Pipe Trades Services MN Welfare Fund Benefits Booklet For Support Workers and their Dependents for Helpers and Pre-Apprentices

Plan Codes: 405 and 410

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

This Benefits Booklet applies only to support workers and their dependents and to helpers and pre-apprentices. If you are a Journeyman, an Apprentice, a Pre-Medicare Retiree, a Medicare Eligible Retiree, a bargaining-unit alumni, or a non-bargaining employee, contact the Fund Office for the appropriate Benefits Booklet.

Contents

1. INTRODUCTION

Dear Member:

Together we have worked diligently to contain the costs of your health and welfare benefits, despite the ever increasing costs the health care industry has experienced. As we continue our efforts to provide you and your Dependents the highest quality health and welfare benefits at the lowest cost, we have undertaken an extensive review of the Fund's benefits and partnerships. This updated Benefits Booklet for the Pipe Trades Services MN Welfare Fund is effective August 1, 2017 and replaces and supersedes all prior booklets that have been issued.

As we issue this new Benefits Booklet, we are changing our medical Preferred Provider Organization ("PPO") to HealthPartners. The PPO provides you access to a network of providers at a lower cost. And the PPO is a partner in helping us help you improve your health through a number of different programs. As part of this transition to a new PPO, we have updated some of your benefits. Please review this document carefully to understand the changes we have made.

We have also updated the format of your Booklet to better fit the various groups of Members. In order to customize the benefits available to you, we have prepared separate booklets for various groups.

We have tried to describe all of your benefits as completely as possible in everyday language. However, if you have any questions, please call the Fund Office or see the information found under Important Contact Information, which sets forth all of the contact information for our partners.

Sincerely,

The Board of Trustees

The Board of Trustees has the sole discretion and authority to administer the Fund and its Plans and to make final determinations regarding an individual's eligibility, any application for benefits, and the interpretation and administration of the Fund's trust agreement, the Plans, and any associated administrative rules. The Trustees' decisions in such matters are final and binding on all persons dealing with the Fund or claiming a benefit under a Plan. The Board of Trustees is the sole and exclusive fact-finder with respect to the Fund and the Plans. The Board of 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. If the Fund makes inadvertent, mistaken, excessive, erroneous, or fraudulent payment of benefits, the Trustees or their representative will have the right to recover these types of payments. The Trustees reserve the right to change, modify, or discontinue all or part of the benefits in this Booklet at any time by action or amendment.

2. IMPORTANT CONTACT INFORMATION

For information about:	Contact:	At:
• Eligibility • Claims and appeals regarding the above	Fund Office	800-515-2818 or 651-645-4540 www.ptsmn.org Submit appeals to: Pipe Trades Services MN Welfare Fund 4461 White Bear Parkway, Suite 1 White Bear Lake, MN 55110
• Wellness Centers	Pipe Trades Services MN Family Health & Wellness Centers	651-348-8851 (all locations) www.ptsmnhealth.org
• Medical benefit questions • Medical Claims questions • Finding an In-Network Healthcare Provider • Medical coverage criteria • Health Club Reimbursement • Medical benefit claims/ appeals	HealthPartners	Member Services 877-822-6706 or 952-967-7080 www.healthpartners.com www.healthpartners.com/public/coverage-criteria/ www.healthpartners.com/public/health/discounts/frequent-fitness/ Submit medical benefit Appeals to: HealthPartners Appeals P.O. Box 1309 Minneapolis, MN 55440-1309 Also see: www.healthpartners.com/hp/legal-notices/disclosures/complaints/index.html

For information about:	Contact:	At:
• Prescription drug benefit questions • Locating a Network Pharmacy • Prescription drug claims and appeals	Fund Office	800-515-2818 or 651-645-4540 www.ptsmn.org/Pharmacy.html Submit appeals to: Pipe Trades Services MN Welfare Fund 4461 White Bear Parkway, Suite 1 White Bear Lake, MN 55110
• Obtaining specialty drugs	Diplomat Specialty Pharmacy	877-977-9118 Submit claims and appeals to: Diplomat Pharmacy, Inc. 4100 South Saginaw Street Flint, MI 48507
CVS Minute Clinic Claims and appeals	CVS MinuteClinic	866-389-ASAP (2727) www.cvs.com/minuteclinic/ (located in select CVS/pharmacy stores) Submit to HealthPartners
Online Clinic Claims and appeals	Virtuwell	www.virtuwell.com Submit to HealthPartners

3. HOW TO USE THIS BOOKLET

The Pipe Trades Services MN Welfare Fund maintains several benefits Plans and Programs that together provide a comprehensive set of benefits. This Benefits Booklet is your guide to those benefits. It describes your rights and obligations under each Plan. We encourage you to review the documents in this Benefits Booklet.

The Plans provide many benefits to help maintain your health and save you money. But you must understand your benefits to take advantage of them. There is a table of contents at the front of the booklet. This will help you find information on particular benefits.

We suggest you keep this Booklet with your important papers for future reference. Capitalized terms throughout this Booklet have the meanings given in the Definitions section of the Uniform Terms for Plans and Programs of the Pipe trades Services Welfare Fund (which is near the end of this Booklet), with the exception that capitalized terms in the dental SPD are as defined in that SPD.

Please be sure to review the Definitions as they contain important descriptions of the terms used in this Booklet.

Periodically, the Trustees may amend one or more of the documents in this Booklet. You will receive a notice of the amendment. If you have questions regarding your benefits or anything in this Booklet, please contact the Fund Office. The only people authorized to answer your questions are the Board of Trustees and the Fund Office.

4. YOUR RESPONSIBILITIES

On an annual basis, you are required to complete the Family Information Statement. In addition, every October / November you will receive your Annual Deductible Election Form. Both of those forms need to be completed and returned to the Fund Office. If you do not return the Family Information Statement, your benefits will be suspended until you complete and return the form.

You must notify the Fund Office 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 or divorced (Support Worker only)
- When you gain or lose a Dependent (Support Worker only)
- Change your address including email address
- Change your telephone number
- When you gain or lose other insurance

Your death benefits are governed by the Fund's standard beneficiary designation. If you want to make changes to your beneficiary, contact the Fund Office.

Call the Fund Office when you:

- Receive workers' compensation benefits
- Receive benefits arising out of an automobile accident

- Return to work after a disability ends
- Enter or are discharged from the uniformed services of the United States
- Plan to retire or are retiring

5. HOW YOU CAN HELP CONTAIN COSTS

This Fund is here to help you and your family. There are a number of things you can do to help contain costs for your family and for everyone in the Fund.

- Visit a Pipe Trades Services MN Family Health & Wellness Centers (see next section for details)
- Go to health care providers who are in the PPO network – The Fund has contracted with HealthPartners who has negotiated discounted rates with providers for nearly all types of services.
- Fill your prescription at contracted network retail pharmacies—The Fund has contracted with Labor Value Rx, a pharmacy benefit manager ("PBM"), to provide you with access to a network of retail pharmacies that have agreed to charge negotiated rates for prescription medications.
- Fill your specialty medication at the contracted specialty pharmacy – The Fund has contracted with Diplomat Specialty Pharmacy, to help you with obtaining the lowest cost medications and the support you and your family need in administering these medications.
- Take generic medications instead of brand name medications whenever possible and approved by your doctor. Request generic drugs whenever possible when your physician is writing you a prescription. You can also ask the pharmacist if a generic equivalent is available if your doctor prescribes a brand-name medication.
- Review receipts and explanations of benefits (EOBs) carefully—if you ever receive an EOB or bill from a hospital that is incorrect, notify the provider, the applicable PPO, and the Fund Office. You will receive 25% of the amount recovered from the Fund Office, up to $500, when your efforts produce an adjusted claim.
- Whenever possible, use outpatient services (including outpatient surgery) rather than obtaining services on an inpatient basis.
- Only use the emergency room in an actual emergency. An emergency room is the most expensive place to obtain care and as a general rule should not be used for minor illness such as sore throats, ear infections, etc. Use urgent care facilities, CVS Minute Clinics or your own physician whenever possible for these situations.

6. PIPE TRADES SERVICES MN FAMILY HEALTH & WELLNESS CENTERS

When you are eligible for benefits from the Fund, you and your family have a unique opportunity. Today's medical delivery system is often times more focused on completing as many procedures as possible; treating patients after they become sick. The Pipe Trades MN Family Health & Wellness Centers ("Wellness Centers") provide convenient access to care with an emphasis on prevention, health 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 purpose of the Pipe Trades MN Family Health & Wellness Centers is threefold:

- To change the way health care is delivered by utilizing employed physicians that only need to think about "what's best for the patient";
- To change the way health care is paid for by eliminating the insurance, paperwork and billing aspects of the current health care system; and,
- To engage members in improving their health and the health of their families.

These Wellness Centers are owned by the Fund and are operated for the benefit of Members.

Who can use the Pipe Trades MN Family Health & Wellness Centers?

- As a Participant in the Pipe Trades Services MN Health Plan, you may use the Wellness Centers, but only when you are a current Participant.
- Individuals who are covered by Medicare (see separate booklet for information for Medicare retirees) are not eligible to use the Wellness Centers.
- You also 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.

