Pipe Trades Services MN Welfare Fund

Benefits Booklet For Journeymen, Apprentices, and their Dependents

Plan Codes: 100; 101; 103; 105; 150; and 402

Effective August 1, 2017

This Benefits Booklet applies to Journeymen, Apprentices, certain non-bargaining unit employees and their Dependents. If you are a helper, a pre-apprentice, a support worker, a pre-Medicare Retiree, or a Medicare eligible Retiree, contact the Fund Office for the appropriate Benefits Booklet.
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. Within this Booklet, each type of benefit is divided into its own Plan or Program. For example, your dental benefit is now separately described with its own Plan Document and Summary Plan Description, which can be found in the table of contents.

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

<table>
<thead>
<tr>
<th>For information about:</th>
<th>Contact:</th>
<th>At:</th>
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</thead>
<tbody>
<tr>
<td>• Eligibility</td>
<td>Fund Office</td>
<td>800-515-2818 or 651-645-4540</td>
</tr>
<tr>
<td>• Weekly Injury and Illness Disability Benefits</td>
<td></td>
<td><a href="http://www.ptsmn.org">www.ptsmn.org</a></td>
</tr>
<tr>
<td>• Accidental Death and Dismemberment Benefits</td>
<td></td>
<td><a href="http://www.ptsmn.org">www.ptsmn.org</a></td>
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<tr>
<td>• Death Benefits</td>
<td></td>
<td>Submit appeals to:</td>
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<tr>
<td>• Jury Duty Benefits</td>
<td></td>
<td>Pipe Trades Services MN</td>
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<tr>
<td>• Bereavement Benefits</td>
<td></td>
<td>Welfare Fund</td>
</tr>
<tr>
<td>• Claims and appeals regarding the above</td>
<td></td>
<td>4461 White Bear Parkway,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suite 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>White Bear Lake, MN 55110</td>
</tr>
<tr>
<td>• Wellness Centers</td>
<td>Pipe Trades</td>
<td>651-348-8851 (all locations)</td>
</tr>
<tr>
<td></td>
<td>Services MN</td>
<td><a href="http://www.ptsmnhealth.org">www.ptsmnhealth.org</a></td>
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<td>Family Health &amp;</td>
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<td></td>
<td>Wellness Centers</td>
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<tr>
<td>• Medical benefit questions</td>
<td>HealthPartners</td>
<td>Member Services</td>
</tr>
<tr>
<td>• Medical Claims questions</td>
<td></td>
<td>877-822-6706 or 952-967-7080</td>
</tr>
<tr>
<td>• Finding an In-Network Healthcare Provider</td>
<td></td>
<td><a href="http://www.healthpartners.com">www.healthpartners.com</a></td>
</tr>
<tr>
<td>• Medical coverage criteria</td>
<td></td>
<td><a href="http://www.healthpartners.com/public/coverage-criteria/">www.healthpartners.com/public/coverage-criteria/</a></td>
</tr>
<tr>
<td>• Medical benefit claims/appeals</td>
<td></td>
<td>Submit medical benefit Appeals to:</td>
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<tr>
<td></td>
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<td>HealthPartners Appeals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 1309</td>
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<td></td>
<td></td>
<td>Minneapolis, MN  55440-1309</td>
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<tr>
<td></td>
<td></td>
<td>Also see:</td>
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<thead>
<tr>
<th>For information about:</th>
<th>Contact:</th>
<th>At:</th>
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<tbody>
<tr>
<td>• Prescription drug benefit questions</td>
<td>Fund Office</td>
<td>800-515-2818 or 651-645-4540</td>
</tr>
<tr>
<td>• Locating a Network Pharmacy</td>
<td></td>
<td><a href="http://www.ptsmn.org/Pharmacy.html">www.ptsmn.org/Pharmacy.html</a></td>
</tr>
<tr>
<td>• Prescription drug claims and appeals</td>
<td></td>
<td>Submit claims/appeals to: Pipe Trades Services MN Welfare Fund 4461 White Bear Parkway, Suite 1 White Bear Lake, MN 55110</td>
</tr>
<tr>
<td>• Obtaining specialty drugs</td>
<td>Diplomat Specialty Pharmacy</td>
<td>877-977-9118</td>
</tr>
<tr>
<td>• Finding a dentist</td>
<td>Delta Dental</td>
<td>800-448-3815 or 651-406-5901</td>
</tr>
<tr>
<td>• Dental claims and appeals</td>
<td></td>
<td><a href="http://www.deltadental.org">www.deltadental.org</a></td>
</tr>
<tr>
<td>• Vision Services</td>
<td>Vision Service Plan (VSP)</td>
<td>800-877-7195</td>
</tr>
<tr>
<td>• Vision claims</td>
<td></td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td>• Vision appeals (filed with the Fund Office)</td>
<td></td>
<td>Submit claims to: VSP Attn: Out-of-Network Claims P.O. Box 385018 Birmingham, AL 35238 (must use ID# with 0000 preceding it)</td>
</tr>
<tr>
<td>For information about:</td>
<td>Contact:</td>
<td>At:</td>
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<tr>
<td>Employee Assistance Program</td>
<td>T.E.A.M</td>
<td>800-634-7710 or 651-642-0182</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.team-mn.org">www.team-mn.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>After Hours Crisis Line: 651-642-0182</td>
</tr>
<tr>
<td>CVS Minute Clinic</td>
<td>CVS MinuteClinic</td>
<td>866-389-ASAP (2727)</td>
</tr>
<tr>
<td>Claims and appeals</td>
<td></td>
<td>(located in select CVS/pharmacy stores)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Submit to HealthPartners</td>
</tr>
<tr>
<td>Online Clinic</td>
<td>Virtuwell</td>
<td><a href="http://www.virtuwell.com">www.virtuwell.com</a></td>
</tr>
<tr>
<td>Claims and appeals</td>
<td></td>
<td>Submit to HealthPartners</td>
</tr>
</tbody>
</table>
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
- When you gain or lose a Dependent
- 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.
• Have your vision supplies and services provided through the contracted network vision specialist. The Fund has contracted with VSP to provide you access to your vision benefits. The Health & Wellness Center in White Bear Lake also offers you a full service VSP clinic.
• Have your dental needs provided by the contracted network specialist – the Fund has contracted with Delta Dental to help you obtain discounted dental services.
• 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**

**Maximum Out-of-Pocket:** $2,000/individual; $6,000/family (excludes Deductible)

**Deductible:** See your Annual Deductible Election form

**Annual Limit:** None

<table>
<thead>
<tr>
<th>Type of Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Expenses (this general rule applies to any Covered Expense that is not subject to one of the specific rules below)</td>
<td>10% Coinsurance, Deductible applies</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Examples: hospital, durable medical equipment</td>
<td>10% Coinsurance, Deductible applies</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>10% Coinsurance, Deductible applies</td>
<td>10% Coinsurance, deductible applies</td>
</tr>
<tr>
<td>Urgent care at a hospital</td>
<td>10% Coinsurance, Deductible applies</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Urgent care at an Office</td>
<td>$25 Copayment, Deductible does not apply</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Office Visits (this rule applies to items and services provided during an Office Visit except durable medical equipment)</td>
<td>$25 Copayment, Deductible does not apply</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Laboratory services not in conjunction with hospital or emergency room visit</td>
<td>You pay $0 (0% Coinsurance) Deductible does not apply</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Laboratory Services in conjunction with a hospital or emergency room visit</td>
<td>10% Coinsurance, Deductible Applies</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Diagnostic imaging in conjunction with an Office Visit</td>
<td>You pay $0 (0% Coinsurance) Deductible does not apply</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Service</td>
<td>Coinsurance/Deductible</td>
<td>Coinsurance/Deductible</td>
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<td>----------------------------------------------</td>
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<tr>
<td>Diagnostic imaging in conjunction with a non-Office Visit</td>
<td>10% Coinsurance, Deductible Applies</td>
<td>20% Coinsurance, Deductible applies For emergency services, 10% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>You pay $0 (0% Coinsurance), Deductible does not apply</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>20% Coinsurance, Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td>Treatment at Pipe Trades Services MN Health &amp; Wellness Centers</td>
<td>You pay $0 (0% Coinsurance), Deductible does not apply</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Treatment at CVS Minute Clinics</td>
<td>You pay $0 (0% Coinsurance), Deductible does not apply</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Treatment via virtuwell (online clinic)</td>
<td>You pay $0 (0% Coinsurance), Deductible does not apply</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>20% Coinsurance up to Annual Limit of $1,100, Deductible applies</td>
<td>20% Coinsurance up to Annual Limit of $1,100, Deductible applies</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>20% Coinsurance up to Annual Limit of $300, Deductible applies</td>
<td>20% Coinsurance up to Annual Limit of $300, Deductible applies</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>10% Coinsurance up to $2,000 limit every 4 years, Deductible applies</td>
<td>20% Coinsurance up to $2,000 limit every 4 years, Deductible applies</td>
</tr>
<tr>
<td>Type of Benefit</td>
<td>In-Network or Out-of-Network^1</td>
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<td>---------------------------------------</td>
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</tr>
<tr>
<td>Preventive Dental Care</td>
<td>You pay $0 (0% Coinsurance)</td>
<td></td>
</tr>
<tr>
<td>Basic Dental Care</td>
<td>You pay $0 (0% Coinsurance)</td>
<td></td>
</tr>
<tr>
<td>Endodontics</td>
<td>40% Coinsurance</td>
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</tr>
<tr>
<td>Periodontics</td>
<td>40% Coinsurance</td>
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</tr>
<tr>
<td>Oral Surgery</td>
<td>40% Coinsurance</td>
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</tr>
<tr>
<td>Major Restorative Dental Care</td>
<td>20% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Prosthetic Repairs and Adjustment</td>
<td>40% Coinsurance</td>
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</tr>
<tr>
<td>Prosthetics</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Orthodontia (Subject to $2,000/individual Lifetime Limit)</td>
<td>You pay $0 (0% Coinsurance)</td>
<td></td>
</tr>
</tbody>
</table>

^1 For Out-of-Network Providers, the PPO will only pay 60% of the allowed amount. You are responsible for 40% of the allowed amount plus any additional charges.
### Pipe Trades Services MN Vision Plan

<table>
<thead>
<tr>
<th>Type of Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye Exam</strong></td>
<td>You pay $0 (0% Coinsurance) (limit one per calendar year)</td>
<td>0% Coinsurance up to Annual Limit of $250, then 100% Coinsurance (Annual limit applies to all vision benefits)</td>
</tr>
<tr>
<td><strong>Frames or Contact Lenses</strong></td>
<td>You pay $0 for frames or contact lenses up to $175, you pay 100% of the cost above $175 $95 frame allowance at Costco Limit one per year</td>
<td>0% Coinsurance up to Annual Limit of $250, then 100% Coinsurance (Annual limit applies to all vision benefits)</td>
</tr>
<tr>
<td><strong>Lenses (single, bifocal, trifocal, lenticular, blended, polycarbonate and progressive)</strong></td>
<td>You pay $0 (0% Coinsurance), limit one pair of lenses per year</td>
<td>0% Coinsurance up to Annual Limit of $250, then 100% Coinsurance (Annual limit applies to all vision benefits)</td>
</tr>
<tr>
<td><strong>Safety Lenses (if your work requires safety eyewear)</strong></td>
<td>You pay $0 (0% Coinsurance), limit one pair of lenses per year</td>
<td>No benefit available</td>
</tr>
</tbody>
</table>

### 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.
### Pipe Trades Services MN Employee Assistance Program

Professional, confidential counseling is available to you and your Dependents at no cost. Counselors are available to discuss common issues such as chemical dependence, depression, and financial issues.

