PIPEFITTERS LOCAL 636 INSURANCE FUND PLAN

2023

Preface

The Board of Trustees of the Pipefitters Local 636 Insurance Fund (the "Fund") defines its health care plan by this Plan Document. Although the Trustees expect to continue the Fund indefinitely, they reserve the right to change or terminate the Fund at any time and for any reason, for any group or class of Participants (Active or Pensioner) or Dependents, as well as for all such groups. Correspondingly, the Trustees may change the level of benefits provided, eliminate an entire category of benefits, or change self-payment requirements at any time and/or for any reason. THERE ARE NO VESTED BENEFITS UNDER THIS PLAN.

The Fund is subj ect to all terms, provisions and limitations stated on the following pages.

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ARTICLE 1 – DEFINITIONS

As used in this document, the following words are defined as follows:

Active Employee means a Journeyman, Apprentice, Residential Refrigeration Journeyman, Residential Refrigeration Apprentice, Mechanical Equipment Tradesman, Mechanical Equipment Serviceman, New Service Journeymen, Senior Maintenance Engineer, Union Employee, Education Fund Employee, Office Employee, Working Principal, or other person on whose account an Employer has made Contributions to the Fund.

Ancillary Services means emergency medicine, anesthesiology, pathology, radiology, and neonatology whether provided by a participating provider or nonparticipating provider; items and services provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services, including radiology and lab services (excluding certain advanced diagnostic laboratory tests per federal guidance or rulemaking).

Apprentice means a person designated as such under the Collective Bargaining Agreement.

Apprenticeship Program is the program established by the Education Fund for the training of apprentices.

Autism Spectrum Disorder is a mental health condition as recognized by generally recognized independent standards of current medical practice and classified as such in the International Classification of Diseases (ICD-11, or subsequent published and approved versions).

Association means the Mechanical Contractors Association of Detroit.

Children or Child means:

(a) Any person up until the first of the month following the month in which he/she turns 26 years of age and either:

(1) is a Participant's natural child or adopted child;
(2) has been placed with a Participant for adoption; or
(3) is a Participant's step-child; or
(4) a child for whom the Participant is legal guardian.

(b) A person who would qualify as a Child under paragraph (a) but for the limitations, who:

(1) prior to 18 years of age had a permanent and irreversible mental or physical impairment, and

(2) as of 18 years of age was, and remains, incapable of sustaining employment,

provided the Participant submitted proof of the above to the Fund Office prior to December 31 of the year in which the person attained 18 years of age; or

(c) An alternate recipient under a Q ualified Medical Child Support Order of a Participant.

Collective Bargaining Agreement. The term "Collective Bargaining Agreement" means any contract entered into between the Union and the Association or any Employer under which the Employer has agreed to contribute to the Fund.

Consent to Out of Network Services means:

(a) a covered person provided informed consent under applicable law to receive either:

(1) post-stabilization services following Emergency Services from an out-of-network provider or out-of-network emergency facility; or

(2) nonemergency services from an out-of-network provider at an in-network facility; and

(b) the Plan receives notice of such consent.

Notwithstanding, Consent to Out of Network Services does not include Ancillary Services or items or services provided as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

Continuing Care Patient means a Covered Person who, with respect to a provider or facility—

(a) is undergoing a course of treatment for a serious and complex condition;

(b) is undergoing a course of institutional or inpatient care;

(c) is scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery;

(d) is pregnant and undergoing a course of treatment for pregnancy; or

(e) is or was determined to be terminally ill (i.e., a medical prognosis that the individual's life expectancy is 6 months or less).

Contributions mean payments to the Fund by an Employer as req uired under a Collective Bargaining Agreement or other written agreement satisfying the req uirements of the National Labor Relations Act.

Covered Person means a Participant and Dependent, unless otherwise indicated in any section of this Plan explaining a particular benefit.

Dependent means a Participant's Spouse and Children.

Disability means a physical or mental condition resulting from a non-occupational injury or illness, which in the opinion of a physician satisfactory to the Trustees, prevents a person from engaging in any regular occupation or employment for remuneration or profit as a pipefitter (or as an office worker, if the definition of Disability applies to an Office Employee); provided, however, that no person shall be deemed to have a Disability if such incapacity was contracted, suffered or incurred while he was engaged in a felonious activity or from service in the Armed Forces of any country.

Education Fund Employee means an instructor or other employee of the Pipefitters Local 636 Education Fund ("Education Fund") on whose behalf the Education Fund makes Contributions to the Fund, except for those individuals who are Office Employees.

Emergency Medical Condition means a medical condition (including a mental health condition or substance use disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services with respect to an Emergency Medical Condition means:

(a) a medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(b) medical examination and treatment that are within the capabilities of the staff and facilities available at such hospital or independent freestanding emergency department as required to Stabilize the patient (regardless of the department of the hospital in which such items or services are furnished), and

(c) unless Consent to Out of Network Services is provided to the Plan by the provider or facility, items and services for which benefits are provided by the Plan that are furnished by a nonparticipating provider or nonparticipating emergency facility after the Covered Person is Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Emergency Medical Condition which gave rise to the initial Emergency Services.

Employer means:

(a) a member of the Association who is bound by the terms of a Collective Bargaining Agreement between the Union and the Association to make Contributions to the Fund;

(b) any other employer engaged in work coming within the jurisdiction of the Union who is obliged, by a Collective Bargaining Agreement or other written agreement satisfying the requirements of the National Labor Relations Act, to make Contributions to the Fund;

(c) the Union to the extent, and solely to the extent, that it acts in the capacity of an employer of its business representatives or other employees on whose behalf it makes Contributions to the Fund;

(d) the Fund, to the extent and solely to the extent that it acts in the capacity of an employer of administrative employees on whose behalf Contributions are made to the Fund; and

(e) the Education Fund, to the extent and solely to the extent that it acts in the capacity of an employer of employees on whose behalf Contributions are made to the Fund.

Fund Office means BeneSys, Inc., **700** Tower Drive, Suite **300**, Troy, Michigan **48098**, telephone number **(248) 813-9800**.

Insurance Fund/Fund means the Pipefitters Local No. 636 Insurance Fund.

Journeyman/Journeymen means persons designated as such pursuant to the terms of a Collective Bargaining Agreement.

Mechanical Equipment Serviceman means persons who have attained such status pursuant to the terms of a Collective Bargaining Agreement.

Mechanical Equipment Tradesman means persons who have attained such status pursuant to the terms of a Collective Bargaining Agreement.

Medically Necessary (or Medical Necessity) means a service, supply, and/or Prescription Drug that is required to diagnose or treat a medical condition and which is:

- Appropriate with regard to the standards of good medical practice and not Experimental or Investigational;
- Not primarily for convenience of the patient or Provider;
- Medically proven to be effective treatment of the condition; and
- The most appropriate supply or level of service which can be safely provided. When applied to inpatient care, this means that the medical symptoms or condition requires that the services cannot be safely or adequately provided on an outpatient basis. When applied to Prescription Drugs, this means the Prescription Drugs that produce comparable effective clinical results.

Mental Health means mental disorders, illnesses, and conditions as defined by generally recognized independent standards of current medical practice and in the International Classification of Diseases (ICD-11, or subsequent published and approved versions).

Office Employee means any individual employed by the Union Education Fund, or Association to perform administrative or clerical duties who is not covered by, or an alumnus of, a collective bargaining agreement between the Union and employers in the pipefitting industry.

Participant means an Active Employee, Pensioner, or Surviving Spouse entitled to coverage under the Fund.

Pensioner means:

(a) A person who has been granted an early, normal, or disability pension by Pipefitters Local 636 Defined Benefit Pension Plan or its predecessor, Plumbers Local No. 98 and Pipefitters Local No. 636 Pension Fund, is a member in good standing of the Union, and either:

(1) Was an Active Employee as of January 1, 2000, did not incur a Break In Service as defined under the Pipefitters Local 636 Defined Benefit Pension Fund after January 1, 2000, and was eligible for benefits under the Fund at least one month in each of the five consecutive years immediately preceding the date upon which he received his first pension check (the purpose of this Rule is to establish that the Pensioner was available for work as a pipefitter through the Union for contributing contractors during the five calendar year period indicated); or

(2) Became an Active Employee after January 1, 2000, or incurred a Break In Service as defined under the Pipefitters Local 636 Defined Benefit Pension Fund after January 1, 2000, and was eligible for benefits under the Fund at least one month in each of the ten consecutive years immediately preceding the date upon which he received his first pension check (the purpose of this Rule is to establish that the Pensioner was available for work as a pipefitter through the Union for contributing contractors during the ten calendar year period indicated); or

(b) Effective July 1, 2002, does not meet the requirements of Paragraph (a) above, but is a member in good standing with the Union and establishes to the satisfaction of the Trustees either:

(1) that he was actually available for work as a pipefitter through the Union for contributing contractors during the applicable period of time (i.e. he was continually on the out of work list), or

(2) that:

(A) it was not possible to meet these requirements due to a Disability that occurred while he was actively working as a pipefitter for a contributing Employer or was available for work as a pipefitter through the Union; and

(B) he has had continuous coverage under either the Fund or his Spouse's comprehensive insurance plan from the time he became ineligible for benefits under the Fund until the time he made an application for benefits as Pensioner; or

(c) Effective July 1, 2002, was an employee organized within 11 years of his retirement and, as a result, cannot meet the requirements of paragraph (a), above, provided he/she is receiving a benefit from the Pipefitters Local 636 Defined Benefit Pension or Defined Contribution Fund, is a member in good standing with the Union, and pays a monthly premium for coverage equal to the cost of providing such coverage plus a 2% administrative fee; or

(d) An individual who:

(1) has been granted an early, normal, or disability pension by Pipefitters Local 636 Defined Benefit Pension Plan or its predecessor, Plumbers Local No. 98 and Pipefitters Local No. 636 Pension Fund;

(2) is a member in good standing of the Union;

(3) was eligible for benefits under the Fund at least one month in each of the ten consecutive years immediately preceding the date upon which he separated from employment in the pipefitting industry and in the month immediately preceding such separation;

(4) upon separation from employment in the pipefitting industry commenced employment with United Way and notified the Trustees of such employment within 30 days of its commencement;

(5) applied for coverage as a Pensioner within 30 days after the termination of his/her employment with United Way; and

(6) had continuous comprehensive coverage from the time his/her eligibility terminated under the Plan until the time of such application.

(e) Does not meet the requirements of paragraph (a) above, but establishes to the satisfaction of the Trustees that:

(1) he/she has been granted an early, normal, or disability pension by Pipefitters Local 636 Defined Benefit Pension Plan (636 DB Plan);

(2) has at least 20 years of credited service under the 636 DB Plan;

(3) is a member in good standing of the Union;

(4) during the time periods set forth in (a), above, for which he/she was not eligible for benefits, he/she was engaged in employment beneficial to the Plan, its Participants, and the industry, as determined in the sole discretion of the Trustees;

(5) upon separation from employment deemed beneficial to the pipefitting industry in (4) above, he/she either applied for a pension benefit from 636 DB Fund or became available for work for contributing contractors as a pipefitter through the Union (i.e., placed on the Union's out of work list or returned to work for a contributing employer);

(6) has had continuous comprehensive coverage under another health plan from the time his/her eligibility terminated under the Plan until he/she applied for a pension benefit from 636 DB Fund or became available for work for contributing contractors as a pipefitter through the Union; and

(7) does not have other health coverage available as a result of his/her employment upon retirement.

Plan means this document, i.e., the Pipefitters Local 636 Insurance Fund Benefit Plan.

Plan Administrator means the Trustees of the Fund.

Plan Year means the period that begins on September 1st each year and ends on August 31st of the following year.

Qualifying Payment Amount (QPA) for an item or service means the median in-network rate for (a) the same of similar services; (b) furnished in the same or a similar facility, (c) by a provider of the same or similar specialty, and (d) in the same or similar geographic area, adjusted as required by applicable regulations for inflation and base billing units, if applicable.

Recognized Amount with respect to an item or service furnished by a nonparticipating provider is (1) for an item or service furnished in a State that has an All-Payer Model Agreement under 1115A of the Social Security Act, the amount the State approves under such system; (2) if there is no applicable All-Payer Model Agreement, an amount determined by a specified State law where the item or service is furnished; or (3) if neither of the above apply, the lesser of (a) the amount billed by the provider or facility or (b) the Qualifying Payment Amount (QPA).

Residential Refrigeration Journeyman means persons who have attained such status pursuant to the terms of a Collective Bargaining Agreement.

Senior Maintenance Engineer means persons who have attained such status pursuant to the terms of a Collective Bargaining Agreement.

Serious and Complex Condition means

(a) In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(b) In the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

Spouse means the Participant's legal spouse who has met all requirements of a valid marriage contract in the state of marriage of such parties.

Stabilized means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Surviving Spouse means that person who was married to the Participant on the date of the Participant's death.

Trustees mean the Trustees of the Pipefitters Local 636 Insurance Fund.

Union means Pipefitters, Steamfitters, Refrigeration, and Air Conditioning Service Local Union No. 636 of the Metropolitan Detroit Area, Michigan.

Union Employee means a business representative or other employee of the Union on whose behalf the Union makes Contributions to the Fund.

Working Principal means any person who performs work covered by the Collective Bargaining Agreement and who has any direct or indirect financial or ownership interest in the Employer, including a shareholder, owner, partner, proprietor, officer, or director of an Employer.

ARTICLE 2 – ELIGIBILITY RULES

2.1 Eligibility Requirements for Active Employee (Excluding Working Principals and Office Employees)

(a) Dollar Bank System

(1) The Fund shall maintain a bookkeeping account for each Active Employee. The account shall be credited with Contributions received on behalf of each Active Employee, and the cumulative amount credited to the account shall be referred to as the Active Employee's "Bank." The Bank shall be credited to a maximum of $8,500.

(2) The cost of coverage for all benefits provided for which an Active Employee is eligible under the Plan shall be deducted monthly from each Active Employee's Bank. The cost of coverage shall be determined from time to time in the sole and exclusive discretion of the Trustees.

The cost of coverage shall vary based upon the plan of medical benefits covering the Active Employee, as set forth in Article 4.

Notwithstanding anything in this Article 2 to the contrary, if an Active Employee serves on jury duty, the cost of coverage shall be prorated based upon the total number of days served on jury duty during a month. For example, if a participant serves six days on jury duty during the month of June, the cost of coverage will be reduced 20% for that month (i.e., six days of jury duty divided by 30 total days in the month of June).

(3) An Active Employee has no right or title to any amounts credited to his/her Bank. All amounts in the Bank are at all times Plan assets. The Bank shall be used exclusively for determining eligibility for benefits. The Trustees may at any time and for any reason terminate the Bank and any credit in any Active Employee's Bank at such time will remain a Plan asset.

(b) Initial Eligibility

A person will become eligible for benefits the first day of the second month following the month in which his Bank is equal to three times the monthly benefit cost of Standard Coverage for a single participant, provided such amount was accumulated in a consecutive 12-month period.

For example, if as of January an Active Employee's Bank is equal to or greater than three times the monthly benefit cost of Standard Coverage for a single participant, then he/she will be provided enrollment information and be eligible for coverage as of March 1.

Special Initial Eligibility Rule for Apprentices

In lieu of the above:

(1) Coverage is provided as follows to individuals who are in the Early Start Program sponsored by the Education Fund:

(a) If an individual commenced work for an Employer under the Collective Bargaining Agreement and established eligibility for benefits prior to entry into the Early Start Program:

(i) His/her Bank will be frozen the first of the month following commencement of the Early Start Program (any Contributions received thereafter will continue to be credited to his/her Bank);

(ii) Coverage will continue until the end of the third consecutive month following completion of the Early Start Program; and

(iii) The first day of the fourth month following completion of the Early Start Program, his/her Bank will be unfrozen, and all eligibility rules set forth in Section 2.1 will apply.

(b) If an individual commenced work for an Employer under the Collective Bargaining Agreement and did not establish eligibility for benefits prior to entry into the Early Start Program:

(i) His/her Bank will be frozen the first of the month following commencement of the Early Start Program (any Contributions received thereafter will continue to be credited to his/her Bank);

(ii) Coverage will begin the first of the month following commencement of the Early Start Program and will continue until the end of the third consecutive month following completion of the Early Start Program; and

(iii) The first day of the fourth month following completion of the Early Start Program, his/her Bank will be unfrozen, and all eligibility rules set forth in Section 2.1 will apply.