Services Offered

The Pipe Trades MN Family Health & Wellness Centers offer all of the primary care services you would expect from a family physician/general practitioner:

- Primary care – colds, flu, asthma, diabetes etc.;
- Acute care – chronic disease care, cardio care etc.;

- Preventive Care – immunizations, physicals, health coaching and counseling;
- Pharmaceuticals – select prepackaged generic medications dispensed on site;
- Chiropractic care;
- Behavioral and mental health care; and,
- Patient education.

The White Bear Lake Wellness Center includes a full-service vision center. For a complete list of available services visit www.ptsmnhealth.org and click on the "Services" tab.

Advantages to Using Pipe Trades MN Family Health & Wellness Centers

The employed physicians at the Wellness Centers are not compensated based on the number of tests or procedures they perform; they also are not incented to see as many patients as possible. Their goal and the goal of our Wellness Centers will be to spend the time necessary with our members; to get to know you and your family and to support you in any way they can to help you improve your health.

The following points show the ways in which our Wellness Centers will be different:

- Initially office visits will be scheduled for 1 hour of physician time, not the usual 10 minutes that is more typical today
- **There is no Deductible for Office Visits at our Pipe Trades MN Family Health & Wellness Centers**
- **There is no Office Visit Copayment for visits at our Pipe Trades MN Family Health & Wellness Centers**
- Generic prescription drugs with no Coinsurance will be dispensed by the physician at the time of the office visit. The Wellness Centers carry approximately 250 of the most common generic prescription drugs.
- Certain lab tests can also be completed at the Wellness Centers.
- An important point to keep in mind is that Participants using our Wellness Centers should be ready and willing to make lifestyle changes; and to understand the key role that a patient has in partnership with a physician to improve their own health and the health of their family members.

Employers do NOT have Access to Your Records

We strictly adhere to the HIPAA Privacy Law and associated rules, which protects every patient's health and medical records and keeps the records secure. We will not share your records with anyone without your consent.

7. SUMMARY OF BENEFITS PROVIDED BY THE FUND

Pipe Trades Services MN Health Plan		
For Support Workers: Maximum Out-of-Pocket: $2,000/individual; $6,000/family (excludes Deductible) For Support Workers: Deductible: $750 Annual Limit: None		
For Helpers/ Pre-Apprentice: Maximum Out-of-Pocket: $2,850 (no Dependent coverage) For Support Workers: Deductible: $3,500 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: hospital, durable medical equipment	10% Coinsurance, Deductible applies	20% Coinsurance, Deductible applies
Emergency Services	10% Coinsurance, Deductible applies	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 (not in conjunction with hospital or emergency room visit)	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance, Deductible applies
Laboratory Services in conjunction with a hospital or emergency room visit	10% Coinsurance, Deductible Applies	20% Coinsurance, Deductible applies For emergency services, 10% Coinsurance, Deductible applies
Diagnostic imaging in an Office	You pay $0 (0% Coinsurance)	20% Coinsurance, Deductible

Visit	Deductible does not apply	applies
Diagnostic imaging in a non-Office Visit	10% Coinsurance, Deductible Applies	20% Coinsurance, Deductible applies For emergency services, 10% Coinsurance, Deductible applies
Preventive Care	You pay $0 (0% Coinsurance), Deductible does not apply	20% Coinsurance, Deductible applies
Prescription Drugs (Support Workers)	20% Coinsurance, Deductible does not apply	Not covered
Prescription Drugs (Helpers / Pre-Apprentice)	30% Coinsurance, Deductible does not apply	Not Covered
Treatment at Pipe Trades Services MN Health & Wellness Centers	You pay $0 (0% Coinsurance), Deductible does not apply	Not applicable
Treatment at CVS Minute Clinics	You pay $0 (0% Coinsurance), Deductible does not apply	20% Coinsurance, Deductible applies
Treatment via virtuwell (online clinic)	You pay $0 (0% Coinsurance), Deductible does not apply	Not applicable
Chiropractic Services	20% Coinsurance up to Annual Limit of $1,100, Deductible applies	20% Coinsurance up to Annual Limit of $1,100, Deductible applies
Acupuncture	20% Coinsurance up to Annual Limit of $300, Deductible applies	20% Coinsurance up to Annual Limit of $300, Deductible applies
Hearing Aids	10% Coinsurance up to $2,000 limit every 4 years, Deductible applies	20% Coinsurance up to $2,000 limit every 4 years, Deductible applies

Pipe Trades Services MN Health Club Reimbursement Program
$20 will be credited toward your health club membership fee for each Member and Spouse who visits a participating health club at least 8 times within a month. Your Spouse may participate in this program, but your Children may not.

8. ELIGIBILITY AND BENEFITS

A. Support Workers, Helpers and Pre-Apprentices Only

This Benefits Booklet applies only to Support Workers and their Dependents, and Helpers and Pre-Apprentices. If you are a Journeymen, Apprentice, pre-Medicare Retiree, Medicare Retiree, contact the Fund Office for the appropriate Benefits Booklet. In this section of this Booklet, the term "you" refers only to a Support Worker, Helper or Pre-Apprentice. Capitalized terms have the meaning given in the Definitions section of the Uniform Terms for Plans and Programs Maintained by the Pipe Trades Services MN Welfare Fund, which are included in this Booklet. You may find additional information about your eligibility and benefits at www.ptsmn.org.

B. Benefits

The Fund maintains many benefits Plans and Programs. When you become eligible for benefits from the Fund, you (and, in some cases, for Support Workers your Dependents) become a participant in the Pipe Trades Services MN Health Plan (which is described later in this Benefits Booklet) and Pipe Trades Services MN Health Club Reimbursement Program.

C. Support Worker, Helpers and Pre-Apprentice Eligibility, Termination of Eligibility

You first become eligible to receive benefits from the Fund under this Benefits Booklet on the first day of the second month following the month in which you perform work as a Support Worker, Helper or Pre-Apprentice that causes the balance of your Dollar Bank to equal or exceed the Fund's Premium. This eligibility rule applies regardless of whether you were eligible for benefits from the Fund under another Benefits Booklet when you became a Support Worker, Helper or Pre-Apprentice. After you initially become eligible for benefits under this Booklet, you will remain eligible until your eligibility is terminated. Your eligibility will terminate on the earliest of the following:

1. The first day of the first month in which the balance of your Dollar Bank is less than the Fund's monthly Premium[1];
2. The day you become eligible for benefits from the Fund in any capacity other than as a Support Worker, Helper or Pre-Apprentice;
3. The day you enter active military service (subject to the provisions of USERRA);

[1] 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 a "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 notice. You may also check your individual Dollar Bank information at www.ptsmn.org. Go to the members page and click on the Eligibility Information tab.

4. The day your local union or district council ceases to require contributions to the Fund on your behalf under a Collective Bargaining Agreement;

5. The day you work for an employer in the Pipe Trades Industry that is not signed to a labor agreement with a pipe trades union (you must notify the Fund Office immediately if you leave the Pipe Trades Industry or become self-employed);

6. The day the Fund is terminated.

If your eligibility terminates and is not reinstated, you must meet the initial eligibility requirements to become eligible for benefits again. For an example of how eligibility works, see the Appendix.

D. **Dependent Eligibility, Termination of Eligibility (For Support Workers Only)**

For Support Workers only, your Dependents first become eligible for benefits on the same day that you first become eligible. Helpers and Pre-Apprentices are only eligible for single coverage. 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 if you submit complete and accurate enrollment forms to the Fund Office within 30 days. If you submit enrollment forms more than 30 days after the date the person became your Dependent, your new Dependent will become eligible on the first day of the month following the month in which you submit enrollment forms. Once eligible, your Dependents remain eligible until their eligibility is terminated.[2] Each of your Dependents' eligibility will terminate on the earliest of the following:

1. The day your eligibility is terminated for any reason other than your death;

2. The last day of the month in which the Dependent ceases to qualify as your Dependent;

3. If you die, the day that is 6 months after the day on which your Dependents would otherwise have ceased to be eligible due to an insufficient balance in your Dollar Bank.[3]

E. **Eligibility Reinstatement: Short Dollars**

If your eligibility is terminated because the balance of your Dollar Bank is less than the monthly Premium but greater than $0, you will receive a "Short Dollars Premium Invoice". The invoice will ask you to pay the difference between the balance in your Dollar Bank and the monthly Premium. If you pay the 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 short dollar invoices.

F. **Eligibility Reinstatement: Extended Eligibility (Support Workers Only)**

For Support Workers only, if 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 through the

[2] Dependent eligibility may be waived by submitting a satisfactory waiver form to the Fund Office. Contact the Fund Office for the proper form.

[3] This extension applies to your Spouse and your Children, but not Children only.

Supplemental Hour Reserve". This benefit is not available for Helpers or Pre-Apprentices. You qualify for extended coverage if:

1. You are not employed by a Contributing Employer;
2. You are seeking work with a Contributing Employer or you are out of work due to a disabling injury or illness (verified by your physician);
3. Contributions were made to the 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;
4. You are not working for an employer in the Pipe Trades Industry that is not a Contributing Employer;
5. You are not covered under another health plan; and,
6. You submit a properly completed application.

If you qualify for extended eligibility, the Fund will credit your Dollar Bank the amount needed to reinstate and continue your eligibility for an extension period, which is three months from the date of termination if you had 1,500 hours contributed in the past 12 months, six months if you had 3,000 hours in the past 24 months, or nine months if you had 4,500 hours in the past 36 months.

