PIPEFITTERS LOCAL 636
FRINGE BENEFIT FUNDS
P.O. BOX 278
TROY, MICHIGAN 48099-0278
(248) 641-4936 (888) 646-8920

November 2025

John Smith
1234 Sample
Troy, MI. 48098

OPEN ENROLLMENT 2026 – APPRENTICE APPLICANTS

Dear Participant,

Open Enrollment is in effect until December 5, 2025. During this time, Apprentice Applicant Participants may choose coverage under the Fund's comprehensive medical, prescription drug, and dental coverage (Standard Plan **only**) or the Opt Out Plan (for those participants who have other health coverage) and receive other benefits offered by the Fund (described below).

WHAT IS MY CURRENT COVERAGE?

You are currently enrolled in:

[COVERAGE]

YOUR ENROLLMENT OPTIONS:

- **If you are enrolled in medical/prescription drug coverage and would like to keep your current coverage in 2026, you do not need to do anything further.**

- **If you would like to make changes for 2026, by December 5, 2025, you must complete and return the one of the following: (1) for Medical/Prescription drug coverage, the enclosed Medical / Dental Election Form; or (2) to elect the Opt Out Plan, the enclosed Opt Out Election Form.**

MEDICAL PLAN

Enclosed please find the Summary of Benefits and Coverage (SBC), which summarizes the Medical and Prescription Drug coverage provided under the Standard Plan. **Blue Cross Blue Shield of Michigan (BCBSM) will be your medical network and Rx provider. BeneSys will pay and process your claims. You may choose dental coverage under a program administered by Delta Dental or DENCAP DHMO.**

For information on Self-Payment Amounts for this medical/prescription drug coverage, please contact the Fund Office or the Local Union

OPT OUT COVERAGE OPTION – OPT OUT PLAN

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If you have other comprehensive health coverage, instead of electing the Medical and Prescription Drug Plan, you may obtain additional benefits by enrolling in the Opt Out Plan.

The Opt Out Plan provides the following benefits:

- **Additional Life Insurance:** Additional Coverage of $50,000. An additional $50,000 accidental death and dismemberment benefit is also provided.
- **Prescription Drug Benefit:** A self-funded prescription drug benefit provides reimbursement for any out-of-pocket cost paid for prescriptions up to $30.00 per one month supply (not to exceed 34 days). Claims for reimbursement must be submitted to the Fund Office within 12 months of the date of service.
- **Dental Coverage**: $2,000 annually, self-funded through the Pipefitters Local 636 Insurance Fund using the Delta Dental network.
- **HRA:** $800 contributed to your Health Reimbursement Account (HRA), to be credited monthly in 12 equal payments, i.e., $66.66 per month.
- **Short -Term Disability:** Upon suffering a Disability, the Fund will pay 70% of weekly income lost up to a maximum of $450.00. This benefit supplements the short-term disability benefit available to all active participants, but in no event may the two benefits combined exceed 70% of weekly income.

OTHER COVERAGE AVAILABLE

In addition, eligible participants, whether enrolled in Comprehensive Coverage or in Opt Out Coverage, have the following benefits available to them:

- **Hearing Benefit / TruHearing**: $3,000 benefit through TruHearing provided every three years for hearing aids, batteries, repairs, and exams. TruHearing is the exclusive vendor for this benefit. More information about this hearing discount program may be found at: www.truhearing.com/ua636. There is no hearing benefit if you do not use TruHearing.
- **Vision Benefit**: Vision coverage will be offered on a fully-insured basis by Delta Vision, a program that is sponsored by Delta Dental and VSP.
- **Health Reimbursement Account (HRA)**: On an annual basis, regardless of which plan you choose (Standard Plan or Opt Out Coverage), you may also elect to pay certain expenses from your HRA through reimbursement such as dental co-payments, vision expenses, and prescription drug copayments. The amounts available for HRA reimbursement vary depending on which coverage election you choose. Please contact the Fund Office for more details.
- **Life Insurance**: Coverage of $50,000 for Active Employees.

If you would like to review the coverage options that are available to you and your family under the Plan, you can obtain additional information regarding these benefits and enrollment information by referring to your SPD or by contacting the Fund Office at (248) 641-4936 or toll free at (888) 646-8920.

WHAT DO I NEED TO DO?

- **If you would like to continue Medical & Prescription Drug Coverage, you do not need to do anything further. You and your dependents will be provided Medical and Prescription Drug Coverage as set forth**

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in the attached SBC, effective January 1, 2026. If you would like to confirm your current coverage election, please contact the Fund Office at (248) 641-4936 or toll free at (888) 646-8920.