(c) All others who commence the Early Start Program:

(i) Beginning the first of the month following completion of the Early Start Program, he/she will receive three consecutive months of coverage; and

(ii) The first day of the fourth month following the completion of the Early Start Program, such individual will be subject to all eligibility rules set forth in Section 2.1.

(2) All other Apprentices shall be eligible for three consecutive months' coverage commencing the first of the month following the month he/she is indentured into the Apprenticeship Program. Thereafter, such individual will be subject to all eligibility rules set forth in Section 2.1.

(3) Notwithstanding any provisions to the contrary:

(a) if an Apprentice is terminated from the Apprenticeship Program, his/her eligibility shall cease the first day of the month following such termination and he/she will be offered COBRA coverage; or

(b) if an individual is terminated from the Early Start Program, his/her eligibility shall cease the first day of the month following such termination and he/she will be offered COBRA coverage.

(c) Continuing Eligibility

Eligibility will continue so long as an Active Employee's Bank is sufficient to pay the cost of coverage. For such purposes, Contributions will be credited as follows:

Contributions Received for Work Month of:*	Will be Credited to the Bank for Eligibility Month of:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

*Contributions are required to be paid the month following the work upon which they are based. Thus, for example, Contributions for the work month of January should be received in February to provide eligibility for March.

(d) Self-Payments

In the event an Active Employee's Bank is not sufficient to cover the applicable cost of coverage for a particular month, coverage may be maintained by way of self-payment.

Active Employees who have elected Opt Out coverage shall pay the monthly self-pay per month established from time to time in the sole discretion of the Trustees.

Active Employees who have elected Comprehensive Plan Coverage (Full or Standard Plan) may self-pay to maintain coverage as follows:

(1) The self-pay amount shall be determined from time to time in the sole and exclusive discretion of the Trustees.

(2) Full Self-Payments: For any month in which the difference between the applicable monthly benefit cost and an Active Employee's Bank is greater than the self-pay amount:

(A) An Active Employee may maintain coverage by paying the self-pay amount.

(B) Any Contributions received for a work month in which the Employee made such a self-payment will be placed in his/her Bank.

(C) An Active Employee can maintain coverage under this provision for 12 consecutive months and thereafter will be offered COBRA coverage.

(D) An Active Employee maintaining coverage under this Section 2.1(d)(2), i.e., full self-payments, is not entitled to weekly disability benefits under Article 6 or extended eligibility under section 2.2.

Notwithstanding, from April 1, 2019, through March 31, 2023, an Active Employee maintaining coverage under this Section 2.1(d)(2), i.e., full self-payments, will be eligible for weekly disability benefits under Article 6 and extended eligibility under section 2.2, provided the Active Employee has:

(i) continuous coverage in the Fund for the three-year period immediately preceding his/her application for weekly disability benefits, and

(ii) 25 Years of Vesting Service in the Pipefitters Local 636 Defined Benefit Fund.

(3) Partial Self-Payments: For any month in which the difference between the applicable monthly benefit cost and an Active Employee's Bank is less than the self-pay amount, the Active Employee may pay this difference to maintain coverage.

(4) Any payments made to maintain coverage under (2) or (3), above, must be received by the Fund Office within 15 days after receipt of notice that eligibility in the Fund will terminate unless self-payment or COBRA coverage is elected. Thereafter, to continue eligibility by self-payment, self-payments must be made continuously, month after month, as necessary to maintain coverage. If a self-payment is missed, an Active Employee will not be permitted to resume eligibility by making self-payments. Once the ability to make self-payments is exhausted and

eligibility is not otherwise re-established, the Active Employee will be offered COBRA.

(5) It is the Active Employee's responsibility at all times to keep track of his eligibility and he can always inquire about eligibility at the Fund Office by telephone, e-mail, or in writing.

(6) The privilege of self-payment is available only to Active Employees who are working as pipefitters for an Employer, or available for work as pipefitters for an Employer, and on the Union's out-of-work list. If an Active Employee on the Union's out-of-work list fails to accept two offered jobs for an Employer within six months, s/he will not be considered available for work and will be ineligible for self-payment.

(7) An Active Employee who has failed to obey a strike notice recommended by the Joint Administrative Committee and issued by the Union will not be entitled to maintain eligibility by way of self-payments.

(8) While on self-pay, an Active Employee can only switch between Options as described in Article 3.

(e) Re-establishing Eligibility

Once an Active Employee loses eligibility under this Section 2.1, he will reestablish eligibility the first day of the second month following the month his Dollar Bank has sufficient credit to pay for the Active Employee's selected plan option. However, if no contributions have been received for 12 consecutive months, an Active Employee must meet the rules for initial eligibility to resume coverage.

(f) Transitional Rule

As of January 1, 2015, a Participant's Bank will be credited with contributions equal to the total number of months of eligibility accrued as of that date, based upon the plan of benefits selected.

(g) Bank at Retirement and Returning to Work as an Active

1. At retirement ("the original retirement date"), the Bank is extinguished and an amount equal to the balance remaining in the Participant's Bank will be credited to the Pensioner's HRA. If Contributions on behalf of the Participant are received subsequent to the original retirement date, a credit equal to the amount of such Contributions will be credited to the Pensioner's HRA only if the total amount credited to the HRA under this paragraph (1) does not exceed the maximum Dollar Bank in effect on the original retirement date.

2. A Pensioner may return to work, re-establish a Bank as an Active Employee, and upon cessation of employment the Bank will again be extinguished. Provided the Pensioner did not receive a benefit from the Pipefitters Local 636 Defined Benefit Fund during this employment, a credit shall be deposited into the Pensioner's HRA equal to the balance remaining in the Bank. However, in no event can the total of all amounts credited to the HRA under this paragraph (2) and (1), above, exceed the maximum Dollar Bank in effect on the original retirement date.

2.2 Disability

If, while eligible, an Active Employee suffers a Disability, he will remain eligible for benefits for up to 26 weeks from the first day of such continuous Disability. If he remains disabled after this 26-week period of continuous Disability, he may apply, in writing, to the Trustees for a 13-week extension of eligibility. Upon application, a second 13-week extension of eligibility may be granted. The first and second 13-week extensions will only be granted if the individual remains Disabled and presents a statement from his physician that his disability is not permanent and he will be able to return to work as a Pipefitter. Notwithstanding the foregoing, any Participant who has been awarded social security disability benefits (other than for a closed period) will be presumed permanently disabled and unable to return to work as a Pipefitter.

If requested, any person receiving coverage pursuant to this provision must submit to an independent medical evaluation to be paid for by the Fund.

Coverage under this provision shall only be allowed for two periods of Disability caused by alcohol or substance abuse (including legal or illegal drugs).

Once an Active Employee's coverage expires under this provision, and he is not otherwise still eligible under his/her Dollar Bank, he may continue medical coverage pursuant to self-payment as set forth in Section 2.1(d).

Eligibility while Disabled is available to an Office Employee only so long as required contributions from the Union or Education Fund on his/her behalf continue to be made to the Fund. Once an Office Employee's eligibility terminates, he/she will be offered COBRA coverage.

This provision does not apply to any Pensioner, or other individual who has retired under the Pipefitters Local 636 Defined Benefit Pension Fund, even if such individual has returned to employment for which Contributions are required to be made to this Fund.

Notwithstanding any term of this Plan to the contrary, the provisions of this section 2.2 apply to an individual with an occupational or non-occupational injury or illness.

2.3 Dependents

(a) General Rules

Dependents are eligible for benefits under the Fund when the Participant of whom they are Dependents is eligible.

(b) Effect of Divorce on Dependent Coverage

If a Participant has a Child or Children and divorces from his Spouse, the Participant and Spouse must inform the Fund Office within 60 days of the divorce so proper coordination of coverage for the Child/Children can be determined.

A Participant's former Spouse is entitled to continue coverage under the Fund pursuant to COBRA Continuation Coverage. In the event that the Judgment of Divorce requires the Participant to provide health insurance coverage for his former spouse, it is the Participant's responsibility to arrange for this coverage. A divorced spouse cannot be covered as a Dependent under the Fund.

(c) Initial Enrollment of New Dependents

To become effective in the current Plan year, a Participant must request that a new Dependent be enrolled in the Plan within 30 days of the date that such person first qualifies as a Dependent. If such notice is timely made, coverage for a Spouse shall be effective the date of the marriage. Coverage for a Child shall be effective the date such person became a "Child" as defined in Article 1. If such enrollment request is not timely made: (a) coverage for a Child, except as set forth in (c), shall be effective the date such person became a Child as defined in Article 1 upon receipt of completed enrollment materials, (b) coverage for a Spouse shall be effective the first day of the first month following receipt of completed enrollment materials, and (c) coverage of an individual who is a Child due to status as a stepchild or legal guardianship shall be effective the first day of the first month following receipt of completed enrollment materials.

(d) Coverage Following Death of a Participant Who Does Not Have a Surviving Spouse

If coverage for Dependent Children covered under the Plan at the time of a Participant's death is not continued pursuant to Section 2.4, following the death of a Participant, and election may be made for the continuation of coverage: (1) by any individual with a familial, or established caretaking, relationship with the deceased Participant's Children who assumes responsibility to make the required self-payments for continued coverage, or (2) by an adult Child of the deceased Participant who assumes responsibility on his or her own behalf to make the required self-payments for continued coverage. This election must be made promptly after the death of the Participant. A monthly payment must be made for this coverage. The monthly rates are as established by the Trustees from time to time. Information regarding current rates is available at the Fund Office. The Trustees are authorized and reserve the right to change this rate at any time.

2.4. Surviving Spouse

A Surviving Spouse who desires to continue eligibility for insurance under the Fund must notify the Fund Office of her election to continue such coverage for herself and any Dependents promptly after the death of the Participant. A monthly payment must be made for this coverage. The monthly rates for Surviving Spouses are as established by the Trustees from time to time. I nformation regarding current rates is available at the Fund Office. The Trustees are authorized and reserve the right to change this rate at any time.

Upon the earlier of a Surviving Spouse becoming Medicare eligible or becoming eligible for a pension from Pipefitters Local No. 636 Defined Benefit Pension Plan or its predecessor, Plumbers Local No. 98 and Pipefitters Local No. 636 Pension Fund, his/her eligibility will terminate under the Fund.

I f a self-payment is not made as indicated above, a Surviving Spouse will not be permitted to resume eligibility by making self-payments. Upon such termination, the Surviving Spouse will be offered COBRA continuation coverage.

A Surviving Spouse is not entitled to disability or death benefits.

For purposes of this provision, a Dependent is any Child of the deceased Participant, including any Children bom to the Surviving Spouse within nine months of the death of the Participant. Coverage under this provision terminates upon the remarriage of the Surviving Spouse.

I f coverage terminates under the Plan, coverage may be available under the Pipefitters Local 636 Retiree I nsurance Fund.

2.5. Pensioner

Subj ect to the limitations set forth below, a person who meets the definition of Pensioner set forth in Article 1, and his Dependents, is eligible for Health Reimbursement Account coverage only under the Fund. I n other words, when an Active Employee becomes a Pensioner, all coverage terminates other than the Health Reimbursement Account.

For each month a Pensioner has made a self-payment to maintain coverage under the Pipefitters Local 636 Retiree I nsurance Fund and performs bargaining unit work at the req uest of the Union, he shall be reimbursed in the amount of the Contributions received by the Fund for such hours worked, provided the reimbursement from this Fund and the Pipefitters Local 636 Retiree I nsurance Fund combined does not exceed one month's self-payment. Such reimbursement shall be made q uarterly. A Pensioner may decline such reimbursement if he/she seeks to re-establish eligibility as an Active Employee.

2.6 Medicare Eligibility

The Fund provides coverage for Medicare eligible Participants and Dependents under a Medicare Policy set forth in Article 22. In the event a Medicare eligible Participant or Dependent does not obtain Medicare when eligible to do so, the Fund will not provide coverage that would have been covered by Medicare or the Medicare Policy.

(It is recommended that an Active Employee contemplating retirement contact the Social Security Administration at least four months before they will reach age 65, as such coverage is required if they are eligible for coverage under the Pipefitters Local 636 Retiree Insurance Fund.)

(a) Disability

A Participant or Dependent suffering from a disability, such as someone receiving a disability pension, becomes eligible for Medicare, regardless of age, after receiving Social Security Disability payments for two years. Such a Participant or Dependent is required to apply for Medicare benefits as soon as he/she becomes eligible for them. Once Medicare eligibility could have been obtained, even if it is not, coverage under the Plan will be coordinated with Medicare. In other words, the Plan will not pay for benefits which would have been paid for by Medicare had it been timely applied for and obtained. Thus, it is strongly recommended that the Social Security Administration be contacted as soon as possible regarding Social Security Disability payments.

(b) Dialysis Patients

After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Covered Person receiving such treatment should contact the Social Security Administration as soon as possible to obtain information regarding Medicare eligibility and take appropriate steps to become eligible for Medicare benefits. Once eligibility could have been obtained, even if it is not, the Plan will be primary (i.e., will provide benefits) only to the extent required by the Medicare Secondary Payer rules.

2.7 Termination

(a) Participants

A Participant's eligibility will terminate the first day of the first month following the month in which eligibility is lost. In addition, notwithstanding any term of this Plan to the contrary:

(1) Eligibility shall immediately terminate for an individual who works for a noncontributing employer in the plumbing and pipefitting industry or who works for a noncontributing employer performing work of the type for which Contributions would be owed if performed for an Employer under the Collective Bargaining Agreement. Such individual will not be entitled to continue coverage by way of self-payments and will be offered COBRA continuation coverage.

(2) Eligibility shall immediately terminate for an individual who works for an employer who is not in the plumbing and pipefitting industry if such individual is not on the Union's out of work list. If an Active Employee on the Union's out-of-work list fails to accept two offered jobs for an Employer within six months, s/he will not be considered available for work and will be ineligible for self-payment. Such individual will not be entitled to continue coverage by way of self-payments and will be offered COBRA continuation coverage.

(b) Dependents

Dependent eligibility terminates on the date he/she ceases to be a Dependent or on the date the Participant's eligibility terminates, whichever is earliest. However, a Dependent Child who by reason of mental or physical handicap is incapable of sustaining employment and had coverage under the Fund on the date of the Participant's death may continue coverage by completion of an F-Rider application and payment of the monthly premium for such coverage.

2.8 Eligibility for Office Employees

Office Employees shall be eligible for coverage the first day of the first month following the month in which their Employer pays the full cost of coverage selected by the Office Employee, which is equal to the cost of coverage deducted from an Active Employee's Bank for similar coverage under the first paragraph in Section 2.1(a)(2). Coverage is effective the first of the month following the month the cost of coverage is received. Office Employees are not allowed to maintain coverage by way of self-payments.

2.9 Working Principals

Unless otherwise noted in this Plan, a Working Principal may participate in the Fund under the same terms and conditions as an Active Employee. Eligibility is based on an Hour Bank as set forth in Section 2.1(a)-(c). A Working Principal may not maintain coverage by way of self-payments. A Working Principal has three options: (1) decline coverage; (2) participate with comprehensive medical coverage under Article 4; or (3) participate with Opt-Out Coverage under Article 5 in lieu of coverage under Article 4.

A Working Principal's coverage election is binding for the Plan Year, subject to the provisions set forth in Article 3 regarding elections changes for those electing Opt Out coverage.

ARTICLE 3 – OPEN ENROLLMENT/ELECTIONS

3.1. Enrollment

Non-Medicare eligible Participants may choose Medical/Rx coverage or Opt Out coverage. A Participant is automatically enrolled in Medical/Rx coverage for the Calendar Year unless at the time of initial enrollment or during the open enrollment month of November (during which changes may be made for the next Calendar Year), he executes an Opt-Out Enrollment Form. This Enrollment Form is available at the Fund Office. A Participant can only Opt-Out of Medical/Rx coverage if:

(a) The Participant is actually enrolled in a group health plan that does not consist solely of excepted benefits (e.g., can be a spouse's plan) (Other Coverage); and

(b) The Other Coverage meets the Affordable Care Act minimum value standard.

