Modification or Termination of Retiree Coverage").

In the event of the Welfare Fund's termination, the assets of the Welfare Fund will be applied to all existing benefit obligations. Any balance that cannot be so applied will be applied to other

uses as, in the opinion of the Trustees, will best service the intentions of the Welfare Fund. Upon the complete disbursement of the Welfare Fund's assets, the Welfare Fund will then terminate.

Amendments or modifications required to comply with federal or state law may be made with retroactive effect, but no amendment, modification, or termination may otherwise deprive you of a benefit to which you are entitled.

I. Discretion to Interpret Welfare Fund and Fact Finding

The Board of Trustees has the exclusive right, power, and authority, in its sole and absolute discretion, to administer and interpret the Welfare Fund, its Plans, this SPD, and all other governing documents of the Welfare Fund. The Board has all powers reasonably necessary to carry out its responsibilities under the Welfare Fund including, but not limited to, the sole and absolute discretionary authority to:

1. Administer the Welfare Fund in accordance with its terms and to interpret the Welfare Fund's policies and procedures;
2. Resolve and clarify inconsistencies, ambiguities, and omissions in the SPD and among and between the SPD and other related documents;
3. Take all actions and make all decisions regarding questions of coverage, eligibility, entitlement to benefits, and benefit amounts; and
4. Process and approve or deny all Claims and appeals for benefits (to the extent Claim adjudication not delegated to a third party).

The decision of the Board of Trustees on any disputed question arising under the Welfare Fund, including, but not limited to, questions of construction, interpretation, and administration, will be final, conclusive, and binding on all persons having an interest in or under the Welfare Fund. Any determination made by the Board of Trustees will be given deference in the event it is subject to judicial review and will be overturned by a court of law only if it is arbitrary and capricious.

The Board of Trustees is the sole and exclusive fact-finder with respect to the Welfare Fund. The Trustees may delegate any portion of its authority to another person or entity by written agreement, in which case a decision under delegated authority will have the same effect as a decision by the Board of Trustees.

J. Reliance on Information

The Board of Trustees may rely upon the information submitted by you as being accurate and not misleading, and will not be responsible for any act or failure to act due to inaccurate or misleading information you provided or due to your direction or lack of direction. The Board of Trustees will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Welfare Fund or its Board of Trustees.

K. Right to Recover Payments

You or your Dependent will be required to furnish information or proof necessary to determine that your, your Dependent's, or your Beneficiary's right to a Welfare Fund benefit. If you, your Dependent, or your Beneficiary fail to submit the requested information or proof, make a false statement, or furnish fraudulent or incorrect information, your, your Dependent's, or your Beneficiary's benefits under the Welfare Fund (and participation in the Welfare Fund, even if you, your Dependent, or your Beneficiary, would otherwise meet the eligibility requirements) may be denied, suspended, or discontinued at any time and for any length of time (including permanently) by the Welfare Fund in the sole and absolute discretion of the Trustees.

If the Welfare Fund makes payment for benefits that are in excess of expenses actually incurred or in excess of Allowed Amounts, due to error (including, for example, a clerical error) or fraud or for any other reason (including, for example, your failure to notify the Fund Office regarding a change in family status), the Welfare Fund reserves the right to recover such overpayment plus interest and costs, through whatever means are necessary, including, without limitation, legal action or by offsetting future benefit payments to you, your Dependent, your Beneficiary, or Dependent's or Beneficiary's heirs, assigns, or estate. You, your Dependent, or your Beneficiary will be liable to the Welfare Fund in the amount of the payments in question plus interest and all collection expenses the Welfare Fund incurs including, without limitation, attorneys' fees.

L. No Guarantee of Tax Consequences

The Welfare Fund does not guarantee that any amounts paid to or for your benefit by the Welfare Fund will be excludable from your gross income for federal state or local income tax purposes. You must determine when each payment from the Welfare Fund is excludable from your gross income for federal, state, and local income tax purposes, and notify the Board of Trustees if you have any reason to believe that the payment is not excludable.

M. Indemnification of the Welfare Fund

If you receive one or more payments or reimbursements from this Welfare Fund and the payments do not qualify for tax-exempt treatment under the Code, you will indemnify and reimburse the Welfare Fund for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or any other taxes.

N. Non-Assignability of Rights

You may not assign, alienate, pledge, sell, encumber, or transfer benefits for which you may become eligible under the Welfare Fund without the written consent of the Trustees. Any assignment by you will be void. To the extent allowed by law, the Welfare Fund will not accept an assignment to a healthcare Provider or facility for any reason, including but not limited to, an assignment of:

- The benefits due under the Welfare Fund.
- The right to receive payments due under the Welfare Fund.

- Any claim you make for damages resulting from a violation or alleged violation of the terms of the Welfare Fund, including any breach of ERISA fiduciary duties.

Welfare Fund benefits may not be subject to attachment or garnishment by any of your creditors or to legal process.

Only you may bring an action against the Welfare Fund or the Trustees that involves the Welfare Fund. Any payments made by the Welfare Fund to a healthcare Provider do not grant the healthcare Provider rights under the Welfare Fund or ERISA.

O. Incompetence, Disappearance, or Death

If payment of any benefit under the Welfare Fund cannot be paid to you due to your incompetence, disappearance, or death, the Welfare Fund will pay the benefits due in accordance with the Standard Beneficiary Designation unless you designate another Beneficiary(ies) by submitting a completed ***Beneficiary Designation Form*** to the Fund Office. Payments made under this Section will constitute full and final discharge of any obligation of the Welfare Fund to the extent of such payments.

P. Disaster and Emergency Relief

The deadlines for certain actions described in this SPD may be delayed or disregarded pursuant to guidance issued by the Secretary of Labor under ERISA § 518 or the Secretary of the Treasury under Code § 7508A(b) upon the occurrence of a Presidentially-declared disaster, a terroristic or military action or a public health emergency. The Welfare Fund intends to comply with such guidance that is applicable to the Welfare Fund and will notify affected individuals as the Trustees deem appropriate in their sole and absolute discretion.

Q. Quasi-Forfeiture of Benefits

If the Fund Office determines that a Participant or Beneficiary is missing when a distribution is required to be made under the terms of this SPD or by law, the amount payable will be forfeited to the Welfare Fund. Forfeited amounts will be held by the Welfare Fund in a forfeiture account and used to pay the necessary and reasonable operating expenses of the Welfare Fund. A Participant or Beneficiary will be treated as missing consistent with the Welfare Fund's Missing Participant and Uncashed Distribution Checks Policies and Procedures. If a missing Participant or Beneficiary is located or requests a distribution after the forfeiture has occurred, only the amount forfeited will be restored to such person. Such person will not be entitled to any interest or earnings on the forfeited amount that may have accrued between the date of forfeiture and the restoration of benefits. Restored benefit amounts will be payable from the Welfare Fund's forfeiture account.

R. Mistaken Contributions

The Welfare Fund may refund Contributions made to the Welfare Trust by an Employer (or other entity) only if the Trustees determine that the Contributions were made due to mistake of fact or law and the Employer (or other entity) requests the refund in writing within six months of the date that the Trustees determine that the Contribution was made by a mistake of fact or law. To the

extent a benefit has already been paid based upon the claimed mistaken Contribution, no refund will be allowed.

S. Restriction on Venue

Any claim you may have relating to or arising under the Welfare Fund may only be brought in the U.S. District Court for the District of Minnesota. No other court is a proper venue or forum for your claim. The U.S. District Court for the District of Minnesota will have personal jurisdiction over you and any other Participant or Beneficiary in the action.

T. Beneficiary Designations

Your Beneficiary for any benefit that may become payable under the Welfare Fund will be the Standard Beneficiary Designation unless you modify or change your Beneficiary(ies) by filing a completed ***Beneficiary Designation Form*** with the Fund Office.

Section 18
Plan Information

This Section of the SPD provides information to help you identify this Welfare Fund and the people involved in its operation. The inclusion of this information is required under ERISA.

A. Effective Date

This restated Plan Document and Summary Plan Description ("**SPD**") supersedes all prior documents pertaining to the same subject and is effective January 1, 2024.

B. Name of the Welfare Fund

The Welfare Fund is known as the Pipe Trades Services MN Welfare Fund. The plans and programs maintained by the Welfare Fund are referenced in Section 5 ("Benefits") and described throughout the SPD.

C. Agent for Service of Legal Process

The Board of Trustees is the Welfare Fund's agent for service of legal process. Any legal documents pertaining to the Welfare Fund must be served upon the Board of Trustees at the Fund Office at:

Board of Trustees of the Pipe Trades Services MN Welfare Fund
4461 White Bear Parkway, Suite 1
White Bear Lake, MN 55110

D. Plan Sponsor and Plan Administrator

The Board of Trustees is both the Plan Sponsor and Plan Administrator, as those terms are defined by ERISA, of the Welfare Fund.

E. Identification Numbers

The Welfare Fund's employer identification number ("**EIN**") is 41-0761972.
The Welfare Fund's Plan Number is 501.

F. Type of Plan

The Welfare Fund is a Taft-Hartley multiemployer employee welfare benefit plan. The Welfare Fund's Plans are maintained to provide the following types of employee welfare benefits: health, dental, vision, EAP, short-term disability, death, accidental death and dismemberment, jury duty pay, and bereavement pay.

G. Fiscal Year

The Fiscal Year of the Welfare Fund begins each May 1 and ends on the following April 30.

H. Trust Fund

The name of the trust is the Pipe Trades Services MN Welfare Trust. All assets are held in trust by the Board of Trustees for the purpose of providing benefits to Participants and defraying reasonable administrative expenses. The Welfare Fund's assets and reserves are invested by the Board of Trustees in index funds that mimic the returns of various equity and fixed income

portfolios, money market funds, and cash. All Welfare Fund benefits are paid directly from the assets of the Welfare Fund.

I. Source of Contributions

Contributions to the Welfare Fund are made by Contributing Employers in accordance with their CBAs or by written agreement with the Board. The Fund Office will provide, upon written request, information as to whether a Contributing Employer is actually contributing to the Welfare Fund. The CBAs require fixed contributions to the Welfare Fund at fixed rates per Hour of Work. Participation Agreements and Reciprocity Agreements establish the basis upon which Contributions are made to the Welfare Fund for Participants who are not covered by a CBA with a Union.

J. Board of Trustees

The Board of Trustees is responsible for the operation of the Welfare Fund. The Board of Trustees consists of an equal number of employer and union representatives of the Contributing Employers and Local Unions. You may contact the Board of Trustees at the address and phone number listed for the Fund Office in Section 3 ("Important Contact Information"). The Board of Trustees has the responsibility of determining rules for participation in the Welfare Fund and for determining the benefits to be offered. The current Trustees are:

Employer Trustees	Union Trustees
Gary Thaden Minnesota Mechanical Contractors Assoc. 10590 Wayzata Boulevard, Suite 100 Minnetonka, MN 55305	Joe Lane Plumbers Local No. 15 708 South Tenth Street Minneapolis, MN 55404
Doug Jones Schulties Plumbing 1521 94th Lane NE Blaine, MN 55449	Scott Seath Pipefitters Local No. 455 1301 L'Orient St St Paul, MN 55117
Michael Tieva Northland Mechanical 9001 Science Center Drive New Hope, MN 55428	Jeremy Miller Plumbers Local No. 34 353 7th St W #104 St Paul, MN 55102
Bryan Norman Pioneer Power, Inc. 2500 Ventura Dr. Woodbury, MN 55125	Jake Pettit Pipefitters Local No. 539 312 Central Ave., Suite 408 Minneapolis, MN 55414
Matt Marquis Minnesota Mechanical Contractors Assoc. 10590 Wayzata Boulevard, Suite 100 Minnetonka, MN 55305	Sam Arnold Plumbers and Pipefitters Local No. 6 3111 19th Street NW Rochester, MN 55901

Section 19
ERISA Rights

As a Welfare Fund Participant, you are entitled to certain rights and protections under ERISA provides that you will be entitled to:

- Examine, without charge, at the Fund Office and other specified locations, such as worksites and union halls all documents governing the Welfare Fund, including insurance contracts, CBAs and a copy of the latest annual report (Form 5500 Series) filed by the Welfare Fund with the DOL, and available at the Public Disclosure Room of the Employee Benefits Security Administration ("**EBSA**").
- Obtain upon written request to the Fund Office copies of documents governing the operation of the Welfare Fund, including insurance contracts and CBAs, and copies of the latest annual report (Form 5500 series) and updated SPD. The Fund Office may make a reasonable charge for the copies.

In addition to creating rights for the Welfare Fund's Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit Plan. The people who operate the Welfare Fund, called "fiduciaries" of the Welfare Fund, have a duty to do so prudently and in the interest of you and other Welfare Fund Participants and Beneficiaries. No one, including your Employer, the Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your Claim for a benefit is denied in whole or in part, you have the right know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Welfare Fund's documents or the latest annual report from the Welfare Fund and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Welfare Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the DOL, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Welfare Fund, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, you should contact the

nearest office of the EBSA, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 20
Definitions

The definitions provided in this Section are used throughout the SPD and have the meaning provided below. Capitalized terms used in the SPD, but not defined in this Section, have the meanings prescribed in the SPD.

Allowed Amount or Allowance

The maximum amount the Welfare Fund will pay for a Covered Expense. For In-Network Providers, the Allowance is the PPO's contracted rate. The Welfare Fund's Allowance for Out-of-Network Providers is determined at the sole and absolute discretion of the Trustees. For the Health Plan, HealthPartners' Out-of-Network pricing schedule is used to determine the Allowed Amount. Allowed Amounts under the Welfare Fund are updated periodically. An Allowed Amount will not be based on a Provider's or facility's charges and will never exceed the charges incurred.

Apprentice

An Employee of a Contributing Employer who meets specific qualification criteria as set forth in a CBA and with respect to whom the Contributing Employer is required by a CBA to contribute to the Welfare Fund at the rate specific for Employees classified as apprentices in the CBA.

Board of Trustees (or Board or Trustees)

The Board of Trustees of the Pipe Trades Services MN Welfare Fund.

CBA

A collective bargaining agreement ("CBA") is a written agreement between a Union and one or more Employers or an association representing Employers that requires Contributions to the Welfare Fund.

Child

Your child under age 26 who is your:

- Biological child;
- Stepchild;
- Legally-adopted child or child placed for adoption; or
- Grandchild or a sibling's child who lives with you in a parent-child relationship, and of whom you have been awarded physical custody by a court or granted legal guardianship, and whose parent is not living in the same household unless the parent is a minor.

The term Child also includes your unmarried children age 26 or older who continue to be dependent on you or your Spouse, due to an inability to engage in any substantial gainful activity by reason of a medically-determinable physical or mental permanent disability. Such an older child may qualify as a Dependent if they were disabled prior to reaching age 26 and you were eligible for coverage when your Child became disabled, regardless of whether or not you were

enrolled in the Welfare Fund at the time. The Welfare Fund requires periodic certification of permanent disability status by the Child's attending physician.