You cease to qualify for extended coverage 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 coverage ends, you may continue your COBRA coverage by paying the COBRA Premium for the remainder of your COBRA coverage period.

G. **Deferral of Eligibility**

You may not defer your eligibility (or that of your Dependents) unless you meet the following criteria[4]:

1. Your employment with a Contributing Employer terminated while you were eligible;
2. You are out of work but actively seeking employment with a Contributing Employer;
3. You have Minimum Value Coverage with a deductible of no more than $2,000; and,
4. You have submitted a satisfactory application to defer eligibility to the Fund Office.

If you meet the criteria for deferral of 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. The general rule that your Dollar Bank is forfeited upon termination will not apply; your Dollar Bank will be frozen while you meet the criteria for a deferral of eligibility. Your eligibility will be reinstated on the first

[4] Non-bargaining unit employees are not eligible for this benefit. Bargaining unit alumni are eligible for this benefit.

day of the first month following the month in which you become employed by a Contributing Employer or you cease to have Minimum Value Coverage through your Spouse. The Fund may request on-going verification of your status to determine your eligibility for deferral.

H. **Rescission of Eligibility**

A rescission of coverage is a cancellation coverage that has retroactive effect. The 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 Fund determines to rescind your eligibility, you will be provided 30 days' advance written notice. If your eligibility is rescinded, you will be liable to the Fund for any benefits you received during or on account of the period of rescinded eligibility plus interest and all collection expenses the Fund incurs. The 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 Fund terminates your coverage retroactive to the date you should have lost eligibility but did not due to an administrative delay.

I. **Retroactive Reconciliation of Eligibility**

Eligibility is determined by reference to the month in which you perform work for a Contributing Employer. In general, the Fund will receive a Contribution for work you performed in the month after you performed the work. In such cases, the Fund will be able to determine whether your work was sufficient to maintain your eligibility before the applicable eligibility month. At times, however, the Fund will receive Contributions for your work several months after you performed the work. When the Fund receives late Contributions, the Fund will retroactively reconcile your eligibility. If your eligibility was terminated but it would not have been if the 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, 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 making one or more short dollar payments that would not have been necessary if the Fund had timely received the late Contributions, the Fund will refund your payments.

9. PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF THE PIPE TRADES SERVICES MN HEALTH PLAN

A. **Introduction**

This Plan is generally designed to mitigate and limit the financial harm that you experience as a result of an unexpected Injury or Illness. It is not designed to cover every healthcare expense, nor is it designed to make healthcare decisions for you. The decisions about how and when you receive care are up to you, not the Plan. The Plan merely determines whether and how much it will pay. You must decide what care is best for you.

B. **Participation**

You become a Participant in this Plan when you become eligible for benefits from the Fund if the applicable Benefits Booklet states that eligibility for benefits entitles you to participate in this Plan. You cease to be a Participant in this Plan when your eligibility for benefits is terminated. The same rules apply separately to each of your Dependents.

C. **What You Pay And What The Plan Pays**

This Plan will reimburse you a portion of your Covered Expenses up to the limits and under the conditions established by the Plan. How a Covered Expense is divided between you and the Plan depends on the Deductible, Copayment, Coinsurance, Maximum Out-Of-Pocket, and whether you incurred the Covered Expense In-Network or Out-Of-Network. These rules apply differently to different types of Covered Expenses – for specific information on how they apply, see the payment schedule below. Note that what you pay and what the Plan pays is determined only for Covered Expenses. Expenses you incur for healthcare that are not Covered Expenses[5] are solely your responsibility. They do not count toward your Deductible or Maximum Out-Of-Pocket and are not subject to a Copayment or Coinsurance.

1. Deductible

The Deductible is the total amount of Covered Expenses you must pay before the Plan pays any Covered Expenses.[6] The Deductible applies on an individual basis and a family basis. If you incur Covered Expenses exceeding the individual Deductible within a calendar year, you have met the individual Deductible and any further Covered Expenses you incur will be paid by the Plan according to the applicable Copayment, Coinsurance, and Maximum Out-Of-Pocket.[7] For Support Workers, if 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 Plan according to the applicable Copayment, Coinsurance, and Maximum Out-Of-Pocket. At the beginning of each calendar year, your Deductible resets except any Covered Expenses applied against the Deductible in the last three months of a calendar year will also be applied against your Deductible for the next calendar year.

For Support Workers, the Deductible is set at $750 per individual/$2,250 for family. For Helpers and Pre-Apprentices, your deductible is set at $3,500.

2. Copayment

A Copayment is a fixed dollar amount (e.g., $25) that you pay for a Covered Expense. The 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.

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[5] For instance, expenses for items or services that are expressly excluded by the Plan, or the portion of an expense that exceeds the Reasonable and Customary amount.

[6] Note, however, that some Covered Expenses are not subject to the Deductible. Such Covered Expenses are paid by the Plan according to the applicable Copayment or Coinsurance regardless of whether you have met your Deductible.

[7] This rule applies separately to each individual in your Family.

3. Coinsurance

Coinsurance is the percent of a Covered Expense that you pay. The Plan pays the remainder of the 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 Out-Of-Pocket is the most you will pay in any calendar year for Covered Expenses that do not count toward a Deductible. For Support Workers, the Maximum Out-Of-Pocket is $2,000/individual and $6,000/Family. For Helpers and Pre-Apprentices, the Maximum Out-Of-Pocket is $2,850. If you, your Dependent, or your Family reaches the applicable Out-Of-Pocket Maximum, the Plan will pay 100% of the applicable Covered Expenses for the remainder of the calendar year. The Maximum Out-Of-Pocket resets each calendar year.

5. In-Network vs. Out-Of-Network

The Plan has contracted with Preferred Provider Organizations, through which the Plan receives significant discounts from healthcare providers within the PPO networks. In general, you may incur Covered Expenses with an Out-Of-Network provider and still receive benefits.[8] But you and the Plan will spend less when you choose In-Network providers. For information on how to locate and contact In-Network healthcare providers, see the back of your ID card or the section entitled Important Contact Information at the beginning of this Benefits Booklet.

The Plan's rules for determining what you pay and what the Plan 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 Plan will always 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 vs. Out-Of-Network, see the Payment Schedule below.

The Plan contracts with PPOs to ensure that when you incur Covered Expenses with an In-Network healthcare provider, the Covered Expense never exceeds the Reasonable and Customary amount. The Plan has no such arrangement with Out-Of-Network healthcare providers. The portion an Out-Of-Network expense that exceeds the Reasonable and Customary amount is not a Covered Expense. The Plan will not pay anything toward that portion of the expense, and the healthcare provider will "balance bill" you.

6. Method For Applying Payment Rules

The Deductible, Coinsurance, Copayment, Maximum-Of-Pocket, 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.[9] It is even possible for a single service event to result in both In-

[8] Some items and services that are covered In-Network are not covered Out-Of-Network.

[9] For instance, some charges from a service event may be Preventive Care with the remainder being subject to the general rule for Covered Expenses.

Network and Out-Of-Network charges.[10] This general rule, however, does not apply to Office Visits[11] or treatment at Pipe Trades Services MN Wellness Centers.

7. Payment Schedule

Pipe Trades Services MN Health Plan		
For Support Workers: Maximum Out-of-Pocket: $2,000/individual; $6,000/family (excludes Deductible) For Support Workers: Deductible: $750 Annual Limit: None		
For Helpers/ Pre-Apprentice: Maximum Out-of-Pocket: $2,850 (no Dependent coverage) For Support Workers: Deductible: $3,500 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: hospital, durable medical equipment	10% Coinsurance, Deductible applies	20% Coinsurance, Deductible applies
Emergency Services	10% Coinsurance, Deductible applies	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

[10] For example, an In-Network provider may order laboratory or radiology services from an Out-Of-Network provider.

[11] Except that charges for durable medical equipment billed with an Office Visit are treated as separate charges.

Laboratory services (not in conjunction with hospital or emergency room visit)	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance, Deductible applies
Laboratory Services in conjunction with a hospital or emergency room visit	10% Coinsurance, Deductible Applies	20% Coinsurance, Deductible applies For emergency services, 10% Coinsurance, Deductible applies
Diagnostic imaging in an Office Visit	You pay $0 (0% Coinsurance) Deductible does not apply	20% Coinsurance, Deductible applies
Diagnostic imaging in a non-Office	10% Coinsurance, Deductible Applies	20% Coinsurance, Deductible applies For emergency services, 10% Coinsurance, Deductible applies
Preventive Care	You pay $0 (0% Coinsurance), Deductible does not apply	20% Coinsurance, Deductible applies
Prescription Drugs (Support Workers)	20% Coinsurance, Deductible does not apply	Not covered
Prescription Drugs (Helpers / Pre-Apprentice)	30% Coinsurance, Deductible does not apply	Not Covered
Treatment at Pipe Trades Services MN Health & Wellness Centers	You pay $0 (0% Coinsurance), Deductible does not apply	Not applicable
Treatment at CVS Minute Clinics	You pay $0 (0% Coinsurance), Deductible does not apply	20% Coinsurance, Deductible applies
Treatment via virtuwell (online clinic)	You pay $0 (0% Coinsurance), Deductible does not apply	Not applicable
Chiropractic Services	20% Coinsurance up to Annual Limit of $1,100, Deductible applies	20% Coinsurance up to Annual Limit of $1,100, Deductible applies
Acupuncture	20% Coinsurance up to Annual Limit of $300, Deductible applies	20% Coinsurance up to Annual Limit of $300, Deductible applies
Hearing Aids	10% Coinsurance up to $2,000 limit every 4 years, Deductible applies	20% Coinsurance up to $2,000 limit every 4 years, Deductible applies