Medicare is not "Other Coverage" for purposes of this provision.

Annually, a Participant is permitted to permanently opt-out of and waive future reimbursements from the FIRA.

There are two plans available under Medical/Rx coverage – Full and Standard. If a Participant does not elect one of the coverage plans for which he/she is eligible, coverage will be provided under the Full Plan for Journeypersons and Working Principals and the Standard Plan for all others.

Except as provided below, a Participant may not switch between Options during a Calendar Year. The Participant's Dependents are enrolled in the same Option as the Participant.

Notwithstanding any term of this Plan to the contrary, an Apprentice may only elect between Full Medical/Rx Coverage or Opt Out Coverage.

See Article 4 for Medical/Rx Coverage and Article 5 for Opt Out Coverage.

3.2. Permitted Election Changes

A Participant may switch coverage Options during a Calendar Year only as follows:

(a) A Participant's acquisition of a new Dependent as a result of marriage, birth, adoption, or placement for adoption, if a request to change an election is made within 30 days of such event. An election change for marriage shall be effective

the first day of the first month following the req uested change. An election change for birth, adoption, or placement for adoption shall be effective the date of birth, adoption, or placement for adoption.

(b) An Opt-Out Participant may switch to Medical/Rx coverage during the Calendar Y ear if each of the following conditions are met:

(1) The Participant was covered under a group health plan or had health insurance coverage at the time he made his election for Opt-Out coverage ("Other Coverage");

(2) The Participant executed an Acknowledgment at the time of his election for Opt-Out coverage verifying he/she had Other Coverage;

(3) The Participant's Other Coverage:

(A) was COBRA coverage and which has been exhausted; or

(B) was non-COBRA coverage which has been terminated as a result of:

(i) loss of eligibility due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, termination of the plan for similarly situated individuals, or cessation of Dependent status; or

(ii) employer contributions toward such coverage were terminated; and

(4) The Participant req uests enrollment in Medical/Rx coverage within 30 days of the termination of the Other Coverage.

An election change for the reasons set forth above shall be effective the first day of the first month following the req uested change.

(c) A Participant taking leave under the Family Medical Leave Act may change his election for the period of time he/she is on such leave.

(d) An Opt-Out Participant may also switch to Medical/Rx coverage during the Calendar Y ear if he/she loses eligibility for Medicaid or the Children's Health I nsurance Program or becomes eligible to participate in a premium assistance program under Medicaid or the Children's Health I nsurance Program. I n both instances, the employee must req uest special enrollment within 60 days of the loss of Medicaid/Children's Health I nsurance Program coverage or of the eligibility determination.

(e) Once per year, a Participant with Medical/Rx coverage can elect to switch from the Full Plan to the Standard Plan. Once per year, a Participant with Medical/Rx coverage under either plan can elect to switch to Opt-Out coverage. Once such election is made, no further changes can be made until the next Open Enrollment.

3.3 Participant on Disability

A Participant entitled to coverage under Section 2.2 (Disability), above, may elect to change coverage Options during such period of time he is disabled and entitled to benefits under Section 2.2, pursuant to the rules set forth in Section 3.2, above.

3.4 Enrolling Dependents During Open Enrollment

During the open enrollment period of November, Participants will have the opportunity to enroll eligible Dependents who were not previously enrolled.

If during open enrollment the Participant states in writing that the reason for declining coverage for a Dependent is because such Dependent has Other Coverage, then if the Other Coverage involuntarily terminates during the Plan Year, the Dependent may enroll in the Plan the first of the month following the date a request to enroll is received, provided this request is made within 30 days of such termination. For purposes of this section:

(a) Coverage involuntarily terminates when:

(1) the other coverage was COBRA coverage and it has been exhausted; or

(2) the other coverage was non-COBRA coverage and it has been terminated as a result of loss of eligibility for the coverage, including due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, termination of the plan for similarly situated individuals, cessation of dependent status, or employer contributions toward such coverage were terminated (and the Dependent Child had no control over such termination of contributions).

(b) Other Coverage is coverage under a group health plan or health insurance coverage, not including accident or disability only policies, coverage issued as a supplement to liability insurance, liability insurance, workers compensation or similar insurance, automobile medical payment insurance, credit only insurance, coverage for on-site medical clinics, or other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits.

ARTICLE 4 – COMPREHENSIVE COVERAGE: MEDICAL, PRESCRIPTION DRUG, AND DENTAL BENEFITS

4.1 Self-Funded Medical Benefits

Medical benefits are self-insured. The Fund has contracted with a preferred provider network. A list of the physicians participating in this network (the Provider Directory) is available at the Fund Office, free of charge. If a Plan Participant receives covered services from a provider who is not a Participating Provider because he or she reasonably relied on incorrect information from the Provider Directory, then the Plan Participant will only be responsible for the Participating Providers' copayment, deductible, or coinsurance. Participants and their Dependents may choose to receive treatment from an out-of-network provider but will generally incur greater out of pocket expenses if they do so. Medical coverage for Medicare eligible participants is provided as set forth in Article 22.

An out-of-network in-patient surgical procedure will be covered at the in-network level, not to exceed charges that would be paid by the Fund if it were performed in-network, where, as determined in the sole discretion of the Trustees: (a) the out-of-network facility and primary physician performing the surgical procedure have recognized expertise in performing the procedure, (b) the procedure is regularly performed by the out-of-network facility on a weekly basis, and (c) the procedure is not performed on a regular basis more than one time per year by any in-network provider.

Services Provided by Nonparticipating Provider at Participating Facility: Notwithstanding any term of the Plan to the contrary, where covered nonemergency items or services are provided by nonparticipating providers at participating facilities, in the absence of Consent to Out of Network Services, the Plan will:

i. not impose a cost sharing requirement greater than the requirement that would apply if the items or services were provided by a participating provider;

ii. calculate cost-sharing as if the total amount that would have been charged for the items or services by a participating provider were equal to the Recognized Amount for such services; and

iii. apply any cost-sharing payments with respect to such items and services toward any in-network deductible or in-network out-of-pocket maximums the same as if the services were received in-network.

Continuing Care Patient: If a covered person is a Continuing Care Patient of a provider or facility that terminates its participating provider status with the Plan as a result of: (a) termination of its contractual relationship as a participating provider (not including termination of the contract for failure to meet quality standards or fraud), or (b) termination of benefits under the Plan due to a change in the terms of the participation of the provider or facility in the network, the Plan will:

i. notify each Continuing Care Patient on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility as set forth in c), below;

ii. provide such individual with an opportunity to notify the Plan of the individual's need for transitional care; and

iii. allow such individual to elect to continue benefits provided under the Plan under the same terms and conditions as would have applied to the individual as a Continuing Care Patient had such termination not occurred, during the period beginning on the date on which the notice under a), above, is provided and ending on the earlier 90 days or the date on which such individual is no longer a Continuing Care Patient with respect to such provider or facility.

(a) Schedule of Benefits

Where an approved surgical procedure involves a cochlear implant, service and parts required to maintain the implant will be covered at in-network levels if the only provider who can provide such service and parts is out-of-network.

Participants may elect, as set forth in Article 3, benefits under the Full or Standard Plan. Subject to the exclusions set below, the following summarizes the Medical benefits provided under the Fund (other than for Medicare eligible participants):

An out-of-network in-patient admission to treat a rare genetic disorder will be covered at the in-network level, not to exceed charges that would be paid by the Fund if it were performed in-network, where, as determined in the sole discretion of the Trustees: (a) the out-of-network facility has recognized expertise in treating the disorder; (b) the out-of-network facility has a specific program dedicated to treating the disorder; (c) there are no in-network facilities with comparable expertise in treating the disorder; and (d) the admission is preauthorized as Medically Necessary for no more than 4 weeks at a time. For purposes of this provision, a condition will be considered "rare" if it appears on the then current U.S. National Institute of Health Genetic and Rare Diseases Information Center.

	Full Plan		**Standard Plan**	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual or Lifetime Maximum on Essential Health Benefits	None	None	None	None
Annual Deductibles - In/Out Satisfies each other	$300/person $600/family	$600/person $1,200/family	$1,000/person $2,000/family	$2,000/person $4,000/family
Annual Out of Pocket Co-Insurance Maximums - In/Out Satisfies each other	$2,500/person $5,000/family	$5,000/person $10,000/family	$5,000/person $10,000/family	$10,000/person $20,000/family
2016 Annual TROOP (Total Real Out of Pocket Maximums for essential health benefits) (includes deductibles, co-	$6,850/person $13,700/ family	No TROOP limit	$6,850/person $13,700/ family	No TROOP limit

insurance and co-pays for medical and Rx)– Annual TROOP to be adj usted annually to eq ual the Maximum Annual Limitation on Cost Sharing established by I I HS				

The below percentages represent the percentage paid by the Plan. If marked with an "*55 5 the Plan pays after satisfaction of the In-Network Deductible set forth above. If marked with an "", the Plan pays after satisfaction of the Out-of-Network Deductible set forth above. "UCR" means usual, customary, and reasonable.**

	Full Plan		**Standard Plan**	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient Hospital				
Facility - I npatient Hospital (Semi-private room)	80%*	70% UCR**	70%*	60% UCR **
Ambulatory Surgery Center	80%*	70% UCR**	70%*	60% UCR**
Surgery	80%*	70% UCR**	70%*	60% UCR**
Anesthesia	80%*	70% UCR**	70%*	60% UCR**
Assistant Surgeon	80%*	70% UCR**	70%*	60% UCR**
I n-Hospital Consultations	80%*	70% UCR**	70%*	60% UCR**
Diagnostic Lab/X-Ray	80%*	70% UCR**	70%*	60% UCR**
I maging (CT/PET scans, MRI)	80%*	70% UCR**	70%*	60% UCR**
Respiratory Therapy	80%*	70% UCR**	70%*	60% UCR**
Acute K idney Dialysis	80%*	70% UCR**	70%*	60% UCR**
Maternity – Delivery/I n-patient services/Birthing Center	80%*	70% UCR**	70%*	60% UCR**
Organ Transplant Benefits	80%*	70% UCR**	70%*	60% UCR**
Outpatient Care				
Pre-Admission Testing	80%*	70% UCR**	70%*	60% UCR**
Surgery (All Related Expenses)	80%*	70% UCR**	70%*	60% UCR**
Diagnostic Lab/X-Ray	80%*	70% UCR**	70%*	60% UCR**
Emergency Services for an Emergency Medical Condition - Facility/Physician Co-pay is waived if emergency care is for accidental inj ury or if admitted.	For out-of-network expenses for Emergency Services for an Emergency Medical Condition, the in-network out-of-pocket maximums apply and the out of network co-insurance and copayment are to be counted towards in-network out-of-pocket maximums.			
	100% after $150 copay*	100% of the Recognized Amount after $150 copay**	100% after $150 copay*	100% of the Recognized Amount after $150 copay**
- Lab/X/Ray/Diagnostic Testing	80%*	80% of the Recognized Amount**	70%*	60% UCR**

	Full Plan		Standard Plan	
Rehabilitation: Occupational/ Physical/ Speech/Respiratoiy Therapy - Limited to a combined maximum of 90 visits per member per year. All visits subj ect to pre-authorization by BCBSM Utilization and Case Management	80%*	70% UCR**	70%*	60% UCR**
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Habilitation Services except for Habilitation Services related to Autism Spectrum Disorder as set forth below.	Not covered	Not covered	Not covered	Not covered
Radiation and Chemotherapy	80%*	70% UCR**	70%*	60% UCR**
Dialysis	80%*	70% UCR**	70%*	60% UCR**
Second surgical opinion	80%*	70% UCR**	70%*	60% UCR**
Mental Health				
I npatient Care/ Outpatient Treatment Program	80%*	70% UCR**	70%*	60% UCR**
Outpatient Psychotherapy	80%*	70% UCR**	70%*	60% UCR**
Autism Spectrum Disorder	80%*	70% UCR**	70%*	60% UCR**
Alcohol/Substance Abuse				
I npatient Care/ Outpatient Treatment Program	80%*	70% UCR**	70%*	60% UCR**
Outpatient Psychotherapy	80%*	70% UCR**	70%*	60% UCR**
Physician's Office/Urgent Care				
Primary care - visit for I llness/I nj ury	100% after $20 co-pay	70% UCR**	100% after $25 co-pay	60% UCR**
Specialists & Consultations	100% after $20 co-pay	70% UCR**	100% after $50 co-pay	60% UCR**
Pre and Post Natal Care which are not preventive care	80%*	70% UCR**	70%*	60% UCR**
Allergy Testing/Treatment	100%*	70% UCR**	70%*	60% UCR**
Diagnostic Lab/X-Ray	**80%***	70% UCR**	70%*	60% UCR**
Colonoscopy – medical necessary (first per year covered under preventative)	80%*	70% UCR**	70%*	60% UCR**
Surgery	80%*	70% UCR**	70%*	60% UCR**
Preventive Services Required to be Covered by Law Preventive service benefits are covered without cost-sharing in-network to the extent req uired under federal law. This means deductibles, co-insurance, and copayments do not apply to these benefits if				

	Full Plan		Standard Plan	
provided in-network. The following is a representative list of items covered by law as preventive services as of May 1, 2023, but is not a complete list of all such items, and this list changes from time to time. For a list of items and services covered as preventive care under federal law at any given time, please visit the following websites: • U.S. Preventive Services Task Force, A & B Recommendations: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Health Resources & Services Administration Adopted-Guidelines for Women, Children, and Youth: https://mchb.hrsa.gov/programs-impact/programs/preventive-guidelines-screenings-women-children-youth • Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html Items and services covered by the Plan for preventive services will be updated and amended automatically as required by law, which may include additions to and subtractions from the representative list of covered items set forth below. Be aware that federal law may limit these benefits to certain individuals by age, sex, health history or status, and impose treatment limitations such as once per lifetime, once per year, etc. Providing all such limitations in this Plan document is not possible. Some of the representative items or services set forth below may indicate coverage once per year, etc., but that does not mean other representative preventive services do not have limitations as to timing, amounts, who is covered, etc. Contact the Fund Office if you have any questions regarding the scope of coverage for any preventive service or item.				
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
For Adults: • Screenings, most commonly covered annually, including the following: o Abdominal Aortic Aneurysm o Cholesterol o Colorectal Cancer (and follow-up, if required by law) o Depression o Hepatitis C o HIV o Hypertension o Latent Tuberculosis	100%	Not covered	100%	Not covered

	Full Plan		Standard Plan	
o Lung Cancer o Prediabetes and Type 2 Diabetes o Syphilis o Unhealthy Alcohol and Drug Use • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Doses, recommended ages, and population may vary. • Tobacco Smoking Cessation Interventions • Unhealthy Alcohol Use Behavioral Counseling • Weight Loss to Prevent Obesity-Related Morbidity and Mortality Behavioral Interventions				
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
For Women: • Screenings, including for the following: o Anxiety o Breast Cancer (Mammography) o Cervical Cancer o Diabetes After Gestational Diabetes o Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults o Osteoporosis o Urinary Incontinence o STIs (including Chlamydia and Gonorrhea) • BRCA-Related Cancer Risk Assessment, Genetic Counseling and Genetic	100%	Not covered	100%	Not covered

	Full Plan		Standard Plan	
Testing • Obesity Prevention Counseling • Sexually Transmitted I nfections Counseling • Well-Women Visits, which include pre-pregnancy, prenatal, postpartum, and interpregnancy visits				
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
For Pregnant Women or Women Who May Become Pregnant: • Screenings, including for the following: o Anxiety o Bacteriuria o Contraception o Gestational Diabetes o Rh(D) I ncompatibility o STI s (including Chlamydia, Gonorrhea, Hepatitis B, HI V, and Syphilis) o Preeclampsia o Urinary Tract or other I nfection • Breastfeeding Services and Supplies (including, but not limited to double electric breast pumps [including pump parts and maintenance] and breast milk storage supplies) • Contraception Education, Counseling, Provision of Contraceptives and Follow-Up Care (including sterilization surgery) • Healthy Weight and Weight Gain Behavioral Counseling • Perinatal Depression Preventive I nterventions • Preeclampsia Prevention • Substance Use Assessment	100%	Not covered	100%	Not covered