Claim

See Section 16 ("Claims and Appeals").

Code

The Internal Revenue Code of 1986, as amended, and any rules or regulations promulgated thereunder.

Coinsurance

The portion of a Covered Expense that you pay after you have satisfied any applicable Deductible and subject to any Limitations or Maximum OOP, as applicable.

Continuing Care Patient

An individual, who, with respect to a Provider or facility is:

- Undergoing a course of treatment for an acute Illness (serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm) or chronic Illness or condition (life-threatening, degenerative, potentially disabling, or congenital, and who requires specialized medical care over a prolonged period of time);
- Undergoing a course of institutional or inpatient care from the Provider or facility;
- Scheduled to undergo non-elective surgery from the Provider, including receipt of post-operative care from such Provider or facility;
- Pregnant or undergoing course of treatment for a pregnancy from the Provider or facility; or
- Or was determined to be terminally ill (under SSA § 1862(dd)(3)(A)) and is receiving treatment for such Illness from such Provider or facility.

Contributing Employer

An Employer obligated to contribute to the Welfare Fund for its Employees pursuant to a CBA, Participation Agreement, or Reciprocity Agreement.

Contribution

A payment to the Welfare Fund:

- By a Contributing Employer (or other person or entity) on behalf of its Employees in accordance with a CBA, Participation Agreement, or Reciprocity Agreement; or
- By a Participant to the Welfare Fund in accordance with one or more of the Plans.

Copies of the relevant rate sheets identifying the Contribution rates for each CBA are available free of charge from the Fund Office and posted on www.ptsmn.org under the *Employers* tab.

Covered Employment

Employment of an Employee by an Employer, including any credited Hours of Work earned in another union's jurisdiction, for which Contributions are received by the Welfare Fund as a result of a Reciprocity Agreement with another plan in such jurisdiction.

Covered Expense

See Section 7C ("What the Health Plan Covers").

Dependent

Your:

- Spouse;
- Child; or
- Person that you are required to provide coverage to under a QMCSO.

An individual who would otherwise qualify as your Dependent will not be considered your Dependent if you file a properly completed ***Waiver of Dependent Coverage*** form with the Fund Office.

Deductible

A Deductible is an aggregate amount you must pay toward Covered Expenses before the Covered Expense becomes subject to Coinsurance. Under the Health Plan, there is generally an overall Deductible per individual Participant and per family. The Welfare Fund begins paying Health Benefits with respect to a Participant when the Participant has incurred Covered Expenses equal to the individual Participant Deductible. The Welfare Fund begins paying Health Benefits with respect to all Participants in a family when the aggregate Covered Expenses of all Participants in the family equal the family Deductible.

Dollar Bank

See Section 6D ("Dollar Bank").

Emergency Care

Generally, Emergency Services provided to treat an Emergency Medical Condition.

Emergency Medical Condition

A medical condition, including a mental health condition or substance abuse disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious medical complications, loss of life, serious impairment of bodily functions, or serious dysfunction of a body part.

Emergency Services

With respect to an Emergency Medical Condition:

- An appropriate medical screening examination that is within the capability of an emergency room of a hospital, independent freestanding emergency department, or an urgent care center authorized by state law to provide emergency services even if the urgent care center is not licensed as an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition;
- Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the independent

freestanding emergency department, as applicable (regardless of the department of the hospital in which such further examination or treatment is furnished); and

- Stabilization services, which are services furnished by Out-of-Network Providers or Out-of-Network facilities after the patient is stabilized as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition (regardless of the department of the hospital in which such further examination or treatment is furnished), until:
  - The treating Provider or facility determines that the individual is able to travel using non-medical transportation or nonemergency medical transportation; and
  - The patient is provided with appropriate written notice to consent to Out-of-Network treatment (see Section 7B(6) ("Coverage under No Surprises Act") and gives informed consent to such Out-of-Network treatment.

This definition applies even if it is more than 72 hours after an accident or 24 hours of a sudden and serious Illness.

If you receive Emergency Care that is covered under the No Surprises Act, you are not required to obtain authorization for the coverage.

For pregnant Dependent Children, charges for treatment that qualifies as Emergency Care is covered and paid in accordance with the No Surprises Act.

Ground ambulance services are not Emergency Services for the purposes of the No Surprises Act and will be covered under the terms and conditions set forth in the SPD.

Employee

An individual for whom the Employer is obligated to make Contributions to the Welfare Fund under a CBA, Participation Agreement, or Reciprocity Agreement.

An individual's status as an Employee who is otherwise eligible to participate in the Welfare Fund pursuant to Section 6A ("Active Employee and Dependent Eligibility, Termination of Eligibility") will be subject to any limitations or restrictions imposed by the Labor Management Relations Act of 1947, the Code, ERISA, and any applicable rules, policies, and procedures adopted by the Trustees (e.g., Alumni Employees).

ERISA

The Employee Retirement Income Security Act of 1974, as amended, and any regulations promulgated thereunder.

Experimental or Investigative

A Prescription Drug, device, medical, behavioral health or dental treatment is Investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or positive effect on health outcomes and will be considered Investigative unless all of the following categories of reliable evidence are met:

- There is final approval from the appropriate government regulatory agency, if required. This includes whether a Prescription Drug or device can be lawfully marketed for its proposed use by the FDA; and

- The Prescription Drug or device or medical, behavioral health or dental treatment or procedure is not the subject of ongoing Phase I, II or III clinical trials; and
- The Prescription Drug, device or medical, behavioral health or dental treatment or procedure is not under study and further studies are not needed (such as post-marketing clinical trial requirements) to determine maximum tolerated dose, toxicity, safety, effect on health outcomes or efficacy as compared to existing standard means of treatment or diagnosis; and
- There is conclusive evidence in major peer-reviewed medical journals demonstrating the safety, effectiveness and positive effect on health outcomes (the beneficial effects outweigh any harmful effects) of the service or treatment when compared to standard established service or treatment. Each article must be of well-designed investigations, using generally acceptable scientific standards that have been produced by nonaffiliated, authoritative sources with measurable results. Case reports do not satisfy this criterion. This also includes consideration of whether a Drug is included in one of the standard reference compendia or **Major Peer-Reviewed Medical Literature** for use in the determination of a Medically Necessary accepted indication of Drugs and biologicals used off-label as appropriate for its proposed use. For this purpose, Major Peer-Reviewed Medical Literature means articles from major peer-reviewed medical journals that have recognized the Prescription Drug or combination of Prescription Drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395x(t)(2)(B), as amended, as acceptable peer review medical literature. Each article must use generally acceptable scientific standards and must not use case reports to satisfy this criterion.

Essential Health Benefits

The benefits described under 42 U.S.C. § 18022 (generally: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care). For purposes of specifically defining Essential Health Benefits, the Trustees will select a state benchmark plan. Contact the Fund Office for information on the current benchmark plan. Being self-insured, the Welfare Fund is not required to cover Essential Health Benefits.

FDA

The U.S. Food and Drug Administration.

Fund Office

Pipe Trades Services MN, Inc. is the "Fund Office" and the entity delegated responsibility for the day-to-day administration of the Welfare Fund including the non-discretionary authority to process Claims, determine eligibility, and perform other ministerial functions on behalf of the Welfare Fund.

Helper

An Employee of a Contributing Employer who meets specific qualification criteria as set forth in a CBA and with respect to whom the Contributing Employer is required by a CBA to contribute to the Welfare Fund at the rate specific for Employees classified as helpers in the CBA.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended, and any regulations promulgated thereunder.

Hour of Work

The hours of work in which an Employee performed services and for which he was paid or entitled to payment, adjusted to include premium hours in accordance with the prevailing CBA.

5. An Hour of Work also means each hour for which back pay, irrespective of mitigation of damage, has been either awarded to the Employee or agreed to by the Employer, which will be credited to the Employee for the computation period or periods to which the award or agreement pertain rather than the computation period in which the award, agreement or payment was made.
6. Hour of Work also includes hours worked in another jurisdiction for which Contributions are paid into the Retiree Health Trust pursuant to a Reciprocity Agreement. Hours of Work transferred from another jurisdiction will be calculated by dividing the total payment made to the Retiree Health Trust by the current applicable CBA rate.

The DOL's regulations found at DOL Reg. §§ 2530.200b-2(b) ("Special rule for determining hours of service") and (c) ("Crediting hours of service to computation periods"), as amended from time to time, are incorporated into the Fund by this reference, but only to the extent not inconsistent with the Retiree Health Fund's definition of Hour of Work.

Illness Or Injury

A condition of the body or mind that is recognized by a consensus of appropriate medical and scientific experts as being harmful to an individual's health or ability to function normally. The Trustees have the authority to determine, in their discretion, whether a condition constitutes an Illness or Injury regardless of your healthcare Provider's conclusion.

In-Network Provider

A healthcare Provider that is part of a PPO with which the Welfare Fund has a contract.

Journeyman Employee

An Employee of a Contributing Employer who meets specific qualification criteria as set forth in a CBA and with respect to whom the Contributing Employer is required by a CBA to contribute to the Welfare Fund at the rate specific for Employees classified as journeyman in the CBA.

Lifetime Limit

The maximum aggregate amount the Welfare Fund will pay toward a certain type of Covered Expense for a single Participant or family at any time.

Maximum OOP

The maximum amount you must pay out of pocket toward Covered Expenses in a calendar year, determined on an individual Participant and family basis. If you, your Dependent, or your family reaches a Maximum OOP, the applicable Plan will pay 100% of your Covered Expenses for that Plan for the remainder of the calendar year. Payments you make toward a Deductible and any other payments expressly identified by a Plan do not apply toward your Maximum OOP. A Maximum OOP resets each calendar year. The foregoing is a general description of a Maximum OOP.

Medically Necessary

A healthcare item, service, or treatment that is:

- Provided or prescribed by a healthcare Provider exercising prudent clinical judgment, acting in accordance with generally accepted standards of medical practice[34], and acting within the scope of his or her license to practice;
- Appropriately provided or prescribed for the purpose of diagnosing or treating an Illness or Injury consistent with the symptoms related to the patient's medical condition;
- Clinically appropriate, in terms of type, frequency, extent, site, and duration;
- Not primarily for the convenience of the patient, the patient's family, a healthcare Provider, or any other person; and
- The most appropriate and cost-effective level of healthcare items or services that can be safely provided. With respect to inpatient, it further means that the patient's healthcare items or services cannot be safely provided in a lower level of healthcare setting.

The fact that a healthcare Provider has prescribed, ordered, recommended, or approved a healthcare item, service, or treatment, or has informed you of its availability, does not by itself make it Medically Necessary.

[34] **Generally accepted standards of medical practice**" means the standards relied upon by the applicable PPO clinical policy, if there is an applicable policy, or, if not, standards that are based on credible scientific evidence published in peer-reviewed, medical literature that is generally recognized by the relevant medical community.

Medicare-Eligible Retiree

A Retiree who is enrolled or is eligible to enroll in Medicare and the Welfare Fund's Retiree Coverage.

Minimum Value Coverage

Coverage under a group health plan or health insurance policy that satisfies the requirements of Code § 36B(c)(2)(C)(ii).

Minute Clinic

A healthcare clinic owned by and operated at a CVS Pharmacy.

Motorized Vehicle

Any vehicle which is a self-propelled road vehicle and off-road vehicle, wheeled or with treads, except an automobile.

NBU Employee

Employees who are not in the bargaining unit of a CBA that requires Contributions to the Welfare Fund.

Office Visit

A healthcare event that takes place in a healthcare Provider's Office during which you incur Covered Expenses. An "**Office**" is a location, other than a hospital, skilled nursing facility, military treatment facility, community health center, state or local public health clinic, or intermediate care facility, where the healthcare Provider(s) routinely provides health examinations, diagnosis, and treatment of Illness or Injury on an ambulatory basis.

Out-of-Network Provider

A healthcare Provider that is not part of a PPO with which the Welfare Fund has a contract.

Participant

An individual who is eligible for benefits from the Welfare Fund. Individuals eligible to participate in one or more Plan(s) of the Welfare Fund are also considered Participants in those Plans (e.g., a Participant in the Dental Plan).

Pension Fund

The Pipe Trades Services MN Pension Fund

Pension Supplement Fund

The Pipe Trades Services MN Pension Supplement Fund

Pipe Trades Industry

Any activity of engaging in or performing, directly or indirectly, any of the trade or work as described in the current applicable CBA to which one of the Unions is a party, except not limited to the geographical jurisdiction of the CBA.

Plan

Each of the following is a Plan of the Welfare Fund:

- The Health Plan (Section 7);
- The Dental Plan (Section 9);
- The Vision Plan; (Section 10);
- The Weekly Disability Program (Section 11);
- The Death Benefits Program (Section 12);
- The AD&D Benefits Program (Section 13);
- The Jury Duty Benefits Program (Section 14); and
- The Bereavement Benefit Program (Section 15).

Plan Year

The 12-month period commencing each May 1 and ending on April 30.

Pre-Medicare Retiree

A Retiree who is not eligible to enroll in Medicare, but is enrolled or eligible to enroll in the Welfare Fund's Retiree Coverage.

Preferred Provider Organization (PPO)

An entity having a network of healthcare Providers, through which the Welfare Fund contracts for services by healthcare Providers within the network to be rendered to Participants at a discounted rate. A PPO may also adjudicate Claims and provide some customer service. See Section 3 ("Important Contact Information") for contact information about Claims and customer service.

Premium

The Premium is the amount that you must pay to maintain your (and your Dependents, if applicable) coverage under the Welfare Fund each month. Your Premium will automatically be deducted from your Dollar Bank (if any dollars remain). You must pay any Premium balance remaining as shown on the ***Short Dollars Premium Invoice*** after your Dollar Bank balance is applied towards your Premium. See Section 6A(7) ("Maintaining Eligibility with Short Dollars Premiums") for more information**.** Retirees electing Dental Plan coverage must pay a separate Premium. See Section 9B(2) ("Dental Coverage for Retirees") for more information.

Prescription Drug

A drug or medication that by law requires a prescription from a healthcare Provider.

Preventive Care

Healthcare items and services as described by 42 U.S.C. § 300gg-13. For a current list of items and services that are Preventive Care, see https://www.healthcare.gov/coverage/preventive-care-benefits/.

Prior Authorization

Prior Authorization is a condition of coverage for certain healthcare items and services under which the items and services are excluded from coverage unless you obtain approval from the Fund Office or the applicable PPO before you incur charges for the items or services. If you do not

obtain Prior Authorization when it is required, the Welfare Fund will not pay benefits for the items and services you received without Prior Authorization. You only need Prior Authorization when it is expressly stated in a Plan's SPD or in the PPO's coverage criteria. Prior Authorization is not available for any item or service for which Prior Authorization is not required. You or your Provider may be required to obtain Prior Authorization for certain services. Your Provider will coordinate the authorization process for any services which must first be authorized. See Section 3 ("Important Contact Information") for information about who to contact for Prior Authorization. A PPO may have a procedure that is called "prior authorization" but that is not required as a condition of coverage under the applicable Plan. In such cases, this definition is not applicable and a Claim in such a case will not be considered a pre-service Claim.