### Pipe Trades Services MN Weekly Injury And Illness Disability Program

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

### Pipe Trades Services MN Death Benefits Program

If you die, your Beneficiary will be paid $7,000. Your Dependents cannot participate in this Program.

### Pipe Trades Services MN Accidental Death and Dismemberment Program

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

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

Your Dependents cannot participate in this Program.

### Pipe Trades Services MN Jury Duty Program

If you are unable to work due to jury duty, you will receive $90 per day and your Dollar Bank will be credited with an amount equal to 8 hours of work per day. Benefits cease when you return to work. Your Dependents cannot participate in this program and you cannot Participate in this Program when you are on Extended Coverage.

### Pipe Trades Services Bereavement Pay Program

In the event of the death of a qualifying family member, you will receive $300. Your Dependents cannot participate in this Program.
8. ELIGIBILITY AND BENEFITS

A. Journeymen and Apprentices Only

This Benefits Booklet applies only to Journeymen, Apprentices, and their Dependents.\(^2\) If you are a helper or pre-apprentice, support worker, 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 Journeyman or an 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, your Dependents) become a participant in the following (each of which is described later in this Benefits Booklet):

1. Pipe Trades Services MN Health Plan;
2. Pipe Trades Services MN Dental Plan;
3. Pipe Trades Services MN Vision Plan;
4. Pipe Trades Services MN Health Club Reimbursement Program;
5. Pipe Trades Services MN Employee Assistance Program;
6. Pipe Trades Services MN Weekly Injury and Illness Disability Program (no Dependent participation);
7. Pipe Trades Services MN Death Benefits Program (no Dependent participation);
8. Pipe Trades Services MN Accidental Death and Dismemberment Program (no Dependent participation);
9. Pipe Trades Services MN Jury Duty Program (no Dependent participation); and,
10. Pipe Trades Services MN Bereavement Pay Program (no Dependent participation).

C. Journeyman and 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 Journeyman or Apprentice that causes the balance of your Dollar Bank to equal or exceed the Fund’s Premium. This eligibility rule

\(^2\) Certain non-bargaining unit employees and bargaining unit alumni are also covered by this booklet pursuant to participation agreements. Those agreements contain terms which supplement this booklet with regard to your qualifications to participate. To the extent your benefits differ from the Journeymen and Apprentices, it will be specifically noted in the booklet.
applies regardless of whether you were eligible for benefits from the Fund under another Benefits Booklet when you became a Journeyman or Apprentice.\(^3\) When you become eligible as a Journeyman or Apprentice, you immediately cease to be eligible for benefits from the Fund under any other Booklet. 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\(^4\);
2. The day you become eligible for benefits from the Fund in any capacity other than as a Journeyman or Apprentice;
3. The day you enter active military service (subject to the provisions of USERRA);
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**

Your Dependents first become eligible for benefits on the same day that you first become eligible. If a person becomes your Dependent while you are eligible (by birth, marriage, adoption, or otherwise), that person becomes eligible on the day he or she becomes your Dependent 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,

\(^3\) For instance, if you are eligible for benefits from the Fund as a helper and you become an Apprentice, you become eligible under this Booklet on the first day of the month following the month in which the balance of your Dollar Bank equals or exceeds the Fund’s monthly Premium (for eligibility as an Apprentice, as opposed to the Premium for eligibility as a Helper). During the period in which you are working as an Apprentice but have not met the conditions for eligibility under this Booklet, the Fund will continue administering your eligibility under the Booklet for helpers and pre-apprentices.

\(^4\) 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](http://www.ptsmn.org). Go to the members page and click on the Eligibility Information tab.
your Dependents remain eligible until their eligibility is terminated. 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.6

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

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 Supplemental Hour Reserve”. You qualify for extended coverage if7:

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.

5 Dependent eligibility may be waived by submitting a satisfactory waiver form to the Fund Office. Contact the Fund Office for the proper form.
6 This extension applies to your Spouse and your Children, but not Children only.
7 Non-bargaining unit employees and bargaining unit alumni are not eligible for this benefit.
If your eligibility is based upon extended coverage, you are not eligible for the Pipe Trades Services MN Weekly Injury and Illness Program, the Pipe Trades Services MN Jury Duty Program or the Pipe Trades Services MN Bereavement Program.

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:

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 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.

8 Non-bargaining unit employees are not eligible for this benefit. Bargaining unit alumni are eligible for this benefit.
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.

J. Retiree Benefits

This Benefits Booklet addresses only the Fund’s benefits for Journeymen, Apprentices, and their Dependents. When you retire, however, the Fund may provide you certain health and welfare benefits. The following is a very brief explanation of the benefits available to Retirees as of the effective date of this Booklet:

- Coverage under the Pipe Trades Services MN Health Plan (the same Plan that covers Journeymen and Apprentices) is available to Retirees who meet the eligibility criteria and pay the Premium.

- The Premium for Retiree coverage may be paid out-of-pocket or, if a Retiree has a positive remaining balance in the Dollar Bank as of the date of retirement, out of the remaining balance.

- For those who qualify, the Premium for Retiree coverage is reduced by a contribution allowance from the Pipe Trades Services MN Retiree Health Trust. The contribution allowance varies depending on the Retiree’s years of service. For a Retiree with 30 years of service⁹, the contribution allowance reduces the Premium by approximately 67%. Retirees with fewer years of service receive a proportionally smaller contribution allowance. For instance, the contribution allowance for a Retiree with 15 years of service reduces the Premium by approximately 33% (1/2 of 67%).

- The available Retiree coverage changes when a Retiree becomes Medicare eligible.

No benefits provided by the Fund (or the Pipe Trades Services MN Retiree Health Trust) are vested. The benefits described above may be changed or eliminated at any time. For more information on how to qualify for Retiree benefits, contact the Fund Office.

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⁹ Years in excess of 30 years of service are disregarded.
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 Expenses¹⁰ 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.¹¹ 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.¹² 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

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¹⁰ 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.

¹¹ 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.

¹² This rule applies separately to each individual in your Family.
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.

Upon initial eligibility and then annually, you may choose the amount of your Deductible by submitting your Annual Deductible Election form to the Fund Office. The lower your Deductible, the higher your monthly Premium will be. At initial eligibility, if you do not submit an Annual Deductible Election form, you will be deemed to have elected a Deductible of $750/individual and $2,250/family. After initial eligibility, if you fail to return your Annual Deductible Election form, you will be deemed to have elected your prior year’s Deductible level.

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.

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. The Maximum Out-Of-Pocket is $2,000/individual and $6,000/Family. 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. 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.

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13 Members who are covered under a residential Collective Bargaining Agreement do not have the option to elect a Deductible. The Deductible Election Form will indicate what options are available to you.

14 Some items and services that are covered In-Network are not covered Out-Of-Network.
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. It is even possible for a single service event to result in both In-Network and Out-Of-Network charges. This general rule, however, does not apply to Office Visits or treatment at Pipe Trades Services MN Wellness Centers.

7. Payment Schedule

<table>
<thead>
<tr>
<th>Pipe Trades Services MN Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Out-of-Pocket: $2,000/individual; $6,000/family (excludes Deductible)</td>
</tr>
<tr>
<td>Deductible: See your Annual Deductible Election form¹⁸</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Expenses (this general rule applies to any Covered Expense that is not subject to one of the specific rules below)</td>
<td>10% Coinsurance, Deductible applies</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Examples: hospital, durable medical equipment</td>
<td>10% Coinsurance, Deductible applies</td>
<td>10% Coinsurance, deductible applies</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>10% Coinsurance, Deductible applies</td>
<td>10% Coinsurance, deductible applies</td>
</tr>
<tr>
<td>Urgent care at a hospital</td>
<td>10% Coinsurance, Deductible applies</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Urgent care at an Office</td>
<td>$25 Copayment, Deductible does not apply</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
</tbody>
</table>

¹⁵ For instance, some charges from a service event may be Preventive Care with the remainder being subject to the general rule for Covered Expenses.
¹⁶ For example, an In-Network provider may order laboratory or radiology services from an Out-Of-Network provider.
¹⁷ Except that charges for durable medical equipment billed with an Office Visit are treated as separate charges.
¹⁸ Members who are covered under a residential Collective Bargaining Agreement do not have the option to elect a Deductible. They will receive notice of their Deductible upon initial eligibility or when the Deductible changes.
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Payment Details</th>
<th>Coinsurance Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits (this rule applies to items and services provided during an Office Visit except durable medical equipment)</td>
<td>$25 Copayment, Deductible does not apply</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Laboratory services (not in conjunction with hospital or emergency room visit)</td>
<td>You pay $0 (0% Coinsurance) Deductible does not apply</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Laboratory Services in conjunction with a hospital or emergency room visit</td>
<td>10% Coinsurance, Deductible Applies</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>For emergency services, 10% Coinsurance, Deductible applies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic imaging in conjunction with an Office Visit</td>
<td>You pay $0 (0% Coinsurance) Deductible does not apply</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Diagnostic imaging in conjunction with a non-Office Visit</td>
<td>10% Coinsurance, Deductible Applies</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>For emergency services, 10% Coinsurance, Deductible applies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>You pay $0 (0% Coinsurance), Deductible does not apply</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>20% Coinsurance, Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td>Treatment at Pipe Trades Services MN Health &amp; Wellness Centers</td>
<td>You pay $0 (0% Coinsurance), Deductible does not apply</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Treatment at CVS Minute Clinics</td>
<td>You pay $0 (0% Coinsurance), Deductible does not apply</td>
<td>20% Coinsurance, Deductible applies</td>
</tr>
<tr>
<td>Treatment via virtuwell (online clinic)</td>
<td>You pay $0 (0% Coinsurance), Deductible does not apply</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>20% Coinsurance up to Annual Limit of $1,100, Deductible applies</td>
<td>20% Coinsurance up to Annual Limit of $1,100, Deductible applies</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>20% Coinsurance up to Annual Limit of $300, Deductible applies</td>
<td>20% Coinsurance up to Annual Limit of $300, Deductible applies</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>10% Coinsurance up to $2,000 limit every 4 years, Deductible applies</td>
<td>20% Coinsurance up to $2,000 limit every 4 years, Deductible applies</td>
</tr>
</tbody>
</table>
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.\textsuperscript{19}

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.