	Full Plan		Standard Plan	
• Tobacco I ntervention and Counseling • Well-Women Visits, which include pre-pregnancy, prenatal, postpartum, and interpregnancy visits				
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
For Infants, Children, Adolescents, & Young Adults (Newborn—21 years old): • Screenings, including for the following: o Anemia o Autism Spectrum Disorder o Behavioral/Social/ Emotional o Blood Pressure o Cervical Dysplasia o Depression and Suicide Risk o Developmental o Dyslipidemia o Hearing o Lead Level o Newborn Blood, Bilirubin, and Critical Congenital Heart Disease o Obesity o Scoliosis o STI s (including but not limited to Chlamydia, Gonorrhea, HI V, and Syphilis) o Tobacco, Alcohol, and Drug Use	100%	Not covered	100%	Not covered

	Full Plan		Standard Plan	
o Tuberculosis o Vision • Fluoride Varnish and Oral Fluoride Supplementation • I mmunizations that have in effect a recommendation from the Advisory Committee on I mmunization Practices of the Centers for Disease Control and Prevention. Doses, recommended ages, and populations may vary. • Oral Health Risk Assessment and Referral • Sudden Cardiac Arrest / Death Risk Assessment • Tobacco, Alcohol, and Drug Use I nterventions • Well-Baby/Child Examinations				
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Routine Services Not Required to be Covered by Law				
Routine Physicals (limited to one per calendar year)	100%	Not covered	100%	Not covered
Prostate Exam/I mmunizations (limited to one per calendar year)	100%	Not covered	100%	Not covered
Affiliates				
Chiropractors Limited to a combined maximum of 24 visits per member per calendar year	$20.00 co pay	70% UCR	$20.00 co-pay	60% UCR
Other Services				
Skilled Nursing Facility (Pre-Approval Req uired) – limited to 120 days per covered person per calendar year	80%*	70% UCR**	70%*	60% UCR**
Private Duty Nursing (Pre-Approval Req uired)	50%*	80% UCR**	50%*	50% UCR**
Home Health Care (Pre-Approval Req uired)	80%*	70% UCR**	70%*	60% UCR**

	Full Plan		Standard Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Home I nfusion Therapy – I f services provided by Americare Medical, all deductible and co-insurance req uirements waived.	80%*	70% UCR**	70%*	60% UCR**
Hospice Care (Pre-Approval Req uired) Up to 28 per-hospice counseling visits before electing hospice services; when elected, four 90-day periods provided through a participating hospice program only; limited to dollar maximum that is reviewed and adj usted periodically (after reaching dollar maximum, members transitions into individual case management)	100%	**100**%	100%	100%
Durable Medical Eq uipment	80%*	70% UCR **	70%*	60% UCR **
Ground Ambulance – limited to 2 trips per confinement	80%*	70% UCR**	70%*	60% UCR*
Air Ambulance (when Medically Necessary) For out-of-network expenses for Air Ambulance, the in-network deductible and in-network out-of-pocket maximums apply and the out of network co-insurance and deductible are to be counted towards in-network out of pocket maximums	80%*	80% of lesser of billed charges of the Q ualified Payment Amount, after deductible*	70%*	70% of lesser of billed charges of the Q ualified Payment Amount, after deductible*
Outpatient Diabetes Management Program (ODMP)	80%* for medical supplies; 100% for self-management training	70% UCR **	80%* for medical supplies; 100% for self-management training	60% UCR**
Hair Prosthesis ("Wig") for hair loss resulting from chemotherapy cancer treatment only.	80% after in-network deductible; $500 maximum; once per lifetime	80% after in-network deductible; $500 maximum; once per lifetime	80% after in-network deductible; $500 maximum; once per lifetime	80% after in-network deductible; $500 maximum; once per lifetime
Hearing Benefit				
Hearing aids, audiometric exam,	100% of	100% of	100% of	100% of

	Full Plan		Standard Plan	
hearing aid evaluation, fitting, hearing aid conformity test up to $3,000.00 every 3 years. Note: A hearing discount program is available through NationsHearing. All terms and conditions of discounts and services available through NationsHearing are governed by the summaries and/or brochures provided by NationsHearing.	Approved Amount	Approved Amount	Approved Amount	Approved Amount
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Coronavirus/COVID-19				
Health Care Provider-ordered COVI D-19 Testing/Facility Charges	80%*	70% UCR**	70%*	60% UCR**
Treatment for COVI D-19	80%*	70% UCR**	70%*	60% UCR**

Telehealth: Telehealth visits through MDLive will be covered 100%.

Maternity Benefits: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benchmark: Effective August 1, 2014, the Plan adopts the Utah state benchmark plan for purposes of defining essential health benefits.

(b) Exclusions

The following services and benefits are not covered by the Plan, unless required to be covered by federal law as a preventative care benefit:

(1) Services provided before the effective date of coverage.

(2) Services provided after the effective date of termination of coverage.

(3) Charges that are not Reasonable and Customary.

(4) Services or supplies not Medically Necessary.

(5) Services or supplies provided mainly as a rest cure, maintenance or custodial care.

(6) Charges related to donating an organ or tissue to an individual other than a Participant or Dependent.

(7) Services for educational or vocational testing or training.

(8) Exercise programs for treatment of any condition, except for physician supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(9) Radial keratotomy or other eye surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera sheet intended for use as comeal bandages.

(10) Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except for open cutting operations), and treatment or corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(11) Charges for travel outside the United States without Plan approval if sole purpose is to obtain medical services, supplies or drugs.

(12) Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(13) Care and treatment of hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a physician unless such hair loss results from chemotherapy/cancer treatment.

(14) Expenses for cosmetic surgery; unless (1) treatment is rendered by a physician for injuries sustained in an accident and such treatment is begun within ninety days after such accident; (2) treatment is for a congenital anomaly; (3) treatment is rendered for reconstruction of the breast, surgery and reconstmction of the other breast for symmetrical appearance, or prostheses and physical complications in all stages of mastectomy; or (4) such surgery is incidental to any other covered illness.

(15) Charges for use of any treatment, supply, device or facility which (a) does not have required governmental approval, or (b) is experimental, investigative or not a generally accepted medical practice.

(16) Services that are not health care services (e.g. personal and convenience, completion of forms, cost of transportation except covered ambulance services).

(17) Services, care, supplies or devices not prescribed by a physician and not directly related to the diagnosis or treatment of illness or injury.

(18) Services not rendered by a licensed physician. In the case of treatment of psychiatric conditions, services must be rendered by a licensed physician, licensed clinical psychologist, or licensed social worker.

(19) Expenses in connection with dental work, except for treatment made necessary by an accident and rendered by a physician or a legally licensed dentist within 90 days of such accident. Notwithstanding, in the event dental procedures are required, as supported by documentation acceptable to the Trustees, to prevent complications arising from the medical treatment of a life-threatening medical condition, the recommended dental procedures will be covered to the extent not covered under the self-insured Delta Dental PPO Option or the fully insured Golden Dental DMO Option.

(20) Charges for services rendered by Participant's or Dependent's immediate family (i.e., spouse, brother, sister, parent, or child) or regular member of the Participant's or Dependent's immediate household.

(21) Services for which a charge would not have been made had no coverage existed; services that the Participant or Dependent is not legally obligated to pay.

(22) Services provided by Employer facilities.

(23) An injury or illness for which the Participant or Dependent is eligible for benefits under any workers' compensation plan.

(24) Claims incurred on or after July 1, 2015, through June 30, 2020, for any injury or illness arising from a motor vehicle accident in the State of Michigan involving a motor vehicle owned or registered by a Participant or his/her Dependent where a required policy of no-fault insurance under Michigan law is not in effect. However, if such a policy of no-fault insurance is in effect, the Plan will pay claims for covered persons arising from such accident ON A SECONDARY BASIS ONLY. The Plan will not duplicate benefits payable by such no-fault policy or any other insurance policy pursuant to which claims arising from such accident are payable.

Claims incurred for an injury or illness arising from a motor vehicle accident in the State of Michigan on or after July 1, 2020.

(25) The Fund shall not be liable for the first Twenty Thousand Dollars ($20,000.00) of incurred medical expenses by a Covered Person for any injury or illness arising from a motorcycle accident in the State of Michigan for which coverage for medical benefits is required by law.

(26) Any injury or illness arising from a motor vehicle accident in a State other than Michigan for which there is in effect, or is required to be in effect, any policy of No-Fault insurance. This exclusion is not applicable to expenses not paid by any policy of No-Fault insurance as a result of state required policy deductibles or maximums. (For any injury or illness arising from a motor vehicle accident in a State other than Michigan for which there is no requirement to maintain No-Fault insurance, the Plan will pay claims for covered persons arising from such accident ON A SECONDARY BASIS ONLY.)

(27) Charges for in-vitro fertilization, GIFT or similar or more extensive procedures.

(28) Charges for food supplements and vitamins.

(29) Custodial care, which means care furnished to aid the Covered Participant in the activities of a normal daily life, such as help to walk, bathe, eat or dress.

(30) Expenses incurred for treatment of injuries, sickness, or disability incurred while the Participant or Dependent was engaged in illegal activity. On a one-time only basis, this provision will not exclude coverage of up to $40,000.00 for treatment of a Participant's injuries arising from a physical altercation with another Participant where, as determined in the sole and exclusive discretion of the Trustees, the physical altercation: (a) does not meet the elements of a felony offense; (b) does not result in a substantial bodily injury to the other Participant that necessitated immediate medical treatment or caused disfigurement, impairment of health, or impairment of any bodily part; (c) does not relate to or arise out of a domestic assault or dispute; and (d) is not the basis of any arrest or criminal charges against the Participant.

(31) Expenses incurred as a result of being under the influence of any illegal drug (or illegal or improper use of a legally prescribed drug).

(32) Any injury or illness resulting from war, whether or not a declared war.

(33) Expenses in connection with care rendered within a facility of, or provided by, the United States Veterans' Administration for service-connected disabilities, I llnesses, or I nj uries.

(34) Expenses incurred for treatment of self-inflicted inj uries, unless they were the result of a physical or mental condition.

(35) Charges for care, items, services, or treatment for gender dysphoria (e.g., sex transformations and gender reassignment) and treatment for inorganic sexual dysfunction or inadeq uacy, including medications, implants, surgery, medical, or psychiatric treatment, both pre- and post-operative care, and related hormone treatments.

(36) Charges related to bariatric surgery. Notwithstanding, the Plan will cover, on a one-time basis only (no repeat or corrective procedures), the procedures set forth in (A), (B), or (C) below, only if the Covered Person meets the indicated criteria, subj ect to a 25% co-insurance (to which out of pocket maximums do not apply), with a maximum benefit of $25,000:

(A) Roux-en-Y Gastric Bypass (RY GB):

To be eligible, Covered Person must satisfy all selection criteria set forth in (i)-(vi), below:

(i) Presence of severe obesity that has persisted for at least five years, defined as any of the following:

(a) Body mass index (BMI) exceeding 40; or

(b) BMI greater than 35 in conj unction with any of the following severe co-morbidities:

(I) Coronary heart disease; or
(I I) Type 2 diabetes mellitus; or
(I I I) Clinically significant obstructive sleep apnea (i.e., patient meets the criteria for treatment of obstructive sleep apnea); or
(I V) Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management); and

(ii) Completed growth (18 years of age or documentation of completion of bone growth); and

(iii) Non-smoking for at least four months prior to surgery; and

(iv) Attempted weight loss in the past without successful long-term weight reduction; and

(v) Must meet either criterion (a) or (b), below:

(a) Physician-supervised nutrition and exercise program: Covered Person must have participated in physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This physician-supervised nutrition and exercise program must meet all of the following criteria:

(I) Nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; and

(II) Nutrition and exercise program(s) must be for a cumulative total of six months or longer in duration and occur within two years prior to surgery, with participation in one program of at least three consecutive months. (Precertification may be made prior to completion of nutrition and exercise program as long as a cumulative of six months participation in nutrition and exercise program(s) will be completed prior to the date of surgery.); and

(III) Covered Person's participation in a physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who supervised the Covered Person's participation. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician. Note: A physician's summary letter is not sufficient documentation. Documentation should include medical records of physician's contemporaneous assessment of patient's progress throughout the course of the

nutrition and exercise program. For Covered Persons who participate in a physician-administered nutrition and exercise program (e.g., MediFast, OptiFast), program records documenting the Covered Person's participation and progress may substitute for physician medical records; or

(b) Multidisciplinary surgical preparatory regimen: Proximate to the time of surgery, Covered Person must participate in an organized multidisciplinary surgical preparatory regimen of at least three months duration meeting all of the following criteria:

(I) Consultation with a dietician or nutritionist; and

(II) Reduced-calorie diet program supervised by dietician or nutritionist; and

(HI) Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by exercise therapist or other qualified professional; and

(IV) Behavior modification program supervised by qualified professional; and

(V) Documentation in the medical record of the Covered Person's participation in the multidisciplinary surgical preparatory regimen. Note: A physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation (documentation should include medical records of the physician's initial assessment of the Covered Person, and the physician's assessment of the Covered Person's progress at the completion of the multidisciplinary surgical preparatory regimen); and

(vi) For Covered Persons who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression), who are currently under the care of a

psychologist/psychiatrist, or who are on psychotropic medications, a pre-operative psychological evaluation and clearance is necessary.

(B) Open or Laparoscopic Vertical Banded Gastroplasty (VBG) and Laparoscopic Adjustable Silicone Gastric Banding (LASGB, Lap-Band): To be eligible, Covered Person must satisfy all selection criteria set forth in (i)-(ii), below:

(i) meet the Selection Criteria for RY GB, set forth above in paragraph (36)(A)(i)-(vi), above; and

(ii) are at increased risk of adverse consequences of a RY GB due to the presence of any of the following co-morbid medical conditions:

(a) Hepatic cirrhosis with elevated liver function tests; or

(b) Inflammatory bowel disease (Crohn's disease or ulcerative colitis); or

(c) Radiation enteritis; or

(d) Demonstrated complications from extensive adhesions involving the intestines from prior major abdominal surgery, multiple minor surgeries, or major trauma; or

(e) Poorly controlled systemic disease.

(C) Laparoscopic Sleeve Gastrectomy:

To be eligible, Covered Person must satisfy all Selection Criteria for RY GB, set forth above in paragraph (36)(A)(i)-(vi).

(D) The above procedures are the only procedures covered by the Plan, which means, among others, the following are not covered procedures under any circumstance:

- Loop gastric bypass;
- Gastroplasty, more commonly known as "stomach stapling" (see below for clarification from vertical band gastroplasty);
- Duodenal switch operation;
- Biliopancreatic bypass (Scopinaro procedure);
- Mini gastric bypass;
- Silastic ring vertical gastric bypass (Fobi pouch)
- Intragastric balloon;

- LASGB, except in limited circumstances noted above in paragraph 36(B); and
- VBG, except in limited circumstances noted above in paragraph 36(B).

(E) Routine cholecystectomy will be covered when performed in concert with covered bariatric procedures.

(37) Charges related to weight loss programs, unless the Covered Person:

(A) has a body mass index ≥ 30 kg/m^2; OR

(B) has a body mass index ≥ 27 and < 30 kg/m^2 and one or more of the following comorbid conditions:

- Coronary artery disease
- Diabetes mellitus type 2
- Sleep apnea
- Obesity-hypoventilation syndrome (Pickwickian syndrome)
- Hypertension (systolic blood pressure ≥ 140 mm HG or diastolic blood pressure ≥ 90 mm Hg on more than one occasion)
- Dyslipidemia:
    i. LDL cholesterol ≥ 160 mg/dL; or
    ii. HDL cholesterol < 35 mg/dL; or
    iii. Serum triglyceride levels ≥ 400 mg/dL;

  and the program is approved as appropriate and monitored by BCBSM Utilization and Case Management.

(38) Gene Therapy

(39) Notwithstanding any other provision of this plan to the contrary, no medical claims will be paid in excess of the stop loss attachment point until funding for such claims is received by the Fund from the stop loss carrier.

(40) Conditions related to developmental delay, learning disabilities, behavioral problems, or intellectual disability.