Diagnostic imaging in a non-Office	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	20% Coinsurance, Deductible does not apply	Not covered
Treatment at Pipe Trades Services MN Health & Wellness Centers	You pay $0 (0% Coinsurance), Deductible does not apply	Not applicable
Treatment at CVS Minute Clinics	You pay $0 (0% Coinsurance), Deductible does not apply	20% Coinsurance, Deductible applies
Treatment via virtuwell (online clinic)	You pay $0 (0% Coinsurance), Deductible does not apply	Not applicable
Chiropractic Services	20% Coinsurance up to Annual Limit of $1,100, Deductible applies	20% Coinsurance up to Annual Limit of $1,100, Deductible applies
Acupuncture	20% Coinsurance up to Annual Limit of $300, Deductible applies	20% Coinsurance up to Annual Limit of $300, Deductible applies
Hearing Aids	10% Coinsurance up to $2,000 limit every 4 years, Deductible applies	20% Coinsurance up to $2,000 limit every 4 years, Deductible applies

D. **What The Plan Covers**

1. In General

The Plan provides benefits for Covered Expenses, which generally include physician, hospital, skilled nursing facility, 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 this Plan.

2. Limitations

Coverage of certain expenses is limited and conditioned as described below. 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 to the extent that such criteria are not inconsistent with this Plan. To review coverage criteria, see the website that is identified under the applicable PPO in the Important Contact Information section at the beginning of this Booklet or contact the Fund Office.

b. Covered Expenses for chiropractic services are limited to $1,100 in total per individual per calendar year. This limitation does not apply to chiropractic services rendered at a Pipe Trades Services MN Wellness Center.

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

d. Covered Expenses for dental work or oral surgery to a natural tooth must be incurred within two years of the date of the causative Injury or Illness, and you must have been a Participant in the Plan when the Injury or Illness occurred. 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 $2,000 (per individual) in any four-year period.

g. Covered Expenses related to rehabilitation and habilitation, e.g. physical therapy or speech, are limited to the expenses for 120 visits per lifetime per individual (rehabilitative and habilitative visits count toward the same limit).

h. Covered Expenses for room and board in-patient treatment are limited to the semi-private room rate.

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

j. Covered Expenses for nutritional supplements are limited in accordance with Centers for Medicare and Medicaid Services national coverage determinations.

k. Covered Expenses for treatment of temporomandibular joint dysfunction ("TMJ") or any condition related to TMJ are limited to $800 per calendar year (per individual). Expenses for radiology related to TMJ do not apply towards this limit.

l. Covered Expenses for participation in sleep studies are limited to $2,000 per calendar year (per individual).

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

n. Prior Authorization is required for organ transplants.

o. Marital counseling is limited to six sessions per lifetime.

E. **What The Plan Does Not Cover**

Notwithstanding anything to the contrary, the following are not Covered Expenses and are excluded from coverage by this Plan:

1. An expense for an item or service that is not Medically Necessary.
2. An expense to the extent that it exceeds the Reasonable and Customary 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 26 U.S.C. § 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 Plan in accordance with the Plan's claims procedure.
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 Plan denies coverage.
9. An expense for which a person or entity other than you or the Plan is or may be liable to pay.[12]
10. An expense to the extent that a third-party (i.e., a person or entity other than you or the Plan) pays the expense, reimburses you for the expense, or otherwise acts to relieve you of the economic burden of paying the expense.
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.
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 this 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.

[12] See the section of this Plan entitled "First Priority Right of Subrogation and Reimbursement" for further information regarding expenses that may or may not be another party's responsibility.

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 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 listing 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 are not applicable to your diagnosis, except as specifically provided by the Plan.

22. An 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. An 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 Retin-A, except if the Retin-A was prescribed by a physician for the treatment of acne.

26. An expense for an antiviral drug (e.g., Tamiflu (oseltamivir) and Relenza (anamivir)), except if the antiviral medication was prescribed for the prevention or treatment of influenza and you are a high-risk patient as defined by the Center for Disease Control.

27. 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 the Fund Office for a list of those medications.

28. An expense for a drug that is prescribed for treatment of erectile dysfunction, except if Medically Necessary.

29. 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).

30. An expense for a compounded drug, as defined by 21 U.S.C. 353a.

31. An expense for a specialty drug except if the drug is obtained from the Fund's designated specialty pharmacy. For a list of specialty drugs, contact the Fund Office. For contact information for the designated specialty pharmacy, see the Important Contact Information section of this Booklet.

32. Expenses for repetitive drug testing.

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

34. 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 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.

35. 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.

36. An expense for an item or service that is primarily for cosmetic purposes such as an expense related to cosmetic surgery, except if the cosmetic surgery is for the treatment of an Injury and you incur the expense within two years of sustaining the Injury.

37. An expense related to gender reassignment surgery and related hormone therapy.

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

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

40. An expense related to artificial heart surgery.

41. An expense related to a thermogram or thermography.

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

43. An expense for a telephone visit.

44. An expense for early intensive intervention services as defined under Minn.Stat. 62A.3094.

45. 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 disorders and chemical or mental health treatment in a licensed residential primary treatment center.

46. 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.

47. 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.

48. 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.

49. An expense related to the diagnosis and treatment of a learning disability.

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

51. 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.

52. An expense related to surgery for temporomandibular joint dysfunction or any related condition.

53. An expense related to or for a wig.

F. **Additional Plan Terms**

The provisions of the section of this Booklet entitled “Uniform Terms For Plans And Programs Maintained By The Pipe Trades Services MN Welfare Fund” are incorporated into this Plan in their entirety

10. PIPE TRADES SERVICES MN HEALTH CLUB REIMBURSEMENT PROGRAM

The Fund provides a monthly $20 per individual health club reimbursement program. $20 will be credited toward your health club membership fees if you visit a participating health club at least 8 times within a month. For Support Workers, your Spouse may also participate in this program. Be sure to present your ID card when you enroll at a participating health club. You can find information on how to locate participating health clubs in the “Important Contact Information” section of this Booklet.

You become a Participant in the Pipe Trades Services MN Health Club Reimbursement Program when you become eligible for benefits from the Fund if the applicable Benefits Booklet states that eligibility for benefits entitles you to participate in this Plan. You cease to be a Participant in this Plan when your eligibility for benefits is terminated. The provisions of the section of this Booklet entitled “Uniform Terms For Plans And Programs Maintained By The Pipe Trades Services MN Welfare Fund” are incorporated into this Program in their entirety.

11. UNIFORM TERMS FOR PLANS AND PROGRAMS MAINTAINED BY THE PIPE TRADES SERVICES MN WELFARE FUND

A. **Payment, Claims, and Appeals**

1. Claims and Appeals Procedures Generally

Below is the standard claims and appeal procedure for all the Plans. However, if the Fund contracts with a PPO to provide claims or appeal adjudication services, that PPO's claims and appeals procedures will supplement the standard claims and appeal procedures. To the extent that a PPO's claims and appeals procedures are inconsistent with the standard claims and appeal procedures, the standard claims and appeals procedures will apply. A PPO appeal procedure that calls for two levels of appeal will not be considered inconsistent with the Plans' standard procedures. See the Important Contact Information section of this Booklet for information on filing claims and appeals with each PPO. Notwithstanding anything to the contrary, the Plans' Claims and appeals will be administered in accordance with 29 C.F.R. § 2560.503-1 and, to the extent applicable, 29 C.F.R. § 2590.715–2719.

2. 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 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 appropriate form provided by the Fund Office, or the request is formatted and submitted in the manner required by the claims procedures of the applicable PPO[13];
- The request provides the information necessary to determine whether the expense is payable under the applicable Plan, or whether Prior Authorization can be granted, or whether you are entitled to payment; and,
- The request is received by the 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.

Each year you must submit a completed Family Information Statement form to the Fund Office. If you do not provide a complete and accurate Family Information Statement form by the deadline stated on the form, any request for payment the Fund or a PPO receives will not be considered a Claim until you submit a satisfactory form. If the Fund or a PPO receives a request for payment of expenses you incurred as a result of an accident, the request will not be considered a Claim until you have submitted a completed "Statement of Claim" form to the Fund Office. If the Fund receives a request for payment of expenses and there is reason to believe that that a person or entity other than you or the Fund may be

[13] If you are unsure which PPO is appropriate for your Claim, contact the Fund Office. See the Important Contact Information section of this Booklet for PPO appeal information.

liable for those expenses, the request will not be considered a Claim until you have submitted a completed "Acknowledgement of Subrogation Rights" form to the Fund Office. You will find these forms online at www.ptsmn.org.