- **If you wish to change your coverage option to Medical and Prescription drug Coverage (Standard Plan) you must return the enclosed Medical / Dental Election form no later than December 5, 2025.**

- **To elect the Opt Out Plan, you must complete and return the enclosed Opt Out Enrollment Form to the Fund Office by December 5, 2025. If enrolling in the Opt Out Plan, you must verify that you have other group health coverage, such as through a spouse, which meets the Affordable Care Act minimum value standard (comprehensive medical coverage which covers at least 60% of the total cost of benefits). (Medicare is not considered "other group health coverage.")**

- **If you have a dependent eligible for coverage who is not currently enrolled whom you would like to enroll, you may add them as of January 1, 2026 if you contact the Fund Office for the necessary paperwork and return the paperwork to the Fund Office by December 5, 2025.**

- **If you have a dependent eligible for coverage who is not currently enrolled and do not enroll him/her at this time, you will not be able to do so until next year unless the necessary written statement is submitted. The written statement should state that the reason you are declining enrollment is because your dependent has other health coverage. Written statement for declining enrollment is due to the Fund Office by December 5, 2025.**

    - **If dependent's other coverage involuntarily terminates during the year, you may enroll dependent mid-year provided a request to do so is received by the Fund Office within 30 days of termination of the other coverage.**

The Trustees for the
Pipefitters Local 636 Insurance Fund

ENCLOSURES

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PIPEFITTERS LOCAL 636 BENEFIT FUNDS
P.O. BOX 278
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MEDICAL / DENTAL ELECTION FORM – Active Apprentice Applicants

***** THIS FORM MUST BE COMPLETED AND RETURNED BY DECEMBER 5, 2025 *****

MEDICAL BENEFITS (choose only one):

		Single Coverage	Family Coverage
☐	**STANDARD PLAN**	$575.00 _____	$825.00 _____

DENTAL BENEFITS (choose only one):

Choose from one of the two dental benefits below if you selected the Standard Plan above.

☐ Delta Dental DPO
☐ DENCAP DHMO

If you wish to elect the Opt Out plan you must complete and return the **separate** Opt Out Enrollment Form.

By signing this form, I acknowledge that I have reviewed the enclosed information and understand the benefits for which I am enrolling. I understand that by using providers (doctors, hospitals etc.) that participate in the Plan's network, I will pay the in-network costs provided in the Plan. Further, I understand that I may be responsible for additional expenses if I do not use a participating provider. I also understand that my election cannot be changed until the next Open Enrollment period unless:

- **I chose Opt-Out Coverage and my other coverage terminates**

  IMPORTANT: If your other health coverage ends, you will be able to enroll in the Comprehensive Plan with Medical and Prescription Drug Coverage during the calendar year, provided that a request to enroll is received by the Fund Office within 30 days after the termination of coverage.

- **I have a Dependent eligible for coverage who is not enrolled in the Plan, and their other coverage involuntarily terminates, provided I had submitted a written statement prior to December 5, 2025, stating that the Dependent was enrolled in other health coverage. Please contact the Fund Office for information on how to submit this statement.**

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IMPORTANT: If your Dependent's coverage involuntarily terminates during the year, you may enroll the Dependent mid-year in Medical and Prescription Drug Coverage provided a request to do so is received by the Fund Office within 30 days of termination of other coverage.

- **I have a new Dependent as a result of marriage, birth, adoption, or placement for adoption.**

  IMPORTANT: If you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you must request enrollment within 30 days of marriage, birth, adoption, or placement for adoption. If such enrollment request is not timely made: (a) coverage for a Child, shall be effective the date such person became a Child as defined in the Plan Document, 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.

- **Once per year, if you have Medical/Rx coverage, you can elect to switch to Opt-Out coverage. Once such election is made, no further changes can be made until the next Open Enrollment.**

I certify that all information provided on this form is true and correct to the best of my knowledge.

Participant's Name: (PRINT)_____

Participant's Signature: _____ Date: _____

Participant's Social Security Number _____

Participant's Phone Number _____

Participant's Email Address _____

Please note, if you would like to enroll in additional Supplemental/Optional Life Insurance, please fill out the appropriate enclosed paperwork and return to the Fund Office by December 5, 2025.

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OPT OUT ELECTION FORM – ACTIVE PARTICIPANTS

***** THIS FORM MUST BE COMPLETED AND RETURNED BY DECEMBER 5, 2025*****

<u>If you are NOT Opting Out, DO NOT fill this form out.</u>

The Fund provides Participants a choice of Medical/Prescription Drug Coverage or Opt-Out Coverage. A dependent is enrolled in the same Option as the Participant. Opt-Out Coverage costs $200 per Month deducted from your Bank.

Opt-Out Coverage consists of the following benefits:

- **Additional Life Insurance:** Additional Coverage of $50,000. An additional $50,000 accidental death and dismemberment benefit is also provided.

- **Prescription Drug Benefit:** A self-funded prescription drug benefit provides reimbursement for any out-of-pocket cost paid for prescriptions up to $30.00 per one month supply (not to exceed 34 days). Claims for reimbursement must be submitted to the Fund Office within 12 months of the date of service.

- **Dental Coverage**: Self-Insured coverage using the Delta Dental network.