(c) Blue Cross Blue Shield of Michigan: Utilization Management

(A) Definitions

(1) Pre-Certification – pre-certification is the process through which a review of the patient's symptoms and proposed treatment is undertaken to determine, in advance, whether

treatment in an inpatient setting is medically necessary and appropriate.

(2) Pre-Authorization – pre-authorization is the process through which a provider obtains a determination that a health care service, treatment plan, prescription drug, or durable medical equipment, is medically necessary prior to that service, treatment plan, drug, or equipment being rendered or obtained.

(B) The following services are subject to Pre-Certification or Pre-Authorization. If they are not Pre-Certified or Pre-Authorized, coverage under the Plan will be denied. Coverage of any services that have been Pre-Certified or Pre-Authorized are also subject to any other applicable Plan terms and conditions.

(1) Services Requiring Pre-Certification

- Inpatient Substance Abuse
- Inpatient Mental Health
- Inpatient Hospital Stay
- Skilled Nursing Facility / Rehabilitation Facility
- Long Term Acute Care Hospital

(2) Services and Items Requiring Pre-Authorization

- Specialty Drugs, including office and outpatient infusion therapy
- All Non-Emergency Air Ambulance transportation
- Bone Marrow Transplants
- Radiology Services:
  - MRI
  - CT
  - MRA
  - PET
  - Echo-Cardiology
  - Nuclear Cardiology
  - In-Lab Sleep Studies
  - Proton Beam Therapy

4.2 Prescription Drug Benefits

(a) Co-Payments and Co-Insurance

Self-funded drug coverage is administered by a pharmacy benefit manager (PBM). The following chart sets forth applicable co-payments and co-insurances to be paid by the covered person based on Full or Standard plan coverage. These

amounts are based on the PBM's Formulary, which is subj ect to change at any time. Further, to obtain coverage certain drugs are subj ect to preauthorization or step therapy. Drugs subj ect to preauthorization or step therapy may be changed from time to time and a list of such drugs is available at Fund Office.

(1) Drugs for which a manufacturer coupon is available

Full or Standard Plan: For any drug which costs over $400 and for which a manufacturer coupon is available, the Covered Person shall pay either:

> a 50% copayment if the Covered Person does not obtain and use an available manufacturer coupon; or

> a 0% copayment if the Covered Person does obtain and use an available manufacturer coupon (however, the Covered Person must pay any copayment req uired at point of sale to use the coupon and the Fund will reimburse the Covered Person for such copayment).

The Flealth Plan Advocate has been retained by the Fund to assist Covered Persons obtain and use available manufacturer coupons.

(2) Drugs for which a manufacturer coupon is not available

The following copayments apply:

PRESCRIPTION BENEFITS		
	Full Plan	**Standard Plan**
IN-NETWORK		
	Retail (34 day supply)	**Retail (34 day supply)**
Tier 1	$10 Co-Pay ($20 Co-Pay for 35-90 day supply)	$10 Co-Pay ($20 Co-Pay for 35-90 day supply)
Tier 2	$40 Co-Pay	$40 Co-Pay
Tier 3	$80 Co-Pay	$80 Co-Pay
Tier 4 Specialty – must use PBM pharmacy	$150 30-day supply only	$150 30-day supply only
	Mail Order	**Mail Order**
Tier 1	$10 Co-Pay 1-34 day supply $20 Co-Pay 35-90 day supply	$10 Co-Pay 1-34 day supply $20 Co-Pay 35-90 day supply
Tier 2	$40 Co-Pay 1-34 day supply $80 Co-Pay 35-90 day supply	$40 Co-Pay 1-34 day supply $80 Co-Pay 35-90 day supply
Tier 3	$80 Co-Pay 1-34 day supply	$80 Co-Pay 1-34 day supply

	$160 Co-Pay 35-90 day supply	$160 Co-Pay 35-90 day supply
Tier 4 Specialty	$150 30-day supply	$150 30-day supply
OUT-OF-NETWORK	Not covered	Not covered

If a covered person purchases a brand name medication that has a generic equivalent available, in addition to the above copayments he/she must pay the difference in price between the brand name medication and its available generic. Notwithstanding, if prescription is written DAW1 (dispense as written by physician) the covered person will not have to pay the difference in price and will only pay the applicable brand name copay.

As noted above, the prescription drug benefit is based upon a formulary drug list, which is a list of preferred medications organized into groups or "Tiers." A full formulary listing is available online. Additional information regarding the purchase of mail-order prescription medication is available on the PBM's member website.

The Fund covers preventive health drugs without cost-sharing, as required by federal law. Preventive health drugs must be: (1) prescribed by a healthcare provider (even for over-the-counter products); and (2) obtained from an in-network pharmacy. Preventive health drugs include the following:

- Antiretrovirals (PrEP)
- Aspirin
- Bowel Preparation Products
- Breast Cancer Prevention Drugs
- Female contraceptives, including but not limited to the full range of FDA-approved contraceptives and emergency contraceptives
- Fluoride
- Folic Acid
- Low to Moderate Dose Statins
- Tobacco Cessation Drugs

Please be aware that federal law may limit these benefits to certain individuals by age, sex, health history or status.

Please contact the Fund Office to obtain a list of covered preventative health drugs and the specific coverage criteria applicable to each drug. You may also find a list of such drugs at U.S. Preventive Services Task Force, A&B Recommendations: www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.

Effective January 1, 2016, all compounded prescriptions must be filled through Orchard Compounding Services.

Inhaler assisting devices are covered with a prescription and over the counter (OTC).

Prescription Nutritional Supplements and prescription Vitamins are covered.

(b) Exclusions/Limitations of Coverage

The following drugs are excluded from coverage, or subject to the limitations set forth below, unless required to be covered by federal law as a preventive care benefit:

- Injectable Vitamins
- Oral Sexual Dysfunction Drugs (other than those specifically covered – e.g., erectile dysfunction drugs are covered with a letter of medical necessity)
- Other lifestyle medications. Some lifestyle medications may be eligible for coverage, with the covered person paying 100% of the cost after the PBM discount is applied. Contact Fund Office for list of excluded lifestyle medications and those covered.
- Cosmetic Drugs
- Smoking Cessation Drugs (other than those specifically covered)
- Diabetic Supplies (other than those specifically covered – i.e., injectables, insulin needles and syringes, lancets and devices, glucometers, glucose test strips and glucagon injectables)
- Injectable Vaccines and Immunizations
- Injectable Growth Hormones (unless covered pursuant to a prior authorization)
- Proton Pump Inhibitors (unless prescribed under step therapy and provided that a first line medication is attempted and determined ineffective before utilization of a branded PPI agent).
- Suboxone, unless prior authorization is received on an annual basis
- Certain drugs subject to coverage pursuant to approved Step Therapy or Prior Authorization programs. A list of drugs subject to Step Therapy and Prior Authorization programs, which may change from time to time in the sole discretion of the Trustees, is available at the Fund Office.
- Bulk Powder Compounds require a letter of medical necessity for plan costs greater than $200.
- Implantable/injectable medications other than those specifically covered.

Further, any and all exclusions under Section 4.1(b) of the Plan also apply to Drug Coverage.

Prescription drug coverage for Medicare eligible participants is provided as set forth in Article 22.

4.3 Dental Benefits

(a) Self-Funded Dental Coverage

Self-funded dental benefits are administered by Delta Dental Plan of Michigan shall be provided to Participants and their Dependents. The maximum benefit is $1,500 per year per Covered Person. A lifetime orthodontic benefit of $1,500 to age 19 is available. The annual maximum does not apply to diagnostic and preventive services. Effective September 1, 2011, the annual maximum shall not apply to children up to the age of 18. Please refer to the applicable Delta Dental summary of benefits for a description of the benefits available, and exclusions and limitations to coverage.

Participants may alternatively elect dental coverage under the Golden Dental Plans DMO, pursuant to which dental services will only be covered if the Covered Person receives treatment from a dentist in the Golden Dental Plan DMO network. The maximum benefit is $1,500 per year per Covered Person, and a lifetime orthodontic benefit of $1,350 is available. Please refer to the applicable Golden Dental Plans DMO summary of benefits for a description of the benefits available, and exclusions and limitations to coverage. As this benefit is fully insured, all claims and appeals regarding such benefits shall be determined by the procedures set forth in the Golden Dental Plan's summary of benefits, not pursuant to Article 12, below.

(b) Limited Implants and Orthodontia Coverage

Implants

If not otherwise covered by the self-insured coverage option selected by the Participant and dental benefits have been exhausted for the plan year, the Fund will provide coverage for the surgical placement of endosteal implants in the maxilla in the event of severe maxillary atrophy and severe masticatory dysfunction for which no other less invasive treatment is available. The Covered Person's physician must submit a treatment plan to the Fund Office for preauthorization. Upon receipt of such plan, and as part of the preauthorization process, the Plan Administrator has the right to request that the Covered Person submit to an examination by a physician selected by the Plan Administrator, such examination to be paid for by the Fund.

To obtain coverage for the above, a Participant must submit to the Fund Office the Explanation of Benefit Form denying such charges, the date of the service, the amount for which coverage is requested, and a completed Preventative Services Claim Form (which is available upon request from the Fund Office). Such information must be submitted to the Fund Office within 12 months of the date of service.

Orthodontia

If not otherwise covered by the dental coverage option selected by the Participant, the Fund will provide coverage for medically necessary orthodontia treatment necessary to prepare a Covered Person for jaw surgery to treat a congenital skeletal Class III malocclusion, and any medically necessary orthodontia treatment subsequent to such surgery, provided such orthodontia treatment is approved by the Administrator prior to the surgery.

ARTICLE 5 – OPT-OUT COVERAGE

As described in Article 3, Active Employees may Opt-Out of coverage provided in Article 4 and receive the following benefits:

Opt-Out Coverage may not be elected by Office Employees.

5.1. Life Insurance

This benefit is available in the amount of $50,000.00. An additional $50,000.00 accidental death and dismemberment benefit is also provided. Both benefits are reduced if a Participant is above age 65. These benefits are provided pursuant to a policy of insurance purchased by the Fund. Further information, including limitations and exclusions to coverage, and coverage for dependents, are set forth in the life insurance policy. All claims and appeals regarding life insurance benefits shall be determined by the procedures set forth in the life insurance policy and not pursuant to Article 12, below.

5.2 Prescription Drug Benefit

A self-funded prescription drug benefit provides reimbursement for any out-of-pocket cost paid for prescriptions (e.g., co-payments) up to $30.00 per one month supply (not to exceed 34 days).

A claim for reimbursement must be submitted to the Fund Office. The claim must include a receipt indicating the drug purchased, date purchased, location purchased, and co-payment paid for it. Such information must be submitted to the Fund Office within 12 months of the date of service.

5.3 Short-Term Disability

Upon suffering a Disability, on a self-insured basis the Fund will pay 70% of weekly income lost up to a maximum of $450.00. This benefit supplements the short-term disability benefit set forth in Section 3.1, but in no event may the two benefits combined exceed 70% of weekly income. This benefit is available to an Active Employee only.

5.4 Vision Benefit

Vision Benefits are provided on a self-insured basis through Vision Service Plan (VSP). A description of the benefits available can be obtained from the Fund Office. To find a VSP provider, Participants can contact VSP at 1-800-877-7195 or by visiting www.vsp.com. Coverage for glasses or contact lenses up to an approved amount once every 12 months. In addition, the Fund will self-insure one pair of safety glasses per year for an Opt-Out Participant and his/her Spouse if his/her Spouse is also an Active Employee.

5.5 Dental Benefits

Dental Benefits are provided on a self-insured basis using the Dentemax network of providers. A benefit schedule can be obtained from the Fund Office. To find a Dentemax provider, Participants can contact Dentemax at 1-800-752-1547 or by visiting www.dentemax.com. Coverage is $2,000 per Participant, per year.

5.6 Health Reimbursement Accounts

All terms and conditions set forth in Section 3.3(e) apply to the HRAs of opt-out Participants, except that opt-out Participants are entitled to additional contributions of up to $800.00 per year, to be credited to each individual account by the Fund in 12 equal monthly installments, i.e., $66.66 per month.

5.7 Hearing Benefits

Hearing benefits are provided as set forth in the chart of benefits in Article 4, Section 4.1(a).

ARTICLE 6 – SELF-FUNDED WEEKLY DISABILITY BENEFITS

If an Active Employee while eligible for benefits under the Fund suffers a Disability, which is not work-related, he will be entitled to a benefit of $300.00 per week (pro-rated daily if necessary), less FICA tax, for up to 26 consecutive weeks.

If an application for Weekly Disability benefits is received by the Fund Office within 60 days of commencement of the Disability (Date of Disability), benefits will be payable as of the Date of Disability provided the individual has been unable to work for at least one week due to the Disability. If an application for Weekly Disability benefits is received by the Fund Office more than 60 days following the Date of Disability, benefits will be payable as of the date the application is received provided the individual is Disabled as of the date of application and has been continuously disabled from the Date of Disability to date of application. Notwithstanding, in no event will Weekly Disability benefits be paid if the application is received more than four months after the Date of Disability.

If an individual receiving Weekly Disability benefits remains disabled after a 26-week period of continuous disability, he may apply, in writing, to the Trustees for a 13-week extension of

benefits. Upon application, a second 13-week extension of eligibility may be granted. The first and second 13-week extensions will only be granted if the individual remains Disabled and presents a statement from his physician that his disability is not permanent, and he will be able to return to work as a Pipefitter. Effective for weeks beginning January 19, 2020, through week ending January 15, 2022, upon application, a third 13-week extension of eligibility may be granted, provided the Disability is work related and the Health Plan Advocate confirms a valid continuing disability, and the injury is not permanent, and the individual will be able to return to work as a pipefitter. Notwithstanding the foregoing, any Participant who has been awarded social security disability benefits (other than for a closed period) will be presumed permanently disabled and unable to return to work as a Pipefitter.

After receipt of benefits, an Active Employee is not eligible for any further disability payments for the same illness or injury until he has been credited with 80 or more hours of work as a Pipefitter for a contributing Employer. Notwithstanding, this 80-hour requirement may be waived where the Participant provides proof, acceptable in the sole discretion of the Trustees, that for a period of no less than two consecutive weeks after the Participant was released to return to work by his physician, he was continually employed by a contributing Employer and/or on the Union's Out of Work List.

If requested, any person receiving benefits pursuant to this provision must submit to an independent medical evaluation to be paid for by the Fund.

This benefit is available to Active Employees only and is self-funded.

Coverage under this provision shall only be allowed for two periods of Disability caused by alcohol or substance abuse (including legal or illegal drugs).

This benefit is not available to Office Employees.
In no event will weekly disability benefits be paid to any Pensioner, or other individual who has retired under the Pipefitters Local 636 Defined Benefit Fund, even if such an individual has returned to employment for which Contributions are required to be made to this Fund.

No benefits will be paid under this provision for any week during which an Active Employee has received a weekly wage loss benefit from a no-fault insurer.

ARTICLE 7 – HEALTH REIMBURSEMENT ACCOUNTS, VISION, AND DEATH BENEFITS

Unless otherwise set forth below, the benefits set forth in this Article 7 are available to all Participants. The HRA is the only benefit in this Plan available to Pensioners.

7.1 Health Reimbursement Accounts

A Health Reimbursement Account (HRA) is established for each Participant. A HRA is an account to be used by the Participant for reimbursement of out-of-pocket health care costs incurred by the Participant or his/her Dependents.

(a) Funding

(1) **Active Employees and Office Employees**

A portion of hourly Employer Contributions received, as determined by the Trustees in their sole discretion from time to time, will be deposited into an Active Employee's HRA.

In its sole discretion, the Employer of an Office Employee may contribute a uniform hourly amount to the individual HRA for each Office Employee.

(2) **Pensioners and Surviving Spouses**

The Trustees will determine the amount, if any, of contributions to be made on an annual basis. The HRA benefit is available for Surviving Spouses under this Fund and Surviving Spouses eligible for coverage under the Pipefitters Local 636 Retiree Insurance Fund. Pensioners who opt out of coverage under the Pipefitters Local 636 Retiree Insurance Fund will be credited with an additional $800.00 per year, to be credited to each individual account by the Fund in 12 equal monthly installments, i.e. $66.66 per month.