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.

\textsuperscript{19} 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.
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 (zanamivir)), 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).


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

This Plan provides certain benefits for dental care. In general, the terms of this Plan are as described in the following Delta Dental PPO Plus Premier - Comprehensive Enhanced Dental Benefits With Orthodontic Coverage Dental Benefit Plan Summary. Notwithstanding anything to the contrary:

A. Except if you decline to participate, you become a Participant in the Pipe Trades Services MN Dental 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 unless you extend your participation under COBRA.

B. You may decline to participate in this Plan at any time by notifying the Fund Office in writing. Declining to participate will have no effect on your Premium for eligibility for benefits from the Fund. 20

C. 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. To the extent that such provisions differ from provisions of the Delta Dental PPO Plus Premier - Comprehensive Enhanced Dental Benefits With Orthodontic Coverage Dental Benefit Plan Summary, the Uniform Terms For Plans And Programs Maintained By The Pipe Trades Services MN Welfare Fund control.

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20 The Pipe Trades Services MN Dental Plan provides only “excepted benefits” as described in 29 U.S.C. § 1191a.
DELTA DENTAL PPO PLUS PREMIER - COMPREHENSIVE ENHANCED Dental Benefits with Orthodontic Coverage

Dental Benefit Plan Summary

Pipe Trades Services MN Welfare Fund
Group Number 50865
Pipe Trades Services MN
Welfare Plan
Dental Benefits
For Plumbers and Pipefitters
in the following
United Association Local Unions

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

Welfare Fund Office
Pipe Trades Services MN Welfare Fund
700 Transfer Road
St. Paul MN 55114 -1420

Telephone: (651) 645-4540
Fax: (651) 645-8119
Web site: www.ptsmn.org

Toll Free: 1(800) 515-2818
e-mail: questions@ptsmnpt.org
The Trustees of this Plan are:

**Employer Trustees**

Doug Jones  
Schulties Plumbing  
1521 94th Ln NE,  
Minneapolis, MN 55449

Kristen Olson  
Major Mechanical  
11201 86th Ave N,  
Maple Grove, MN 55369

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

Gary Thaden  
MMCA  
830 Transfer Rd  
St. Paul, MN 55114

**Union Trustees**

Scott Gale  
Plumbers Local No. 15  
708 S 10th St  
Minneapolis, MN  55404

Jeff Huberty  
Plumbers Local No. 34  
411 Main St  
St. Paul MN  55102

Tom Vail  
Pipefitters Local No. 455  
700 Transfer Rd  
St. Paul, MN 55114

Paul Batsche  
Pipefitters Local No. 539  
312 Central Ave Rm. 408  
Minneapolis, MN 55414

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**IMPORTANT INFORMATION ABOUT THE WELFARE PLAN**

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

1. **Name of Plan.** This Plan is known as the Pipe Trades Services MN Welfare Plan.

2. **Board of Trustees.** A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Association and Union representatives, selected by the Associations and Local Unions who have entered into working agreements which relate to this Plan. These working agreements are described in Item 6, which follows. If you wish to contact the Board of Trustees, you may use the address and telephone number below:

3. **Plan Sponsor and Administrator.** The Board of Trustees is both the Plan Sponsor and Plan Administrator.

4. **Identification Numbers.** The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 41-0761972.

5. **Agent for Service of Legal Process.** The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees at the Welfare Fund Office or upon any individual Trustee. Note that arbitration is available instead of a court action.
ADMINISTRATION

The following information is provided as required by the Employee Retirement Income Security Act (ERISA) of 1974.

PLAN SPONSOR, FIDUCIARY AND ADMINISTRATOR:
Pipe Trades Services MN Welfare Fund
700 Tranfer Road
St. Paul, MN  55114
Telephone:  (651) 645-4540

AGENT FOR SERVICE OF LEGAL PROCESS:
Pipe Trades Services MN Welfare Fund
700 Tranfer Road
St. Paul, MN  55114
Telephone:  (651) 645-4540

FUNDING: This Plan is self-funded. Your contribution towards the cost of the coverage under the Plan will be determined by the Pipe Trades Services MN Welfare Plan each year and communicated to you prior to the effective date of any changes in the cost of the coverage.

Welfare Fund IDENTIFICATION NUMBER:  41-0761972
Welfare Fund PLAN NUMBER:  501
DELTA GROUP NUMBER:  50865

PLAN BENEFITS ADMINISTERED BY:
Delta Dental of Minnesota
National Dedicated Service Center
P.O. Box 59238
Minneapolis, Minnesota  55459
(651) 406-5901 or (800) 448-3815
www.deltadentalmn.org

Please Contact Delta Dental

If you have questions regarding your coverage or payment of your claims, etc.

PLAN BENEFITS ADMINISTERED BY:
Delta Dental of Minnesota
National Dedicated Service Center
P.O. Box 59238
Minneapolis, Minnesota  55459
(651) 406-5901 or (800) 448-3815
www.deltadentalmn.org
DENTAL BENEFIT PLAN SUMMARY

This is a Summary of your Group Dental Program (PROGRAM) prepared for Covered Persons with:

Pipe Trades Services MN Welfare Fund (GROUP)

This Program has been established and is maintained and administered in accordance with the provisions of your Group Dental Plan Contract Number 50865 issued by Delta Dental of Minnesota (PLAN).

IMPORTANT

This booklet is subject to the provisions of the Group Dental Agreement and cannot modify this agreement in any way; nor shall you accrue any rights because of any statement in or omission from this booklet.

DELTA DENTAL OF MINNESOTA

Administrative Offices
Delta Dental of Minnesota
National Dedicated Service Center
P.O. Box 59238
Minneapolis, Minnesota 55459
(651) 406-5901 or (800) 448-3815
www.deltadentalmn.org
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SUMMARY OF DENTAL BENEFITS

Your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta is different for Delta Dental PPO dentists, participating dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase. If a Delta Dental PPO dentist provides dental services, the payment percentages may increase, resulting in lower out-of-pocket costs.

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta Dental PPO</th>
<th>Delta Dental Premier</th>
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<tr>
<td>Diagnostic and Preventive Service</td>
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<tr>
<td>Basic Service</td>
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<tr>
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<tr>
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<td>Major Restorative Services</td>
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<tr>
<td>Prosthetic Repairs and Adjustments</td>
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<tr>
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<td>60%</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Benefit Maximums**

The Program pays up to a maximum of $2,500.00 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

Exclusion – The benefit maximum does not apply to Diagnostic & Preventive services, for eligible dependent children up to age 18.

Orthodontics is subject to a separate lifetime maximum of $2,000.00 per Covered Person.

**Deductible**

There is no deductible applicable under this Plan.

**Coverage Year**

A Coverage Year is a 12-month period in which benefit maximums apply. Your Coverage Year is January 1 to December 31.
DESCRIPTION OF COVERED PROCEDURES

Pretreatment Estimate
(Estimate of Benefits)

IT IS RECOMMENDED THAT A PRETREATMENT ESTIMATE BE SUBMITTED TO THE PLAN PRIOR TO TREATMENT IF YOUR DENTAL TREATMENT INVOLVES MAJOR RESTORATIVE, PERIODONTICS, PROSTHETICS OR ORTHODONTIC CARE (SEE DESCRIPTION OF COVERAGES), TO ESTIMATE THE AMOUNT OF PAYMENT. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND THE PATIENT. SUBMISSION OF A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND THE PATIENT TO KNOW WHAT BENEFITS ARE AVAILABLE TO THE PATIENT BEFORE BEGINNING TREATMENT. THE PRETREATMENT ESTIMATE WILL OUTLINE THE PATIENT’S RESPONSIBILITY TO THE DENTIST WITH REGARD TO CO-PAYMENTS, DEDUCTIBLES AND NON-COVERED SERVICES AND ALLOWS THE DENTIST AND THE PATIENT TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE TREATMENT BEGINS. THIS PROCESS DOES NOT PRIOR AUTHORIZATE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED DELTA DENTAL PAYMENT IS BASED ON THE PATIENT’S CURRENT ELIGIBILITY AND CURRENT AVAILABLE CONTRACT BENEFITS. THE SUBSEQUENT SUBMISSION OF OTHER CLAIMS, A CHANGE IN ELIGIBILITY, A CHANGE IN THE CONTRACT COVERAGE OR THE EXISTENCE OF OTHER COVERAGE MAY ALTER THE DELTA DENTAL FINAL PAYMENT AMOUNT AS SHOWN ON THE PRETREATMENT ESTIMATE FORM.

After the examination, your dentist will establish the dental treatment to be performed. If the dental treatment necessary involves major restorative, periodontics, prosthetics or orthodontic care, a participating dentist should submit a claim form to the Plan outlining the proposed treatment.

A Pretreatment Estimate of Benefits statement will be sent to you and your dentist. You will be responsible for payment of any deductibles and coinsurance amounts or any dental treatment that is not considered a covered service under the Plan.

Benefits

The Program covers the following dental procedures when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Program shall be provided whether the dental procedures are performed by a duly licensed physician or a duly licensed dentist, if otherwise covered under this Program, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist’s care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, the Plan may require that a Covered Person be examined by a dental consultant retained by the Plan in or near the Covered Person’s place of residence. The Plan shall hold such information and records confidential.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR DELTA DENTAL PPO AND DELTA DENTAL PREMIER NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Delta Dental of Minnesota does not determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Delta Dental of Minnesota evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Other dental services may be recommended or prescribed by your dentist, which are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by the Plan. While
these services may be prescribed by your dentist and are dentally necessary for you, they may not be a dental service that is benefited by this Plan or they may be a service where the Plan provides a payment allowance for a service that is considered to be optional treatment. If the Plan gives you a payment allowance for optional treatment that is covered by the plan, you may apply this Plan payment to the service prescribed by your dentist which you elected to receive. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. Determination of services necessary to meet your individual dental needs is between you and your dentist.