- **HRA:** $800 contributed to your Health Reimbursement Account (HRA), to be credited monthly in 12 equal payments, i.e., $66.66 per month.

  Short-Term Disability: Upon suffering a Disability, the Fund will pay 70% of weekly income lost up to a maximum of $450.00. This benefit supplements the short-term disability benefit available to all active participants, but in no event may the two benefits combined exceed 70% of weekly income.

In addition, opt-out participants remain eligible for the following benefits that are also provided to participants electing Medical / Prescription Drug Coverage:

- **Hearing Benefit / TruHearing**: $3,000 benefit through TruHearing provided every three years for hearing aids, batteries, repairs, and exams. TruHearing is the exclusive vendor for this benefit. More information about this hearing discount program may be found at: www.truhearing.com/ua636. There is no hearing benefit if you do not use TruHearing.
- **Vision Benefit**: Vision coverage will be offered on a fully-insured basis by Delta Vision, a program that is sponsored by Delta Dental and VSP.

- **Health Reimbursement Account (HRA)**: On an annual basis, regardless of which plan you choose (Standard Plan or Opt Out Coverage), you may also elect to pay certain expenses from your HRA through reimbursement such as dental co-payments, vision expenses, and prescription drug copayments. The amounts available for HRA reimbursement vary depending on which coverage election you choose. Please contact the Fund Office for more details.

- **Life Insurance**: Coverage of $50,000 for Active Employees.

To elect the Opt Out Plan, you must complete and return this Opt Out Enrollment Form to the Fund Office by December 5, 2025. If enrolling in the Opt Out Plan, you must verify that you have other group health coverage, such as through a spouse, which meets the Affordable Care Act minimum value standard (comprehensive medical coverage which covers at least 60% of the total cost of benefits) (Medicare is not considered "other group health coverage.")

Your election cannot be changed until the next Open Enrollment period unless:

- You have chosen Opt Out Coverage and your other Coverage terminates.

  IMPORTANT: If your health coverage ends, you will be able to enroll in Medical and Prescription Drug Coverage during the calendar year, provided that a request to enroll is received by the Fund Office within 30 days after the termination of coverage.

- You have a Dependent eligible for coverage who is not enrolled, and you have provided a written statement prior to December 5, 2025, stating that the Dependent was enrolled in other health coverage, and the Dependent's coverage involuntarily terminates.

  IMPORTANT: If your Dependent's coverage involuntarily terminates during the year, you may enroll the Dependent mid-year in Medical and Prescription Drug Coverage, provided a request to do so is received by the Fund Office within 30 days of termination of the other coverage.

- You have a new Dependent as a result of marriage, birth, adoption, or placement for adoption.

  IMPORTANT: If you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you must request enrollment within 30 days of marriage, birth, adoption, or placement for adoption. If such enrollment request is not timely made: (a) coverage for a Child, shall be effective the date such person became a Child as defined in the Plan Document, 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.

Other than these events, you may not elect Medical/Prescription Drug coverage until the next open enrollment period.

If you choose to enroll in the Opt Out plan, please complete the following:

Participant Information

_____ __ __ _____

Name: Last First M.I. M F Date of Birth

_____

Social Security No.

Election Statement

By signing below, I acknowledge that I voluntarily elect to Opt Out of Medical/Prescription Drug coverage for myself and my eligible dependents, if any. I further verify that I have other group health coverage which does not consist solely of excepted benefits and meets the Affordable Care Act minimum value standard (comprehensive medical coverage which covers at least 60% of the total cost of benefits). I understand that Medicare is not considered "other group health coverage." **I have attached proof of other health coverage.**

_____ _____

Signature Date

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-248-641-4936. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,000**/person; **$2,000**/family Out-of-Network **$2,000**/person; **$4,000**/family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, In-Network preventive services, in-network office visits, chiropractic care, and prescription benefits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Medical Coinsurance: **$5,000**/person; **$10,000**/family Out-of-Network Medical Coinsurance : **$10,000**/person; **$20,000**/family The overall out-of-pocket limit for copayments, deductibles, and co-insurance on in-network essential health benefits (medical and prescription drugs) is: **2026:** $10,600 Individual / $21,200 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Self-payments, premiums, balance-billing charges, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit

Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see **www.bcbsm.com** or call the number on the back of your ID card	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	40% coinsurance	Deductible does not apply to in-network visits
	Specialist visit	$50 copay per visit	40% coinsurance	Deductible does not apply to in-network visits
	Preventive care/screening/ immunization	No charge	Not Covered.	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	40% coinsurance	Preauthorization may be required. Please contact BCBSM
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	Preauthorization may be required. Please contact BCBSM
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com	Generic drugs (Tier 1)	Retail & Mail Order (1-34 day supply): $10 co-pay Retail & Mail Order (35-90 day supply) $20 co-pay	Not covered.	For information on women's contraceptive coverage contact Fund Office/BCBSM. Drugs which cost over $400 are subject to coupon program, call 866-680-4869. Formulary subject to change. For drugs subject to preauthorization or step therapy contact Fund Office/BCBSM
	Preferred brand drugs (Tier 2)	Retail & Mail Order (1-34 day supply): $40 co-pay Mail Order (35-90 day supply) $80 co-pay	Not covered.	
	Non-preferred brand drugs (Tier 3)	Retail & Mail Order (1-34 day supply): $80 co-pay	Not covered.	