Provider

A person or entity that is licensed under applicable law to treat Illnesses and Injuries.

QMCSO

A qualified medical child support order ("QMCSO") is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction requiring the Welfare Fund to recognize an Employee's or Spouse's Child as an alternate recipient as defined by ERISA § 609(a). Such order must be approved in accordance with any procedures adopted by the Board of Trustees.

Retiree

An individual who has submitted a completed ***Retirement Application*** to the Welfare Fund and whose ***Retirement Application*** has been approved by the Trustees or the person the Trustees have delegated such authority.

Specialty Drug

A Prescription Drug that may require special handling or ongoing monitoring and assessment by a healthcare Provider, or is relatively difficult to expense. Specialty Drugs are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. For a list of Specialty Drugs, contact Optum Specialty Pharmacy. See Section 3 ("Important Contact Information").

Spouse

An individual with whom you validly entered a formal legal relationship, denominated under the law of the state or foreign jurisdiction where the relationship was entered as a "marriage", that has not been legally dissolved, annulled, subject to separation, or otherwise terminated by the law of any state or foreign jurisdiction. The Welfare Fund may require proof of a valid marriage before recognizing an individual as a Spouse. An individual will not be treated as your Spouse if you and the individual reside apart for a period of six months or more.

Standard Beneficiary Designation

Your Spouse; or if none, your child or children in equal shares, and the share of any child who does not survive you to his or her children living at your death in equal shares; or if none, to your parents in equal shares; or if none, to your brothers and sisters in equal shares; or if none, to your estate. The term "child" as used for this purpose includes both natural-born and adopted children, but not stepchildren.

Support Worker

An Employee of a Contributing Employer who meets specific qualification criteria as set forth in a CBA and with respect to whom the Contributing Employer is required by a CBA to contribute to the Welfare Fund at the rate specific for Employees classified as support workers in the CBA.

Union or Local Union

Pipe Fitters Local No. 539, Plumbers Local Union No. 15, Pipe Fitters Local No. 455, Plumbers Local Union No. 34, Plumbers and Pipe Fitters Local No. 6, and any other Local Union chartered by the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada or other union representing Employees working in a capacity related to the Pipe Trades Industry whose bargaining unit is accepted for participation in the Welfare Fund by the Trustees.

Urgent Care Claim

A Claim under circumstances where application of the Welfare Fund's normal claims procedure would result in a delay in administering an item or service that could seriously jeopardize your life, health, or ability to regain maximum function, or where the delay would subject you to severe and unmanageable pain.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and any regulations promulgated thereunder.

Welfare Fund

The Pipe Trades Services MN Welfare Fund

Appendix A
Eligibility Example

The table below illustrates an Eligibility Example of how a Journeyman Employee with sporadic Hours of Work maintains Welfare Fund coverage.

This example assumes a $1,600 Premium and that the Journeyman Employee does not have a Dollar Bank balance prior to March. Although your Premium may be different, the process of determining your eligibility for Welfare Fund coverage will remain the same.

Work Month	Eligibility Month	Eligibility?	Credit to Dollar Bank[35]	Short Dollars Premium	Premium Paid	Dollar Bank Balance After Premium
March	May	No	$775	$0	$0	$775
April	June	Yes	$1,650	$0	$1,600	$825
May	July	Yes	$950	$0	$1,600	$175
June	August	Yes	$0	$1,425	$1,600	$0
July	September	Yes	$1,625	$0	$1,600	$25
August	October	No	$0	$0	$0	$0

	Hours Worked in March
No Eligibility In May	In March, the Journeyman Employee first performed Hours of Work, but $775 was not enough credit to the Employee's Dollar Bank to cover the May Premium for Welfare Fund coverage.

	Hours Worked in April
Initial Eligibility in June	In April, the Journeyman Employee performed enough Hours of Work to earn a $1,650 credit to the Employee's Dollar Bank. The Employee's Dollar Bank balance becomes $2,425 ($775 (March) + $1,650 (April)), which is sufficient to cover the June Premium for Welfare Fund Coverage ($1,600).

	Hours Worked in May
Eligibility in July Using Dollar Bank	In May, the Journeyman Employee performed enough Hours of Work to earn a $950 credit to the Employee's Dollar Bank. $950 plus the $825 Dollar Bank balance after paying the June Premium is sufficient to pay the July Premium. After paying the July Premium, the Employee will have a Dollar Bank balance of $175 (($950+$825 carryover)-$1,600). See Section 6D ("Dollar Bank") for more information.

[35] Based on the Contributions to the Welfare Fund for Hours of Work in the "Work Month" above.

Short Dollars Premium for August Coverage	**Hours Worked in June** In June, the Journeyman Employee did not have any Hours of Work. The Premium is $1,600, but the Employee only has a Dollar Bank balance of $175—not enough to cover the Premium. The Journeyman Employee pays the Short Dollars Premium of $1,425 out of pocket to maintain Welfare Fund coverage for August. See Section 6A(7) ("Maintaining Eligibility with Short Dollars Premiums") for more information.

Eligibility in September	**Hours Worked in July** In July, the Journeyman Employee performed enough Hours of Work to earn a $1,625 credit to the Employee's Dollar Bank. The Employee's Dollar Bank balance prior to the Premium payment is $1,625 ($1,625 + $0 carryover). After the Premium payment of $1,600, the Employee will have a remaining Dollar Bank balance of $25.

Coverage Terminates In October	**Hours Worked in August** In August, the Journeyman Employee did not work resulting in $0 being credited to the Employee's Dollar Bank. The Employee only has $25 ($0 + $25 carryover) in the Dollar Bank to pay for the Premium. Because the Employee does have a Dollar Bank balance, the Employee could pay the Short Dollars Premium to maintain October coverage. The Short Dollars Premium would be $1,575 ($1,600 - $25). • The Journeyman Employee elects not to pay the Short Dollars Premium and his coverage terminates on September 30. The $25 remaining in the Employee's Dollar Bank is also forfeited to the Welfare Fund. • If the Employee has at least one year of work history, the Employee may be eligible for Extended Eligibility to maintain Welfare Fund coverage. See Section 6A(8) ("Extending Your Eligibility") for more information. • The Employee also has the right to elect COBRA continuation coverage. However, the Premium for COBRA continuation coverage for October would exceed the amount the Employee would have paid for the Short Dollars Premium. See Section 6E ("Notice of Continuation Coverage Rights Under COBRA") for more information.

Appendix B
Medicare Basics

Parts of Medicare		
Part A Hospital Insurance	**Part B Medical Insurance**	**Part D Drug Coverage**
Helps cover inpatient care in hospitals, skilled nursing facility care, hospice care, and home healthcare.	Helps cover: • Services from Providers • Outpatient care • Home healthcare • Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment) • Many preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits)	Helps cover the cost of Prescription Drugs (including many recommended shots or vaccines). You join a Medicare drug plan in addition to Original Medicare, or you get it by joining a Medicare Advantage Plan with drug coverage. Plans that offer Medicare drug coverage are run by private insurance companies that follow rules set by Medicare.

Your Medicare Options

When you first sign up for Medicare and during certain times of the year, you can choose which way to get your Medicare coverage. There are 2 main ways:

Original Medicare

- Original Medicare includes Part A and Part B.
- You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).
- You can use any doctor or hospital that takes Medicare, anywhere in the U.S.
- To help pay your out-of-pocket costs in Original Medicare (like your 20% Coinsurance), you can also buy supplemental coverage, like Medicare Supplement Insurance (Medigap), or have coverage from a former employer or union, or Medicaid.

Medicare Advantage (known as Part C)

- Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D.
- In most cases, you will need to use doctors who are in the plan's network.
- Plans may have lower out-of-pocket costs than Original Medicare.
- Plans may offer some extra benefits that Original Medicare does not cover—like vision, hearing, and dental services.

When can I sign up for Medicare?

Most people sign up for both Part A (Hospital Insurance) and Part B (Medical Insurance) when they are first eligible (usually when they turn 65). Generally, there are risks to signing up later,

like a gap in your coverage or having to pay a penalty. However, in some cases, it might make sense to sign up later.

If you miss an enrollment period, you might qualify for a **Special Enrollment Period**.

Your first chance to sign up—the **Initial Enrollment Period**	Generally, when you turn 65. Your Initial Enrollment Period lasts for seven months, starting three months before you turn 65, and ending 3 months after the month you turn 65. Avoid the penalty—if you miss your seven-month Initial Enrollment Period, you may have to wait to sign up and pay a monthly late enrollment penalty for as long as you have Part B coverage. The penalty goes up the longer you wait. You may also have to pay a penalty if you have to pay a Part A premium, also called **Premium-Part A**.
Signing up for **Premium-free Part A** later	You can sign up for Part A any time after you turn 65. Your Part A coverage starts 6 months back from when you sign up or when you apply for benefits from Social Security (or the Railroad Retirement Board). Coverage cannot start earlier than the month you turned 65. After your Initial Enrollment Period ends, you can sign up for Part B and Premium-Part A during one of the other enrollment periods.
Between January 1-March 31 each year is the **General Enrollment Period**	You can sign up between January 1-March 31 each year. This is called the General Enrollment Period. Your coverage starts the month after you sign up. You might pay a monthly late enrollment penalty, if you do not qualify for a Special Enrollment Period.
Special Enrollment Period	After your first chance to sign up (Initial Enrollment Period), there are certain situations when you can sign up for Part B (and Premium-Part A) without paying a late enrollment penalty. A Special Enrollment Period is only available for a limited time. If you do not sign up during your Special Enrollment Period, you will have to wait for the next General Enrollment Period and you might have to pay a monthly late enrollment penalty. You will have a special enrollment opportunity if you have or had health insurance through your job, your Spouse's job (or a family member's job if you are disabled (COBRA continuation coverage is not considered group health plan coverage for this purpose). See www.medicare.gov for a complete list of events that entitle you to a Special Enrollment Period.

Appendix C
Delta Dental SPD for Employees

Delta Dental of Minnesota

DELTA DENTAL PPO PLUS PREMIER™- COMPREHENSIVE ENHANCED Dental Benefits

with Orthodontic Coverage

Dental Benefit Plan Summary

Pipe Trades Services MN Welfare Fund

Client Number 50865

Pipe Trades Services MN
Welfare Fund
Dental Benefits

For Plumbers and Pipefitters in the following United Association Local Unions

Minneapolis & St. Cloud Plumbers Local #15
St. Paul & Mankato Plumbers Local #34
St. Paul & Mankato Pipefitters Local #455
Minneapolis & St. Cloud Pipefitters Local #539
Rochester Plumbers & Pipefitters Local #6

Welfare Fund Office

Pipe Trades Services MN, Inc.
4461 White Bear Parkway, Suite 1
White Bear Lake, MN 55110
Telephone: (651) 645-4540
Fax: (651) 645-8119
Web site: www.ptsmn.org
e-mail: info@ptsmn.org

Board of Trustees
Pipe Trades Services MN Welfare Fund
4461 White Bear Parkway, Suite 1
White Bear Lake, MN 55110
Telephone: (651) 645-4540

The Trustees of this Plan are:

Employer Trustees

Doug Jones
Schulties Plumbing
1521 94th Lane NE,
Blaine, MN 55449

Bryan Norman
Pioneer Power, Inc.
2500 Ventura Dr.
Woodbury, MN 55125

Michael Tieva
Northland Mechanical
9001 Science Center Dr
New Hope, MN 55428

Gary Thaden
MMCA
10590 Wayzata Boulevard, Suite 100
Minnetonka, MN 55305

Matt Marquis
MMCA
10590 Wayzata Boulevard, Suite 100
Minnetonka, MN 55305

Union Trustees

Joe Lane
Plumbers Local No. 15
8625 Monticello Ln N, Suite 1
Maple Grove, MN 55369

Jeremy Miller
Plumbers Local No. 34
353 7th Street W, # 104
St. Paul MN 55102

Scott Seath
Pipefitters Local No. 455
1301 L'Orient St
St. Paul, MN 55117

Jake Pettit
Pipefitters Local No. 539
312 Central Ave., Suite 408
Minneapolis, MN 55414

Sam Arnold
Plumbers and Pipefitters Local No. 6
3111 19th Street NW
Rochester, MN 55901

IMPORTANT INFORMATION ABOUT THE WELFARE PLAN

The following information is provided to help you identify this Plan and the people who are involved in its operation;

1. **Name of Plan.** This Plan is known as the Pipe Trades Services MN Welfare Fund.
2. **Board of Trustees.** The Board of Trustees of the Pipe Trades Services MN Welfare Fund is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Associations and Local Unions who have entered into working agreements which relate to this Plan. These working agreements are described in Item 6, which follows. If you wish to contact the Board of Trustees, you may use the address and telephone number on Page 2.
3. **Plan Sponsor and Administrator.** The Board of Trustees is both the Plan Sponsor and Plan Administrator.
4. **Identification Numbers.** The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 41-0761972.
5. **Agent for Service of Legal Process.** The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees at the Welfare Fund Office or upon any individual Trustee. Note that arbitration may be available instead of a court action.
6. **Funding:** This Plan is self-funded. Your contribution towards the cost of the coverage under the Plan will be determined by the Trustees each year and communicated to you prior to the effective date of any changes in the cost of the coverage.

Please Contact Delta Dental if you have questions regarding your coverage or payment of your claims, etc.

DELTA DENTAL CLIENT NUMBER: 50865

PLAN BENEFITS ADMINISTERED BY:
Delta Dental of Minnesota
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815
www.DeltaDentalMN.org

DENTAL BENEFIT PLAN SUMMARY

This is a Summary of your Client Dental Program
(**PROGRAM**) prepared for Covered Persons with:

Pipe Trades Services MN Welfare Fund
(**CLIENT**)

This Program has been established and is maintained and administered in accordance with the provisions of your Client Dental Plan Contract Number **50865** issued by Delta Dental of Minnesota (**PLAN**).

This booklet is subject to the provisions of the Client Dental Plan Contract. If there is an inconsistency between this booklet and the Client Dental Plan Contract, the Client Dental Plan Contract controls.

DELTA DENTAL OF MINNESOTA

Administrative Offices
Delta Dental of Minnesota
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815
www.DeltaDentalMN.org

The Plan Sponsor is required by law to maintain the privacy of your Protected Health Information, to provide you with notice of its legal duties and privacy practices with respect to your Protected Health Information and to notify you following a breach of unsecured Protected Health Information. Delta Dental of Minnesota is obligated to protect the privacy of your Protected Health Information because it provides administrative services for your dental benefits. Because Delta Dental is not the Plan Administrator for your dental benefits nor is it acting as an insurer of your dental benefits, your Plan Administrator's Notice of Privacy Practices shall control.