ONLY those services listed are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of covered services, please see the “Pretreatment Estimate” section of this booklet.

PREVENTIVE CARE
(Diagnostic & Preventive Services)

Oral Evaluations - Covered 2 times per calendar year period.

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per calendar year period limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 2 times per calendar year period.

Comprehensive Periodontal Evaluation - Covered 2 times per calendar year period.

Radiographs (X-rays)
- Bitewings - Covered at 2 series of bitewings per calendar year period.
- Full Mouth (Complete Series) or Panoramic - Covered 1 time per 36-month period.
- Periapical(s) - Single X-rays.
- Occlusal
- Extraoral

Dental Cleaning
- Prophylaxis - Covered 2 times per calendar year period.

Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

NOTE: A prophylaxis performed on a Covered Person under the age of 14 will be benefited as a child prophylaxis. A prophylaxis performed on a Covered Person age 14 or older will be benefited as an adult prophylaxis.

- Periodontal Maintenance - Covered 2 times per calendar year period.

Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Fluoride Treatment - Topical application of fluoride.
Space Maintainers

Sealants or Preventive Resin Restorations

Pulp Vitality Test

Diagnostic Cast

EXCLUSIONS - Coverage is NOT provided for:
1. Oral Hygiene Instructions.
2. Accession of tissue - Please submit to your Medical Plan.

BASIC SERVICES

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations
   ➢ Anterior (front) Teeth - Treatment to restore decayed or fractured permanent or primary anterior teeth.
   ➢ Posterior (back) Teeth - This service is not covered under Basic Services. Refer to the Complex or Major Restorative Services section of your benefits.

Other Basic Services
• Restorative cast post and core build-up, including pins and posts - See benefit coverage description under Complex or Major Restorative Services.
• Crown pin retention - Per tooth in addition to restoration.
• Pre-fabricated or Stainless Steel Crown
• Composite Resin Crown - Full resin-based composite coverage of tooth.
• Sedative Fillings
• Office visits and consultations
• Therapeutic drug injections
• Treatment of complications (post surgical)

Adjunctive General Services
• Intravenous Conscious Sedation, Non-Intravenous Conscious Sedation, Anagesia, Anxiolysis Nitrous Oxide, and IV Sedation - Covered when performed in conjunction with covered services.

EXCLUSIONS - Coverage is NOT provided for:
1. Deep sedation/general anesthesia, analgesia, analgesic agents, medicines, or drugs for non-surgical or surgical dental care, when done alone or in conjunction with a non-covered service.
2. Case presentation
3. Athletic mouthguard, enamel microabrasion, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents, tooth bonding and veneers.

5. Amalgam or composite restorations placed for preventive or cosmetic purposes.

**BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)**

Endodontic Therapy on Primary Teeth
- Pulpal Therapy
- Therapeutic Pulpotomy

Endodontic Therapy on Permanent Teeth
- Root Canal Therapy

Complex or other Endodontic Services
- Apexification
- Retrograde filling

**EXCLUSIONS - Coverage is NOT provided for:**

1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.
5. Apicoectomy/Periradicular Services - Please submit to your Medical Plan.
6. Root Amputation - Please submit to your Medical Plan.
7. Hemisection, includes root removal - Please submit to your Medical Plan.
8. Surgical procedure for isolation of tooth with rubber dam - Please submit to your Medical Plan.

**PERIODONTICS (GUM & BONE TREATMENT)**

Basic Non Surgical Periodontal Care - Treatment for diseases for the gingival (gums) and bone supporting the teeth.
- Periodontal scaling & root planning
- Full mouth debridement - Covered 1 time per lifetime.

Intravenous Conscious Sedation, Non-Intravenous Conscious Sedation, Anagesia, Anxiolysis Nitrous Oxide, and IV Sedation - Covered when performed in conjunction with covered services.

**EXCLUSIONS - Coverage is NOT provided for:**

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of biologic materials used to aid in soft tissue and osseous tissue regeneration - Please submit to your Medical Plan.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
6. Deep sedation/general anesthesia, analgesia, analgesic agents, medicines, or drugs for non-surgical or surgical periodontal care, when done alone or in conjunction with a non-covered service.
7. Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth - Please submit to your Medical Plan.
8. Bone replacement graft - Please submit to your Medical Plan.
9. Guided tissue regeneration - Please submit to your Medical Plan.
10. Soft tissue allograft - Please submit to your Medical Plan.

**ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)**

**Basic Extractions**
- Removal of Coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

**Complex Surgical Extractions**
- Surgical removal of erupted tooth

**EXCLUSIONS - Coverage is NOT provided for:**
1. Intravenous conscious sedation and IV sedation when performed alone or in conjunction with a non-covered service.
2. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital - Please submit to your Medical Plan.
3. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
4. Surgical exposure of impacted or unerupted tooth for orthodontic reasons - Please submit to your Medical Plan.
5. Surgical repositioning of teeth - Please submit to your Medical Plan.
6. Inpatient or outpatient hospital expenses - Please submit to your Medical Plan.
7. Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa. - Please submit to your Medical Plan.
8. Surgical removal of impacted tooth - Please submit to your Medical Plan.
10. Oroantral fistula closure - Please submit to your Medical Plan.
11. Tooth reimplantation - accidentally evulsed or displaced tooth - Please submit to your Medical Plan.
12. Sinus Perforation - Please submit to your Medical Plan.
13. Surgical exposure of impacted or unerupted tooth to aid eruption - Please submit to your Medical Plan.
14. Biopsy of oral tissue - Please submit to your Medical Plan.
15. Transseptal fiberotomy - Please submit to your Medical Plan.
16. Alveoloplasty - Please submit to your Medical Plan.
17. Vestibuloplasty - Please submit your Medical Plan.
18. Excision of benign/malignant lesion - Please submit your Medical Plan.
19. Incision & drainage of abscess - Please submit your Medical Plan.
20. Removal or nonodontogenic or odontogenic cyst or tumor - Please submit to your Medical Plan.
22. Radical resection of mandible with bone graft - Please submit to your Medical Plan.
23. Radical excision - Please submit to your Medical Plan.
24. Removal of Torus Palatinus or Torus madibularis - Please submit to your Medical Plan.
25. Removal of foreign body - Please submit to your Medical Plan.
26. Maxillary sinusotomy for removal of tooth fragment or foreign body - Please submit to your Medical Plan.
27. Treatment of Compound fractures - Please submit to your Medical Plan.
28. Temporomandibular Joint Disorder (TMJ) - Please submit to your Medical Plan.
29. Suture of small wounds - Please submit to your Medical Plan.
30. Complicated sutures - Please submit to your Medical Plan.
31. Repair of maxillofacial soft and hard tissue defect - Please submit to your Medical Plan.
32. Frenulectomy (frenectomy or frenotomy) - Please submit to your Medical Plan.
33. Excision of hyperplastic tissue - Please submit to your Medical Plan.
34. Implant-mandible for augmentation purposes - Please submit to your Medical Plan.
35. Surgical reduction of fibrous tuberosity - Please submit to your Medical Plan.
36. Sislolithotomy - Please submit to your Medical Plan.
37. Excision of salivary gland - Please submit to your Medical Plan.
38. Sialodochoplasty - Please submit to your Medical Plan.
39. Closure of salivary fistula - Please submit to your Medical Plan.
40. Emergency tracheotomy - Please submit to your Medical Plan.
41. Cornoidectomy - Please submit to your Medical Plan.
42. Tooth transplantation - Please submit to your Medical Plan.
43. Surgical access to erupted tooth - Please submit to your Medical Plan.

**Complex or Major Restorative Services**
Services performed to restore lost tooth structure as a result of decay or fracture

**Posterior (back) Teeth Composite (white) Resin Restorations** - If the posterior (back) tooth requires a restoration due to decay or fracture.

**Gold foil restorations**

**Inlays**

**Onlays**

**Permanent Crowns**
Implant Crowns - See Prosthetic Services.

Crown Repair

Restorative cast post and core build-up, including post and pin

Canal prep & fitting of preformed dowel & post

Occlusal guard (Bruxism only)

Occlusal adjustments

EXCLUSIONS - Coverage is NOT provided for:
1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
4. Temporary, provisional or interim crown.
5. Veneers.

PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)

Reline, Rebase, Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s)

Adjustments

Removable Prosthetic Services (Dentures and Partials)

Fixed Prosthetic Services (Bridge)

Fixed Partial Denture Retainers (Inlays, Onlays, Crowns)

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 5-year period for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.

Restorative cast post and core build-up, including pins and posts.

EXCLUSIONS - Coverage is NOT provided for:
1. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
2. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
3. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

4. Services or supplies that have the primary purpose of improving the appearance of your teeth.

5. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

**ORTHODONTICS**

Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

**Limited Treatment**

Treatments which are not full treatment cases and are usually done for minor tooth movement.

**Interceptive Treatment**

A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

**Comprehensive (complete) Treatment**

Full treatment includes all records, appliances and visits.

**Removable Appliance Therapy** - An appliance that is removable and not cemented or bonded to the teeth.

**Fixed Appliance Therapy** - A component that is cemented or bonded to the teeth.

**Repair or replacement of lost/broken/stolen appliances**

**LIMITATION:** Treatment in progress (appliances placed prior to eligibility under this Plan) will be benefited on a pro-rated basis.

**EXCLUSIONS -** Coverage is NOT provided for:

1. Monthly treatment visits that are inclusive of treatment cost.
2. Inpatient or outpatient hospital expenses.
3. Osteoplasty - Please submit to your Medical Plan.
4. LeFort procedures - Please submit to your Medical Plan.
5. Appliance removal (not by dentist who placed appliance), includes removal of archbar - Please submit to your Medical Plan.
6. Tooth transplantation - Please submit to your Medical Plan.
7. Surgical exposure of impacted or unerupted tooth for Orthodontic - Please submit to your Medical Plan.
8. Device placement.

**Orthodontic Payments**

Benefit payments are made when treatment begins (appliances are installed), until the lifetime maximum benefits are exhausted (see Benefit Maximums in this Plan Summary).

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated plan payment amount. This form serves as a claim form when treatment begins.
When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and his/her signature. After benefit and eligibility verification by the Plan, a benefit payment will be issued.