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Mail Order (35-90 day supply) $160 co-pay		Must use BCBSM for all specialty medication needs after permitted one-time retail fill. The pharmacy may be reached at 1-866-515-1355. Formulary subject to change. For drugs subject to preauthorization or step therapy contact Fund Office/BCBSM.
	Specialty drugs (Tier 4)	**Limited to 30-day supply only**. $150 co-pay	Not available.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	Preauthorization may be required for certain procedures. Please contact BCBSM
	Physician/surgeon fees	30% coinsurance	40% coinsurance	Preauthorization may be required for certain procedures. Please contact BCBSM
If you need immediate medical attention	Emergency room care	$150 copay per visit	$150 copay per visit	Copay waived if accidental injury or admitted. Out-of-Network is copay plus max payment of greatest of (a) median payment to in-network; (b) UCR; or (c) Medicare approved amount.
	Emergency medical transportation	30% coinsurance	40% coinsurance	Coverage is for ground ambulances; benefit limited to 2 trips per confinement.
	Urgent care	$25 copay per visit	40% coinsurance	Deductible does not apply to in-network visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	Benefit is limited to a semi-private room; Preauthorization required.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	Preauthorization required. Please contact BCBSM
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	40% coinsurance	
	Inpatient services	30% coinsurance	40% coinsurance	Preauthorization required.
If you are pregnant	Office visits	30% coinsurance	40% coinsurance	

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	———— None ————
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	———— None ————
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	
	Rehabilitation services	30% coinsurance	40% coinsurance	Limited to combined rehabilitation therapies maximum of 90 visits per member per year.
	Habilitation services	Not Covered	Not Covered	For coverage related to treatment of mental health conditions and substance use disorders, contact BCBSM.
	Skilled nursing care	30% coinsurance	40% coinsurance	Preauthorization required. Limited to a maximum of 120 days per member per calendar year.
	Durable medical equipment	30% coinsurance	40% coinsurance	Durable Medical Equipment over $500 requires preauthorization
	Hospice services	100%	100%	Preauthorization required
If your child needs dental or eye care	Children's eye exam	$10 Copay	Up to $45 allowance	Fully Insured Vision Benefits via Delta Vision. Call Fund Office for more information/brochures. Prescription glasses or contact lenses, not both. One pair of lenses every 12 months. One frame every 24 months.
	Children's glasses	Lenses covered in full after copay $130 frames allowance	Single vision lenses up to $30 allowance. Frames up to $70 allowance.	

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Delta Dental: covered at no charge or DENCAP: covered at no charge	Not Covered	Delta Dental: diagnostic/preventive services covered no charge; maximum benefit $1,500 per covered adult/no max for children to age 18. Dependents covered until age 26. A lifetime orthodontic benefit of $1,500 to age 19 is available. DENCAP: maximum benefit $1,500 per year per covered person; lifetime limit orthodontics $1,200 for adults and $1,800 for children.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery (limited exceptions)
- Infertility Treatment
- Long Term Care
- Any service/treatment not medically necessary
- Weight Loss Programs
- Routine foot care
- Non-emergency care when traveling outside the United States
- Services covered under No-Fault Insurance

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Hearing Aids
- Chiropractic Care
- Routine eye care (adult)
- Bariatric Surgery (Limited to once per lifetime; precertification required)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Your State insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Fund Office by calling the number on the back of your ID card. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid,

CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al216-267-3344 or 888-424-7488.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 216-267-3344 or 888-424-7488.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 216-267-3344 or 888-424-7488.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 216-267-3344 or 888-424-7488.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage based on the Standard Plan.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1000
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1000
Copayments	$50
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,610**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1000
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$1000
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1000
Specialist *copayment*	$50
Hospital (facility) copayment	$0*
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1000
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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The plan would be responsible for the other costs of these EXAMPLE covered services. * Copay waived for accidental injury or if admitted.

PIPEFITTERS
LOCAL 636
FRINGE BENEFIT FUNDS
P.O. BOX 278
TROY, MICHIGAN 48099-0278
(248) 641-4936 (888) 646-8920
Email: enrollmentdocs@benesys.com Fax: (248) 430-8222

VITAL INFORMATION FORM

MEMBER Information: *(Please Print)*

Last: _____ First: _____ Middle: _____

Address/City/State/Zip: _____

Social Security Number: _____-_____-_____Telephone: _____(Cell or Home)

Email Address:_____Alternate Phone:_____(Cell or Home)

Date of Birth: _____/_____/_____ Gender: (*circle one*) Male Female

Marital Status: (*circle one*) Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____Current Status: (*circle one*) Active Retired Disabled COBRA

Medicare Claim Number (MBI) *If Applicable*:

Member # _____ Spouse # _____Dependent (NAME)#_____

DEPENDENTS: - Include Spouse (If additional space is needed, please use 2nd sheet)

NAME	RELATION	DATE OF BIRTH	SOCIAL SECURITY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

BENEFICIARY: (Death Benefits)
If a minor is named as beneficiary, insurance proceeds can only be paid to a legally appointed/qualified guardian.