(3) Amounts in the HRA accumulate over time, i.e. unused amounts may accumulate and be carried over year to year.

(4) Like all other benefits provided by the Fund, the Fund may terminate the HRA at any time for any reason. Participants have no vested interests in the HRAs. At all times, amounts in the HRA are the property of the Fund. Eligibility to receive reimbursement from the HRA terminates when the Participant is no longer eligible for benefits and any unused amounts remaining in the Participant's account at such time remain the property of the Fund.

(5) Notwithstanding (4), a Participant whose eligibility has terminated may continue to use his/her HRA if, in the sole and absolute discretion of the Trustees, he has become employed by the UA in employment that is deemed beneficial to the industry and this Fund, and at the time eligibility terminated had at least 20 consecutive years of coverage under the Fund. If approved under this provision, a Participant can continue eligibility for HRA benefits until the earlier of exhaustion of HRA funds or if such employment terminates and the Participant does not retire.

(6) Notwithstanding (4), an Office Employee whose eligibility has terminated due to retirement who has had 20 or more years of continuous coverage in

the Insurance Fund as of the date of his/her retirement may continue to use the balance in his/her HRA until exhaustion of HRA funds.

(c) Reimbursable Expenses

To the extent that an eligible Participant has credit in his or her individual HRA, this amount may be used to reimbursement of out-of-pocket health care costs incurred by the Participant or his/her Dependents, such as:

(1) Dental co-payments and expenses;
(2) Vision expenses;
(3) Medical expenses not otherwise covered by insurance, including deductibles;
(4) Self-payments;
(5) Premiums paid for other health insurance (excluding individual market coverage);
(6) Prescription drug co-payments; and
(7) Other IRS approved medical expenses (pursuant to §213 of the Internal Revenue Code), including over-the-counter drugs as defined by the FDA, and amounts paid for menstrual care products.

Types of expenses that cannot be reimbursed are, for example, over the counter vitamins, and reduced calorie or diet-related food. (Note that the cost of weight reduction programs are reimbursable expenses provided they are ordered due to a specific diagnosed medical condition, such as obesity, hypertension, etc.

(c) Submission of Expenses for Reimbursement

Covered expenses will be reimbursed provided; (1) they are submitted to the Fund Office within 12 months from the date an Explanation of Benefits (EOB) statement was provided for the covered expenses, or if no EOB is issued for such expense, then within 12 months from the date that the expense was incurred, and (2) the Participant was eligible at the time the claim was incurred.

Benefits are subject to IRS limitations (§213 of the Internal Revenue Code) and the Plan will be administered in accordance with these limitations.

In order for payment to be made, proof of payment must be submitted.

(d) Account Balances Upon Termination of Eligibility

Upon termination of eligibility, a Participant's HRA will be suspended, to be reinstated if the Participant re-establishes eligibility within 12 months of such termination. If Contributions are not received on behalf of the Participant within 12 months, the balance in the HRA will remit to the Fund.

(e) Account Balances Upon Death of Participant

Upon the death of an Active Employee or Pensioner, any balance in his/her HRA will transfer to his/her Surviving Spouse, provided such individual otherwise qualifies for Surviving Spouse coverage.

Upon the death of an Active Employee, an amount equal to the balance of his/her Ban, per Section 2.1, shall be deposited in his/her HRA for use by the Surviving Spouse.

Upon the death of a Surviving Spouse, his/her HRA will terminate (i.e. any remaining balances are not available for use by dependents).

(f) Election

On an annual basis a Participant can elect to limit expenses paid from his/her HRA to reimbursement of dental, vision, and preventive care expenses only. In addition, if at any time during the calendar year the Participant's spouse becomes eligible for an HSA, he/she may make this election for the remainder of the calendar year.

7.2 **Death Benefit**

(a) Insured Basic Life and Accidental Death and Dismemberment Benefits

Active Employees are eligible for coverage under a fully insured life insurance policy purchased by the Fund. The amount of coverage is $50,000.00. Accidental death and dismemberment coverage is also provided for Active Employees, up to $50,000.00. Further information, including limitations and exclusions to coverage, are set forth in the life insurance policy.

(b) Insured Supplemental Life and Accidental Death and Dismemberment and Dependent Life and Accidental Death and Dismemberment Benefits

Active Employees have the option to purchase Supplemental Life Insurance, Supplemental Accidental Death and Dismemberment Insurance, Dependent Life Insurance, and Dependent Accidental Death and Dismemberment Insurance. Further information, including limitations and exclusions to coverage, are set forth in the applicable insurance policy.

(c) Beneficiary Designation

The Death Benefit is payable to the beneficiary(ies) designated by the Active Employee on the Beneficiary Designation card. Each Active Employee shall have the right to change his beneficiary at any time by written notice, submitted

directly to the Fund Office or the insurance company, and the change shall become effective on the date of receipt by the Plan or insurance company.

If a beneficiary is not designated, or if the designated beneficiary predeceases the Active Employee, then beneficiary shall mean, in the following order: (1) Spouse; (2) Children; (3) Parents; (4) Siblings, or the insurance company may choose to pay your Estate.

In the event of any conflict between the provisions of this Plan and the insurance policy, including the proper determination of the beneficiary, the terms of the insurance policy and the determination by the insurance company controls.

(d) Claims and Appeals

All claims and appeals regarding insured life insurance benefits shall be determined by the procedures set forth in the applicable life insurance policies and not pursuant to Article 12, below.

7.3 **Davis and VSP Vision**

Discounted Vision Coverage is available Davis Vision Affinity Discount Plan and the VSP Vision Program. Participants may also voluntarily purchase additional coverage under the Davis Vision Voluntary Fashion Value Plan. All terms and conditions are governed by the brochures and summaries provided by Davis Vision and VSP, respectfully.

ARTICLE 8 – ADDITIONAL EXCLUSIONS AND LIMITATIONS

In addition to all other applicable exclusions and limitations pertaining to the benefits provided by the Fund, in no event will any benefit, other than the Death Benefit, be payable for:

(a) Care rendered within any facility of, or provided by, the United States Veterans' Administration for military related injuries or conditions, or benefits or services that are available from any federal or state government agency, municipality, county or other political subdivision or community agency or from any foundation or similar entity (excluding Medicaid) to the extent not prohibited by applicable law;

(b) Loss caused by war or any act of war (declared or undeclared) or suffered while in military, air or naval service of any country;

(c) Expenses incurred as a result of being under the influence of any illegal drug (or illegal or improper use of a legally prescribed drug) or as a result of an injury incurred while engaged in an illegal activity.

(d) Expenses for injuries or conditions compensable under Workers' Compensation;

(e) Any benefit otherwise excluded or limited by the terms of the insurance policies purchased by the Fund covering Participants and Dependents and/or any benefits guides describing coverage provided by the Fund;

(f) Any expense which the Covered Person is not legally obligated to pay; or

(g) Effective January 1, 2013, the first Twenty Thousand Dollars ($20,000.00) of incurred medical expense by a Covered Person for any injury or illness arising from a motorcycle accident in the State of Michigan for which coverage for medical benefits is required by law.

ARTICLE 9 – COORDINATION OF BENEFITS

9.1 Application

This provision shall apply in determining the benefits for an allowable expense if the sum of:

(a) the benefits that would be payable under the Plan in the absence of this provision; and

(b) the benefits that would be payable under any other plan in the absence of a coordination of benefits provision, would exceed such allowable expense payable under this Plan.

9.2. Coordination

Another plan without a coordinating provision shall always be deemed to be the primary Plan. If another plan has a provision that makes this Plan primary, then:

(a) The plan covering the patient directly rather than as a dependent is primary and the other is secondary.

(b) If a child is covered under both parents' plans, the plan that covers the parent whose birthday occurs earlier in the calendar year shall be considered the primary plan.

(c) If neither (a) nor (b) applies, the plan covering the patient longest is primary.

(d) With respect to dependents of divorced parents, benefits are determined in the following order:

(1) if there is a court decree, the plan that covers the dependent of the parent with responsibility to provide coverage pursuant to such decree;
(2) the plan covering the parent with custody of the dependent;
(3) the plan covering the spouse, if any, of the parent with custody of the dependent;

(4) the plan covering the parent without custody;
(5) the plan covering the spouse of the parent without custody; or
(6) if none of the foregoing applies, coordination of benefits shall be determined in accordance with the Michigan Coordination of Benefits Act (MCL 550.251, et seq.), or any successor law.

(e) For Medicare-eligible Participants and/or Dependents, this section supersedes all other rules regarding coordination of benefits.

(1) Benefits will be coordinated with Medicare according to the Medicare Secondary Payer (MSP) Rules when applicable.
(2) The following addresses specific situations where MSP Rules are applicable:

(A) Coordination with Coverage By Virtue of Current Employment Status—
In the event a Medicare-eligible Covered Person in this Plan is also eligible under any Other Plan as a dependent of an actively employed spouse:

- Medicare is secondary to the Other Plan and primary to this Plan; and
- The Other Plan is primary to this Plan.

(B) End Stage Renal Disease:
After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Participant or Dependent receiving such treatment should contact the Social Security Administration as soon as possible to obtain information regarding Medicare eligibility and take appropriate steps to become eligible for Medicare benefits. Once eligibility could have been obtained, even if it is not, the Plan will be primary (i.e. will provide benefits) only to the extent required by Medicare's Secondary Payer rules.

(f) With respect to a Participant or Dependent on COBRA Continuation of Coverage from any other plan, this plan will be secondary.

(g) Motor Vehicle Accidents

If coverage for a motor vehicle accident is not excluded under Section 4.1(b)(24) or (26), the Fund will only provide coverage on a secondary basis. If coverage is provided on a secondary basis, this means that if the Participant or Dependent is involved in a motor vehicle accident, the claims should first be submitted to his/her no-fault carrier (or other auto carrier) and any expenses not paid by such carrier (for example, deductibles, co-payments, etc.) will be paid by the Fund.

If the motor vehicle accident involves a Medicare eligible individual, the order of payment is the no-fault carrier (or other auto carrier) primary, Medicare secondary, and then the Fund if not otherwise excluded.

As to any Plan Year to which this provision is applicable, the benefits that would be payable under the Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of such reduced benefits and the benefits payable for such allowable expenses under another plan(s) shall not exceed the total allowable expenses under this Plan. Benefits payable under another plan include the benefits that would have been payable had the claim been duly filed under that plan.

Notwithstanding anything in this section to the contrary, a Participant or Dependent will never receive less if covered by two or more plans than he would receive if covered by this Plan alone; provided, however, that this Plan will pay no more than an amount which would bring total coverage up to the amount which would have been provided under this Plan.

For the purpose of coordination of benefits with other plans, as allowed by applicable law the Plan shall retain the right, without the consent of or notice to any person, to release or to obtain from any insurance company or other organization or person, any information, with respect to any Participant or Dependent, which the Plan deems to be necessary for the purpose of implementing this provision. Any person claiming benefits under the Plan shall furnish to the Plan such information as may be necessary to administer this provision and as allowed by applicable law.

Whenever payments have been made by the Plan with respect to allowable expenses in a total amount which is at any time in excess of the maximum amount of payment necessary at that time to satisfy the requirements of this provision, the Fund has the right to recover such excess payments from among one or more of the following: any persons to or for, or with respect to whom such payments were made; any insurance companies; or any other organizations.

ARTICLE 10 – THIRD PARTY LIABILITY

10.1 Subrogation

(a) In General

Subrogation means the Fund has the right to recover from a Covered Person those amounts paid by the Fund for medical care or other expenses due to an injury caused by a third party (for example, another person or company). To the extent benefits are paid by the Fund to a Covered Person for medical, dental, wage loss, or other expenses arising out of such an injury, the Plan is subrogated to any claims the Covered Person may have against the third party who caused the injury. In other words, the Participant or Dependent must repay to the Plan the

benefits paid on his or her behalf out of any recovery received from a third party and/or any applicable insurer.

The Fund's right of subrogation applies to any amounts recovered, whether or not designated as reimbursement for medical expenses or any other benefit provided by the Fund. The right of subrogation applies regardless of the method of recovery, i.e. whether by legal action, settlement or otherwise.

The Fund's right to subrogation applies regardless of whether the injured Participant or Dependent has been fully compensated, or made whole, for his or her losses and/or expenses by the third party or insurer, as the Fund's right to subrogation applies to any full or partial recovery. This provision is intended to make it clear that this provision shall apply in lieu of the "make whole" doctrine. The Fund has first priority to any funds recovered by the injured Covered Person from the third party or insurer.

Further, the Plan does not have any responsibility for the injured Participant or Dependent's attorneys' fees, i.e., the common fond doctrine will not be applied.

The Fund also has a lien on any amounts recovered by a Participant or Dependent due to an injury caused by a third party, and such lien will remain in effect until the Fund is repaid in foil for benefits paid because of the injury.

(c) Conditions to Payment of Benefits

If a Covered Person sustains an injury caused by a third party, the Fund will pay benefits related to such injury (provided such benefits are otherwise properly payable under the terms and conditions of the Plan), provided all the following conditions are met:

(1) As soon as reasonably possible, the Covered Person must notify the Fund Office that he or she has an injury caused by a third party.

(2) Prior to the receipt of benefits for such injury, the injured Covered Person must assign to the Fund his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the injury. If such assignment is not made before the receipt of benefits, then the receipt of benefits automatically assigns to the Fund any rights the Participant or Dependent may have to recover payments from any third party or insurer. (If the recovery so assigned exceeds the benefits paid by the Fund, such excess shall be delivered to the Covered Person or other person as required by law.)

(3) The Covered Person does not take any action that would prejudice the Fund's subrogation rights.

(4) The Covered Person cooperates in doing what is necessary to assist the Fund in any recovery, which includes but is not limited to executing and delivering all necessary instruments and papers.

(c) Right to Pursue Claim

The Fund's subrogation rights allows the Fund to directly pursue any claims the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim.

(d) Enforcement

If it becomes necessary for the Plan to enforce this provision by initiating any action against the Covered Person, the Covered Person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome. The Plan shall be entitled to enforce this provision by way of an equitable restitution, constructive trust, or any other equitable remedy. At the Fund's option, it may enforce this provision by deducting amounts owed from future benefits.

10.2 Workers' Compensation

The Fund does not pay any claims covered by workers' compensation. If a Participant or Dependent receives any benefits that are properly payable by workers' compensation, then this Fund must be indemnified by the Participant or Dependent for the amount paid for such benefits. The Fund shall be indemnified out of the proceeds received from the Participant or Dependent in settlement of any workers' compensation claim. The Participant must complete any forms required by the Fund to preserve its rights under this section. At the Fund's option, it may enforce this provision by deducting amounts owed from future benefits.

If the Fund authorizes the payment of benefits pending resolution of a contested worker's compensation claim, eligibility for and payment of such benefits remains subject to all other terms and conditions set forth in this Plan.

ARTICLE 11 – RECIPROCITY

Upon receipt of a Reciprocity Authorization and subject to the rules and regulations adopted by the Trustees, the Fund may enter into reciprocity agreements pursuant to which (1) Contributions received on behalf of individuals who are working on a temporary basis in the jurisdiction of the Union will be forwarded to such individuals' home locals, and (2) contributions received from other health and welfare funds on behalf of Participants will be credited by the Fund.

ARTICLE 12 – INTERNAL CLAIMS AND APPEALS PROCESS

For benefits provided under the fully insured policies, and the Medicare Policy set forth in Article 22, claims and appeals will be governed solely by the procedures set forth in the documents governing such benefits, and not by the provisions of Article 12 and 12A.

12.1 Types of Claims Covered

For purposes of the procedures set forth below, the following terms are used to define health claims:

Urgent health claims: claims that req uire expedited consideration in order to avoid j eopardizing the life or health of the Claimant or subj ecting the Claimant to severe pain;
Pre-service health claims: for example, pre-certification of a hospital stay or predetermination of dental coverage;

Post-service health claims: for example, Claimant or his Physician submits a claim after claimant receives treatment from Physician; and

Concurrent claims: claims for a previously approved ongoing course of treatment subseq uently reduced or terminated, other than by plan amendment or plan termination.
Rescission of Coverage: retroactive cancellation of coverage.

Disability Claims: initial claims for disability benefits or any rescission of coverage of a disability benefit.