**Exclusions**
Coverage is NOT provided for:

a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.

b) Dental services or health care services not specifically covered under the Group Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature). Please submit to your Medical Plan.

c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.

e) Dental services completed prior to the date the Covered Person became eligible for coverage.

f) Services of anesthesiologists - Please submit to your Medical Plan.

g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

h) Deep sedation/general anesthesia, analgesia, analgesic agents, medicines, or drugs for non-surgical or surgical dental care, when done alone or in conjunction with a non-covered service.

i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

k) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

m) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.

n) Case presentations

o) Incomplete, interim or temporary services.

p) Corrections of congenital conditions during the first 24 months of continuous coverage under this Plan. Please submit to your Medical Plan.

q) Athletic mouth guards, enamel microabrasion and odontoplasty.

r) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
s) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

t) Bacteriologic tests.
u) Cytology sample collection - Please submit to your Medical Plan.
v) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.
w) The replacement of an existing partial denture with a bridge.
x) Veneers.
y) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
z) Provisional splinting, temporary procedures or interim stabilization.
aa) Placement or removal of sedative filling, base or liner used under a restoration.
bb) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital - Please submit to your Medical Plan.
cc) Accession of tissue - Please submit to your Medical Plan.
dd) Apicoectomy/Periradicular Services - Please submit to your Medical Plan.
e) Root Amputation - Please submit to your Medical Plan.
ff) Hemisection, includes root removal - Please submit to your Medical Plan.
gg) Surgical procedure for isolation of tooth with rubber dam - Please submit to your Medical Plan.

hh) Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth - Please submit to your Medical Plan.
i) Bone replacement graft - Please submit to your Medical Plan.
jj) Guided tissue regeneration - Please submit to your Medical Plan.
k) Soft tissue allograft - Please submit to your Medical Plan.
ll) The controlled release of biologic materials used to aid in soft tissue and osseous tissue regeneration - Please submit to your Medical Plan.
m) Therapeutic agent - Please submit to your Medical Plan.
nn) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa - Please submit to your Medical Plan.

oo) Surgical removal of impacted tooth - Please submit to your Medical Plan.
pp) Surgical removal of residual tooth roots - Please submit to your Medical Plan.
qq) Oroantral fistula closure - Please submit to your Medical Plan.
rr) Tooth reimplantation - accidentally evulsed or displaced tooth - Please submit to your Medical Plan.
s) Sinus Perforation - Please submit to your Medical Plan.
tt) Surgical exposure of impacted or unerupted tooth to aid eruption - Please submit to your Medical Plan.
uu) Biopsy of oral tissue - Please submit to your Medical Plan.
vv) Transseptal fiberotomy - Please submit to your Medical Plan.
ww) Alveoloplasty - Please submit to your Medical Plan.
xx) Vestibuloplasty - Please submit your Medical Plan.
yy) Excision of benign/malignant lesion - Please submit your Medical Plan.
zz) Incision & drainage of abscess - Please submit your Medical Plan.
aaa) Surgical repositioning of teeth - Please submit to your Medical Plan.
bbb) Removal or nonodontogenic or odontogenic cyst or tumor - Please submit to your Medical Plan.
ccc) Partial ostectomy/sequestrectomy for removal of non-vital bone - Please submit to your Medical Plan.
ddd) Radical resection of mandible with bone graft - Please submit to your Medical Plan.
eee) Radical excision - Please submit to your Medical Plan.
fff) Removal of Torus Palatinus or Torus madibularis - Please submit to your Medical Plan.
ggg) Removal of foreign body - Please submit to your Medical Plan.

hhh) Maxillary sinusotomy for removal of tooth fragment or foreign body - Please submit to your Medical Plan.

iii) Treatment of Compound fractures - Please submit to your Medical Plan.
jjj) Temporomandibular Joint Disorder (TMJ) - Please submit to your Medical Plan.
kkk) Suture of small wounds - Please submit to your Medical Plan.
lll) Complicated sutures - Please submit to your Medical Plan.

mmm) Repair of maxillofacial soft and hard tissue defect - Please submit to your Medical Plan.
nnn) Osteoplasty - Please submit to your Medical Plan.

ooo) LeFort procedures - Please submit to your Medical Plan.

ppp) Frenulectomy (frenectomy or frenotomy) - Please submit to your Medical Plan.

qqq) Excision of hyperplastic tissue - Please submit to your Medical Plan.
rrr) Appliance removal (not by dentist who placed appliance), includes removal of archbar - Please submit to your Medical Plan.

sss) Implant-mandible for augmentation purposes - Please submit to your Medical Plan.
ttt) Surgical reduction of fibrous tuberosity - Please submit to your Medical Plan.

uuu) Sisilolithotomy - Please submit to your Medical Plan.

vvv) Excision of salivary gland - Please submit to your Medical Plan.

www) Sialodochoplasty - Please submit to your Medical Plan.

xxx) Closure of salivary fistula - Please submit to your Medical Plan.

yyy) Emergency tracheotomy - Please submit to your Medical Plan.

zzz) Cornoidectomy - Please submit to your Medical Plan.

aaaa) Tooth transplantation - Please submit to your Medical Plan.

bbbb) Surgical access to erupted tooth - Please submit to your Medical Plan.

cccc) Device placement.

dddd) Amalgam or composite restorations placed for preventive or cosmetic purposes.
LIMITATION:

Hospital and other expenses incurred in connection with dental work or oral surgery for the repair of natural teeth or other body tissues and which are required as a result of a non-occupational accidental bodily injury within two years of the date of the injury should be submitted to the Medical Plan. Both the injury and dental work or oral surgery must occur while the individual is eligible for benefits.

For other dental procedure exclusions and limitations, refer to the Description of Coverages in this Dental Benefit Plan Summary.

Post Payment Review

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 - Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed are subject to recovery. Delta Dental’s right to conduct post payment review and its right of recovery exists even if a Pretreatment Estimate was submitted for the service.

ELIGIBILITY - Please refer to the Pipe Trades Services MN Welfare Fund SPD for Eligibility descriptions and definitions.

Please refer to the PIPE TRADES SERVICES MN WELFARE FUND SPD for COBRA eligibility

PLAN PAYMENTS

Participating Dentist Network

A Delta Dental PPO network dentist is a dentist who has signed Delta Dental PPO agreement with Delta Dental of Minnesota. The dentist has agreed to accept the Delta Dental PPO allowable charge as payment in full for covered dental care. You will be responsible for any applicable coinsurance amounts listed in the Summary of Dental Benefits section. A network dentist will not bill more than the Delta Dental PPO allowable charge. A network dentist will also file the claim directly with Delta Dental.

A Delta Dental participating dentist is a dentist who has signed a participating and membership agreement with Delta Dental of Minnesota. The dentist has agreed to accept Delta Dental’s allowable charge as payment in full for covered dental care. You will be responsible for any applicable coinsurance amounts listed in the Summary of Dental Benefits section. A network dentist will not bill more than Delta Dental’s allowable charge. A Delta Dental participating dentist will also file the claim directly with Delta Dental.

Listings of participating providers are available to Subscribers as a separate document and are furnished by the Group without charge. Names of Participating Dentists can be obtained, upon request, by calling Delta, from directory listings furnished to the Group or from the Plan’s internet web site at www.deltadentalmn.org. Refer to the General Information section of this booklet for detailed information on how to locate a participating provider using the Plan’s internet web site.
Covered Fees

Under this Program, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a participating Delta Dental PPO/Delta Dental Premier dentist with the plan. There may also be a difference in the payment amount if your dentist is not a participating dentist with Delta. This payment difference could result in some financial liability to you. Claim payments are based on the treating dentist's submitted charge, not to exceed the reasonable and customary schedule established by the Plan.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR DELTA AND DELTA DENTAL PPO NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Claim Payments

PAYMENTS ARE MADE BY THE PLAN ONLY WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED. THE PLAN MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR PROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING. IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

ANY BENEFITS PAYABLE UNDER THIS PLAN ARE NOT ASSIGNABLE BY ANY COVERED PERSON OR ANY ELIGIBLE DEPENDENT OF ANY COVERED PERSON.

Delta Dental Premier Dentists:

Claim payments are based on the Plan’s Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental Premier dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental Premier dentists is the lesser of: (1) The fee pre-filed by the dentist with their Delta Dental organization; (2) The Maximum Amount Payable as determined by Delta Dental; (3) The fee charged or accepted as payment in full by the Delta Dental Premier dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient’s Delta Dental program.

Delta Dental PPO Dentists:

Claim payments are based on the Plan’s Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental PPO dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental PPO dentists is the lesser of: (1) The fee pre-filed by the dentist with their Delta Dental organization; (2) The Delta Dental PPO Maximum Amount Payable as determined by Delta Dental; (3) The fee charged or accepted as payment in full by the Delta Dental PPO dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient’s Delta Dental program.

Nonparticipating Dentists:

Claim payments are based on the Plan’s Payment Obligation, which for nonparticipating dentists is the treating dentist's submitted charge or the Table of Allowances established solely by Delta Dental, whichever is less. The Table of Allowances is a schedule of fixed dollar maximums established by Delta Dental for services rendered by a licensed dentist who is a nonparticipating dentist. Claim payments are sent directly to the Covered Person.
THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NONPARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NONPARTICIPATING PROVIDER, ANY BENEFITS PAYABLE UNDER THE GROUP CONTRACT ARE PAID DIRECTLY TO THE COVERED PERSON.

Coordination of Benefits (COB)

If you or your dependents are eligible for dental benefits under this Program and under another dental program, benefits will be coordinated so that no more than 100% of the Plan Payment Obligation is paid jointly by the programs. The Plan Payment Obligation is determined prior to calculating all percentages, deductibles and benefit maximums.

The Coordination of Benefits provision determines which program has the primary responsibility for providing the first payment on a claim. In establishing the order, the program covering the patient as an employee has the primary responsibility for providing benefits before the program covering the patient as a dependent. If the patient is a dependent child, the program with the parent whose month and day of birth falls earlier in the calendar year has the primary payment responsibility. If both parents should have the same birth date, the program in effect the longest has the primary payment responsibility. If the other program does not have a Coordination of Benefits provision, that program most generally has the primary payment responsibility.

NOTE: When Coordination of Benefits applies for dependent children, provide your dentist with the birth dates of both parents.

Assignment of Benefits

Any benefits which may be payable under this dental benefit Plan are not assignable.

Claim and Appeal Procedures

Initial Claim Determinations

All claims should be submitted within 12 months of the date of service. An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notification of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information we need, and you will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will be denied.

Appeals

In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal.