DELTA DENTAL OF MINNESOTA
NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Delta Dental of Minnesota is required by law to maintain the privacy of your Protected Health Information, to provide you with this notice of its legal duties and privacy practices with respect to your Protected Health Information and to notify you following a breach of unsecured Protected Health Information. This notice is being issued to comply with the requirements of the Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rules"). Individually identifiable information about your past, present or future health condition, the provision of health care to you, or payment for such health care is considered "Protected Health Information" ("PHI").
Health care includes dental care.

Our Permitted Uses and Disclosures of Your Protected Health Information

We use and disclose PHI about you without your authorization for treatment, payment, and health care operations.

Treatment: We may disclose PHI to your dentist(s) for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seek information from us as to whether the service has been previously provided.

Payment: We use and disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we use and disclose your PHI in order to process your claims.

Health Care Operations: We use and disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use and disclose your PHI to evaluate the quality of dental services that were performed or to check for fraud and abuse.

We may not however, use or disclose any PHI that is considered genetic information under Federal Law for underwriting purposes.

We may be asked by the sponsor of your dental benefits to provide your PHI to the sponsor. We will do so if permitted by law.

Unless you object, we may disclose your PHI to a family member, other relative, person authorized by law, or any other person you identify as involved in your care or the payment related to your care. Only PHI relevant to that person's involvement in your care or the payment related to your care will be disclosed. You can restrict this disclosure at any time, subject to certain limitations. If you are incapacitated or in the event of an emergency, we will exercise professional judgment to determine whether a disclosure of this type is in your best interest.

We may also use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may use or disclose your PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We may disclose PHI in response to a court or administrative order, subpoena, discovery request or other lawful process if certain conditions are met and the required assurances are received. We provide PHI when otherwise required by law, such as for law enforcement purposes. We may disclose your PHI to public health or other appropriate authorities to lessen a serious or imminent threat to the health or safety of you or the public. In other situations, not described here, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment and health care operations).

We reserve the right to change this notice at any time and for any reason. We reserve the right to make the revised or changed notice effective for PHI we currently maintain as well as any information received in the future. A copy of our most current notice will be posted at www.DeltaDentalMN.org.

Individual Rights

In most cases, you have the right to view or get a copy of your PHI which is held in a particular record set by us. You may request copies for a nominal per-page charge. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances.

We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you. You also have the right to receive notice following an unauthorized access, use or disclosure of your PHI if that unauthorized access, use or disclosure is considered a "breach" as defined by the HIPAA Privacy Rules.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, request a paper copy of this Notice or if you have any questions, complaints or concerns, please contact:

Customer Service
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815

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SUMMARY OF DENTAL BENEFITS

Your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta is different for Delta Dental PPO™ dentists, Delta Dental Premier® dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase.

Service Category Description	Delta Dental PPO™ Dentists	Delta Dental Premier® Dentists	Nonparticipating Dentists
Diagnostic and Preventive Services	100%	100%	100%
Basic Services	100%	100%	100%
Endodontics	60%	60%	60%
Periodontics	60%	60%	60%
Oral Surgery	60%	60%	60%
Major Restorative Services	80%	80%	80%
Prosthetic Repairs and Adjustments	60%	60%	60%
Prosthetics	60%	60%	60%
Orthodontics	100%	100%	100%

Benefit Maximums

The Program pays up to a maximum of $2,500.00 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

Exclusion – The benefit maximum does not apply to Diagnostic & Preventive services, for eligible dependent children up to age 18.

Orthodontics is subject to a separate lifetime maximum of $2,000.00 per Covered Person.

Deductible

There is no deductible applicable under this Plan.

Coverage Year

A Coverage Year is a 12-month period in which benefit maximums apply. Your Coverage Year is January 1 to December 31.

DESCRIPTION OF COVERED PROCEDURES

Pretreatment Estimate
(Estimate of Benefits)

IT IS A GOOD IDEA TO GET A PRETREATMENT ESTIMATE FOR YOUR DENTAL CARE THAT INVOLVES MAJOR RESTORATIVE, PERIODONTIC, PROSTHODONTIC, OR ORTHODONTIC CARE. THE PRETREATMENT ESTIMATE IS RECOMMENDED, BUT NOT REQUIRED FOR YOU TO RECEIVE BENEFITS FOR COVERED DENTAL CARE. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND YOU. SUBMISSION OF A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND YOU TO KNOW WHAT BENEFITS YOU HAVE AND IF THE TREATMENT IS COVERED. THE PRETREATMENT ESTIMATE OUTLINES WHAT YOU HAVE TO PAY TO THE DENTIST, SUCH AS CO-PAYMENTS AND DEDUCTIBLES. IT ALLOWS THE DENTIST AND YOU TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE YOUR TREATMENT BEGINS. THIS PROCESS DOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED PAYMENT IS BASED ON YOUR CURRENT ELIGIBILITY AND CONTRACT BENEFITS IN EFFECT AT THE TIME OF THE ESTIMATE. THIS IS AN ESTIMATE ONLY. FINAL PAYMENT WILL BE BASED ON THE CLAIM THAT IS SUBMITTED ONCE THE TREATMENT IS COMPLETED. SUBMISSION OF OTHER CLAIMS, A CHANGE IN ELIGIBILITY, A CHANGE IN YOUR COVERAGE, OR OTHER COVERAGE YOU HAVE MAY ALTER THE PAYMENT.

After the exam, your dentist will tell you the dental treatment that should be given. If the dental treatment involves major restorative, periodontics, prosthetics or orthodontic care, the dentist should submit a claim form to the Plan for the proposed treatment. The Plan will review and determine if the treatment is covered and estimate the amount of payment.

A Pretreatment Estimate of Benefits statement will be sent to you and your dentist. You will be responsible to pay for any deductibles and coinsurance amounts. You will also be responsible to pay for any dental treatment that is not considered a covered service under the Plan.

Benefits

The Program covers the following dental procedures when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Program shall be provided whether the dental procedures are performed by a duly licensed physician or a duly licensed dentist, if otherwise covered under this Program, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, the Plan may require that a Covered Person be examined by a dental consultant retained by the Plan in or near the Covered Person's place of residence. The Plan shall hold such information and records confidential.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR DELTA DENTAL PPO™ AND DELTA DENTAL PREMIER® NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Delta Dental of Minnesota performs dental necessity reviews to determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. It is Delta Dental of Minnesota's policy that a licensed dentist reviews claims where a dental necessity determination is made, and denies the oral health service where dental necessity has not been demonstrated. Denials based solely on coverage specifications, limitations, and exclusions under the enrollee's contract are not considered utilization review and not evaluated for dental necessity. Delta Dental of

Minnesota evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Other dental services may be recommended or prescribed by your dentist, which are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by the Plan. While these services may be prescribed by your dentist and are dentally necessary for you, they maynot be a dental service that is benefited by this Plan or they may be a service where the Plan provides a payment allowance for a service that is considered to be optional treatment. If the Plan gives you a payment allowance for optional treatment that is covered by the plan, you may apply this Plan payment to the service prescribed by your dentist which you elected to receive. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. Determination of services necessary to meet your individual dental needs is between you and your dentist.

ONLY those services listed are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of covered services, please see the "Pretreatment Estimate" section of this booklet.

PREVENTIVE CARE
(Diagnostic & Preventive Services)

Oral Evaluations - Covered 2 times per calendar year period.

Comprehensive Periodontal Evaluation - Covered 2 times per calendar year period.

Radiographs (X-rays)

- **Bitewings** - Covered at 2 series of bitewings per calendar year period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 36-month period.
- **Periapical(s)** - Single X-rays.
- **Occlusal**
- **Extraoral**

Dental Cleaning

- **Prophylaxis** - Covered 2 times per calendar year period.

  Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

- **Periodontal Maintenance** - Covered 2 times per calendar year period.

  Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Fluoride Treatment - Topical application of fluoride.

Space Maintainers

Sealants or Preventive Resin Restorations Pulp

Vitality Test

Diagnostic Cast

EXCLUSIONS - Coverage is NOT provided for:

1. Oral Hygiene Instructions.
2. Accession of tissue - Please submit to your Medical Plan.

BASIC SERVICES

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior teeth.
- **Posterior (back) Teeth** - This service is not covered under Basic Services. Refer to the Complex or Major Restorative Services section of your benefits.

Other Basic Services

- **Restorative cast post and core build-up, including pins and posts** - See benefit coverage description under Complex or Major Restorative Services.
- **Crown pin retention** - Per tooth in addition to restoration.
- **Pre-fabricated or Stainless-Steel Crown**
- **Composite Resin Crown** - Full resin - based composite coverage of tooth.
- **Sedative Fillings**
- **Office visits and consultations**
- **Therapeutic drug injections**
- **Treatment of complications (post-surgical)**

Adjunctive General Services

- **Intravenous Conscious Sedation, Non-Intravenous Conscious Sedation, Analgesia, Anxiolysis Nitrous Oxide, and IV Sedation** - Covered when performed in conjunction with covered services.

EXCLUSIONS - Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesia, analgesic agents, medicines, or drugs for non-surgical or surgical dental care, when done alone or in conjunction with a non-covered service.
2. Case presentation
3. Athletic mouthguard, enamel microabrasion, and odontoplasty.

4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents, tooth bonding and veneers.
5. Amalgam or composite restorations placed for preventive or cosmetic purposes.

BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**

Complex or other Endodontic Services

- **Apexification**
- **Retrograde filling**

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.
5. Apicoectomy/Periradicular Services - Please submit to your Medical Plan.
6. Root Amputation - Please submit to your Medical Plan.
7. Hemisection, includes root removal - Please submit to your Medical Plan.
8. Surgical procedure for isolation of tooth with rubber dam - Please submit to your Medical Plan.

PERIODONTICS (GUM & BONE TREATMENT)

Basic Non-Surgical Periodontal Care - Treatment for diseases for the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planning**
- **Full mouth debridement** - Covered 1 time per lifetime.

Intravenous Conscious Sedation, Non-Intravenous Conscious Sedation, Analgesia, Anxiolysis Nitrous Oxide, and IV Sedation - Covered when performed in conjunction with covered services.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.

3. The controlled release of biologic materials used to aid in soft tissue and osseous tissue regeneration - Please submit to your Medical Plan.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Deep sedation/general anesthesia, analgesia, analgesic agents, medicines, or drugs for non-surgical or surgical periodontal care, when done alone or in conjunction with a non-covered service.
6. Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth - Please submit to your Medical Plan.
7. Bone replacement graft - Please submit to your Medical Plan.
8. Guided tissue regeneration - Please submit to your Medical Plan.
9. Soft tissue allograft - Please submit to your Medical Plan.

ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)

Basic Extractions

- Removal of Coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation and IV sedation when performed alone or in conjunction with a non-covered service.
2. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital - Please submit to your Medical Plan.
3. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
4. Surgical exposure of impacted or unerupted tooth for orthodontic reasons - Please submit to your Medical Plan.
5. Surgical repositioning of teeth - Please submit to your Medical Plan.
6. Inpatient or outpatient hospital expenses - Please submit to your Medical Plan.
7. Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa. - Please submit to your Medical Plan.
8. Surgical removal of impacted tooth - Please submit to your Medical Plan.
9. Surgical removal of residual tooth roots - Please submit to your Medical Plan.
10. Oroantral fistula closure - Please submit to your Medical Plan.
11. Tooth reimplantation - accidentally avulsed or displaced tooth - Please submit to your MedicalPlan.
12. Sinus Perforation - Please submit to your Medical Plan.
13. Surgical exposure of impacted or unerupted tooth to aid eruption - Please submit to your Medical Plan.
14. Biopsy of oral tissue - Please submit to your Medical Plan.
15. Transseptal fiberotomy - Please submit to your Medical Plan.
16. Alveoloplasty - Please submit to your Medical Plan.

17. Vestibuloplasty - Please submit your Medical Plan.
18. Excision of benign/malignant lesion - Please submit your Medical Plan.
19. Incision & drainage of abscess - Please submit your Medical Plan.
20. Removal or nonodontogenic or odontogenic cyst or tumor - Please submit to your Medical Plan.
21. Partial ostectomy/sequestrectomy for removal of non-vital bone - Please submit to your Medical Plan.
22. Radical resection of mandible with bone graft - Please submit to your Medical Plan.
23. Radical excision - Please submit to your Medical Plan.
24. Removal of Torus Palatinus or Torus mandibularis - Please submit to your Medical Plan.
25. Removal of foreign body - Please submit to your Medical Plan.
26. Maxillary sinusotomy for removal of tooth fragment or foreign body - Please submit to your Medical Plan.
27. Treatment of Compound fractures - Please submit to your Medical Plan.
28. Temporomandibular Joint Disorder (TMJ) - Please submit to your Medical Plan.
29. Suture of small wounds - Please submit to your Medical Plan.
30. Complicated sutures - Please submit to your Medical Plan.
31. Repair of maxillofacial soft and hard tissue defect - Please submit to your Medical Plan.
32. Frenulectomy (frenectomy or frenotomy) - Please submit to your Medical Plan.
33. Excision of hyperplastic tissue - Please submit to your Medical Plan.
34. Implant-mandible for augmentation purposes - Please submit to your Medical Plan.
35. Surgical reduction of fibrous tuberosity - Please submit to your Medical Plan.
36. Sislolithotomy - Please submit to your Medical Plan.
37. Excision of salivary gland - Please submit to your Medical Plan.
38. Sialodochoplasty - Please submit to your Medical Plan.
39. Closure of salivary fistula - Please submit to your Medical Plan.
40. Emergency tracheotomy - Please submit to your Medical Plan.
41. Cornoidectomy - Please submit to your Medical Plan.
42. Tooth transplantation - Please submit to your Medical Plan.
43. Surgical access to erupted tooth - Please submit to your Medical Plan.

COMPLEX OR MAJOR RESTORATIVE SERVICES

Services performed to restore lost tooth structure as a result of decay or fracture

Posterior (back) Teeth Composite (white) Resin Restorations - If the posterior (back) tooth requires a restoration due to decay or fracture.

Gold foil restorations

Inlays

Onlays

Permanent Crowns

Implant Crowns - See Prosthetic Services.

Crown Repair

Restorative cast post and core build-up, including post and pin Canal

prep & fitting of preformed dowel & post

Occlusal guard (Bruxism only)

Occlusal adjustments

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
4. Temporary, provisional or interim crown.
5. Veneers.

PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)

Reline, Rebase, Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Adjustments

Removable Prosthetic Services (Dentures and Partials) Fixed

Prosthetic Services (Bridge)

Fixed Partial Denture Retainers (Inlays, Onlays, Crowns)

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 5-year period for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.