NAME	RELATION	BIRTHDAY	S.S. #	ADDRESS/CITY/STATE/ZIP	%
_____ (Primary)	_____	___/___/___	____-___-____	_____	_____
_____ (Secondary)	_____	___/___/___	____-___-____	_____	_____

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits. ***A copy of the marriage certificate must be submitted to add a new spouse. Copies of birth certificates for all new dependents must be submitted. Copies of complete divorce decrees must be submitted for any new step children.***

_____ _____

MEMBER SIGNATURE **Date**

(OVER)

OTHER INSURANCE INQUIRY

***Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage, or if there has been any change in other insurance coverage*.**

General Information:

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone #: (_____)_____

Policy/Group Number: _____

Effective date of coverage: _____ is insurance active? _____

Termination date if applicable: _____

Coverage is: (*circle one*) Single Family

Children are covered until age: _____

Type of coverage: (*circle all that apply*) Medical Dental Vision Prescription

List covered dependents: _____

_____

Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

Any materials submitted by myself or on behalf of any eligible person that contain a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

I Have No Other Insurance: _____
Initial Here/Sign Below

_____ _____

Member Signature **Date**

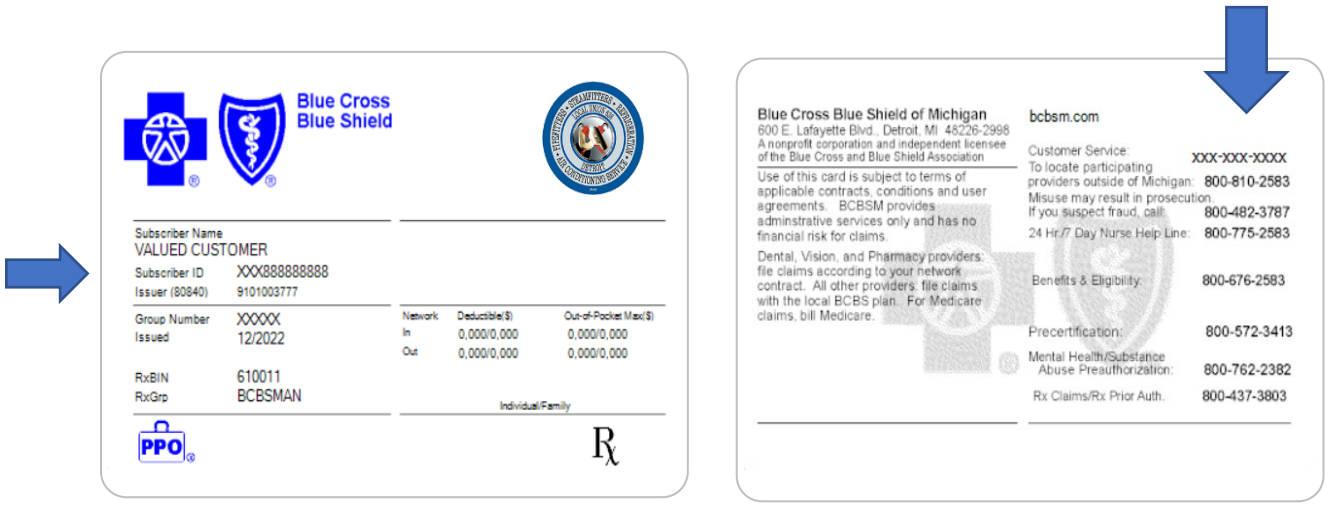
Welcome to Blue Cross Blue Shield of Michigan

As a member of Blue Cross, you have comprehensive health care coverage that gives you access to the largest network of doctors and hospitals in Michigan and nationwide. More than 80% of the doctors and 90% of the hospitals in the United States are part of our PPO network. In Michigan, PPO access is even greater. Whether home or away, you can be confident that your Blue Cross member ID card ensures you'll receive quality health care.

Your member ID card has important information you need to get care

Things you should do:

- Confirm your ID card is correct.
- Download the Blue Cross mobile app to get access to your ID card anytime, anywhere.
- Note: Your new ID card should have arrived in MONTH/YEAR.



1. Member name: The subscriber's name
2. Member ID: The subscriber's assigned contract number, which allows health care providers to identify you and your benefits
3. Customer service phone numbers for you and your providers are on the back of your member ID card.