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

3. How Benefits are Paid and How to File a Claim.

When you incur Covered Expenses and you file a Claim, the Fund will reimburse you for those Covered Expenses to extent provided by the Plan. In many cases, your Healthcare Provider will file a Claim on your behalf using the information on your ID card.[14] In such cases, you will not need to personally file a Claim.[15] 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 Healthcare Provider submits a Claim that is determined to be payable, you be will presumed to have directed the Fund to pay your reimbursement directly to the Healthcare Provider on your behalf. The Fund will then pay your reimbursement to the Healthcare Provider in full satisfaction of the Fund's obligation to reimburse you. If you incur Covered Expenses and another person or entity does not file a Claim on your behalf, you must file the Claim. Obtain the appropriate form by contacting the Fund Office.[16]

If the Fund attempts to pay a Healthcare Provider on your behalf and the Healthcare Provider does not cash the check within 180 days, the Fund will make the payment to you instead. If the Fund attempts to reimburse you and you do not cash the check within 180 days, the Fund will attempt to locate you to make payment using a commercial locator service. If efforts to locate you fail, you will forfeit your right to reimbursement one year from the date that the 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 Urgent Care). If you (or another person on your behalf) do not file a Claim for reimbursement of an expense within one year of the date you incur the expense, you forfeit any right to reimbursement that you would have had if you had filed a timely Claim.

4. How The Fund Decides Whether To Pay Your Claim, and How You Can Appeal

When the 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 that decision in writing. With respect to a claim for health benefits, you will generally be notified via a form

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[14] Note that, although a Healthcare Provider may file a Claim on your behalf, you cannot assign your right to receive payment from a Plan (or any rights associated with your right to payment) to any person or entity.

[15] You are, however, still responsible for ensuring that the Healthcare Provider files a timely, complete, and accurate Claim. You may appoint a representative to act on your behalf with respect to one or more Claims by filing a written form with the Fund Office. Contact the Fund Office to obtain the appropriate form.

[16] Contact information for the Fund Office is in the "Important Contact Information" section of this Booklet.

called an "Explanation of Benefits". This form may be from the Fund Office or a PPO. 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 health care 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 Plan provisions 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 appeal procedures, including, if the denied claim was for Urgent Care, a description of the expedited appeal procedure for Urgent Care claims;
- A statement that you have a right to bring a civil action under ERISA Section 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 PHS Act section 2793 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 health care 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 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 you disagree with decision to deny your Claim, you have 180 days to appeal in writing.[17] For all appeals, your request for appeal must include the specific reasons you feel the determination or the Claim denial was improper. 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

[17] 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 under the same rules that apply to a Claim.

copies). The 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 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 time-frame.

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, 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. You may request the right to appear in person before the Board.[18] 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.

If your appeal is denied (in whole or in part) the notice of 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 health care 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;
- Refer to the specific Fund provision(s) on which the decision is 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;

[18] 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 Section 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 PHS Act section 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 health care 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 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 of 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 for health benefits within 15 days of the date the applicable PPO receives your Claim.

If you disagree with the Trustees' decision[19], you have one year to file a lawsuit in federal court under ERISA section 502, or you have one year to request binding arbitration with the Fund. If you request binding arbitration, you waive your right to file a lawsuit.

If you disagree with an appeal decision[20] as it relates to a rescission of coverage or the denial of Claim involving medical judgment, you have 4 months following the decision to request review of the decision by an independent entity accredited by URAC called an independent review organization ("IRO"). Requesting Independent Review does not toll the limitations period for filing an action in court. If you request Independent Review and the IRO determines that the decision on your Claim does not involve medical judgment or rescission, the IRO will not review the decision. If the IRO determines that your appeal is reviewable, the IRO will notify you and you will have 10 days to provide the IRO any information you wish the IRO to consider. If the IRO determines that your Claim is payable by the applicable Plan, the Fund will promptly pay your Claim according to the terms of the Plan. The Fund may appeal the IRO's decision in federal court. If the Fund prevails in court, you will be liable to re-pay the Fund. If the IRO determines that your Claim is not payable by the applicable Plan, the Fund will not pay your Claim unless and until a court or arbitrator issues a final decision reversing the Fund's decision regarding your Claim. In general, an IRO decision will be issued within 50 days of your request for

[19] 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.

[20] If there are two levels of appeal pertaining to your Claim, you may request Independent Review only after receiving the decision on the second level of appeal.

Independent Review. Expedited Independent Review may be available. Contact the Fund Office for further information on the Independent Review Process.

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

	Post-Service	Prior Authorization	Urgent Care Claim
Initial Decision[21]	Within 30 days of Claim receipt	Within 15 days of Claim receipt	Within 72 hours of Claim receipt (24 hours if more information needed to process claim)[22]
Extension Period[23]	15 days	15 days	None
Appeal Request	Within 180 days	Within 180 days	Within 180 days
Appeal Decision[24]	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 of appeal).	Within 30 days (or 15 days if there are two levels of appeal)	Within 72 hours
Extension Period[25]	2 extensions, each till the next Board meeting	None	None
Independent Review Request	Within four months of receipt of appeal decision	Within four months of receipt of appeal decision	Within four months of receipt of appeal decision
Request for Arbitration	Within one year of receipt of appeal decision	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	Within one year of receipt of appeal decision

21 This is when you will receive notice of the decision.
22 24 hours if the Claim pertains to a cessation of coverage of an ongoing course of treatment.
23 You will be advised in writing in advance if an extension will be necessary.

24 This is when you will receive notice of the decision.
25 You will be advised in writing in advance if an extension will be necessary.

B. Coordination Of Benefits With Other Plans

The Fund does not provide benefits for items and services to a greater extent than you are responsible for the cost of those items and services. If you are covered by another plan or plans then benefits under this Fund will be coordinated with other sources of compensation so that the combined payments do not total more than the amount you actually incurred. The Fund will coordinate benefits in accordance with the model rules established by the National Association of Insurance Commissioners in effect at the time you incur Covered Expenses.[26] The 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 Fund should have paid.

When the 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 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.

C. First Priority Right of Subrogation and Reimbursement[27]

1. First Priority Right of Subrogation

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

2. First Priority Right of Reimbursement

The Fund also has a first priority right of reimbursement. The Fund's first priority right of reimbursement includes all amounts paid by the Fund to you or your Dependent or paid on your behalf

[26] Contact the Fund Office for a copy of the NAIC model rules.

[27] Throughout this section, the term "you" means you or your Dependent jointly and severally, including you on behalf of your minor Dependent.

as determined by the Trustees as set forth below. The 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 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 Fund is preempted by ERISA. The amount of the Fund's right to subrogation and reimbursement includes all amounts the Fund has paid to you or your Dependent and amounts paid on your or your Dependent's behalf. The amount of the Fund's right also includes all amounts the Fund incurs for attorney fees and costs enforcing its subrogation or reimbursement rights. The Fund's first priority right of subrogation and first priority right of reimbursement will not be reduced by any attorney fees or costs that you or your Dependent incur. The Fund will not pay any portion of your or your Dependent's attorney fees or costs. The Trustees have the sole discretion to determine which benefits the 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.

3. Establishment of a Constructive Trust

A constructive trust is automatically established for the benefit of the 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.

4. Duty to Cooperate and Assist the Fund

You will assist the Fund in protecting its rights to recovery, and you will do nothing to prejudice the Fund's rights. You will assist the Fund in any action it brings. If the Fund believes that you have suffered an illness or injury for which there is potentially another individual, entity or insurer responsible, the Fund will forward forms to you to complete. The Fund may withhold benefits otherwise payable until you execute all documents required by the Fund, including an agreement in writing to:

a. Reimburse the Fund to the extent of benefits paid by the Fund (plus reasonable costs of collection, including reasonable attorney fees); and

b. Provide the Fund with a lien to the extent of benefits provided to you by the Fund (plus reasonable costs of collection, including reasonable attorney fees).

If you fail to cooperate or assist the Fund or otherwise take action which prejudices the Fund's rights, the Fund will offset all claims for you and your Dependent until such time as the Fund has recovered the full amount of its subrogation and reimbursement interest.

D. **Continuation of Coverage, Family and Medical Leave, Military Leave[28]**

COBRA, USERRA, and FMLA do not apply to all Fund benefits. COBRA, USERRA, and FMLA apply only to the Pipe Trades Services MN Health, the Pipe Trades Services MN Dental Plan, the Pipe Trades Services MN Vision Plan, and the Pipe Trades Services MN Health Club Reimbursement Program.

[28] Throughout this section, the term "you" means a Member and not a Dependent.

If your participation in an applicable Plan is terminated, you may qualify to continue your participation under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA Coverage will begin on the day that coverage under the Plan would otherwise have been lost. Under COBRA Coverage, your benefits will be the same as those of a similarly situated Participant who does not have COBRA Coverage. However, you must pay a monthly premium for COBRA Coverage. For more information about COBRA Coverage, contact the Fund Office.

A COBRA qualifying event occurs when you cease to be eligible because:

- Your Employer reduced your hours;
- Your Employer terminated your employment (for any reason other than gross misconduct); or,
- You depleted your hour bank.

A COBRA qualifying event occurs for your Dependent(s) when your Dependent(s) lose eligibility because:

- You died;
- You were divorced or legally separated;
- Your Child failed to continue qualifying as a Dependent; or,
- You became eligible for Medicare.

You must notify the Fund Office within 60 days of the date you or your Dependent ceased to be a Participant due to a qualifying event (except if the qualifying event is due to a reduction of your hours or your termination, in which case the Fund Office will determine whether you experienced a qualifying event). If you do not notify the Fund Office within 60 days, you cannot elect COBRA Coverage.