Restorative cast post and core build-up, including pins and posts.

EXCLUSIONS - Coverage is NOT provided for:

1. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
2. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

3. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
4. Services or supplies that have the primary purpose of improving the appearance of yourteeth.
5. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

ORTHODONTICS

Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

Limited Treatment

Treatments which are not full treatment cases and are usually done for minor tooth movement.

Interceptive Treatment

A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

Comprehensive (complete) Treatment

Full treatment includes all records, appliances and visits.

Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.

Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.

Repair or replacement of lost/broken/stolen appliances

LIMITATION: Treatment in progress (appliances placed prior to eligibility under this Plan) will be benefited on a pro-rated basis.

EXCLUSIONS - Coverage is NOT provided for:

1. Monthly treatment visits that are inclusive of treatment cost.
2. Inpatient or outpatient hospital expenses.
3. Osteoplasty - Please submit to your Medical Plan.
4. LeFort procedures - Please submit to your Medical Plan.
5. Appliance removal (not by dentist who placed appliance), includes removal of archbar - Please submit to your Medical Plan.
6. Tooth transplantation - Please submit to your Medical Plan.
7. Surgical exposure of impacted or unerupted tooth for Orthodontic - Please submit to your Medical Plan.
8. Device placement.

Orthodontic Payments

Benefit payments are made when treatment begins (appliances are installed), until the lifetime maximum benefits are exhausted (see Benefit Maximums in this Plan Summary).

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated plan payment amount. Thisform serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and his/her signature. After benefit and eligibility verification by the Plan, a benefit payment will be issued.

Exclusions
Coverage is NOT provided for:

a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.

b) Dental services or health care services not specifically covered under the Client Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature). Please submit to your Medical Plan.

c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

d) Dental services performed for elective or cosmetic purposes. NOTE: Dental services may be subject to pre-payment clinical review of dental records. If services are found to not be dentally necessary, we reserve the right to deny such services and the member is responsible for the full charge. Dental services are subject to post-payment clinical review of dental records. If services are found not to be dentally necessary, we reserve the right to collect any payment and the member is responsible for the full charge.

e) Dental services completed prior to the date the Covered Person became eligible forcoverage.

f) Services of anesthesiologists - Please submit to your Medical Plan.

g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

h) Deep sedation/general anesthesia, analgesia, analgesic agents, medicines, or drugs for non-surgical or surgical dental care, when done alone or in conjunction with a non-covered service.

i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

k) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

m) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.

n) Case presentations

o) Incomplete, interim or temporary services.

p) Corrections of congenital conditions during the first 24 months of continuous coverage under this Plan Please submit to your Medical Plan.

q) Athletic mouth guards, enamel microabrasion and odontoplasty.

r) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.

s) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

t) Bacteriologic tests.

u) Cytology sample collection - Please submit to your Medical Plan.

v) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

w) The replacement of an existing partial denture with a bridge.

x) Veneers.

y) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

z) Provisional splinting, temporary procedures or interim stabilization.

aa) Placement or removal of sedative filling, base or liner used under a restoration.

bb) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital - Please submit to your Medical Plan.

cc) Accession of tissue - Please submit to your Medical Plan.

dd) Apicoectomy/Periradicular Services - Please submit to your Medical Plan.

ee) Root Amputation - Please submit to your Medical Plan.

ff) Hemisection, includes root removal - Please submit to your Medical Plan.

gg) Surgical procedure for isolation of tooth with rubber dam - Please submit to your Medical Plan.

hh) Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth - Please submit to your Medical Plan.

ii) Bone replacement graft - Please submit to your Medical Plan.

jj) Guided tissue regeneration - Please submit to your Medical Plan.

kk) Soft tissue allograft - Please submit to your Medical Plan.

ll) The controlled release of biologic materials used to aid in soft tissue and osseous tissue regeneration - Please submit to your Medical Plan.

mm) Therapeutic agent - Please submit to your Medical Plan.

nn) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa - Please submit to your Medial Plan.

oo) Surgical removal of impacted tooth - Please submit to your Medical Plan.

pp) Surgical removal of residual tooth roots - Please submit to your Medical Plan.

qq) Oroantral fistula closure - Please submit to your Medical Plan.

rr) Tooth reimplantation - accidentally avulsed or displaced tooth - Please submit to your Medical Plan.

ss) Sinus Perforation - Please submit to your Medical Plan.

tt) Surgical exposure of impacted or unerupted tooth to aid eruption - Please submit to your Medical Plan.

uu) Biopsy of oral tissue - Please submit to your Medical Plan.

vv) Transseptal fiberotomy - Please submit to your Medical Plan.

ww) Alveoloplasty - Please submit to your Medical Plan.

xx) Vestibuloplasty - Please submit your Medical Plan

yy) Excision of benign/malignant lesion - Please submit your Medical Plan.

zz) Incision & drainage of abscess - Please submit your Medical Plan.

aaa) Surgical repositioning of teeth - Please submit to your Medical Plan.

bbb) Removal or nonodontogenic or odontogenic cyst or tumor - Please submit to your Medical Plan

ccc) Partial ostectomy/sequestrectomy for removal of non-vital bone - Please submit to your Medical Plan.

ddd) Radical resection of mandible with bone graft - Please submit to your Medical Plan.

eee) Radical excision - Please submit to your Medical Plan.

fff) Removal of Torus Palatinus or Torus mandibularis - Please submit to your Medical Plan.

ggg) Removal of foreign body - Please submit to your Medical Plan.

hhh) Maxillary sinusotomy for removal of tooth fragment or foreign body - Please submit to your Medical Plan.

iii) Treatment of Compound fractures - Please submit to your Medical Plan.

jjj) Temporomandibular Joint Disorder (TMJ) - Please submit to your Medical Plan.

kkk) Suture of small wounds - Please submit to your Medical Plan.

lll) Complicated sutures - Please submit to your Medical Plan.

mmm) Repair of maxillofacial soft and hard tissue defect - Please submit to your Medical Plan.

nnn) Osteoplasty - Please submit to your Medical Plan.

ooo) LeFort procedures - Please submit to your Medical Plan.

ppp) Frenulectomy (frenectomy or frenotomy) - Please submit to your Medical Plan.

qqq) Excision of hyperplastic tissue - Please submit to your Medical Plan.

rrr) Appliance removal (not by dentist who placed appliance), includes removal of archbar - Please submit to your Medical Plan.

sss) Implant-mandible for augmentation purposes - Please submit to your Medical Plan.

ttt) Surgical reduction of fibrous tuberosity - Please submit to your Medical Plan.

uuu) Sislolithotomy - Please submit to your Medical Plan.

vvv) Excision of salivary gland - Please submit to your Medical Plan.

www) Sialodochoplasty - Please submit to your Medical Plan.

xxx) Closure of salivary fistula - Please submit to your Medical Plan.

yyy) Emergency tracheotomy - Please submit to your Medical Plan.

zzz) Cornoidectomy - Please submit to your Medical Plan.

aaaa) Tooth transplantation - Please submit to your Medical Plan.

bbbb) Surgical access to erupted tooth - Please submit to your Medical Plan.

cccc) Device placement.

dddd) Amalgam or composite restorations placed for preventive or cosmetic purposes.

LIMITATION:

Hospital and other expenses incurred in connection with dental work or oral surgery for the repair of natural teeth or other body tissues and which are required as a result of a non-occupational accidental bodily Injury within two years of the date of the Injury should be submitted to the Medical Plan. Both the injury and dental work or oral surgery must occur while the individual is eligible for benefits.

For other dental procedure exclusions and limitations, refer to the Description of Coverages in this Dental Benefit Plan Summary.

Post Payment Review

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 - Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed are subject to recovery. Delta Dental's right to conduct post payment review and its right of recovery exists even if a Pretreatment Estimate was submitted for the service.

ELIGIBILITY - Please refer to the Pipe Trades Services MN **Welfare Fund SPD for Eligibility descriptions and definitions.**

Please refer to the PIPE TRADES SERVICES MN WELFARE FUND SPD for COBRA eligibility

PLAN PAYMENTS

Participating Dentist Network

A Delta Dental PPO™ network dentist is a dentist who has signed a Delta Dental PPO™ membership agreement with his/her local dental plan. The dentist has agreed to accept the Delta Dental PPO™ allowable charge as payment in full for covered dental care. You will be responsible for any applicable coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental PPO™ network dentist will not bill more than the Delta Dental PPO™ allowable charge. A Delta Dental PPO™ dentist will also file the claim directly with Delta Dental.

A Delta Dental Premier® dentist is a dentist who has signed a Delta Dental Premier® membership agreement with his/her local dental plan. The dentist has agreed to accept Delta Dental's allowable charge as payment in full for covered dental care. You will be responsible for any applicable coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental Premier® network dentist will not bill more than the A Delta Dental Premier® allowable charge. A Delta Dental Premier® dentist will also file the claim directly with Delta Dental.

Listings of participating providers are available to Subscribers as a separate document and are furnished by the Client without charge. Names of Participating Dentists can be obtained, upon request, by calling Delta, from directory listings furnished to the Client or from the Plan's internet web site at www.DeltaDentalMN.org. Refer to the General Information section of this booklet for detailed information on how to locate a participating provider using the Plan's internet web site.

Covered Fees

Under this Program, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a participating Delta Dental PPO™/Delta Dental Premier® dentist with the plan. There may also be a difference in the payment amount if your dentist is not a participating dentist with Delta. This payment

difference could result in some financial liability to you. Claim payments are based on the treating dentist's submitted charge, not to exceed the reasonable and customary schedule established by the Plan.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR DELTA DENTAL PREMIER® AND DELTA DENTAL PPO™ NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Notice of Claim

Written notice of claim must be given to Delta Dental within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Policyholder or the beneficiary shall be presented to Delta Dental at P.O. Box 9120, Farmington Hills, MI 48333-9120.

Claim Forms

Delta Dental, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished for filing proofs of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you shall be deemed to have complied with the requirements of this policy.

Claim Payments

PAYMENTS ARE MADE BY THE PLAN ONLY WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED. THE PLAN MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR PROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING. IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

ANY BENEFITS PAYABLE UNDER THIS PLAN ARE NOT ASSIGNABLE BY ANY COVERED PERSON OR ANY ELIGIBLE DEPENDENT OF ANY COVERED PERSON.

Delta Dental Premier® Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental Premier® dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental Premier® dentists is the lesser of: (1) The Maximum Amount Payable as determined by Delta Dental; or (2) The fee charged or accepted as payment in full by the Delta Dental Premier® dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Delta Dental PPO™ Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental PPO™ dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental PPO™ dentists is the lesser of: (1) The Delta Dental PPO™ Maximum Amount Payable as determined by Delta Dental; or (2) The fee charged or accepted as payment in full by the Delta Dental PPO™ dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Nonparticipating Dentists:

Claim payments are based on the Plan's Payment Obligation, which for nonparticipating dentists is the treating dentist's submitted charge or the amount established solely by Delta Dental, whichever is less. Claim payments are

sent directly to the Covered Person.

THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NONPARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NONPARTICIPATING PROVIDER, ANY BENEFITS PAYABLE UNDER THE CLIENT CONTRACT ARE PAID DIRECTLY TO THE COVERED PERSON.

Coordination of Benefits (COB)

If you or your dependents are eligible for dental benefits under this Program and under another dental program, benefits will be coordinated so that no more than 100% of the Plan Payment Obligation is paid jointly by the programs. The Plan Payment Obligation is determined prior to calculating all percentages, deductibles and benefit maximums.

The Coordination of Benefits provision determines which program has the primary responsibility for providing the first payment on a claim. In establishing the order, the program covering the patient as an employee has the primary responsibility for providing benefits before the program covering the patient as a dependent. If the patient is a dependent child, the program with the parent whose month and day of birth falls earlier in the calendar year has the primary payment responsibility. If both parents should have the same birth date, the program in effect the longest has the primary payment responsibility. If the other program does not have a Coordination of Benefits provision, that program most generally has the primary payment responsibility.

NOTE: When Coordination of Benefits applies for dependent children, provide your dentist with the birth dates of both parents.

Assignment of Benefits

Any benefits which may be payable under this dental benefit Plan are not assignable.

Time of Payment of Claim

Any benefits due under this Policy for any loss other than loss for which this Policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss.

Claim and Appeal Procedures

Initial Claim Determinations

All claims should be submitted within 12 months of the date of service. An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notification of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information we need, and you will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will be denied.

Appeals

In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal.

Your appeal must include your name, your identification number, Client number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to:

Delta Dental of Minnesota
Attn: Professional Services Appeals and Grievances
PO Box 30416
Lansing, MI 48909

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. Because all benefit determinations are based on a preset schedule of dental services eligible under your plan, claims are not reviewed to determine dental necessity or appropriateness. In all cases where professional judgment is required to determine if a procedure is covered under your plan's schedule of benefits, we will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, we will identify any dental professional whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

To the extent your plan is covered by ERISA, after you have exhausted all appeals, you may file a civil action under section 502(a) of ERISA.

Authorized Representative
You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available at our web site or by calling Customer Service. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

GENERAL INFORMATION

Health Plan Issuer Involvement

The benefits under the Plan are not guaranteed by Delta Dental under the Contract. As Claims Administrator, Delta Dental pays or denies claims on behalf of the Plan and reviews requests for review of claims as described in the Claim and Appeals Procedures section.

Privacy Notice

Delta Dental of Minnesota will not disclose non-public personal financial or health information concerning persons covered under our dental benefit plans to non-affiliated third parties except as permitted by law or required to adjudicate claims submitted for dental services provided to persons covered under our dental benefit plans.

How to Find a Participating Dentist

A real-time listing of participating dentists is available in an interactive directory at the Plan's user-friendly web site, www.DeltaDentalMN.org. The Plan highly recommends use of the web site for the most accurate network information. Go to http://www.DeltaDentalMN.org/find-a-dentist and enter your zip code, city or state to find local participating dentists. You can also search by dentist or clinic name. The Web site also allows you to print out a map

directing you to the dental office you select. **The Find A Dentist Search is an accurate and up-to-date way to obtain information on participating dentists.**

To search for and verify the status of participating providers, select "Find A Dentist" on the www.DeltaDentalMN.org home page. Select the Product or Network in the drop-down menu, and search by city and state, zip code or provider or clinic name. If your dentist does not participate in the network, you may continue to use that dentist, although you will share more of the cost of your care and could be responsible for dental charges up to the dentist's full billed amount.

If you do not have Internet access, other options are available to find a network dentist or verify that your current dentist is in the network.

- When you call to make a dental appointment, always verify the dentist is a participating dentist. **Be sure to specifically state that your Welfare Plan is providing the Dental program.**

- Contact our Customer Service Center at: (800) 448-3815. Customer Service hours are 7 a.m. to 7 p.m., Monday through Friday, Central Time.