Web or mobile, get the most from your health plan

Health insurance can be confusing. To help you understand and manage your costs and care, we offer a wide range of tools on our website, **bcbsm.com**. Once you register for an online member account, nearly everything you can do on the website you can also do on your smartphone or tablet.

Don't have an online account with us yet? It only takes a few minutes to register. Go to **bcbsm.com** and select the login tab in the upper right-hand corner. You'll need your **member ID card** handy to complete the process.

You can also access your online account by using our app. To get our app, search "BCBSM" in the App Store℠ or on Google Play™.

What can you find online or on the mobile app?

- **My Coverage**– Find detailed health plan information, who is on your health plan, what we pay for, what you pay for and more.
- **My Claims** – See a list of all claims.
- **ID Card** – Request additional ID cards or view a virtual one.
- **Find a Doctor** – This includes hospitals, urgent care, behavioral health services and
- 24-Hour Nurse Line.
- **Health & Well-Being** – Take the health assessment and find helpful resources.
- **Spending Accounts** – Find account balances and quick links to helpful information on your account.
- **Forms and Documents** – Get claim forms and many other helpful resources to manage your online member account.
- **Discounts** – You'll have access to money-saving programs, such as Blue365®. This national program offers access to discounts and savings from selected companies on health-related products and services. You can also find discounts for Healthy Roads and Weight Watchers.

DELTA DENTAL®

Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group #5030-0001, 0002, 0003, 0099 (Active Members & COBRA)
Pipefitters Local 636 Insurance Fund

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the Dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Non-Participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	75%
Palliative Treatment – to temporarily relieve pain	100%	100%	75%
Sealants – to prevent decay of permanent teeth	100%	100%	75%
Brush Biopsy – to detect oral cancer	100%	100%	75%
Bitewing Radiographs – bitewing X-rays	100%	100%	75%
All Other Radiographs – other X-rays	100%	100%	50%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	50%	50%
Endodontic Services – root canals	80%	50%	50%
Periodontic Services – to treat gum disease	80%	50%	50%
Oral Surgery Services – extractions and dental surgery	80%	50%	50%
Other Basic Services – misc. services	80%	50%	50%
Relines and Repairs – to prosthetic appliances	80%	50%	50%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	through age 18 and under	through age 18 and under	through age 18 and under

* When you receive services from a Non-Participating Dentist, the percentages in this column indicate the portion of Delta Dental's Non-Participating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable once per calendar year for people age 13 and under.

- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first permanent molars for people age eight and under and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Crowns, onlays and substructures are payable once per tooth in any seven-year period.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Full and partial dentures are payable once in any seven-year period.
- Bridges are payable once in any seven-year period.
- Implants are payable once per tooth in any seven-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any seven-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,500 per Member total per Benefit Year on all services, except diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services. $1,500 per Member total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible – Delta Dental PPO™ Dentist - None.

Delta Dental Premier® Dentist - $50 Deductible per Member total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Non-Participating Dentist - $50 Deductible per Member total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, bitewing X-rays, sealants, and orthodontic services.

Waiting Period – Eligibility for benefits is determined by the terms of the Pipefitters Local 636 Insurance Fund Plan document.

Eligible People – Eligibility for benefits is determined by the terms of the Pipefitters Local 636 Insurance Plan Document (the "Plan"). A summary of these provisions can be found in the Pipefitters Local 636 Insurance Fund Summary Plan Description. **IF THERE ARE ANY INCONSISTENCIES BETWEEN THE TERMS OF THE PLAN AND THE DELTA DENTAL CARE CERTIFICATE, OR ANY OTHER DOCUMENT PUBLISHED BY DELTA DENTAL, THE TERMS OF THE PLAN CONTROL.**

If you and your spouse are both eligible under this contract, you may be enrolled as both a subscriber on your own application card and as a dependent on your spouse's application card. Your dependent children may be enrolled on both application cards as well. Delta Dental will coordinate benefits.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Benefits will cease on the last day of the month in which your employment is terminated.

DELTA DENTAL®

Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group #5030-0004 (Opt-Outs)
Pipefitters Local 636 Insurance Fund

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the Dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Non-Participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Palliative Treatment – to temporarily relieve pain	100%	70%	70%
Minor Restorative Services – fillings and crown repair	100%	70%	70%
Endodontic Services – root canals	100%	70%	70%
Periodontic Services – to treat gum disease	100%	70%	70%
Oral Surgery Services – extractions and dental surgery	100%	70%	70%
Other Basic Services – misc. services	100%	70%	70%
Relines and Repairs – to prosthetic appliances	100%	70%	70%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	through age 18 and under	through age 18 and under	through age 18 and under

* When you receive services from a Non-Participating Dentist, the percentages in this column indicate the portion of Delta Dental's Non-Participating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable twice per calendar year with no age limit.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.

- Sealants are payable once per tooth per three-year period for first and second permanent molars for people age 18 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $2,000 per Member total per Benefit Year on all services, except oral exams, preventive services, X-rays, brush biopsy, sealants, and orthodontic services. $1,500 per Member total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible – Delta Dental PPO™ Dentist - None.