If your COBRA qualifying event is a reduction in your hours or termination of your employment, the maximum period of COBRA Coverage for you and your Dependents is 18 months, beginning on the day coverage would otherwise end. However, if a second qualifying event occurs during this 18-month period, the maximum period of COBRA Coverage extends to 36 months. If you or one of your Dependents is totally disabled at the time of the initial qualifying event (or within 60 days of the initial qualifying event, as determined by the Social Security Administration), the maximum period of COBRA Coverage is 29 months. You must notify the Fund Office within 60 days of the date that Social Security determines that you or your Dependent is totally disabled. If the qualifying event is divorce, separation, failure to continue qualifying as a Dependent, or Medicare eligibility, the maximum period of COBRA Coverage is 36 months. If you become entitled to Medicare benefits before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum period of COBRA coverage for your Dependents ends on the later of 36 months after you became entitled to Medicare or 18 months (or 29 months, if there is a disability extension) after the date of your termination of employment or reduction of hours.

Your COBRA Coverage will end on the earliest of the following dates:

- The date on which you have not paid the applicable COBRA premium;
- The date on which the you become entitled to receive benefits under Medicare;

- The end of the applicable maximum period of COBRA Coverage;
- The date on which the Plan terminates;
- The date you become covered under another group health plan; or
- The date you engage in conduct that would justify terminating coverage of a similarly situated participant or beneficiary not receiving COBRA Coverage (such as fraud).

Notwithstanding any provision to the contrary in an applicable Plan, if you go on a qualifying leave under the Family and Medical Leave Act ("FMLA") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), then to the extent necessary to permit your employer to comply with FMLA or USERRA, as applicable, the Fund will continue to maintain your benefits on the same terms and conditions that would apply if you were still an employee.

E. **Privacy of Your Health Information**

HIPAA requires the Fund to protect the confidentiality and security of your private health information. A description of your rights under HIPAA can be found in the Fund's Notice of Privacy Practices, which you can find with your Benefits Booklet.

The Fund will not use or disclose information your protected health information except as necessary for treatment, payment, and health plan operations, or as permitted or required by law. The Fund will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of your protected health information. The Fund requires all of its business associates to enter written contracts with the Fund requiring them to protect the confidentiality and security of your private health information to the same degree as the Fund. The Fund will not, without your written authorization, use or disclose your protected health information for employment-related actions and decisions.

The Fund will generally de-identify your protected health information (that is, the Fund will strip away all the information that could be used to identify you) before providing it to the Board of Trustees for health plan operations purposes, such as appeals. The Fund will disclose your protected health information without de-identification to the Board of Trustees only after receiving a certification from the Board of Trustees in accordance with 45 C.F.R. § 164.504(f)(2)(ii). If the Fund provides your protected health information to the Board of Trustees, the Board of Trustees will adhere to the same policies and procedures as the Fund regarding the use, disclosure, confidentiality, and security of your protected health information. The Board of Trustees will not disclose your protected health information to any person or entity other than the Fund, and the Board of Trustees will report to the Fund any security incident of which it becomes aware.

You have the right to see and copy your protected health information, to receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Fund or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. Contact the Fund Office for a copy of the Notice of Privacy Practice, for answers to your questions about the privacy of your health information; or if you wish to file a complaint under HIPAA.

F. Genetic Information Nondiscrimination Act

Generally, the Plans will not require you or your family members to provide genetic information or undergo genetic testing. However, a Plan 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 applicable Plan will request the relevant genetic information. Any genetic information the Plan receives will be used or disclosed by the Plan only as permitted by the Plan's Privacy Practices. If you decline to provide the information, the Plan will deny coverage.

G. Newborns Act

Under federal law, the Pipe Trades Services MN Health Plan 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 Plan may not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours for a cesarean section).

H. Women's Health and Cancer Rights Act

The Plans comply with the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage is provided in a manner determined in consultation with the attending physician and the patient for: all stages of reconstruction of the breast on which the mastectomy is performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; treatment of physical complications of the mastectomy, including lymphedema. Plan limits, deductibles, copayments, and coinsurance apply to these benefits.

I. Information About The Plans

The following information is provided to help you identify this Fund and the people who are involved in its operation, as required under ERISA.

1. Effective Date

The restated Plan Document and Summary Plan Description of each Plan in this Booklet supersedes all prior documents pertaining to the same subject and is effective August 1, 2017.

2. Name Of Fund And Plan

The Fund is known as the Pipe Trades Services MN Welfare Fund. The Fund has established and maintains: the Pipe Trades Services MN Health Plan; the Pipe Trades Services MN Dental Plan; the Pipe Trades Services MN Vision Plan; the Pipe Trades Services MN Health Club Reimbursement Program; the Pipe Trades Services MN Employee Assistance Program; the Pipe Trades Services MN Weekly Injury and Illness Disability Program; the Pipe Trades Services MN Death Benefits Program; the Pipe Trades Services MN Accidental Death and Dismemberment Program; the Pipe Trades Services MN Jury Duty Program; and the Pipe Trades Services MN Bereavement Pay Program. You are only eligible for the Plans and Programs as provided.

3. Agent For Service Of Legal Process

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

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

4. 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 Plans.

5. Identification Numbers

The number assigned to this Fund by the Internal Revenue Service is 41-0761972. The number assigned by the Trustees to the Pipe Trades Services MN Health Plan is 501.

6. Type Of Plan

The Plans are maintained to provide: benefits for treatment of accidental injury and illness; limited scope dental benefits; limited scope vision benefits; health club reimbursement benefits; employee assistance benefits; weekly injury and illness disability benefits; death benefits; accidental death and dismemberment benefits; jury duty benefits; and bereavement pay benefits.

7. Fiscal Year

The fiscal year of the Fund and each Plan begins on May 1 and ends on April 30.

8. Trust Fund

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to Members and their Dependents and defraying reasonable administrative expenses. The Fund's assets and reserves are invested by the Board of Trustees in certificates of deposit, government securities, corporate bonds, corporate stocks, and other investment vehicles. All benefits are paid directly from the assets of the Fund.

9. Source Of Contributions

Contributions to the Fund are made by Contributing Employers in accordance with their Collective Bargaining Agreements or by written agreement with the Board of Trustees. The Fund Office will provide, upon written request, information as to whether a Contributing Employer is actually contributing to this Fund. The Collective Bargaining Agreements require fixed contributions to the Fund at fixed rates per hour worked. Participation agreements establish the basis upon which contributions are made to the Fund for Participants who are not covered by a Collective Bargaining Agreement.

10. Board Of Trustees

The Board of Trustees is responsible for the operation of this Fund. The Board of Trustees consists of an equal number of employer and union representatives, selected by the Contributing Employers and the Union who have entered into Collective Bargaining Agreements or participation agreements. You may contact the Board of Trustees at the address and phone number listed in your Benefits Booklet. The Board of Trustees has the responsibility of determining rules for participation in the Fund's Plans and for determining the benefits to be offered. The Board of Trustees will exercise complete and sole

discretionary authority to construe, interpret, and apply all of the terms of the Plan Document and Summary Plan Description of each of the Plans. The Board of Trustees will exercise complete and sole discretionary authority to determine all facts relevant to applying the terms of the Plans. The Fund Office has non-discretionary authority to process claims, determine eligibility, and perform other ministerial functions on behalf of the Fund and its Plans. Certain PPOs have been delegated authority to adjudicate certain Claims and appeals. If at any time, the Fund Office or a PPO is in doubt as to the proper interpretation of a Plan, the Fund Office or PPO will notify the Board of Trustees, which will determine the proper interpretation. The Board of Trustees will exercise complete and sole discretionary authority to review all appealed claim denials except to the extent that the Board expressly delegates this authority.

The current Trustees are:

Employer Trustees
Gary Thaden
Minnesota Mechanical Contractors Association
830 Transfer Road
St. Paul, MN 55114

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

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

Kristen Olson
Major Mechanical, Inc.
11201 86th Avenue North
Maple Grove, MN 55369

Union Trustees
Scott Gale
Plumbers Local No. 15
708 South Tenth Street
Minneapolis, MN 55404

Tom Vail
Pipefitters Local No. 455
1301 L'Orient St
St Paul, MN 55117

Jeff Huberty
Plumbers Local No. 34
353 7th St W #104
St Paul, MN 55102

Jake Pettit
Pipefitters Local Union 539
312 Central Ave., Suite 408
Minneapolis, MN 55414

11. Amendment Of The Plans, Termination Of The Fund

The Board of Trustees intends to continue the Fund indefinitely. The Trustees retain the right to amend the Plans at any time, prospectively or retrospectively to the extent permitted by law. Any amendment to a Plan will be binding on all covered persons on the effective date of the amendment. The Trustees also retain the right to terminate a Plan or the Fund. In this event, the assets of the Plan or 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 Fund. Upon the disbursement of the entire Fund, the Fund will then terminate.

12. 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 Fund or the Board of Trustees.

13. Effect Of Mistake

In the event of a mistake by the Fund as to your eligibility or benefits, the Fund will endeavor to correct the mistake by placing persons and entities affected by the mistake in the positions they would have held had the mistake not been made to the extent that it deems administratively possible and legally permissible. If a mistake resulted in an overpayment by the Fund, the Fund may take any appropriate action to collect the overpayment, including, without limitation, adjusting your account, offsetting your benefits, or filing suit.