Using Your Dental Program

Dentists who participate with Delta under this Program are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Delta cannot and does not make any representations as to the quality of treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service.

If your dentist is a participating dentist, the claim form will be available at the dentist's office. If

your dentist is nonparticipating, claim forms are available by calling:

Delta Dental of Minnesota - (651) 406-5901 or (800) 448-3815

The Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.

The dental office will file the claim form with the Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

* YOUR DELTA CLIENT NUMBER
* YOUR WELFARE PLAN (CLIENT NAME)
* YOUR IDENTIFICATION NUMBER (your dependents must use **YOUR** identification number)
* YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

Cancellation and Renewal

The Program may be canceled by the Plan only on an anniversary date of the Client Dental Plan Contract, or at any time the Client fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Program, Covered Persons of the Client have no right to continue coverage under the

Program or convert to an individual dental coverage contract.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Plan Administration

The Plan Administrator, who is listed on the inside front cover of this brochure, is a named fiduciary under the Program and shall be responsible for the management and control of this Program.

The Plan Administrator is responsible for determining the level of benefits for the Program as described in this brochure. The Plan Administrator reserves the power at any and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to modify or amend, in whole or in part, any or all provisions of the Plan, provided, however, that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under thePlan.

Funding Policy and Payment

The funding policy and method requires that the Client Subscriber submit payments on a monthly basis.

Procedure to Request Information

If you have any questions about this Program, contact the Plan Administrator who is listed in the inside front cover of this brochure.

Statement of ERISA Rights

As a participant in the Program, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine without charge at the Plan Administrator's office and at other specified locations such as work sites and union halls, all Plan documents, including insurance contracts, and copies of all documents such as detailed annual reports and Plan descriptions filed by the Plan with the U.S. Department of Labor.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for thecopies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Group, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal

court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your right, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If it finds your claim is frivolous, you will be responsible for these costs and fees. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DELTA DENTAL OF MINNESOTA

FOR CLAIMS
Delta Dental of Minnesota
P.O. Box 9120
Farmington Hills, MI 48333-9120
(651) 406-5901 or (800) 448-3815

FOR ELIGIBILITY
Delta Dental of Minnesota
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815

CORPORATE LOCATION
500 Washington Avenue South
Suite 2060
Minneapolis, MN 55415
(651) 406-5900 or (800) 328-1188
www.DeltaDentalMN.org

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Appendix D
Delta Dental SPD for Retirees

Delta Dental of Minnesota

DELTA DENTAL PPO PLUS PREMIER™ - COMPREHENSIVE STANDARD

Dental Benefit Plan Summary

Pipe Trades Services MN Welfare Fund - Retirees

Client Number 004059

Pipe Trades Services MN
Welfare Fund
Retiree Dental Benefits

For Plumbers and Pipefitters in the following United Association Local Unions

Minneapolis & St. Cloud Plumbers Local #15
St. Paul & Mankato Plumbers Local #34
St. Paul & Mankato Pipefitters Local #455
Minneapolis & St. Cloud Pipefitters Local #539
Rochester Plumbers & Pipefitters Local #6

Welfare Fund Office

Pipe Trades Services MN, Inc.
4461 White Bear Parkway, Suite 1
White Bear Lake, MN 55110
Telephone: (651) 645-4540
Fax: (651) 645-8119
Web site: www.ptsmn.org
e-mail: info@ptsmn.org

Board of Trustees
Pipe Trades Services MN Welfare Fund
4461 White Bear Parkway, Suite 1
White Bear Lake, MN 55110
Telephone: (651) 645-4540

The Trustees of this Plan are:

Employer Trustees

Doug Jones
Schulties Plumbing
1521 94th Lane NE,
Blaine, MN 55449

Bryan Norman
Pioneer Power, Inc.
2500 Ventura Dr.
Woodbury, MN 55125

Michael Tieva
Northland Mechanical
9001 Science Center Dr
New Hope, MN 55428

Gary Thaden
MMCA
10590 Wayzata Boulevard, Suite 100
Minnetonka, MN 55305

Matt Marquis
MMCA
10590 Wayzata Boulevard, Suite 100
Minnetonka, MN 55305

Union Trustees

Joe Lane
Plumbers Local No. 15
8625 Monticello Ln N, Suite 1
Maple Grove, MN 55369

Jeremy Miller
Plumbers Local No. 34
353 7th Street W, # 104
St. Paul MN 55102

Scott Seath
Pipefitters Local No. 455
1301 L'Orient St
St. Paul, MN 55117

Jake Pettit
Pipefitters Local No. 539
312 Central Ave., Suite 408
Minneapolis, MN 55414

Sam Arnold
Plumbers and Pipefitters Local No. 6
3111 19th Street NW
Rochester, MN 55901

IMPORTANT INFORMATION ABOUT THE WELFARE PLAN

The following information is provided to help you identify this Plan and the people who are involved in its operation;

1. **Name of Plan.** This Plan is known as the Pipe Trades Services MN Welfare Fund.
2. **Board of Trustees.** The Board of Trustees of the Pipe Trades Services MN Welfare Fund is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Associations and Local Unions who have entered into working agreements which relate to this Plan. These working agreements are described in Item 6, which follows. If you wish to contact the Board of Trustees, you may use the address and telephone number on Page 2.
3. **Plan Sponsor and Administrator.** The Board of Trustees is both the Plan Sponsor and Plan Administrator.
4. **Identification Numbers.** The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 41-0761972.
5. **Agent for Service of Legal Process.** The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees at the Welfare Fund Office or upon any individual Trustee. Note that arbitration may be available instead of a court action.
6. **Funding:** This Plan is self-funded. Your contribution towards the cost of the coverage under the Plan will be determined by the Trustees each year and communicated to you prior to the effective date of any changes in the cost of the coverage.

Please Contact Delta Dental if you have questions regarding your coverage or payment of your claims, etc.

DELTA DENTAL CLIENT NUMBER: 004059

PLAN BENEFITS ADMINISTERED BY:
Delta Dental of Minnesota
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815
www.DeltaDentalMN.org

DENTAL BENEFIT PLAN SUMMARY

This is a Summary of your Client Dental Program
(**PROGRAM**) prepared for Covered Persons with:

Pipe Trades Services MN Welfare Fund - Retirees
(**CLIENT**)

This Program has been established and is maintained and administered in accordance with the provisions of your Client Dental Plan Contract Number **004059** issued by Delta Dental of Minnesota (**PLAN**).

This booklet is subject to the provisions of the Client Dental Plan Contract. If there is an inconsistency between this booklet and the Client Dental Plan Contract, the Client Dental Plan Contract controls.

DELTA DENTAL OF MINNESOTA

Administrative Offices
Delta Dental of Minnesota
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815
www.DeltaDentalMN.org

The Plan Sponsor is required by law to maintain the privacy of your Protected Health Information, to provide you with notice of its legal duties and privacy practices with respect to your Protected Health Information and to notify you following a breach of unsecured Protected Health Information. Delta Dental of Minnesota is obligated to protect the privacy of your Protected Health Information because it provides administrative services for your dental benefits. Because Delta Dental is not the Plan Administrator for your dental benefits nor is it acting as an insurer of your dental benefits, your Plan Administrator's Notice of Privacy Practices shall control.

DELTA DENTAL OF MINNESOTA
NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Delta Dental of Minnesota is required by law to maintain the privacy of your Protected Health Information, to provide you with this notice of its legal duties and privacy practices with respect to your Protected Health Information and to notify you following a breach of unsecured Protected Health Information. This notice is being issued to comply with the requirements of the Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rules"). Individually identifiable information about your past, present or future health condition, the provision of health care to you, or payment for such health care is considered "Protected Health Information" ("PHI").
Health care includes dental care.

Our Permitted Uses and Disclosures of Your Protected Health Information

We use and disclose PHI about you without your authorization for treatment, payment, and health care operations.

Treatment: We may disclose PHI to your dentist(s) for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seek information from us as to whether the service has been previously provided.

Payment: We use and disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we use and disclose your PHI in order to process your claims.

Health Care Operations: We use and disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use and disclose your PHI to evaluate the quality of dental services that were performed or to check for fraud and abuse.

We may not however, use or disclose any PHI that is considered genetic information under Federal Law for underwriting purposes.

We may be asked by the sponsor of your dental benefits to provide your PHI to the sponsor. We will do so if permitted by law.

Unless you object, we may disclose your PHI to a family member, other relative, person authorized by law, or any other person you identify as involved in your care or the payment related to your care. Only PHI relevant to that person's involvement in your care or the payment related to your care will be disclosed. You can restrict this disclosure at any time, subject to certain limitations. If you are incapacitated or in the event of an emergency, we will exercise professional judgment to determine whether a disclosure of this type is in your best interest.

We may also use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may use or disclose your PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We may disclose PHI in response to a court or administrative order, subpoena, discovery request or other lawful process if certain conditions are met and the required assurances are received. We provide PHI when otherwise required by law, such as for law enforcement purposes. We may disclose your PHI to public health or other appropriate authorities to lessen a serious or imminent threat to the health or safety of you or the public. In other situations, not described here, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment and health care operations).

We reserve the right to change this notice at any time and for any reason. We reserve the right to make the revised or changed notice effective for PHI we currently maintain as well as any information received in the future. A copy of our most current notice will be posted at www.DeltaDentalMN.org.

Individual Rights

In most cases, you have the right to view or get a copy of your PHI which is held in a particular record set by us. You may request copies for a nominal per-page charge. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances.

We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you. You also have the right to receive notice following an unauthorized access, use or disclosure of your PHI if that unauthorized access, use or disclosure is considered a "breach" as defined by the HIPAA Privacy Rules.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, request a paper copy of this Notice or if you have any questions, complaints or concerns, please contact:

Customer Service
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815

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SUMMARY OF DENTAL BENEFITS

Your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta is different for Delta Dental PPO™ dentists, Delta Dental Premier® dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase.

Service Category Description	Delta Dental PPO™ Dentists	Delta Dental Premier® Dentists	Nonparticipating Dentists
Diagnostic and Preventive Services	100%	80%	80%
Basic Services	100%	50%	50%
Endodontics	90%	50%	50%
Periodontics	80%	50%	50%
Oral Surgery Simple Extractions All Other Extractions	 100% 80%	 50% 80%	 50% 80%
Major Restorative Services	60%	50%	50%
Prosthetic Repairs and Adjustments	60%	50%	50%
Prosthetics	60%	50%	50%

Benefit Maximums

The Program pays up to a maximum of $2,000.00 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

Deductible

There is a $25.00 deductible per Covered Person each Coverage Year. The

deductible does not apply to Diagnostic and Preventive services.

The deductible will not be applied to dental services rendered by a Delta Dental PPO dentist.

Coverage Year

A Coverage Year is a 12-month period in which deductibles and benefit maximums apply. Your Coverage Year is January 1 to January 1.

DESCRIPTION OF COVERED PROCEDURES

Pretreatment Estimate
(Estimate of Benefits)

IT IS A GOOD IDEA TO GET A PRETREATMENT ESTIMATE FOR YOUR DENTAL CARE THAT INVOLVES MAJOR RESTORATIVE, PERIODONTIC, PROSTHODONTIC, OR ORTHODONTIC CARE. THE PRETREATMENT ESTIMATE IS RECOMMENDED, BUT NOT REQUIRED FOR YOU TO RECEIVE BENEFITS FOR COVERED DENTAL CARE. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND YOU. SUBMISSION OF A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND YOU TO KNOW WHAT BENEFITS YOU HAVE AND IF THE TREATMENT IS COVERED. THE PRETREATMENT ESTIMATE OUTLINES WHAT YOU HAVE TO PAY TO THE DENTIST, SUCH AS CO-PAYMENTS AND DEDUCTIBLES. IT ALLOWS THE DENTIST AND YOU TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE YOUR TREATMENT BEGINS. THIS PROCESS DOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED PAYMENT IS BASED ON YOUR CURRENT ELIGIBILITY AND CONTRACT BENEFITS IN EFFECT AT THE TIME OF THE ESTIMATE. THIS IS AN ESTIMATE ONLY. FINAL PAYMENT WILL BE BASED ON THE CLAIM THAT IS SUBMITTED ONCE THE TREATMENT IS COMPLETED. SUBMISSION OF OTHER CLAIMS, A CHANGE IN ELIGIBILITY, A CHANGE IN YOUR COVERAGE, OR OTHER COVERAGE YOU HAVE MAY ALTER THE PAYMENT.

After the exam, your dentist will tell you the dental treatment that should be given. If the dental treatment involves major restorative, periodontics, prosthetics or orthodontic care, the dentist should submit a claim form to the Plan for the proposed treatment. The Plan will review and determine if the treatment is covered and estimate the amount of payment.

A Pretreatment Estimate of Benefits statement will be sent to you and your dentist. You will be responsible to pay for any deductibles and coinsurance amounts. You will also be responsible to pay for any dental treatment that is not considered a covered service under the Plan.

Benefits

The Program covers the following dental procedures when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Program shall be provided whether the dental procedures are performed by a duly licensed physician or a duly licensed dentist, if otherwise covered under this Program, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, the Plan may require that a Covered Person be examined by a dental consultant retained by the Plan in or near the Covered Person's place of residence. The Plan shall hold such information and records confidential.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN DELTA DENTAL PPO AND DELTA DENTAL PREMIER® NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Delta Dental of Minnesota performs dental necessity reviews to determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. It is Delta Dental of Minnesota's policy that a licensed dentist reviews claims where a dental necessity determination is made, and denies the oral health service where dental necessity has not been demonstrated. Denials based solely on coverage specifications, limitations, and exclusions under the enrollee's contract are not considered utilization review and not evaluated for dental necessity. Delta Dental of

Minnesota evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Other dental services may be recommended or prescribed by your dentist which are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by the Plan. While these services may be prescribed by your dentist and are dentally necessary for you, they maynot be a dental service that is benefited by this Plan or they may be a service where the Plan provides a payment allowance for a service that is considered to be optional treatment. If the Plan gives you a payment allowance for optional treatment that is covered by the plan, you may apply this Plan payment to the service prescribed by your dentist which you elected to receive. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. Determination of services necessary to meet your individual dental needs is between you and your dentist.

ONLY those services listed are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of covered services, please see the "Pretreatment Estimate" section of this booklet.

PREVENTIVE CARE
(Diagnostic & Preventive Services)

Oral Evaluations
Any type of evaluation (checkup or exam) is covered 1 time per 6-month period.

Radiographs (X-rays)

- **Bitewings**- Covered at 1 series of bitewings per 12-month period.
- **Full Mouth (Complete Series) or Panoramic –** Covered 1 time per 36-month period.
- **Periapical(s)**
- **Occlusal** – Covered at 2 series per 24-month period.