12.2 Initial Submission of Claims

Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, claims should be submitted to the prescription benefit manager, or the dental network provider as applicable. All other claims for benefits, including medical benefits, should be submitted to the Fund Office. No claims will be paid by the Fund if they are not submitted for payment within 12 months of the date incurred.

12.3 Notice That Additional Information is Needed to Process Claim

After the claim is submitted, the Fund deadline to provide notice to Claimant that the claim is incomplete (with explanation of additional information is necessary to process claim) is:

- For Urgent Health Claims – 24 hours after receiving improper claim
- For Pre-Service health claims – 5 days after receiving improper claim.

After receipt of notice from the Fund that the claim is incomplete, the Claimant's deadline to supply the Fund the information req uested to complete claim is:

- For Urgent Health Claims – 48 hours after receiving notice
- For Pre-Service Health Claims – 45 days after receiving notice
- For Post-Service Health Claims – 45 days after receiving notice
- For Disability Claims – 45 days after receiving notice.

12.4 Avoiding Conflicts of Interest

The Fund must ensure that all claims and appeals are adj udicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adj udicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

12.5 Initial Decision on A Claim

(a) Additional Evidence

(1) The Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is req uired to be provided under (b), below, to give the Claimant a reasonable opportunity to respond prior to that date; and

(2) Before the Fund can issue an initial benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is req uired to be provided under (b), to give the claimant a reasonable opportunity to respond prior to that date.

(b) The Fund deadline for making an initial decision on a claim is:

- For Urgent Health Claims – As soon as possible, taking into account medical exigencies, but not later than 72 hours after receiving initial claim, if it was complete; or 48 hours after receiving completed claim or after the 48-hour claimant deadline for submitting information needed to complete claim, whichever is earlier.
- For Pre-Service Health Claims – 15 days after receiving the initial claim. A 15-day extension permitted is Plan needs more information and it has provided notice of same to Claimant during initial 15-day period. Fund

deadline for responding is tolled while awaiting req uested information from Claimant.

- For Post-Service Health Claims – 30 days after receiving initial claim. A 15-day extension permitted if Plan needs more information and has provided notice of same to claimant during initial 30-day period. Fund deadline for responding is tolled while awaiting req uested information from Claimant.
- For Disability Claims – 45 days after receiving the initial claim. A 30-day extension is permitted if the Plan needs more information and has provided proper notice of same to Claimant. An additional 30-day extension is permitted if the Plan needs more information and has provided notice of same to claimant during first 30-day extension. Fund deadline for responding is tolled while awaiting additional information from Claimant.

12.6 Adverse Benefit Determination

Notice of an adverse benefit determination will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary;
- the internal rule or similar guideline relied upon in denying the claim, or, if applicable, a statement that such rule or similar guideline does not exist;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable);
- a statement describing the availability, upon req uest, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of available internal appeal process and how to initiate the external review process for an adverse benefit determination which involves a medical condition of the claimant for which the timeframe for completion of the internal appeal would j eopardize the life or health of the claimant or would j eopardize the claimant's ability to regain maximum function;
- if applicable, a statement of the Claimant's right to bring a civil action after further denial on appeal or external appeal.

With respect to adverse benefit determination involving disability claims, the adverse benefit determination must also include the following:

- An explanation of the basis for disagreeing with any of the following:
  - The health care professionals that treated the Claimant;
  - The advice of the health professional obtained by the Plan; or
  - A disability determination from the Social Security Administration.

- A statement that the Claimant is entitled to receive, free or charge and upon req uest, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.
- The adverse benefit determination must be in a culturally and linguistically appropriate manner.

12.7 Internal Appeals

(a) Adverse Benefit Determinations

A Claimant may appeal any Adverse Benefit Determination received under Section 12.6. An Adverse Benefit Determination means any of the following:

- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan;
- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;
- failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate;
- rescission of coverage; or
- A denial, reduction, termination, or failure to provide or make payment (in whole or in part) for a disability benefit or any rescission or coverage of a disability benefit.

(b) Submission of Internal Appeals

An appeal is a written req uest to the Trustees (or Blue Cross Blue Shield of Michigan (BCBSM) for Tier 4 Specialty Drug Appeals) setting forth issues to consider related to the benefit denial, along with any additional comments the claimant may have. A Claimant, free of charge and upon req uest, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

The Fund will not consider a req uest for diagnosis and treatment information, in itself, to be a req uest for an internal appeal.

The Plan will continue to provide coverage for an ongoing course of treatment pending the outcome of an internal appeal.

The review on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without

regard to whether such information was submitted or considered in the initial benefit determination. Appeals must be submitted to the Fund Office. Notwithstanding, 1st level Appeals for Tier 4 Specialty Drugs must be submitted to Blue Cross Blue Shield of Michigan (BCBSM) and, if applicable, a 2nd level Appeal may be submitted to the Fund Office.

(c) Time for Submitting Internal Appeals

A Claimant must appeal a benefit denial within the following time limits:

- For Urgent Health Claims – 180 days after receiving denial.
- For Pre-Service Health Claims – 180 days after receiving denial.
- For Post-Service Health Claims – 180 days after receiving denial.
- For Concurrent Claims – Claimant must be given enough time to appeal decision before termination effective.
- For Disability Claims – 180 days after receiving denial.

Notwithstanding, appeals for Tier 4 Specialty Drugs have the following time limits:

- First level appeal to BCBSM: 180 days.
- Second level appeal to Trustees after BCBSM denial of above: 60 days.

ALL APPEALS MUST BE TIMELY SUBMITTED. A CLAIMANT WHO DOES NOT TIMELY SUBMIT AN APPEAL WAIVES HIS/HER RIGHT TO HAVE THE BENEFIT CLAIM SUBSEQUENTLY REVIEWED ON INTERNAL APPEAL, ON EXTERNAL REVIEW, OR IN A COURT OF LAW.

(d) Notice of Decision on Internal Appeal

The notice of a decision on appeal will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- a statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rule or similar guideline does not exist;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, if applicable),
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- a description of the external review process, including information regarding how to initiate the external review process;
- a statement of the Claim's right to bring a civil action under ERISA §502(a);
- a statement describing any contractual limitation period that applies to the Claimant's right to bring an action under ERISA §502(a) and the calendar date on which such contractual limitation expires;
- the availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration, 1-866-444-3272, or the Michigan Office of Financial and Insurance Regulation, MiCHAP, P.O. Box 30220, Lansing, Michigan 48909, (877) 999-6442; and
- The following statement: "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."

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

With respect to a notice of decision on appeal involving disability claims, the notice of decision on appeal must also include the following:

- An explanation of the basis for disagree with any of the following:
  - The health care professionals that treated the Claimant;
  - The advice of the health professional obtained by the Plan; or
  - A disability determination from the Social Security Administration.
- A statement that the Claimant is entitled to receive, free of charge, upon request, reasonable access to copies of all documents, records, and other information relevant.

The Fund deadline for deciding an appeal of a benefit denial and notifying the Claimant of its decision is:

- For Urgent Health Claims – 72 hours after receiving appeal.
- For Pre-Service Health Claims – 30 days after receiving the appeal if one level appeal is applicable.
- For Post-Service Health Claims:
  Medical Benefits – The Fund Office, without deference to the claim denial, shall decide the initial appeal, and inform the claimant of its decision 30 days after receiving appeal. A second appeal to the Trustees must be filed within 60 days of receipt of this first appeal denial. The Trustees shall decide this appeal at a Board Meeting.*
  Other Benefits – The Trustees shall decide the appeal at a Board Meeting.*
- For Concurrent Claims – Prior to termination of previously approved course of treatment.
- For Disability Claims – The Trustees shall decide the appeal at a Board Meeting.*

* Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made no later than the date of the second Board Meeting following the Trustees receipt of the appeal. If special circumstances require a further extension, upon due notice to the Claimant, the decision shall be made no later than the third board meeting following receipt of appeal. The Plan shall notify the Claimant of the Trustees decision on appeal no later than 5 days after the decision is made.

12.8 Deemed Exhaustion of Internal Claims and Appeals Process

If the Plan fails to adhere to all of the requirements in this Article 12 with respect to any claim for benefits, the Claimant is deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Article 12A. The Claimant is also entitled to pursue any available remedies under Section 502(a) of ERISA, or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

In addition to the above, if the Plan fails to strictly adhere to all procedures with respect to a claim for disability benefit and the Claimant chooses to pursue available remedies under ERISA §502(a), the claim is deemed denied on review without the exercise of discretion by the Trustees.

Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause,

prej udice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant.

The Claimant may req uest a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

I f an external reviewer or a court rej ects the Claimant's req uest for immediate review on the basis that the Plan met the standards for the exception to the deemed exhaustion rule, the Claimant has the right to resubmit and pursue the internal appeal of the claim. I n such a case, within a reasonable time after the external reviewer or court rej ects the claim for immediate review (not to exceed ten days), the Plan shall provide the Claimant with the notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

12.9 Discretion of Trustees

The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

12.10 Limitations of Actions

For adverse benefit denials not subj ect to external review, no action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal. For adverse benefit denials subj ect to external review, a req uest for external review must be made within the time limitations provided in Section 12A.2. I n the event a Claimant does not abide by these time limitations, he/she waives his/her right to any further review of an adverse determination, including waiving his/her right to have the determination reviewed in a court of law.

ARTICLE 12A – EXTERNAL REVIEW PROCESS

12A.1 Eligibility for External Review

The external review process applies to any final internal adverse benefit determination that involves (1) medical j udgment, including, but not limited to, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or experimental or investigational treatment (excluding, however, determinations that involve only contractual or legal interpretation without any use of medical j udgment); (2) whether the Plan is complying with the nonq uantitative treatment limitation provisions

which, in general req uire parity in the application of medical management techniq ues; (3) consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in ERI SA sections 716 and 717;or (4) a rescission of coverage (whether or not the rescission has any effect on any particular benefits at that time). Weekly disability benefits are not subj ect to external review.

A denial, reduction, or termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the req uirements for eligibility under the terms of the Plan, or based on a Plan exclusion, is not eligible for the external review process.

12A.2 Request for External Review

A Claimant must file a req uest for an external review with the Fund within four months after receipt of a notice of the final internal appeal. I f he/she fails to do so, he/she waives the right to an external review or review in a court of law.

The Fund will not consider a req uest for diagnosis and treatment information, in itself, to be a req uest for an external review.

12A.3 Preliminary Review

Within five business days following the receipt of the external review req uest, the Fund must complete a preliminary review of the req uest to determine whether:

(a) The Claimant is or was covered under the Plan at the time the health care item or service was req uested or provided;

(b) The final adverse benefit determination does not relate to the Claimant's failure to meet the req uirements for eligibility under the terms of the Plan;

(c) The Claimant has exhausted the Plan's internal appeal process; and

(d) The Claimant has provided all the information and forms req uired to process an external review.

Within one business day after completion of the preliminary review, the Fund must issue a notification in writing to the Claimant. I f the req uest is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-ESBS (3272)). I f the req uest is not complete, the notification must describe the information or materials needed to make the req uest complete and the Fund must allow a Claimant to perfect the req uest for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

12A.4 **Referral to Independent Review Organization**

(a) The Fund must assign an independent review organization (IRO) to conduct the external review.

(b) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the IRO within ten business days additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the Fund. Upon receipt of such information, the Fund may reconsider its final internal decision on appeal, but such reconsideration will not delay the external review. If the Fund decides to provide coverage, within one business day after such decision the Fund must provide written notice of same to the Claimant and the IRO and the IRO must then terminate the external review.

(c) Within five business days after the date of assignment, the Fund will provide to the IRO documents and any information considered in making the final decision on internal appeal, but failure to do so will not delay the conduct of the external review. If the Fund fails to timely provide this information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination and notice of such decision will be provided by the IRO to the Claimant and Fund within one business day.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) The Claimant's medical records;
(2) The attending health care professional's recommendation;
(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant, or the Claimant's treating provider;
(4) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(e) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and deliver its decision to the Claimant and the Fund.

(f) The IRO's decision notice will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(2) the date the IRO received the assignment and the date of the IRO decision;

(3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;

(6) A statement that judicial review may be available to the Claimant; and

(7) Current contact information, including phone number, for any applicable state office of health insurance consumer assistance or ombudsman established under PHS Act §2793.

(g) The external reviewer's decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law. The Plan must provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

(h) The IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, Fund, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

12A.5 Expedited External Review

A Claimant can make a request for an expedited external review at the time the Claimant receives:

(a) An adverse benefit determination which involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(b) A final internal appeal denial which involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant, or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Fund must take the steps for Preliminary Review outlined above under the standard external review procedures and immediately send the notification of such review to the claimant.

Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO as outlined in Section 12.3A, above. The Plan must provide or transmit all necessary documents and information considered in making the final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

The plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation to the Claimant and the Fund.

12A.6 Discretion of Trustees

The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

12A.7 Limitations of Actions

No action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on External Review. In the event a Claimant does not bring an action within such 180 days, he/she waives his/her right to any further review of an adverse determination in a court of law.

ARTICLE 13 – COBRA

13.1 Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to participants and their dependents when they would otherwise lose group health coverage.

13.2 Nature of COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A participant, his spouse, and dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

A participant will become a qualified beneficiary if coverage is lost under the Plan because either one of the following qualifying events happens:

(a) Hours of employment are reduced such that hours are insufficient to maintain eligibility, or
(b) Employment ends for any reason other than gross misconduct.

The spouse of a participant will become a qualified beneficiary if coverage is lost under the Plan because any of the following qualifying events happens:

(a) Death of spouse;
(b) Spouse's hours of employment are reduced such that hours are insufficient to maintain eligibility;

(c) Spouse's employment ends for any reason other than his or her gross misconduct;
(d) Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
(e) Divorce from the participant.

Dependent children become qualified beneficiaries if coverage is lost under the Plan because any of the following qualifying events happens:

(a) The parent-participant dies;
(b) The parent-participant's hours of employment are reduced such that hours in the hour bank are insufficient to maintain eligibility;
(c) The parent-participant's employment ends for any reason other than his or her gross misconduct;
(d) The parent-participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
(e) The parents become divorced; or
(f) The child stops being eligible for coverage under the plan as a "dependent child."

13.3 When COBRA Coverage Is Available

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the participant, the employer must notify the Plan Administrator of this qualifying event within 30 days of the death. The Plan Administrator will monitor whether a qualifying event has occurred due to reduction in hours, termination of employment, or Medicare eligibility.

13.4 Participant/Spouse Obligation to Give Notice to Plan of Certain Qualifying Events

In the event of divorce or a dependent child loses eligibility for coverage as a dependent child (for example, exceeds age limitations), or if after COBRA coverage is elected a qualified beneficiary becomes covered under another group health plan, the participant and his spouse both have an obligation to notify the Plan Administrator of such event within 60 after this qualifying event occurs. This notice must include: the name of the participant, the social security number of the participant, the name of the qualified beneficiaries (for example, a former spouse after divorce or a child no longer eligible for coverage as a dependent), the qualifying event (for example, the date of a divorce), and the date on which the qualifying event occurred. If timely notice is not provided, the right to COBRA coverage is forfeited.

Further, failure to timely notify the Plan of a divorce or a child losing eligibility gives the Plan the right to hold the participant and his/her spouse separately and fully liable for any benefits paid by the Plan which would not have been paid had the Plan received timely

notification of such event. At its sole election, the Plan may suspend the payment of future benefits until such amount has been recovered.

13.5 How COBRA Coverage Is Provided

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within 14 days. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

The COBRA notice will contain information regarding the premium that must be paid for COBRA coverage, which is 102% of the cost to the Plan for such coverage. If the period of COBRA coverage is extended due to disability, discussed below, the premium is 150% of the cost to the Plan.

Coverage under the Plan will be terminated upon the occurrence of a qualifying event and will be retroactively reinstated to the date of the qualifying event once a qualified beneficiary elects COBRA continuation coverage and pays the applicable premium. See Section 13.7 below regarding the election period for COBRA coverage.

13.6 Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage, as follows:

(a) When the qualifying event is the death of the participant, the participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

(b) When the qualifying event is the end of employment or reduction of the participant's hours of employment, and the participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until 36 months after the date of Medicare entitlement.