14. Fraud, Intentional Misrepresentation

If, as a result of your fraud or intentional misrepresentation of a material fact, the Fund makes payments to you or on your behalf that would not otherwise have been made, you will be liable to the Fund in the amount of the payments plus interest and all collection expenses the Fund incurs including, without limitation, attorney's fees. The Fund may take any legal action necessary to collect, including, without limitation, offsetting any benefits that are owed to you and filing a lawsuit.

15. No Guarantee Of Tax Consequences

The Fund does not guarantee that any amounts paid to or for your benefit by the Fund will be excludable from your gross income for federal state or local income tax purposes. You must determine when each payment from the 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.

16. Indemnification Of Fund And Plan

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

17. Non-Assignability Of Rights

You may not assign your right to benefits under a Plan or your right to payment from the Fund. You may not assign any right associated with your right to benefits under a Plan or your right to payment from the Fund. Except as required by law, the Fund will not recognize any assignment of your benefits or right to payment, or any attempt by another person to assert rights pertaining to your benefits or right to payment, or any claims by your creditors. Only you may bring an action against the Fund or the Trustees that involves a Plan or the Fund.

18. Incompetence, Disappearance, or Death

If payment of any benefit under this Plan cannot be paid to you due to your incompetence, disappearance, or death, the Fund may make payment of the benefits due in accordance with the standard beneficiary designation. Payments made under this section will constitute full and final discharge of all obligations of this Fund to the extent of such payments.

J. **Your Rights Under ERISA**

As a Participant in the Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). 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 Plan, including insurance contracts, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain upon written request to the Fund Office copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Fund Office may make a reasonable charge for the copies.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an 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 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 Plan documents or the latest annual report 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 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 Fund's money, or if you are discriminated against for asserting your rights, 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 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 your Plan, 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 Employee Benefits Security Administration, 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.

K. **DEFINITIONS**

1. Apprentice

An employee of a Contributing Employer with respect to whom the Contributing Employer is required by a Collective Bargaining Agreement to contribute to the Fund at the rate for apprentices.

2. Benefits Booklet (Booklet)

The set of documents that describes the Fund's benefits plans and programs for each class of the Fund's Participants. There are multiple Benefits Booklets. The Fund Office will provide you these documents when you become eligible for benefits and upon request.

3. Board Of Trustees (Trustees)

The trustees of the Pipe Trades Services MN Welfare Fund.

4. Child

A natural child; a stepchild; an adopted child; a child placed with you in anticipation of adoption; a grandchild who lives with you in a parent-child relationship, and of whom you have been awarded physical custody of the child by a court or granted legal guardianship, and whose parent is not living in the same household unless the parent is a minor.

5. Claim

See the section of this Benefits Booklet entitled "What is a Claim?".

6. Code

The Internal Revenue Code.

7. Coinsurance

The portion of a Covered Expense that you pay after you have satisfied any applicable Deductible and subject to any limitations or Maximum Out-Of-Pocket, as applicable.

8. Collective Bargaining Agreement

An agreement between the Union and one or more Employers or an association representing Employers that requires contributions to the Fund.

9. Collectively Bargained Employee

An Employee on whose behalf a Contributing Employer is required to contribute to the Pipe Trades Services MN Welfare Fund by a Collective Bargaining Agreement. This includes an individual who is not currently employed by a Contributing Employer if a Contributing Employer would be required to contribute to the Pipe Trades Services MN Welfare Fund by a Collective Bargaining Agreement upon employing the individual.

10. Contributing Employer

An employer obligated to contribute to the Fund for its employees pursuant to a Collective Bargaining Agreement or Participation Agreement.

11. Contribution

A payment to the Fund by a Contributing Employer in accordance with a Collective Bargaining Agreement; a payment by a person or entity to the Fund under a participation agreement, a reciprocity

agreement, an agreement of merger or transfer; or a payment by a Participant to the Fund in accordance with the Plan.

12. Covered Expense

See the section of the Pipe Trades Services MN Health Plan entitled "What the Plan Covers".

13. Dependent

Your Spouse; your Child who is under the age of 26; your Child who is age 26 or older if the Child is incapable of self-support as the result of a disability that began before the child reached age 26; or a person you are required to provide coverage to under a Qualified Medical Child Support Order. An individual who would otherwise qualify as your Dependent will not be considered your Dependent if the Fund Office receives a properly completed waiver of coverage with respect to the individual.

14. Deductible

A Deductible is an aggregate amount you must pay toward Covered Expenses before the Covered Expense becomes subject to Coinsurance. There is generally an overall Deductible per individual and per family. A Plan begins paying benefits with respect to an individual when the individual has incurred Covered Expenses equal to the individual Deductible. A Plan begins paying with respect to all individuals in a family when the aggregate Covered Expenses of all individuals in the family equal the family Deductible. There may be Deductibles for specific benefits. The foregoing is a general description of Deductibles. For information on the Deductibles in a particular Plan, see the Plan's SPD.

15. Disability Retirement

As used in this booklet, a Member is eligible for a Disability Retirement if the Trustees, in their sole discretion, have deemed you to be permanently and totally disabled on the basis of evidence that:

- You have been totally disabled by bodily injury or a physical or mental condition and your disability prevents you from engaging in work in any job classification in a Collective Bargaining Agreement;
- Your disability will be permanent and continuous for the remainder of your life; and
- You are unable to engage in gainful employment of any kind, except for activity of a type other than that specified in the Collective Bargaining Agreement for which you are able to earn less than $1,200 per month.

16. Designated Beneficiary or Standard Beneficiary Designation

Your Designated Beneficiary will be the Standard Beneficiary Designation followed by the Fund, unless you complete and file with the Fund Office a form changing your beneficiary. The Standard Beneficiary Designation is to 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; 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 personal representative of your estate.

17. Dollar Bank

The Dollar Bank is a notional accounting of Contributions made by your employer to the Fund on your behalf. You can find the balance of your Dollar Bank as of the first day of the current month 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 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, your Premium will be deducted from your Dollar Bank on the first day of each month. 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 collective bargaining agreement that requires contributions to the Fund, your entire Dollar Bank balance will be immediately forfeited. If your eligibility is terminated and not reinstated via a short dollar payment or the supplemental hour reserve, the balance of your Dollar Bank on the date of termination is forfeited unless an exception applies. The Dollar Bank is merely a means of determining your eligibility for benefits from the Fund. The Dollar Bank may be amended or eliminated at any time. You are not vested in any of the Fund's benefits. At retirement any balance in your Dollar Bank will be used to pay your Premium.

18. Emergency Services

Services as defined by 29 C.F.R. § 2590.715-2719A(b)(4)(ii). Generally, this means a medical screening examination for an emergency medical condition provided by an emergency department of a hospital and such further medical examination and treatment at the hospital that is necessary to stabilize the patient.

19. Employee

An individual who is employed by a Contributing Employer that is classified as a common-law employee, not including the following: any leased employee including but not limited to those individuals defined as leased employees in Code §414(n); any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; any employee covered under a collective bargaining agreement that does not provide for contributions to this Plan; any self-employed individual; any partner in a partnership; and any more-than 2% shareholder in a Subchapter S corporation, including those deemed to be a more than 2% shareholder by virtue of the Code §318 ownership attribution rules.

20. ERISA

The Employee Retirement Income Security Act of 1974, as amended.

21. Experimental or Investigative

An item or service that: has not been approved by the appropriate governmental authority, or that has been approved for an intended use that differs from the manner in which it was used; that does not have reliable evidence to establish a consensus conclusion among relevant experts recognizing the safety and effectiveness of the item or service under the conditions in which it is used; that is the subject of on-going research or investigational studies regarding the relevant intended use; with respect to which there is significant scientific evidence that the item or service is not safe and effective for the relevant intended use; or that is considered Experimental and Investigative under the relevant PPO's coverage criteria (to the extent that such criteria are not inconsistent with the relevant Plan). The Trustees have the authority to determine, in their discretion, whether an item or service is Experimental

or Investigative regardless of whether a physician has prescribed, ordered, recommended, or approved it.

22. 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 Fund's Plans are not required to cover Essential Health Benefits.

23. Fund Office

The person or entity to which the Board of Trustees delegates non-discretionary authority to process claims, determine eligibility, and perform other ministerial functions on behalf of the Fund and its Plans.

24. Fund

The Pipe Trades Services MN Welfare Fund.

25. Healthcare Provider

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

26. Helper / Pre-Apprentice

An individual meeting the qualifications of this classification as provided in the relevant Collective Bargaining Agreement.

27. HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended.

28. 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.

29. Independent Review

A review of a decision on appeal by an independent entity accredited by URAC called an independent review organization ("IRO").

30. In-Network

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

31. Journeyman

An employee of a Contributing Employer with respect to whom the Contributing Employer is required by a Collective Bargaining Agreement to contribute to the Fund at the rate for journeymen.

32. Lifetime Limit

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

33. Maximum Out-Of-Pocket

The maximum amount you must pay toward Covered Expenses in a calendar year, determined on an individual and family basis. If you, your Dependent, or your family reaches a maximum out-of-pocket, the applicable Plan will pay 100% of the applicable Covered Expenses 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 Out-of-Pocket. A Maximum Out-Of-Pocket resets each calendar year. The foregoing is a general description of a Maximum Out-of-Pocket. For information on the Maximum Out-of-Pocket in a particular Plan, see the Plan's SPD.