Dental Cleaning

- **Prophylaxis or Periodontal Maintenance** – Any combination of these procedures is covered 1 time per 6-month period.

  Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

  Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Fluoride Treatment - Topical application of fluoride. Covered 1 time per 12-month period for dependent children through the age of 18.

EXCLUSIONS – Coverage is NOT provided for:

1. Oral hygiene instructions.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations – Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.

- **Posterior (back) Teeth** - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

  Benefits shall be limited to the same surfaces and allowances for amalgam (silver filling). The patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

LIMITATION: Coverage for amalgam or composite restorations shall be limited to only 1 service per tooth surface per 24-month period.

Other Preventive and Basic Services

- **Pre-fabricated or Stainless-Steel Crown -** Covered 1 time per 60-month period for eligible dependent children through the age of 18.

- **Sealants or Preventive Resin Restorations** - Any combination of these procedures is covered 1 time per lifetime for permanent first and second molars of eligible dependent children through the age of 15.

- **Space Maintainers -** Covered 1 time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth.

  LIMITATION: Repair or replacement of lost/broken appliances is not a covered benefit.

Adjunctive General Services

- **Intravenous Conscious Sedation and IV Sedation –** Covered when performed in conjunction with complex surgical service.

  LIMITATION: Intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

EXCLUSIONS – Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dentalcare.
2. Case presentation and office visits.
3. Athletic mouthguard, enamel microabrasion, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes but is not limited to whitening agents, tooth bonding and veneers.

5. Placement or removal of sedative filling, base or liner used under a restoration.

6. Restorative cast post and core build-up, including pins and posts.

7. Amalgam or composite restorations placed for preventive or cosmetic purposes.

Basic Endodontic Services (Nerve or Pulp Treatment)

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy Endodontic**

Therapy on Permanent Teeth

- **Root Canal Therapy**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.
5. Apicoectomy.
6. Root Amputation.
7. Apexification.
8. Retrograde filling.
9. Hemisection.

Periodontics (Gum & Bone Treatment)

Basic Non-Surgical Periodontal Care – Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing –** Covered 1 time per 24 months
- **Full mouth debridement**-- Covered 1 time per lifetime

Complex Surgical Periodontal Care – Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan.

- **Gingivectomy/gingivoplasty**
- **Gingival flap**
- **Apically positioned flap**
- **Osseous Surgery**
- **Bone replacement graft**

- **Pedicle soft tissue graft**
- **Free soft tissue graft**
- **Subepithelial connective tissue graft**
- **Soft tissue allograft**
- **Combined connective tissue and double pedicle graft**
- **Distal/proximal wedge**

LIMITATION: Only 1 complex surgical periodontal service is a benefit covered 1 time per 36- month period per single tooth or multiple teeth in the same quadrant.

EXCLUSIONS – Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis, inhalation of nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

Oral Surgery (Tooth, Tissue, or Bone Removal)

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Alveolectomy
- Alveoloplasty
- Vestibuloplasty

LIMITATION: The Other Complex Surgical Procedures are covered only when required to prepare for dentures.

Temporomandibular Joint Disorder (TMJ) as covered under Minnesota Statutes Section 62A.043 Subd. 3 –

Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints, is subject to the coordination of benefits. A Pre-treatment Estimate of Benefits is recommended.

NOTE: If you or your dependents currently have medical insurance coverage, the claim must be first submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to the Plan for further benefit (see Coordination of Benefits). You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to this Plan.

If you or your dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under this dental Plan within the noted Plan limitations, maximums, deductibles and payment percentages of treatment costs.

LIMITATIONS

1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such dental procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by Minnesota Statute 62A.25 provided, however, that such procedures are dental reconstructive surgical procedures.

2. Inpatient or outpatient dental expenses arising from dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statute section 62A.042.

   For programs without orthodontic coverage: Dental orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit plan.

   For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation and IV sedation when performed with non-surgical dental care.
2. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
5. Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
6. Any oral surgery except for simple and surgical extractions.
7. Surgical repositioning of teeth.

8. Inpatient or outpatient hospital expenses.
9. Cytology sample collection – Collection of oral cytology sample via scraping of the oral mucosa.

COMPLEX OR MAJOR RESTORATIVE SERVICES

Services performed to restore lost tooth structure as a result of decay or fracture

Gold foil restorations – Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances**. T**he patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit. Covered 1 time per 24-month period.

Inlays – Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Onlays and/or Permanent Crowns - Covered 1 time per 5 year period per tooth.

Implant Crowns – See Prosthetic Services.

Crown Repair – Covered 1 time per 12-month period per tooth.

EXCLUSIONS – Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Restorative cast post/core or core build-up
6. Canal prep & fitting of preformed dowel & post.
7. Temporary, provisional or interim crown.
8. Occlusal procedures, including occlusal guard and adjustments.

Prosthetic Services (Dentures, Partials, and Bridges)

Reline and Rebase – Covered 1 per 24-month period;

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) – Covered 1 per 6-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Denture Adjustments – Covered 2 times per 12-month period:

- when the denture is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments – Covered 2 times per 24-month period:

- when the partial or bridge is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) – Covered 1 time per 5-year period;

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) – Covered 1 time per 5-year period;

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 5 years;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Implant Supported Fixed and Removable Prosthetic (Crowns, Bridges, Partials and Dentures) – A restoration that is retained, supported and stabilized by an implant. Implants and related services are NOT covered.

> LIMITATION: This procedure receives an optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient's responsibility. For example: A single crown to restore one open space will be given the benefit of a Fixed Partial Denture Pontic (one unit). The optional benefit is subject to all contract limitations on the benefited service.

EXCLUSIONS – Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Initial installation of full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Covered Person under this Plan. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this Plan for more than 24 months.
3. Coverage for congenitally missing teeth. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this dental benefit plan for more than 24 months.

4. Interim removable or fixed prosthetic appliances (dentures, partials or bridges)
5. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges)
6. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
7. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
8. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
9. Services or supplies that have the primary purpose of improving the appearance of your teeth.
10. Placement or removal of sedative filling, base or liner used under a restoration.
11. Restorative cast post and core build-up, including pins and posts.
12. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
13. Coverage shall be limited to the least expensive professionally acceptable treatment.

Exclusions
Coverage is NOT provided for:

a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.

b) Dental services or health care services not specifically covered under the Client Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

d) Dental services performed for elective or cosmetic purposes. NOTE: Dental services may be subject to pre-payment clinical review of dental records. If services are found to not be dentally necessary, we reserve the right to deny such services and the member is responsible for the full charge. Dental services are subject to post-payment clinical review of dental records. If services are found not to be dentally necessary, we reserve the right to collect any payment and the member is responsible for the full charge.

e) Dental services completed prior to the date the Covered Person became eligible for coverage.

f) Services of anesthesiologists.

g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

h) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

k) Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants.

l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

m) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.

n) Case presentations, office visits and consultations.

o) Incomplete, interim or temporary services.

p) Corrections of congenital conditions during the first 24 months of continuous coverage under this Plan.

q) Athletic mouth guards, enamel microabrasion and odontoplasty.

r) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.

s) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

t) Bacteriologic tests.

u) Cytology sample collection.

v) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

w) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).

x) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).

y) Services for the replacement of an existing partial denture with a bridge.

z) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

aa) Provisional splinting, temporary procedures or interim stabilization.

bb) Placement or removal of sedative filling, base or liner used under a restoration.

cc) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

dd) Oral hygiene instruction.

ee) Restorative cast post/core or core build-up, including pins and posts.

ff) Occlusal procedures, including occlusal guard and adjustments.

gg) Amalgam or composite restorations placed for preventive or cosmetic purposes.

Limitations

a) Optional Treatment Plans: in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the

dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

b) Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by MN Statute 62A.25 provided, however, that such services are dental reconstructive surgical services.

c) Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statues Section 62A.042. For Programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For Programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall besecondary.

For other dental procedure exclusions and limitations, refer to the Description of Coverage in this Dental Benefit Plan Summary.

Post Payment Review

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 – Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed are subject to recovery. Delta Dental's right to conduct post payment review and its right of recovery exists even if a Pretreatment Estimate was submitted for the service.

Optional Treatment Plans

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

ELIGIBILITY

Covered Persons under this Program are:

Employees

a) All eligible employees who have met the eligibility requirements as established by the Client and stated within this Dental Benefit Plan Summary under Effective Date of Coverage.

b) Employees on Family and Medical Leave as mandated by the Federal FMLA.

Dependents

A) Spouse, meaning:

1. Married;
2. Legally separated;

B) Dependent children to the age of 26, including:

1. Natural-born and legally adopted children (including children placed with you for legal adoption. NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
2. Stepchildren who reside with you.
3. Grandchildren who are financially dependent on you and reside with you.
4. Children who are required to be covered by reason of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders ("QMCSOs") from the Plan Administrator.
5. Children who become handicapped prior to reaching the Plan's limiting age if:
    - they are primarily dependent upon you; and
    - are incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness or mental disorders;

NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a dependent, but not both. Your eligible dependent children may be covered under either parent's coverage, but not both.

NOTE: Neither the amount of support provided by the employee to a dependent child nor the residency of the child, will be used as an excluding or limiting factor for the child's eligibility for coverage of payment for benefits under this dental benefit plan.

Effective Dates of Coverage

Eligible Employee:

All eligible employees of the Client Subscriber as of November 1, 1999 and all eligible employees of the Client Subscriber following discontinuation of dental coverage due to retirement.

Eligible Dependents:

Your eligible dependents, as defined, are covered under this Program:

a) On the date you first become eligible for coverage, if dependent coverage is provided or elected.
b) On the date you first acquire eligible dependents, or add dependent coverage subject to the open enrollment requirements of the Client, if any.
c) On the date a new dependent is acquired if you are already carrying dependent coverage. LIMITATION: Dependents of an eligible employee who are in active military service are not eligible for coverage under the Program.

Children may be added to the Program at the time the eligible employee originally becomes effective or may be added anytime up to 30 days following the child's 3rd birthday. If a child is born or adopted after the employee's original effective date, such child may be added anytime between birth (or date of adoption) and 30 days following the child's 3rd birthday. In the event that the child is not added by 30 days following their 3rd birthday, that child may be added only if there is a Family Status Change or at the next Open Enrollment period, if any.

The eligibility of all Covered Persons, for the purposes of receiving benefits under the Program, shall, at all times, be

contingent upon the applicable monthly payment having been made for such Covered Person by the Client on a current basis.

Open Enrollment

There is no Open Enrollment under this plan.

Family Status Change

Your benefit elections are intended to remain the same for the entire Coverage Year. During the Coverage Year, you will be allowed to change your benefits only if you experience an eligible Family Status Change which includes:

- Change in legal marital status such as marriage or divorce.
- Change in number of dependents in the event of birth, adoption, or death.
- Change in your or your spouse's employment - either starting or losing a job.
- Change in your or your spouse's work schedule, such as going from full-time to part-time or part- time to full-time, or beginning or ending an unpaid leave of absence.
- Change in dependent status, such as if a child reaches maximum age under the Plan.
- Change in residence or work location so you are no longer eligible for your current health plan.
- Become eligible for Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage.
- Termination of Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage because you or your dependents are no longer eligible.
- Loss of other coverage.

Due to federal regulations, the changes you make to your benefits must be consistent with the Family Status Change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current dental coverage but it is not consistent to drop your dental coverage altogether.

If you experience one of the above eligible Family Status Changes during the year, you have 31 days (except in the case of qualification for or termination of employment assistance under Medicaid/CHIP, in which case the employee has 60 days after the date of eligibility) from the event to change your elections. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next Open Enrollment period. You may obtain a Family Status Change Form by contacting your Employer. All changes are effective the date of the change.

Termination of Coverage

Your coverage and that of your eligible dependents ceases on the earliest of the following dates:

a) On the date in which (1) you cease to be eligible; (2) your dependent is no longer eligible as a dependent under the Program.

b) On the date the Program is terminated.

c) On the date the Client terminates the Program by failure to pay the required Client Subscriber payments, except as a result of inadvertent error.

For extended eligibility, see Continuation of Coverage.

The Client or Plan Sponsor reserves the right to terminate the Plan, in whole or in part, at any time (subject to applicable collective bargaining agreements). Termination of the Plan will result in loss of benefits for all covered persons. If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination.

Continuation of Coverage (COBRA)

Dental benefits may be continued should any of the following events occur, provided that at the time of occurrence this Program remains in effect and you or your spouse or your dependent child is a Covered Person under this Program:

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, retirement, leave of absence, lay-off, or employee becomes ineligible (except gross misconduct dismissal)	Employee and dependents	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage.
Divorce, marriage dissolution, or legal separation	Former Spouse and any dependent children who lose coverage	Earliest of: 1. Enrollment date in other group coverage, or 2. Date coverage would otherwise terminate.
Death of Employee	Surviving spouse and dependent children	Earliest of: 1. Enrollment date in other group coverage, or 2. Date coverage would have otherwise terminated under the contract had the employee lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to Employee's entitlement to Medicare	Spouse and dependents	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Employee's total disability	Employee and dependents	Earliest of: 1. Date total disability ends, or 2. Date coverage would otherwise end.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and dependents	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or dependent electing COBRA.
Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving Spouse and dependents	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in other group coverage.

You or your eligible dependents have 60 days from the date you lose coverage, due to one of the events described

above, to inform the Client that you wish to continue coverage; except that, in the case of death of an eligible employee, such notification period to continue coverage shall be 90 days.

1. Choosing Continuation

   If you lose coverage, your employer must notify you of the option to continue coverage within 10 days after employment ends. If coverage for your dependent ends because of divorce, legal separation, or any other change in dependent status, you or your covered dependents must notify your employer within 60 days.

   You or your covered dependents must choose to continue coverage by notifying the employer in writing. You or your covered dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your covered dependents ineligible to choose continuation at a later date. You or your covered dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered dependents must pay charges monthly in advance to the employer to maintain coverage in force.

   Charges for continuation are the Client rate plus a two percent administration fee. All charges are paid directly to your employer. If you or your covered dependents are totally disabled, charges for continuation are the Client rate plus a two percent administration fee for the first 18 months. For months 19 through 29, the employer may charge the Client rate plus a 50 percent administration fee.

2. Second qualifying event

   If a second qualifying event occurs during continuation, a dependent qualified beneficiary may be entitled to election rights of their own and an extended continuation period. This rule only applies when the initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

   When a second qualifying event occurs such as the death of the former covered employee, the dependent must notify the employer of the second event within 30 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlier of the date coverage would otherwise terminate or 36 months.

   A qualified beneficiary is any individual covered under the health plan the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.