Your appeal must include your name, your identification number, group number, claim number, and dentist’s name as shown on the Explanation of Benefits. Send your appeal to:

Delta Dental of Minnesota
Attention: Appeals Unit
PO Box 551
Minneapolis, MN  55440-0551
You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. Because all benefit determinations are based on a preset schedule of dental services eligible under your plan, claims are not reviewed to determine dental necessity or appropriateness. In all cases where professional judgment is required to determine if a procedure is covered under your plan’s schedule of benefits, we will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, we will identify any dental professional whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

To the extent your plan is covered by ERISA, after you have exhausted all appeals, you may file a civil action under section 502(a) of ERISA.

Authorized Representative
You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available at our web site or by calling Customer Service. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

GENERAL INFORMATION

Health Plan Issuer Involvement
The benefits under the Plan are not guaranteed by Delta under the Contract. As Claims Administrator, Delta pays or denies claims on behalf of the Plan and reviews requests for review of claims as described in the Claim and Appeals Procedures section.

Privacy Notice
Delta Dental of Minnesota will not disclose non-public personal financial or health information concerning persons covered under our dental benefit plans to non-affiliated third parties except as permitted by law or required to adjudicate claims submitted for dental services provided to persons covered under our dental benefit plans.

How to Find a Participating Dentist
A real-time listing of participating dentists is available in an interactive directory at the Plan’s user friendly web site, www.deltadentalmn.org. The Plan highly recommends use of the web site for the most accurate network information. Go to http://www.deltadentalmn.org/findAdentist and enter your zip code, city or state to find local participating dentists. You can also search by dentist or clinic name. The Web site also allows you to print out a map directing you to the dental office you select. The Dentist Search is an accurate and up-to-date way to obtain information on participating dentists.
To search for and verify the status of participating providers, select “Dentist Search” on the www.deltadentalmn.org home page. Select the Product or Network in the drop-down menu, and search by city and state, zip code or provider or clinic name. If your dentist does not participate in the network, you may continue to use that dentist, although you will share more of the cost of your care and could be responsible for dental charges up to the dentist's full billed amount.

If you do not have Internet access, other options are available to find a network dentist or verify that your current dentist is in the network.

- When you call to make a dental appointment, always verify the dentist is a participating dentist. Be sure to specifically state that your Welfare Plan is providing the Dental program.
- Contact our Customer Service Center at: (651) 406-5901 or (800) 448-3815. Customer Service hours are 7 a.m. to 7 p.m., Monday through Friday, Central Standard Time.

Using Your Dental Program

Dentists who participate with Delta under this Program are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Delta cannot and does not make any representations as to the quality of treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service.

If your dentist is a participating dentist, the claim form will be available at the dentist's office.

If your dentist is nonparticipating, claim forms are available by calling:

Delta Dental of Minnesota National Dedicated Service Center - (651) 406-5901 or (800) 448-3815

The Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.

The dental office will file the claim form with the Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

* YOUR DELTA GROUP NUMBER
* YOUR WELFARE PLAN (GROUP NAME)
* YOUR IDENTIFICATION NUMBER (your dependents must use YOUR identification number)
* YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

Cancellation and Renewal

The Program may be canceled by the Plan only on an anniversary date of the Group Dental Plan Contract, or at any time the Group fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Program, Covered Persons of the Group have no right to continue coverage under the Program or convert to an individual dental coverage contract.
EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Plan Administration

The Plan Administrator, who is listed on the inside front cover of this brochure, is a named fiduciary under the Program and shall be responsible for the management and control of this Program.

The Plan Administrator is responsible for determining the level of benefits for the Program as described in this brochure. The Plan Administrator reserves the power at any and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to modify or amend, in whole or in part, any or all provisions of the Plan, provided, however, that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the Plan.

Funding Policy and Payment

The funding policy and method requires that the Group Subscriber submit payments on a monthly basis.

Procedure to Request Information

If you have any questions about this Program, contact the Plan Administrator who is listed in the inside front cover of this brochure.

Statement of ERISA Rights

As a participant in the Program, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine without charge at the Plan Administrator's office and at other specified locations such as work sites and union halls, all Plan documents, including insurance contracts, and copies of all documents such as detailed annual reports and Plan descriptions filed by the Plan with the U.S. Department of Labor.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Group, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your right, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If it finds your claim is frivolous, you will be responsible for these costs and fees. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W, Washington, D.C. 20210.
DELTA DENTAL OF MINNESOTA

FOR CLAIMS AND ELIGIBILITY
Delta Dental of Minnesota
National Dedicated Service Center
P.O. Box 59238
Minneapolis, Minnesota 55459
(651) 406-5901 or (800) 448-3815

FOR APPEALS
P.O. Box 551
Minneapolis, Minnesota 55440-0551

CORPORATE LOCATION
500 Washington Avenue South
Suite 2060
Minneapolis, MN 55415
(651) 406-5900 or (800) 328-1188
www.deltadentalmn.org

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11. PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF THE PIPE TRADES SERVICES MN VISION PLAN

This Plan provides certain benefits for vision care through a PPO. The PPO has contracted with various providers and facilities to provide vision benefits to you at a discounted rate. 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.

A. Eligibility

1. Except if you decline to participate, you become a Participant in the Pipe Trades Services MN Vision 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 unless you extend your participation under COBRA.

2. You may decline to participate in this Plan at any time by notifying the Fund Office in writing. Declining to participate will have no effect on your Premium for eligibility for benefits from the Fund.

B. In-Network Benefits Per Calendar Year

1. One eye exam is covered with 0% Coinsurance. You pay $0 for the exam.

2. A $175 frame allowance at retail, $95 frame allowance at Costco. You have 0% Coinsurance up to $175. After $175, you pay 100%.

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

4. In lieu of a pair of frames and lenses, the Plan provides a $175 allowance for regular contact lenses. You pay 0% Coinsurance up to $175. After $175, you pay 100%.

5. One pair of safety lenses are covered in full if the nature of the Employee’s work requires safety eyewear.

C. Out of Network Benefits

The Plan provides you a $250 allowance for vision benefits from an Out of Network provider. You pay 0% Coinsurance up to $250. After $250, you pay 100%. If you use an In Network provider for your eye exam, the cost of an eye exam will be deducted from your $250 allowance. Safety lenses are not eligible for any benefit from an Out of Network provider.
D. **Exclusions**

1. Cosmetic materials
2. Optional cosmetic processes
3. Anti-reflective coating
4. Color coating
5. Mirror coating
6. Scratch coating
7. Laminated lenses
8. Oversized lenses
9. Ultraviolet protected lenses
10. Medical or surgical treatment of the eyes.
11. Corrective vision treatment that is Experimental or Investigative.
12. Diabetic eye exams.

E. **Claims Processing**

The PPO provider will process all claims within 30 days after the PPO provider has received a completed claim, unless special circumstances require additional time. In such cases, the PPO provider may obtain an extension of fifteen (15) days of this time limit by providing notice to you and the reason for the extension. ²¹

²¹ The Pipe Trades Services MN Vision Plan provides only “excepted benefits” as described in 29 U.S.C. § 1191a.
12. 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. 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.

13. PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF THE PIPE TRADES SERVICES MN EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (“EAP”) is a professional counseling service.22 You become a Participant in the Pipe Trades Services MN Employee Assistance 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.

Through the EAP, you can speak with a counselor to help you with a range of life’s issues, such as:

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

The EAP’s services are completely confidential and professional counselors are available to you free of charge. The only cost you may be responsible for is if you accept a referral to services that are not part

22 The Pipe Trades Services MN Employee Assistance Program is an employee benefit plan that provides only “excepted benefits” as described in 29 U.S.C. § 1191a.
of the EAP program. If there is a need to refer you to other services for further treatment, staff will coordinate the referral with specialized treatment centers and hospitals in your area. If you are referred to a specialist, the cost associated with going to that specialist will be your responsibility. If the specialist is in the medical field, you should check with the Fund Office for information regarding your benefits.

You are encouraged to contact the EAP when a situation first develops, including emergencies. You can reach a member advocate 24 hours a day, 365 days a year by calling the phone number shown in the “Important Contact Information” section of this Booklet.

14.  PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF THE PIPE TRADES SERVICES MN WEEKLY INJURY AND ILLNESS DISABILITY PROGRAM

While you have a non-occupational total disability resulting from an Injury or Illness that prevents you from working, the Fund will pay you $500 per week (for a maximum of 26 weeks) and will credit your Dollar Bank with 37.5 hours per week up to a maximum of 975 hours. This Program is for Member only, not a Dependent. You are also not eligible if you are on extended eligibility.

- This benefit will become payable beginning with the first day of disability due to an Injury.
- Benefits become payable on the earlier of the eighth day of disability due to an Illness or the day you are hospitalized or have surgery due to an Illness.
- Successive periods of disability separated by less than two weeks of continuous active employment will be considered one continuous period of disability unless the disabilities are from different and unrelated causes, and you return to full-time work for at least one day.

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

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

- Unemployment compensation;
- Workers' compensation;
- No-fault auto disability;
- Other third-party liability;
- Retirement benefits; and,
- Extended coverage or COBRA continuation coverage.
IRS regulations require that FICA tax be deducted from your Weekly Injury and Sickness Disability Benefit. 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.

15. PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF THE PIPE TRADES SERVICES MN DEATH BENEFITS PROGRAM

The Fund will pay a death benefit of $7,000 to your Beneficiary in accordance with the Standard Beneficiary Designation if you die while you are eligible to participate in this program. Contact the Fund Office for a Beneficiary designation form if you wish to change your Beneficiary designation. Payment will be promptly made in a lump sum after the Fund Office receives a satisfactory application for benefits from your Beneficiary (or an authorized representative of your estate). This Program is for Members only, not Dependents. 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.

16. PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF THE PIPE TRADES SERVICES MN ACCIDENTAL DEATH AND DISMEMBERMENT PROGRAM

In the event you sustain any of the following losses as a direct result of an accidental injury, either on or off the job, the following benefit will be paid in addition to a Death Benefit:

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

The loss must occur within 90-days from the day of the injury. Loss of limb means severance at or above the wrist or ankle joint. Loss of sight means the total and irrecoverable loss of sight.

If more than one of the above losses is suffered as the result of any one injury, not more than the full benefit amount shown will be payable. This benefit is only payable for losses suffered by a Member, not a Dependent.

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23 Throughout this section, the term “you” means only a Member and not a Dependent.
Since the purpose of this coverage is to provide benefits for losses due to accidental injuries, no benefits are paid for any loss caused by or contributed by a:

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

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.