Delta Dental Premier® Dentist or Non-Participating Dentist - $50 Deductible per Member total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to oral exams, preventive services, X-rays, brush biopsy, sealants, and orthodontic services.

Waiting Period – Eligibility for benefits is determined by the terms of the Pipefitters Local 636 Insurance Fund Plan document.

Eligible People – Eligibility for benefits is determined by the terms of the Pipefitters Local 636 Insurance Plan Document (the "Plan"). A summary of these provisions can be found in the Pipefitters Local 636 Insurance Fund Summary Plan Description. **IF THERE ARE ANY INCONSISTENCIES BETWEEN THE TERMS OF THE PLAN AND THE DELTA DENTAL CARE CERTIFICATE, OR ANY OTHER DOCUMENT PUBLISHED BY DELTA DENTAL, THE TERMS OF THE PLAN CONTROL.**

Coordination of Benefits – If you and your spouse are both eligible under this contract, you may be enrolled as both a subscriber on your own application card and as a dependent on your spouse's application card. Your dependent children may be enrolled on both application cards as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which your employment is terminated.

Stay in network and save

As a Delta Dental PPO (Point-of-Service) member, you may see any dentist you like. However, you will likely save the most money and receive the highest level of coverage when you visit a Delta Dental PPO dentist.

Delta Dental PPO dentists	• No balance billing on covered services • Most significant network discounts with more than 395,000 office locations nationwide* • Dentists file claims for member
Delta Dental Premier® dentists	• No balance billing on covered services • Significant network discounts with the most office locations nationwide—460,000* • Dentists file claims for member
Out-of-network dentists	• Balance billing • No network discounts • May need to file own claims

How it works:

As shown below, your lowest out-of-pocket costs result from going to a Delta Dental PPO dentist.

Example savings for a crown by network	Submitted charge	Maximum allowed fee	Percentage paid by Delta Dental	Amount Delta Dental pays	Amount dentist can balance bill	Total amount you pay	Total network savings
Delta Dental PPO	$1,100	$754	50%	$377	$0	$377	**$346** ✓
Delta Dental Premier	$1,100	$988	50%	$494	$0	$494	$112
Out-of-network	$1,100	$798	50%	$399	$302	$701	$0

Delta Dental PPO dentists

Delta Dental PPO dentists have **agreed to charge $754 for the $1,100 service, a savings of $346.** Your **Delta Dental plan covers 50 percent** of the cost. Assuming you've already met your deductible for the year, **Delta Dental will pay $377** and **you'll pay $377.**

Delta Dental Premier dentists

Delta Dental Premier dentists have **agreed to charge $988—a savings of $112** compared to the fee the dentist usually charges. Delta Dental's payment is based on the maximum allowed fee amount of $988. Assuming you've met your deductible, **Delta Dental will cover 50 percent** of that $988, **paying $494.** With a Delta Dental PPO (Point-of-Service) plan, the dentist cannot bill you the difference between Delta Dental's payment and the Delta Dental Premier maximum allowed fee.

Out-of-network dentists

Out-of-network dentists **have not agreed to charge lower fees and can bill the full $1,100.** For payment to nonparticipating dentists, Delta Dental establishes a nonparticipating dentist fee, which is the maximum fee allowed for the procedure, meaning **Delta Dental pays $399.** The dentist can bill you the difference between Delta Dental's payment and what they charge. This leaves **you with a bill of $701, which includes the $302 the out-of-network dentist can "balance bill."**

NOTE: Payment examples above are illustrative only. Fees and reimbursements can vary by location and dentist. They do however represent how payment is determined.
*Delta Dental Plans Association, December 2024.

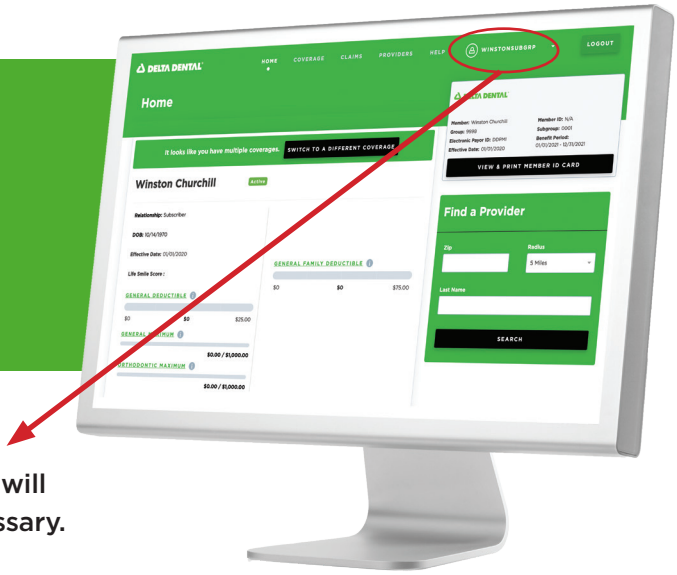
Find Delta Dental participating dentists near you by using the search feature on our website or by calling Delta Dental toll-free at 800-524-0149.