3. Terminating Continuation of Coverage – COBRA

   Continuation of Coverage – COBRA for you and your eligible dependents, if selected, shall terminate on the last day of the month in which any of the following events first occur:

   a) The expiration of the specified period of time for which Continuation of Coverage – COBRA can be maintained; as mandated by applicable State or Federal law;

   b) This Program is terminated by the Client Subscriber;

   c) The Client Subscriber's or Covered Person's failure to make the payment for the Covered Person's Continuation of Coverage;

Questions regarding Continuation of Coverage – COBRA should be directed to your employer. Your employer will

explain the regulations, qualifications and procedures required when you continue coverage.

PLAN PAYMENTS

Participating Dentist Network

A Delta Dental Premier® dentist is a dentist who has signed a Delta Dental Premier® membership agreement with his/her local Delta Dental Plan. The dentist has agreed to accept Delta Dental's Maximum Amount Payable as payment in full for covered dental care. Delta Dental's Maximum Amount Payable is a schedule of fixed dollar maximums established solely by Delta Dental for dental services provided by a licensed dentist who is a participating dentist. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental Premier® dentist has agreed not to bill more than Delta Dental's Maximum Amount Payable. A Delta Dental Premier® dentist has also agreed to file the claim directly with Delta Dental.

A Delta Dental PPO™ network dentist is a dentist who has signed a Delta Dental PPO™ agreement with his/her local Delta Dental Plan . The dentist has agreed to accept the Delta Dental PPO™ Maximum Amount Payable as payment in full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental PPO™ dentist has agreed not to bill more than the Delta Dental PPO™ Maximum Amount Payable. A Delta Dental PPO™ dentist has also agreed to file the claim directly with Delta Dental.

Names of Participating Dentists can be obtained, upon request or from the Plan's internet web site at www.DeltaDentalMN.org. Refer to the General Information section of this booklet for detailed information on how to locate a participating provider using the Plan's internet web site.

Covered Fees

Under this Program, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a participating Delta Dental PPO™ dentist with the plan. There may also be a difference in the payment amount if your dentist is not a participating dentist with Delta Dental. This payment difference could result in some financial liability to you. The amount is dependent on the nonparticipating dentist's charges in relation to the amount determined by Delta Dental.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN THE DELTA DENTAL PREMIER® AND DELTA DENTAL PPO™ NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Notice of Claim

Written notice of claim must be given to Delta Dental within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Policyholder or the beneficiary shall be presented to Delta Dental at P.O. Box 9120, Farmington Hills, MI 48333-9120.

Claim Forms

Delta Dental, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished for filing proofs of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you shall be deemed to have complied with the requirements of this policy.

Claim Payments

PAYMENTS ARE MADE BY THE PLAN ONLY WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED.

THE PLAN MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR PROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING. IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

ANY BENEFITS PAYABLE UNDER THIS PLAN ARE NOT ASSIGNABLE BY ANY COVERED PERSON OR ANY ELIGIBLE DEPENDENT OF ANY COVERED PERSON.

Delta Dental Premier® Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental Premier® dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental Premier® dentists is the lesser of: (1) The Maximum Amount Payable as determined by Delta Dental; or (2) The fee charged or accepted as payment in full by the Delta Dental Premier® dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Delta Dental PPO™ Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental PPO™ dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental PPO™ dentists is the lesser of: (1) The Delta Dental PPO™ Maximum Amount Payable as determined by Delta Dental; or (2) The fee charged or accepted as payment in full by the Delta Dental PPO™ dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Nonparticipating Dentists:

Claim payments are based on the Plan's Payment Obligation, which for nonparticipating dentists is the treating dentist's submitted charge or the amount established solely by Delta Dental, whichever is less. Claim payments are sent directly to the Covered Person.

THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NONPARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NON-PARTICIPATING PROVIDER, ANY BENEFITS PAYABLE UNDER THE CLIENT CONTRACT ARE PAID DIRECTLY TO THE COVERED PERSON.

Coordination of Benefits (COB)

If you or your dependents are eligible for dental benefits under this Program and under another dental program, benefits will be coordinated so that no more than 100% of the Plan Payment Obligation is paid jointly by the programs. The Plan Payment Obligation, as defined above, is determined prior to calculating all percentages, deductibles and benefit maximums.

The Coordination of Benefits provision determines which program has the primary responsibility for providing the first payment on a claim. In establishing the order, the program covering the patient as an employee has the primary responsibility for providing benefits before the program covering the patient as a dependent. If the patient is a dependent child, the program with the parent whose month and day of birth falls earlier in the calendar year has the primary payment responsibility. If both parents should have the same birth date, the program in effect the longest has the primary payment responsibility. If the other program does not have a Coordination of Benefits provision, that program most generally has the primary payment responsibility.

NOTE: When Coordination of Benefits applies for dependent children, provide your dentist with the birth dates of

both parents.

Time of Payment of Claim

Any benefits due under this Policy for any loss other than loss for which this Policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss.

Claim and Appeal Procedures

Initial Claim Determinations

All claims should be submitted within 12 months of the date of service**.** An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notification of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information we need, and you will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will bedenied.

Appeals

In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal.

Your appeal must include your name, your identification number, Client number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to:

Delta Dental of Minnesota
Attn: Professional Services Appeals and Grievances
PO Box 30416
Lansing, MI 48909

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. Because all benefit determinations are based on a preset schedule of dental services eligible under your plan, claims are not reviewed to determine dental necessity or appropriateness. In all cases where professional judgment is required to determine if a procedure is covered under your plan's schedule of benefits, we will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, we will identify any dental professional whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

To the extent your plan is covered by ERISA, after you have exhausted all appeals, you may file a civil action under section 502(a) of ERISA.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your

behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available at our web site or by calling Customer Service. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

GENERAL INFORMATION

Health Plan Issuer Involvement

The benefits under the Plan are not guaranteed by Delta Dental under the Contract. As Claims Administrator, Delta Dental pays or denies claims on behalf of the Plan and reviews requests for review of claims as described in the Claim and Appeals Procedures section.

Privacy Notice

Delta Dental of Minnesota will not disclose non-public personal financial or health information concerning persons covered under our dental benefit plans to non-affiliated third parties except as permitted by law or required to adjudicate claims submitted for dental services provided to persons covered under our dental benefit plans.

How to Find a Participating Dentist

A real-time listing of participating dentists is available in an interactive directory at the Plan's user-friendly web site, www.DeltaDentalMN.org. The Plan highly recommends use of the web site for the most accurate network information. Go to http://www.DeltaDentalMN.org/find-a-dentist and enter your zip code, city or state to find local participating dentists. You can also search by dentist or clinic name. The Web site also allows you to print out a map directing you to the dental office you select. **The Find A Dentist Search is an accurate and up-to-date way to obtain information on participating dentists.**

To search for and verify the status of participating providers, select "Find A Dentist" on the www.DeltaDentalMN.org home page. Select the Product or Network in the drop-down menu, and search by city and state, zip code or provider or clinic name. If your dentist does not participate in the network, you may continue to use that dentist, although you will share more of the cost of your care and could be responsible for dental charges up to the dentist's full billed amount.

If you do not have Internet access, other options are available to find a network dentist or verify that your current dentist is in the network.

- When you call to make a dental appointment, always verify the dentist is a participating dentist.
  Be sure to specifically state that your employer is providing the Dental program.

- Contact our Customer Service Center at: (651) 406-5901 or (800) 448-3815448-3815. Customer Service hours are 7 a.m. to 7 p.m., Monday through Friday, Central Time.

Using Your Dental Program

Dentists who participate with Delta Dental under this Program are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Delta Dental cannot and does not make any representations as to the quality of treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service.

If your dentist is a participating dentist, the claim form will be available at the dentist's office. If

your dentist is nonparticipating, claim forms are available by calling:

Delta Dental of Minnesota - (651) 406-5901 or (800) 448-3815

The Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.

The dental office will file the claim form with the Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

* YOUR DELTA DENTAL CLIENT NUMBER
* YOUR EMPLOYER (CLIENT NAME)
* YOUR IDENTIFICATION NUMBER (your dependents must use **YOUR** Identification number)
* YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENTCHILDREN

Cancellation and Renewal

The Program may be canceled by the Plan only on an anniversary date of the Client Dental Plan Contract, or at any time the Client fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Program, Covered Persons of the Client have no right to continue coverage under the Program or convert to an individual dental coverage contract.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Plan Administration

The Plan Administrator, who is listed on the inside front cover of this brochure, is a named fiduciary under the Program and shall be responsible for the management and control of this Program.

The Plan Administrator is responsible for determining the level of benefits for the Program as described in this brochure. The Plan Administrator reserves the power at any and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to modify or amend, in whole or in part, any or all provisions of the Plan, provided, however, that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under thePlan.

Funding Policy and Payment

The funding policy and method requires that the Client Subscriber submit payments on a monthly basis.

Procedure to Request Information

If you have any questions about this Program, contact the Plan Administrator who is listed in the inside front cover of this brochure.

Statement of ERISA Rights

As a participant in the Program, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine without charge at the Plan Administrator's office and at other specified locations such as work sites and union halls, all Plan documents, including insurance contracts, and copies of all documents such as detailed annual reports and Plan descriptions filed by the Plan with the U.S. Department of Labor.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Client, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your right, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If it finds your claim is frivolous, you will be responsible for these costs and fees. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DELTA DENTAL OF MINNESOTA

FOR CLAIMS
Delta Dental of Minnesota
P.O. Box 9120
Farmington Hills, MI 48333-9120
(651)406-5901 or (800)448-3815

FOR ELIGIBILITY
Delta Dental of Minnesota
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815

CORPORATE LOCATION
500 Washington Avenue South
Suite 2060
Minneapolis, MN 55415
(651) 406-5900 or (800) 328-1188
www.deltadentalmn.org

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Updated 5/2015
Updated 4/2011
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Appendix E
Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND RETAIN IT WITH YOUR IMPORTANT PAPERS.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of the Pipe Trades Services MN Welfare Plan ("Plan"), the Pipe Trades Services MN Retiree Health Trust, the Pipe Trades Services MN Pension Fund, the Pipe Trades Services MN Pension Supplement Fund and/or Pipe Trades Health Care Services, Inc. and Pipe Trades Services MN, Inc. (collectively "PTSMN") to protect the privacy of your medical information. PTSMN provides health, dental, vision and disability benefits to you as described in your summary plan descriptions. PTSMN receives and maintains your medical information in the course of providing these health benefits to you. PTSMN hires business associates to help it provide these benefits to you. These business associates also receive and maintain your medical information in the course of assisting PTSMN.

THE EFFECTIVE DATE OF THIS NOTICE IS MAY 25, 2023. PTSMN is required to follow the terms of this notice until it is replaced. PTSMN reserves the right to change the terms of this notice at any time. If PTSMN makes changes to this notice, PTSMN will revise it and send a new notice to all participants at that time. PTSMN reserves the right to make the new changes apply to all your medical information maintained by PTSMN before and after the effective date of the new notice.

Purposes for which PTSMN May Use or Disclose Your Medical Information Without Your Consent or Authorization

PTSMN may use and disclose your medical information for the following purposes:

- **Payment**. For example, PTSMN may use or disclose your medical information to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment.
- **Health Care Operations**. For example, PTSMN may use or disclose your medical information (i) to conduct quality assessment and improvement activities, (ii) for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (iii) to authorize business associates to perform data aggregation services, and (iv) to engage in care coordination or case management. However, we will not use your genetic information for underwriting purposes.
- **Health Services**. PTSMN may use your medical information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan may disclose your medical information to its business associates to assist the Plan in these activities.
- **As Required By Law**. For example, PTSMN must allow the U.S. Department of Health and Human Services to audit PTSMN records. PTSMN may also disclose your medical information

as authorized by and to the extent necessary to comply with workers' compensation or other similar laws.

- **To Business Associates**. PTSMN may disclose your medical information to business associates PTSMN hires to assist PTSMN. Each business associate of PTSMN must agree in writing to ensure the continuing confidentiality and security of your medical information.
- **To Plan Sponsor**. PTSMN may disclose to the Plan Sponsor (i.e. the Pipe Trades Services MN Welfare Fund, Pipe Trades Services MN Retiree Health Trust, Pipe Trades Services MN Pension Fund, or Pipe Trades Services MN Pension Supplement Fund), in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. PTSMN may also disclose to the Plan Sponsor that fact that you are enrolled in, or disenrolled from the Plan. The Plan may disclose your medical information to the Plan Sponsor for Plan administrative functions that the Plan Sponsor provides to the Plan if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your medical information. The Plan Sponsor must also agree not to use or disclose your medical information for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor without your written authorization.

PTSMN may also use and disclose your medical information as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for limited law enforcement purposes.
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this.
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To a governmental agency authorized to oversee the health care system or government programs.
- To federal officials for lawful intelligence, counterintelligence and other national security purposes.
- To public health authorities for public health purposes.
- To appropriate military authorities, if you are a member of the armed forces.

Uses and Disclosures with Your Permission

PTSMN will not use or disclose your medical information for any other purposes unless you give PTSMN your written authorization to do so. For example, in general and subject to specific conditions, we will not use or disclose your protected health information for marketing, and we will not sell your protected health information, unless you give us a written authorization. If you give PTSMN written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information PTSMN maintains, unless PTSMN has taken action in reliance on your authorization.

Your Rights

You may make a written request to PTSMN to do one or more of the following concerning your medical information that PTSMN maintains:

- To put additional restrictions on PTSMN's use and disclosure of your medical information. PTSMN does not have to agree to your request. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out of pocket and in full.
- To communicate with you in confidence about your medical information by a different means or at a different location than PTSMN is currently doing. PTMSN does not have to agree to your request, but will honor reasonable requests as long as they continue to allow PTMSN to collect premiums and pay claims. Your request must specify the alternative means or location to communicate with you in confidence.
- To see and get copies of your medical information. In limited cases, PTSMN does not have to agree to your request. If the information is in an electronic health record, you may be able to receive the information in an electronic format.
- To request an amendment (or Agreement) to your medical information. In some cases, PTSMN does not have to agree to your request, in which case you will be allowed to place a statement of disagreement with your medical information.
- To receive a list of disclosures of your medical information that PTSMN and its business associates made for certain purposes for the last 6 years.
- To send you a paper copy of this notice if you received this notice by e-mail or on the internet.
- To be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

If you want to exercise any of these rights described in this notice, please contact the Fund Office (below). PTSMN will give you the necessary information and forms for you to complete and return to the Fund Office. In some cases, PTSMN may charge you a nominal, cost-based fee to carry out your request.

Complaints

If you believe your privacy rights have been violated by PTSMN, you have the right to complain to PTSMN or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with PTSMN at the Fund Office (below). We will not retaliate against you if you choose to file a complaint with PTSMN or with the U.S. Department of Health and Human Services.

Fund Office

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact the following Fund Office:

Fund Office:	Pipe Trades Services MN, Inc.
Telephone:	651-645-4540
Email:	jonathanm@ptsmn.org
Website:	www.ptsmn.org
Address:	4461 White Bear Parkway, Suite 1 White Bear Lake, MN 55110