17. PIPE TRADES SERVICES MN JURY DUTY PROGRAM

The Fund provides a Jury Duty benefit to a Member, which is a per diem payment for involuntary unemployment due to jury duty. The payment is $90 per day. The Fund will also credit your Dollar Bank with 8 hours of credit for each day you complete jury duty. Evidence of jury duty by way of a jury duty voucher is required.

You are not eligible for this benefit if you are receiving disability payments, unemployment compensation, if you are under extended eligibility or COBRA. The purpose of this benefit is to reimburse Members for lost time from work. Only a Member, not a Dependent is eligible for this benefit. Please contact the Fund Office for a Jury Duty form. 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.

18. PIPE TRADES SERVICES MN BEREAVEMENT BENEFIT PROGRAM

Upon submission of an acceptable Bereavement Benefit Form, the Fund will make a payment to you in the amount of $300 for the death of the following relatives:

- Spouse
- Son, stepson, son-in-law, step-son-in-law
- Daughter, stepdaughter, daughter-in-law, step-daughter-in-law
- Mother, stepmother, mother-in-law, step-mother-in-law
- Father, stepfather, father-in-law, step-father-in-law;
- Brother, stepbrother, brother-in-law (your sister's husband or your spouse's brother)
- Sister, stepsister, sister-in-law (your brother's wife or spouse's sister)
- Grandfather, step-grandfather, (grandfather of spouse is not covered)
- Grandmother, step-grandmother, (grandmother of spouse is not covered)
- Grandchildren
You are not required to miss work in order to receive the Bereavement Benefit. However, a copy of the obituary notice, death certificate or such evidence as the Trustees may request is required in order to receive the benefit.

You are not eligible for this benefit if you are receiving disability payments, unemployment compensation or on COBRA. This benefit is only payable for the Member, not Dependents. Please contact the Fund Office for a Bereavement Benefit form. 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.

19. 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 PPO24;

• 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,

24 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.
• 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 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.\(^{25}\) In such cases, you will not need to personally file a Claim.\(^{26}\) 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.\(^{27}\)

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

\(^{25}\) 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.

\(^{26}\) 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.

\(^{27}\) Contact information for the Fund Office is in the “Important Contact Information” section of this Booklet.
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 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.\textsuperscript{28} 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 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.\textsuperscript{29} 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):

\textsuperscript{28} 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.

\textsuperscript{29} 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.
• 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;

• 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’ decision30, 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 decision31 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

30 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.
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 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.

<table>
<thead>
<tr>
<th></th>
<th>Post-Service</th>
<th>Prior Authorization</th>
<th>Urgent Care Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Decision(^32)</td>
<td>Within 30 days of Claim receipt</td>
<td>Within 15 days of Claim receipt</td>
<td>Within 72 hours of Claim receipt (24 hours if more information needed to process claim)(^33)</td>
</tr>
<tr>
<td>Extension Period(^34)</td>
<td>15 days</td>
<td>15 days</td>
<td>None</td>
</tr>
<tr>
<td>Appeal Request</td>
<td>Within 180 days</td>
<td>Within 180 days</td>
<td>Within 180 days</td>
</tr>
<tr>
<td>Appeal Decision(^35)</td>
<td>5 days after the first Board meeting that is more than 30 days from receipt of appeal request (or within 30 days for a first level of appeal).</td>
<td>Within 30 days (or 15 days if there are two levels of appeal)</td>
<td>Within 72 hours</td>
</tr>
</tbody>
</table>

\(^31\) 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.

\(^32\) This is when you will receive notice of the decision.

\(^33\) 24 hours if the Claim pertains to a cessation of coverage of an ongoing course of treatment.

\(^34\) You will be advised in writing in advance if an extension will be necessary.

\(^35\) This is when you will receive notice of the decision.
### Post-Service Prior Authorization Urgent Care Claim Extension Period

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<tr>
<th></th>
<th>Post-Service</th>
<th>Prior Authorization</th>
<th>Urgent Care Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extension Period</td>
<td>2 extensions, each till the next Board meeting</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Independent Review Request</td>
<td>Within four months of receipt of appeal decision</td>
<td>Within four months of receipt of appeal decision</td>
<td>Within four months of receipt of appeal decision</td>
</tr>
<tr>
<td>Request for Arbitration</td>
<td>Within one year of receipt of appeal decision</td>
<td>Within one year of receipt of appeal decision</td>
<td>Within one year of receipt of appeal decision</td>
</tr>
<tr>
<td>File Lawsuit</td>
<td>Within one year of receipt of appeal decision</td>
<td>Within one year of receipt of appeal decision</td>
<td>Within one year of receipt of appeal decision</td>
</tr>
</tbody>
</table>

### 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. 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.

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36 You will be advised in writing in advance if an extension will be necessary.

37 Contact the Fund Office for a copy of the NAIC model rules.
C. First Priority Right of Subrogation and Reimbursement

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 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.

38 Throughout this section, the term “you” means you or your Dependent jointly and severally, including you on behalf of your minor Dependent.
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.

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

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, the Pipe Trades Services MN Health Club Reimbursement Program, and the Pipe Trades Services MN Employee Assistance Program.

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:

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39 Throughout this section, the term “you” means a Member and not a Dependent.
• 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.

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

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

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

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

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

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

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

**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. 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.

16. 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.

17. 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.

18. 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.

19. ERISA

20. 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.

21. 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.

22. 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.

23. Fund
The Pipe Trades Services MN Welfare Fund.

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

25. HIPAA
26. 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.

27. Independent Review
A review of a decision on appeal by an independent entity accredited by URAC called an independent review organization (“IRO”).

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

29. 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.

30. 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.

31. 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.

32. 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, 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,

40 “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.
• Not more costly than an alternative that is likely to produce similar therapeutic or diagnostic results.

33. 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).

34. 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).

35. Minute Clinic
A healthcare clinic owned and operated by a CVS pharmacy.

36. 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.

37. 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.

38. Out-Of-Network
A Healthcare Provider that is not part of a PPO with which the Fund has a contract.

39. 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.

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

41. 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.

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

43. Post-Service Claim
A Claim for reimbursement of an expense that you have already incurred when you file the Claim.
44. 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.

45. Premium
The Premium 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.

46. 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.

47. Pre-Service Claim
A request for authorization to incur expenses when such a request is a condition of coverage of the expenses.

48. 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/.

49. 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 in the 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.

41 Sometimes referred to as the dollars applied amount or the monthly cost of coverage.
50. 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.

51. 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.

52. 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.

53. 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.

54. 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.

55. 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.
20. APPENDICES

A. Eligibility Example

<table>
<thead>
<tr>
<th>Work Month</th>
<th>Eligibility Month</th>
<th>Eligibility</th>
<th>Dollars Worked</th>
<th>Short Dollar Payment</th>
<th>Premium Deducted</th>
<th>Dollar Bank Balance&lt;sup&gt;42&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar</td>
<td>May</td>
<td>No</td>
<td>$550</td>
<td>$0</td>
<td>$0</td>
<td>$550</td>
</tr>
<tr>
<td>Apr</td>
<td>Jun</td>
<td>Yes</td>
<td>$1,350</td>
<td>$0</td>
<td>$1,199</td>
<td>$701</td>
</tr>
<tr>
<td>May</td>
<td>Jul</td>
<td>Yes</td>
<td>$600</td>
<td>$0</td>
<td>$1,199</td>
<td>$102</td>
</tr>
<tr>
<td>Jun</td>
<td>Aug</td>
<td>Yes</td>
<td>$0</td>
<td>$1,097</td>
<td>$1,199</td>
<td>$0</td>
</tr>
<tr>
<td>Jul</td>
<td>Sept</td>
<td>Yes</td>
<td>$1,300</td>
<td>$0</td>
<td>$1,199</td>
<td>$101</td>
</tr>
<tr>
<td>Aug</td>
<td>Oct</td>
<td>No</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

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.

1. 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).

2. Continuing eligibility in July: At the end of the April/Jun 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.

3. Short dollar payment for August eligibility: At the end of the May/Jul work/eligibility period, the individual’s Dollar Bank balance is $102 ($1,301 - $1,199).<sup>43</sup> 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

<sup>42</sup> Balance as of the last day of the month.
<sup>43</sup> 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.

4. 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.

5. 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.
C. Family Information Statement

YYYYY Family Information Statement

Please enter or correct the following information and return in the enclosed envelope.

Member Information

Member ID: 987654
Local Union Number: 0034
Telephone Number: 6518675309
Date Of Birth: 01/01/1972
Gender: M

Spouse Information

Spouse Name: JANE DOE
Social Security Number: 456987123
Date of Marriage: 07/04/2000
Date of Birth: 01/10/1975
Spouse Employer:

Dependent Children (Through the month in which they turn 26)

Name       Date Of Birth  Relationship**  Social Security Number  Gender
WILLIAM DOE 03/25/2004   SON        321456987             M
MELINDA DOE 09/24/2006   DAUGHTER   789654123             F

**If dependent children are listed as "step son" or "step daughter", who is the natural Parent:

Email: calltheplumber@gmail.com

☐ I consent to receive selected non-confidential email from PTSMN.  ☐ I do not consent to receive selected non-confidential email from PTSMN.

Does your spouse or dependent children have any other insurance?  Y  ☐ N  ☐

If yes, complete reverse side.

I hereby authorize any insurance company, employer, hospital or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this plan. I certify that the above information is true and correct to the best of my knowledge.

Signature: ___________________________ Date: ___________________________
The purpose of the coordination of benefits provision in the PTSMN Welfare Plan is to enable you to receive the most benefits available if you have coverage under more than one plan; Please provide details regarding other coverage below.

### Coordination of Benefits Information

The purpose of the coordination of benefits provision in the PTSMN Welfare Plan is to enable you to receive the most benefits available if you have coverage under more than one plan; Please provide details regarding other coverage below.

<table>
<thead>
<tr>
<th>Insured Member's name: (spouse)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective Date</strong></td>
<td><strong>Termination Date</strong></td>
</tr>
<tr>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>RX</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td></td>
</tr>
</tbody>
</table>

check covered services: [ ] exam [ ] glasses [ ] contacts

List other dependents covered by this plan: __________________________________________

Is there an associated HRA in addition to the coverage above? [x] Yes [ ] No  It would pay before PTSMN
Is there an associated HSA plan in addition to the coverage above? [x] Yes [ ] No (if yes, PTSMN will not COB)
Note: An HSA participant cannot have any other coverage. *Contact your HR department or benefit Administrator with questions regarding HSA regulations.

Please **read** the enclosed page for information about the **order of primary liability** for the claims of the dependent children. Then fill in the details regarding the other plans through which they have coverage.