For example, if a participant becomes entitled to Medicare eight months before the date on which his eligibility terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

(c) In all other events, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation

coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

(1) Disability Extension

If the qualified beneficiary or anyone in his family covered under the Plan is determined by the Social Security Administration to be disabled and notifies the Plan Administrator in a timely fashion, all covered family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. To obtain this extension, the disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

The Plan Administrator must also be notified of any subsequent determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This notice must be provided within 30 days of such determination.

(2) Second Qualifying Event Extension

If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, the covered spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the participant or former participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if such event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The Plan Administrator must be notified of this second qualifying event within 60 days of such event.

13.7 The Election Period for COBRA Continuation

Qualified beneficiaries have 60 days after receipt of the Election Notice, which will be sent to each qualified beneficiaries' last known address, to elect COBRA continuation

coverage. Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

13.8 Premium Payment for COBRA Coverage

Following an election, a qualified beneficiary has 45 days to pay the initial COBRA premium. If this is not timely paid, coverage will not be reinstated and the qualified beneficiary will not be given a second chance to reinstate coverage.

Payments are thereafter due on the first day of the month of coverage. The postmark will serve as proof of the date paid. There is a 30-day grace period to make such payment. If payments are not made within this period, coverage will terminate and the qualified beneficiary will not be given an opportunity to reinstate coverage.

If, for whatever reason, the Plan pays medical benefits for a month in which the premium was not timely paid, the qualified beneficiary will be required to reimburse the Plan for such benefits.

The premium equals the cost to the Plan of providing coverage plus a 2% administration fee. In the event of extended coverage as a result of a disability for the 19th – 29th months of coverage, the Plan will charge 150% of the cost of providing coverage.

13.9 Scope of Coverage

COBRA coverage only pertains to health benefits available under the Plan. Coverage for such benefits under COBRA is the same as those the qualified beneficiary had the day before coverage initially terminated. Coverage may change while on COBRA coverage due to Plan amendments that effect all participants in the plan. A qualified beneficiary may also be able to elect different coverage options during the period of time he is on COBRA coverage, provided such a right is available to similarly situated active employees.

13.10 Enrollment of Dependents During Period of COBRA Coverage and Coverage Options

A child bom to, adopted by, or placed for adoption with a Participant during a period of COBRA coverage is considered to be a qualified beneficiary, provided that the Participant has elected continuation coverage for himself/herself. If a Participant desires to add such a child to COBRA coverage, he must notify the Fund Office within 30 days of the adoption, placement for adoption, or birth.

During the COBRA coverage period, a Participant may add an eligible dependent who initially declined COBRA coverage because of alternative coverage and later lost such coverage due to certain qualifying reasons. If a Participant desires to add such a child to COBRA coverage, he must notify the Fund Office within 30 days of the loss of coverage.

13.11 Qualified Medical Child Support Orders

If a Child is enrolled in the Plan pursuant to a qualified medical child support order while the Participant was an active employee under the Plan, he is entitled to the same rights under COBRA as any dependent Child.

13.12 Termination of COBRA Coverage

COBRA continuation coverage terminates the earliest of the last day of the maximum coverage period, the first day timely payment (including payment for the full amount due) is not made, the date upon which the Plan terminates, the date after election of COBRA that a qualified beneficiary becomes covered under any other group health plan, or the date after election if a qualified beneficiary becomes entitled to Medicare benefits and such entitlement would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred.

In the case of a qualified beneficiary entitled to a disability extension, COBRA continuation coverage terminates the later of: (a) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination from Social Security that the qualified beneficiary is no longer disabled, whichever is earlier; or (b) the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

13.13 Keep the Plan Informed of Address Changes

A participant or his spouse must keep the Plan Administrator informed of any changes in the addresses of family members and is advised to keep a copy of any notices sent to the Plan Administrator.

13.14 Exclusions from COBRA Coverage

Notwithstanding anything in this Article to the contrary, COBRA coverage will not be offered to:

(a) Anyone who is a Working Principal, or the spouse, child, parent, or sibling of a Working Principal, if the reason for loss of coverage is failure of the Employer to remit required contributions; or

(b) Any Participant, or Spouse or Child of such Participant, not included in (a), above, if the Participant fails to obey a strike notice issued as a result of failure of an Employer to pay contributions.

ARTICLE 14 – QUALIFIED MEDICAL SUPPORT ORDER

As set forth below, and in accordance with §609 of ERISA, this Plan shall provide benefits as required by a Qualified Medical Support Order.

14.1 Q ualified Medical Child Support Order ("Q MCSO") means a medical child support order—

(a) which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, and

(b) clearly specifies

(1) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient (i.e. child/ren) covered by the order (except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any alternate recipient);

(2) a reasonable description of the type of coverage to be provided to each alternate recipient, or the manner in which such type of coverage is to be determined;

(3) the period to which such order applies; and

(4) the plan to which the order applies.

14.2 A medical child support order will fail to be a Q MCSO if it req uires the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the req uirements of 42 U.S.C. §1396g-1.

14.3 Procedures for Determining Q ualified Status of Medical Support Orders.
Upon receipt of a medical child support order, the following procedures will be used when determining whether it is a Q ualified Medical Child Support Order pursuant to the terms of ERI SA:

(a) The Participant and any potential Alternate Recipients and/or their designated representatives will be immediately notified in writing that the Order has been received by the Fund and has been referred to legal counsel for determination of its status within 45 days, such notice to include a provision permitting an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order and a copy of the plan's procedures for determining the q ualified status of the order.

(b) The Order will be simultaneously referred to the Fund Attorneys for review and a determination of its status. This determination will be made within 45 days after receipt of the Order or within any time period that may be established by federal regulations in the future.

(c) After determining the status of an Order, the Participant and Alternate Recipients and/or their designated representatives will be notified in writing. If the Q MCSO is acceptable, the Alternate Recipients and/or their designated representative will be informed of the Alternative Recipient's health benefits and of the Plan's procedures to provide benefits.

(d) If the Funds' legal counsel determines that an Order is not a Q MCSO, legal counsel will suggest necessary modifications. During this interim period, the Fund may either provide coverage or wait and provide retroactive coverage once the Q MCSO is approved.

Once a child is enrolled in the Fund pursuant to a Q MCSO, the Fund cannot disenroll or eliminate coverage unless the Fund is provided with written evidence that the Court or Administrative Order is no longer in effect or that the child will be enrolled in comparable health insurance through another insurer effective no later than the date of the disenrollment.

14.4 National Medical Support Notice Deemed to be a Q MCSO

(a) If the Plan receives an appropriately completed National Medical Support Notice and the Notice meets the requirements of Section 9.1, the Notice shall be deemed to be a Q MCSO.

(b) In any case in which an appropriately completed National Medical Support Notice is issued in the case of a child of a participant plan who is a noncustodial parent of the child, and the Notice is deemed under Section 9.4(a) to be a qualified medical child support order, the Fund Office, within 40 business days after the date of the Notice, shall –

(1) notify the State agency issuing the Notice with respect to such child whether coverage of the child is available under the terms of the plan and, if so, whether such child is covered under the plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a State or political subdivision thereof substituted for the name of such child pursuant to Section 9.1(b)(1)) to effectuate the coverage; and

(2) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

(c) Nothing in this subparagraph shall be construed as requiring the Plan, upon receipt of a National Medical Support Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt of such Notice.

14.5 Any payment for benefits made by the Fund pursuant to a Q MCSO in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

14.6 The Plan will comply with any other req uirements of §609 of ERI SA regarding Q MCSO.

ARTICLE 15 – FAMILY AND MEDICAL LEAVE ACT

Certain Employers are req uired to continue to make contributions to the Fund on behalf of an employee while such employee is on a medical leave of absence pursuant to the federal Family and Medical Leave Act ("FMLA").Details concerning FMLA leave are available from the Participant's Employer. Req uests for FMLA leave must be directed to such Employer; the Plan cannot determine whether or not a person q ualifies for FMLA leave. I f a dispute arises between a Participant and his Employer concerning eligibility for FMLA leave, the Participant may continue health coverage by making COBRA payments. I f the dispute is resolved in the Participant's favor, the Plan will refund COBRA payments made by the Participant upon receipt of the FMLA-req uired contributions from the Employer.

I f the Employer continues a Participant's coverage during an FMLA leave and the Participant fails to return to work, he may be req uired to repay the Employer for all contributions paid to the Plan for such coverage during the leave. The Fund will not return any contributions to the Employer. Failure to return to work at the end of a FMLA Leave may constitute a Q ualifying Event under COBRA.

ARTICLE 16 – INTERPRETATION OF PLAN DOCUMENTS

The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

ARTICLE 17 – ABSENCE DUE TO MILITARY DUTY

I f coverage under the Plan is terminating due to military service, a Participant may elect to continue the health coverage under the Plan for up to 24 months after the absence begins, or for the period of military service, if shorter. The Participant must notify the Fund Office as soon as he volunteers for or is called to active duty. The maximum premium that will be charged is 102% of the full premium for the coverage. However, if the military service is for 30 or fewer days, the maximum premium will be the self-payment amount.

Upon termination for military duty, a Participant's eligibility shall be frozen, with reinstatement under that same status upon his/her discharge from the military. Exclusions and waiting periods will not be imposed upon re-employment provided coverage would have been afforded had the person not been absent for military service, unless there are disabilities that the Veterans Administration determines to be service related. For these benefits to apply, however, the period

of service must be less than five years and a Participant must return to work as a Pipefitter under the Collective Bargaining Agreement within the following time frames:

- For uniformed service of less than 31 days, by the next work day after the end of service plus eight hours, or as soon as possible after the end of the eight-hour period if reporting earlier is impossible through no fault of the Participant.
- For service of more than 30 days but less than 181 days, within 14 days of completing the service, or the next full calendar day if returning earlier is impossible through no fault of the Participant.
- For service of more than 180 days, within 90 days after completion of the service.

ARTICLE 18 – CHANGES TO OR TERMINATION OF COVERAGE

The Trustees reserve the right to amend, alter, or terminate any or all coverages hereunder, for any or all classes of Participants or Dependents, at any time.

The Trustees also have the right to change required self-payment amounts for any benefit or class of Participants or Dependents, including the right to impose self-payment for coverage that previously had been provided without requiring such self-payments.

ARTICLE 19 – GENDER NEUTRALITY

Any term in this Plan stated in the masculine gender is also intended to be in the feminine gender, where applicable, and vice versa.

ARTICLE 20 – HIPAA PLAN SPONSOR PROVISIONS

20.1 Protected Health Information ("PHI"), as defined in HIPAA, shall only be disclosed to the Plan Sponsors in accordance with the following procedures:

PHI will only be disclosed to Plan Sponsors when and if necessary to carry out the Fund's payment and health care operations. In particular, it is anticipated that such disclosures may be necessary to verily eligibility or to make a decision on appeal. All such disclosures will be made in accordance with HIPAA and its corresponding regulations.

The Plan Sponsors agree to:

(a) Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

(d) Report to the group health plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(e) Provide individuals access to PHI as req uired by the privacy rules;

(f) Provide individuals the right to amend PHI maintained in a designated record set as req uired by the privacy rules;

(g) Make available the information req uired to provide an accounting of disclosures or PHI as req uired by the privacy rules;

(h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the Director of the Secretary of Health and Human Services, or its designee, for purposes of determining compliance by the group health plan with this subpart;

(i) I f feasible, return or destroy all PHI received from the plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

G) Provide for adeq uate separation between the group health plan and the plan sponsor. To do so:

(1) Only those employees of the Plan Sponsor who are also Trustees of this Fund shall be given access to the PHI;

(2) Access to PHI for such individuals shall be limited to the plan administration functions that the Plan Sponsor performs for the group health plan; and

(3) Any issue of noncompliance by such persons with these provisions shall be referred to the Trustees for resolution and appropriate action.

20.2 The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to the Health I nsurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the **"**Security Regulations**"**). The following provisions apply to Electronic Protected Health I nformation (**"**ePHI**"**) that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI (1) it receives pursuant to an appropriate authorization (as described in 45 C.F.R. §164.504(f)(1)(ii) or (iii)), or (2) that q ualifies as Summary Health I nformation and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. §164.508). I f other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations.

The Plan Sponsor shall, in accordance with the Security Regulations:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan.

(b) Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Plan Sponsor will use ePHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures or this Plan provision shall be subject to the Plan's disciplinary procedure.

(c) Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.

(d) Report to the Plan any Security Incident of which it becomes aware.

ARTICLE 21 – RIGHT TO RECOVER AMOUNTS PAID FOR BENEFITS DUE TO MISTAKE OR FRAUD AND OUTSTANDING AMOUNTS

21.1 Rescission

Rescission means the retroactive cancellation of coverage. Where coverage was provided as a result of fraud or an intentional misrepresentation of a material fact by a Participant or Dependent, or an individual seeking coverage on behalf of such Participant or Dependent, the Plan will rescind coverage. A 30-day notice of rescission will be provided, but termination of coverage will be retroactive to the date coverage should or would have been terminated if the fraud or intentional misrepresentation had not occurred (Date of Rescission). The intent of this provision is to rescind coverage to the full extent allowed by federal law.

Providing false information to maintain or obtain coverage, or knowingly cooperating in any actions designed to provide false information to maintain or obtain coverage, is an example of a fraud or intentional misrepresentation of material fact. Examples of fraud or intentional misrepresentation of material fact also include, but are not limited to, failing to inform the Fund Office of: (1) a divorce, (2) employment with a noncontributing employer in the plumbing and pipefitting industry, (3) performing work of the type covered by the Collective Bargaining agreement for a noncontributing employer; or (4) any other event which makes a Participant or Dependent ineligible for coverage.

In the event coverage is rescinded, in addition to any legal and equitable means of recovery available, the Plan has the right to pursue the Participant or Dependent, jointly and severally, for the full amount paid for such coverage from the date of cancellation, including all costs and attorney's fees, expended in collecting the amount owed. At the

Plan's sole option, it may enforce this provision by offsetting future benefits until the amount owed has been recovered.

Nothing in this section limits the rights of the Plan to prospectively terminate coverage where such coverage was previously provided as a result of a mistake, intentional misrepresentation, or fraud. Further, nothing in this section limits the right of the Plan to cancel coverage retroactively for failure of a Participant or Dependent to make a self-payment, where there has been a reasonable delay in terminating coverage due to administrative recordkeeping.

21.2 Outstanding Payments

All monies payable to a Participant that have not been cashed or otherwise redeemed by the Participant within 12 months of the date of issuance will become null and void. After the expiration of the 12-month period, the monies shall remain assets of the Fund free and clear of claims made by any person or entity seeking to assert an interest in such monies.

In the event any other payment issued by the Fund, for any reason, has not been redeemed by the payee for a period of 24 months, or such lesser time as set forth on the payment issued by the Fund, such payment is void and reverts to the Plan as a plan asset.

Article 22 – Medicare Eligible Participants and Dependents

Medicare eligible Participants and Dependents are provided medical and prescription drug coverage via a fully insured Medicare coordinated policy (Medicare Policy) and will be enrolled in the Medicare Policy. The terms and conditions of such coverage are set forth in the Medicare Policy. Non-Medicare eligible dependents of Medicare eligible Participants are covered under the Fund's self-insured medical and prescription drug plan set forth in Article 4.

Coverage under the Medicare Policy may be limited if such person has not timely applied for and obtained Medicare. It is the Participant's or Dependent's responsibility to timely obtain Medicare coverage. If he/she does not do so, he/she is responsible for the costs of medical expenses that otherwise would have been covered by Medicare or the Medicare Policy.
All Medicare eligible Participants and Dependents will automatically be enrolled in the Medicare Policy at the earliest enrollment opportunity after Medicare eligibility is obtained.

If a Participant has other coverage under a Spouse's plan or any other type of medical plan (Other Coverage), he/she must contact the Fund Office so benefits can be properly coordinated. If he/she does not do so, he/she may be responsible for the costs of medical expenses that otherwise would have been paid by the Other Coverage.

IN WITNESS WHEREOF, the Board of Trustees has approved and adopted this Pipefitters Local No. 636 I nsurance Fund Plan on 11/13, 2023.

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