34. Medically Necessary

An item or service that is:

- Provided or prescribed by a Healthcare Provider exercising prudent clinical judgment, acting in accordance with generally accepted standards of medical practice[29], and acting within the scope of his or her license to practice;
- Provided or prescribed for the purpose of diagnosing or treating an Illness or Injury;
- Clinically appropriate, in terms of type, frequency, extent, site, and duration;
- Considered safe and effective for diagnosis or treatment of the patient's Illness or Injury;
- Not primarily for the convenience of the patient or Healthcare Provider, or another Healthcare Provider; and,
- Not more costly than an alternative that is likely to produce similar therapeutic or diagnostic results.

35. Member

An individual who is eligible for benefits from the Fund by virtue of employment (rather than or in addition to being eligible as a Dependent).

36. Minimum Value Coverage

Coverage under a group health plan or health insurance policy that satisfies the requirements of 26 U.S.C. § 36B(c)(2)(C)(ii).

37. Minute Clinic

A healthcare clinic owned and operated by a CVS pharmacy.

[29] "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.

38. Motorized Vehicle

A Motorized Vehicle refers to any vehicle which is a self-propelled road vehicle and off-road vehicle, wheeled or with treads, except an automobile.

39. 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.

40. Out-Of-Network

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

41. Participant

An individual who is eligible for benefits from the Fund and who is permitted to participate in the applicable Plan under the Eligibility and Benefits section of the applicable Benefits Booklet.

42. Pipe Trades Industry

Any work within the jurisdiction of the United Association of Plumbers, Fitters, Welders and Service Techs.

43. Plan (Plans), Program

The Pipe Trades Services MN Health Plan; Pipe Trades Services MN Dental Plan; Pipe Trades Services MN Vision Plan; Pipe Trades Services MN Health Club Reimbursement Program; Pipe Trades Services MN Employee Assistance Program; Pipe Trades Services MN Weekly Injury and Illness Disability Program; Pipe Trades Services MN Death Benefits Program; Pipe Trades Services MN Accidental Death and Dismemberment Program; Pipe Trades Services MN Jury Duty Program; or the Pipe Trades Services MN Bereavement Pay Program as indicated by context.

44. Plan Year

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

45. Post-Service Claim

A Claim for reimbursement of an expense that you have already incurred when you file the Claim.

46. Pre-Apprentice / Helper

An individual meeting the qualifications of this classification as provided in the relevant Collective Bargaining Agreement.

47. Preferred Provider Organization (PPO)

An entity having a network of health care providers, through which a Plan 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 the Important Contact Information section of this Booklet for information about who to contact for Claims or customer service.

48. Premium

The Premium[30] is the amount that will be deducted from your Dollar Bank (if any dollars remain) to provide you (and your Dependents) eligibility for one month. The amount of the Premium depends on your deductible under the Pipe Trades Services MN Health Plan. You will have the ability to choose the deductible (and corresponding Premium) when you first become eligible and annually thereafter at the end of each calendar year. At your initial eligibility, if you do not choose a deductible, you will be deemed to have elected the default Deductible. Thereafter, if you do not choose a deductible, you will be deemed to have elected your prior year's Deductible. Your enrollment materials will provide you information about the current Premium and Deductible. The Premium may be changed prospectively at any time.

49. Prescription Drug

A drug that may not be legally sold in the United States to a person without a valid prescription from a Healthcare Provider who is licensed to write the prescription.

50. Pre-Service Claim

A request for authorization to incur expenses when such a request is a condition of coverage of the expenses.

51. 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/.

52. 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 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 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 physician may be required to obtain Prior Authorization for certain services. Your physician will coordinate the authorization process for any services which must first be authorized. See the section of this Booklet entitled 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.

53. Qualified Medical Child Support Order

A judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction requiring that the Fund recognize an Employee's or Spouse's Child as an alternate recipient as defined by ERISA Section 609(a). Such order must be approved in accordance with procedures adopted by the Board of Trustees.

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[30] Sometimes referred to as the dollars applied amount or the monthly cost of coverage.

54. Reasonable And Customary Charge

The amount that Healthcare Providers in a geographic area usually charge for an item or service. In general, the Reasonable and Customary Charge is 140% of the amount that Medicare will reimburse for the item or service or a percentage of a comparable schedule if the service is not available on the Medicare fee schedule.

55. Retiree

An individual who has submitted an acceptable application for retirement to the Fund and whose application has been approved by the Trustees or the person the Trustees have delegated such authority.

56. 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 Plan may require proof of a valid marriage before recognizing an individual as a Spouse. An individual will be presumed to no longer be your Spouse if you and the individual reside apart for a period of six months or more unless you submit satisfactory documentation to the contrary.

57. Summary Plan Description Or SPD

One or more sections of this Booklet whose titles begin with "Plan Document and Summary Plan Description", as indicated by context. Each Summary Plan Description and Plan Document is intended to satisfy both the requirement under ERISA to have a written Plan Document and the requirement under ERISA to have a written Summary Plan Description.

58. Support Worker

An individual meeting the qualifications of this classification as provided in the relevant Collective Bargaining Agreement.

59. Urgent Care Claim

A Claim under circumstances where application of the 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.

12. APPENDICES

A. **Eligibility Example**

Work Month	Eligibility Month	Eligibility	Dollars Worked	Short Dollar Payment	Premium Deducted	Dollar Bank Balance[31]
Mar	May	No	$550	$0	$0	$550
Apr	Jun	Yes	$1,350	$0	$1,199	$701
May	Jul	Yes	$600	$0	$1,199	$102
Jun	Aug	Yes	$0	$1,097	$1,199	$0
Jul	Sept	Yes	$1,300	$0	$1,199	$101
Aug	Oct	No	$0	$0	$0	$0

The above table illustrates how eligibility would function for a hypothetical individual who performs sporadic work for a Contributing Employer beginning in March and ending in July. This example assumes that the individual's Premium is $1,199 per month. **Your Premium may be different, but the process for determining eligibility is the same.**

5. Initial eligibility in June: The individual first performed work in March, but $550 dollars worked was not enough work to become eligible in May, the corresponding eligibility month. In April, the individual has $1,350 dollars worked. With $1,900 total dollars worked ($550 from March plus $1,350 from April), the individual has sufficient dollars to become eligible in June (because $1,900 is greater than the $1,199 Premium).

6. Continuing eligibility in July: At the end of the April/June work/eligibility period, the individual's Dollar Bank balance is $701 ($550 + $1,350 - $1,199). This balance carries over to the next period, in which the individual has an additional $600 dollars worked. $1,301 ($701 + $600) is greater than the $1,199 Premium, so the individual remains eligible for July.

7. Short dollar payment for August eligibility: At the end of the May/July work/eligibility period, the individual's Dollar Bank balance is $102 ($1,301 - $1,199).[32] This balance carries over to the next period, in which the individual has $0 additional dollars worked. Because the balance for the June/August work/eligibility period is less than the $1,199 Premium, the individual's eligibility terminates. However, the Dollar Bank balance is greater than $0. As such, the individual has the option to make a short dollar payment

[31] Balance as of the last day of the month.
[32] You will receive a Short Dollars Premium Invoice from the Fund Office.

equal to the difference between the Premium and the Dollar Bank balance. The individual pays $1,097 ($1,199 - $102) and reinstates eligibility.

8. Continuing eligibility in September: At the end of the June/August work/eligibility period, the individual's Dollar Bank balance is $0 ($102 + $1,097 - $1,199). This balance carries over to the next period, in which the individual has an additional $1,300 dollars worked. $1,300 ($0 + $1,300) is greater than the $1,199 Premium, so the individual remains eligible for September.

9. Eligibility terminates at the beginning of October: At the end of the July/September work/eligibility period, the individual's Dollar Bank balance is $101 ($1,300 - $1,199). This balance carries over to the next period, in which the individual has $0 additional dollars worked. Because the balance for the August/October work/eligibility period is less than the $1,199 Premium, the individual's eligibility terminates at the beginning of the first day of October. However, the Dollar Bank balance is greater than $0. As such, the individual has the option to make a short dollar payment equal to the difference between the Premium and the Dollar Bank balance. The individual could pay $1,098 ($1,199 - $101) to reinstate eligibility, but does not. Consequently, the individual's eligibility is not reinstated. Because eligibility terminated and was not reinstated, the individual's remaining Dollar Bank balance ($101) is forfeited.

B. **Notice of Privacy 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.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
- Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.
- Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

We typically use or share your health information in the following ways.

- Help manage the health care treatment you receive: We can use your health information and share it with professionals who are treating you. Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

- Run our organization: We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. Example: We use health information about you to develop better services for you.

- Pay for your health services: We can use and disclose your health information as we pay for your health services. Example: We share information about you with your dental plan to coordinate payment for your dental work.

- Administer your plan: We may disclose your health information to your health plan sponsor for plan administration. Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- We can share health information about you for certain situations such as: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety; doing research.

- Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director: We can share health information about you with organ procurement organizations and we can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests: we can use or share health information about you: for workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; for special government functions such as military, national security, and presidential protective services.
- Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Questions, Language Services

For answers to your questions or for a copy of this notice in another language, contact the Fund Office at 800-515-2818 or 651-645-4540.