### Dependents Child with coverage other than listed above: (name)

**One form will need to be completed for each dependent child who has other coverage.** Contact the fund office for additional forms or make copies.

| Coordination of Benefits Information for Insurance Plan from: (check box or state other relationship) |
|-------------------------------------------------|---|
| [ ] Employer of Dependent Child | [ ] Spouse of Dependent Child | [ ] Other parent/step-parent | [ ] Other:__________ |

<table>
<thead>
<tr>
<th>Dependent Child with coverage other than listed above: (name)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective Date</strong></td>
<td><strong>Termination Date</strong></td>
</tr>
<tr>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>RX</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td></td>
</tr>
</tbody>
</table>

check covered services: [ ] exam [ ] glasses [ ] contacts

Is there an associated HRA in addition to the coverage above? [x] Yes [ ] No  It would pay before PTSMN
Is there an associated HSA plan in addition to the coverage above? [x] Yes [ ] No (if yes, PTSMN will not COB)
Note: An HSA participant cannot have any other coverage. *Contact your HR department or benefit Administrator with questions regarding HSA regulations.

For Claims on behalf of dependent children, and after review of the enclosed document, please state which plan has **Primary Liability**

Name of Primary Plan: __________________________________________

---

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**Important Notes on Coordination of Benefits for the Pipe Trades Services MN Welfare Plan:**

In the event that you or any of your eligible dependents have purchased or acquired an individual policy for health care benefit coverage, the individual policy will be primary and will pay benefits first. The Welfare Fund will coordinate with the individual policy and pay benefits as the secondary carrier up to a maximum of 100 percent of the Allowable Expenses.

In all other cases, the following order of coordination of benefits will be used to determine the amount of benefits payable under this Plan and the amounts to be paid by any Other Plans:

1. A plan without coordination of benefits pays its benefits before a plan which contains coordination of benefits.
2. A plan which covers a person other than as a Dependent pays its benefits before a plan, which covers the person as a Dependent.

The order of coordination of benefits for plans that cover the dependent child is listed below

1. Coverage from the employer of the dependent child will pay primary.
2. The plan which covers the parent whose birthday (month and day) falls first in the calendar year pays first and a plan of the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan covering the parent for the longer period of time pays first.
3. In the case of a dependent child of divorced or separated parents:
   a) If there is a court decree, which established financial responsibility for medical expenses, the plan covering the dependent children of the parent who has that legal responsibility will be primary.
   b) If there is not a court decree, establishing such financial responsibility, the plan which covers the parent with custody will be primary.
   c) If there is not a court decree establishing such financial responsibility and the parent with custody has remarried, the order of benefit coordination will be:
      the plan of the parent with custody,
      the plan of the stepparent with custody,
      the plan of the parent without custody.
4. If the dependent child has coverage from a spouse in addition to coverage from a parent/stepparent, the plan that has covered the person for the longer period of time will be primary.

Accurate and timely information regarding other insurance will help us to process your claims more efficiently and serve you better! This includes informing the plan when other coverage ends. Thank you for providing this important information.
To Members and Spouses of the Pipe Trades Services MN Welfare Fund

FAMILY STATEMENT REQUEST

Your Family Statement is an Important Document. Annual updates are necessary for PTSMN to maintain compliance and to accurately process your health claims. Please complete the following steps:

✓ Verify all information

✓ As Required by the Affordable Care Act please correct any dependent Social Security information that is missing or inaccurate

✓ Correct any inaccurate information or information that may have changed since last year

✓ Fill in any incomplete information

✓ Sign the form (your signature is required)

✓ Return in the envelope provided

✓ PTSMN cannot accept this information over the phone

✓ Single members must also review, complete, sign and return this form

✓ If we do not receive a completed form, your claims will be delayed.

Thank you in advance for your cooperation – your prompt response will allow us to serve you better!
**Pipe Trades Services MN - Enrollment Form**

*PTSMN FAX 651-645-8119    PHONE 651-645-4540*

**For office use only**

<table>
<thead>
<tr>
<th>PTSMN ID</th>
<th>Spouse</th>
<th>Dependent Child</th>
</tr>
</thead>
</table>

**To be entered by Local Union Office**

1. (Check One) [ ] New Member [ ] Updated information for existing member

2. (Check One) [ ] Pre-apprentice [ ] Apprentice - If apprentice, CIRCLE program year: 1 2 3 4 5 [ ] Journeyman [ ] Other

3. Trade Code ________

4. Description or Comments ______________________________________________________

5. Local (Circle One) 6 Rochester 15 Mpls 15 St Cloud 15 Gas Distribution 34 St Paul 34 Mankato 455 St Paul 455 Mankato 539 Mpls 539 St Cloud

**Employee Information**

Please provide a copy of your Social Security Card

**PLEASE PRINT CLEARLY**

<table>
<thead>
<tr>
<th>1. Last name</th>
<th>2. <em><strong><strong>-</strong></strong></em>-_______</th>
<th>3. __<strong>/</strong><strong><strong>/</strong></strong></th>
<th>4. M / F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Gender(circle)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Home address</th>
<th>6. (____)</th>
<th>7. (____)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 8. [ ] I consent to receive selected non-confidential email from PTSMN ______________________ |

**Spouse / Coordination of Benefits Information**

Please provide a copy of your Certified Marriage Certificate

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Gender(circle)</td>
<td>Date of Marriage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15. Is your spouse employed? [ ] Yes [ ] No  If Yes, Please list below Name, Address, and Phone Number of Employer:</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer name</th>
<th>Employer Address</th>
<th>Employer Phone #</th>
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</table>

| 16. Is your spouse covered under another Insurance Plan? [ ] Yes [ ] No |

17. If yes, Check coverage that applies to spouse’s plan: [ ] Medical [ ] Dental [ ] Vision [ ] Prescription Drug

18. List Name of spouse’s Insurance Plan, Policy Number, and Effective date.

<table>
<thead>
<tr>
<th>Insurance name</th>
<th>Policy Number</th>
<th>Policy Effective Date</th>
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<tbody>
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</table>

19. Check spousal coverage that applies to dependent children: [ ] Medical [ ] Dental [ ] Vision [ ] Prescription Drug

This plan uses the Birthday Rule to determine which plan is the primary payer for your dependent children’s coverage based on whose birth date comes first in the year yours or your spouses.

*(Continued on reverse side)*
## Dependent Children Information (to age 26)

Please provide a copy of the Birth Certificate

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>Relationship (son, daughter, step-child)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

21. Are any of the dependent children covered through a plan other than listed above? (Line Item: 18.)

- Yes
- No

If Yes:

<table>
<thead>
<tr>
<th>Policy Holder</th>
<th>Social Security Number</th>
<th>Policy Name</th>
<th>Policy Number</th>
</tr>
</thead>
</table>

Name of Dependent(s) Covered

Is this policy obligated to pay first?

- Yes
- No

This policy includes:

- Medical
- Dental
- Vision
- Prescription Drug

### Please Sign Below

I hereby authorize any insurance company, hospital, physician, or employer to release information to the Pipe Trades Services MN with regard to me or any of my dependents, which may have a bearing on the benefits payable under this plan. I certify that the above information is true and correct to the best of my knowledge.

Member’s Signature: ___________________________ Date: ______/_____/_______
STANDARD BENEFICIARY DESIGNATION

The following is the Standard Beneficiary Designation that will be used by each of the Pension Trust, Pension Supplement Plan, Welfare Fund and Retiree Health Trust.

IF THE FOLLOWING SEQUENCE OF BENEFICIARIES IS ACCEPTABLE TO YOU, NO FURTHER ACTION IS NECESSARY.

Standard Beneficiary Designation
1. To my spouse, or if none;
2. To my child or children in equal shares, and the share of any child who does not survive me to his or her children living at my death in equal shares or if none;
3. To my parents in equal shares, or if none;
4. To my brothers and sisters in equal shares, or if none;
5. To the personal representative of my estate.

The terms “child and “children” as used in this beneficiary designation shall include both natural born and adopted children.

If this order of preference is not acceptable to you, you must complete the Optional Beneficiary Designation below and return it to the Fund Office.

Optional Beneficiary Designation:

Member Name (Print) ____________________________________________
PTSMN Member ID #________________ Local #________

STEP ONE: First tell us your preference for payment of any benefits available upon your death by using numbers to indicate the order of your preference. Tell us in Step Two below any special instructions you have, like if a certain percentage goes to a particular individual.

______To my spouse, or if none
______To my child or children in equal shares, and the share of any child who does not survive me to his or her children living at my death in equal shares or if none;
______To my parents in equal shares, or if none;
______To my brothers and sisters in equal shares, or if none;
______To my personal representative for my estate, or if none;
______To my
______To my

STEP TWO: Next tell us any special instructions you have for your beneficiary designation, such as if a specific percentage of benefits should go to a particular individual or if you do not want beneficiaries at the same level to receive equal amounts. (Please request an additional form to list additional beneficiaries.)

1. Beneficiary Ranking No. __________ Relationship ____________________________ Percentage __________

   Name __________________________________________________________ Date of Birth __________

   Address _________________________________________________________ Phone _____________________
STEP TWO continued:

2. Beneficiary Ranking No._________ Relationship________________________________ Percentage ________________
   Name_________________________________________ Date of Birth____________
   Address________________________________________ Phone____________________

3. Beneficiary Ranking No._________ Relationship________________________________ Percentage ________________
   Name_________________________________________ Date of Birth____________
   Address________________________________________ Phone____________________

4. Beneficiary Ranking No._________ Relationship________________________________ Percentage ________________
   Name_________________________________________ Date of Birth____________
   Address________________________________________ Phone____________________

If an organization, institution or trust is a named beneficiary provide: (Please include a copy of the trust document.)

Name_________________________________________________ Tax ID Number _____________________
Address______________________________________________________________________________________________

Any Other Special Instructions:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

STEP THREE: Tell us which Plans this designation applies to:

Pension Plan____ Welfare Plan____ Pension Supplement Plan____ Retiree Health Trust____ All Plans____

STEP FOUR: Sign your form. By signing this form you reject the standard beneficiary designation and are directing the Plan(s) to follow your designation. A special note, for the Pension Plan and Pension Supplement Plan, by law, if you are married and do not name your spouse as the first beneficiary, your spouse must consent in writing to waive primary beneficiary status. The written consent must be completed on additional forms available at the Fund Office. Please call the Fund Office to request the complete waiver forms.

Member Signature _________________________________________________ Date _________________

Member Name (print) ________________________________________________