DELTA DENTAL®

Stay informed about your dental benefits with member portal

Member Portal is designed to give you 24/7 access to important information regarding your dental benefits.

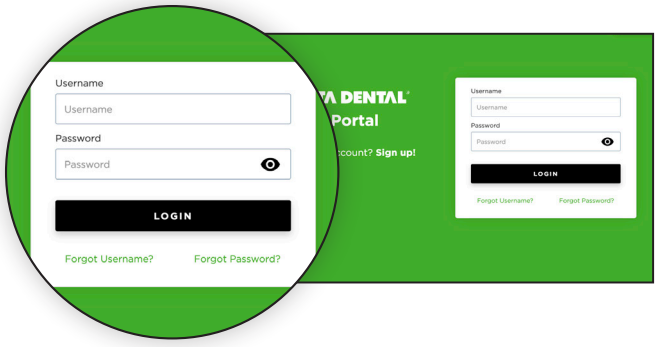
Use this secure online tool for access to eligibility information, current benefits information, claims information and more.



Once you have logged in to Member Portal, remember to sign up for electronic delivery of Explanation of Benefits (EOB) statements by checking the "Paperless Preferences" box. You will be able to view your EOBs online and print copies when necessary.

All users must first register to gain access to the Member Portal. Privacy of your online benefit information is assured through highly secure encryption technology.

Get started today



1. Visit www.memberportal.com.
2. Log in.

   NOTE: Member Portal has replaced Consumer Toolkit®. If you currently have a Consumer Toolkit account, your username and password for Consumer Toolkit will work for Member Portal.

   - If you have already registered, enter your credentials and click the "Login" button.
   - If you are new to Member Portal, click the "Sign up!" link to register.

     NOTE: You will need the subscriber's (the person whose name is on the benefit package) member ID. The member ID is an assigned number unique to the subscriber. In most cases, the member ID is the same as the subscriber's Social Security number.
3. Complete required fields and follow the on-screen instructions.
4. Select your own username and password to access the site.

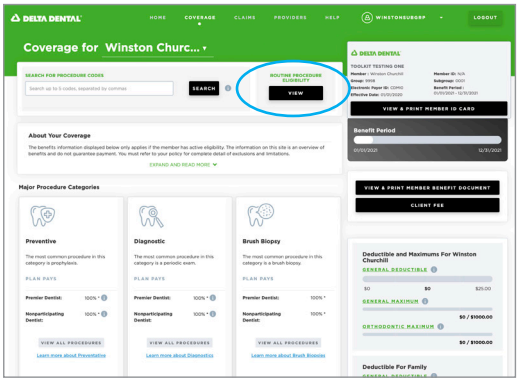
Additional help can be accessed through the Help menu within Member Portal. If you need further assistance, call Toolkit Support at 866-356-0301.

See reverse for additional features.

Member Portal features

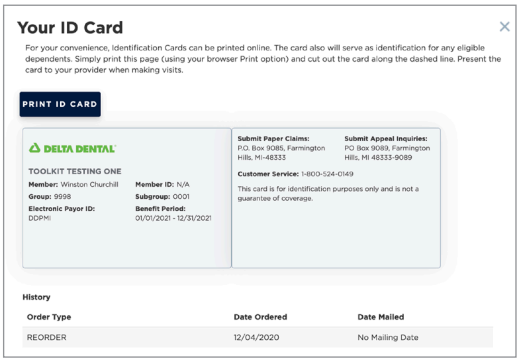
Find your benefits

Confirm eligibility and review benefits by clicking the **Coverage** link at the top.



Print ID card

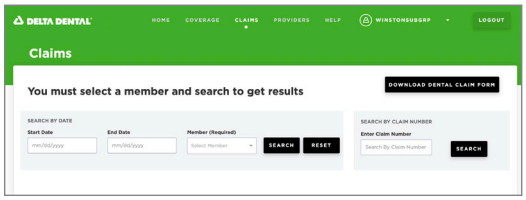
View and print your ID card 24/7 by following the **Print ID Card** link.

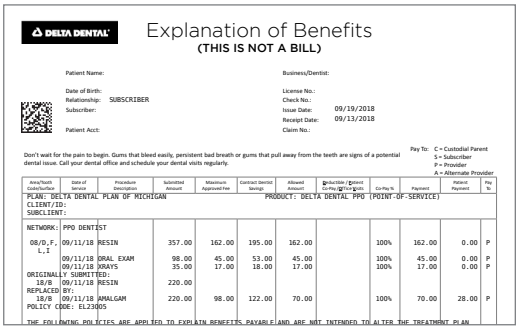


View your EOBs

Review and print EOBs by clicking the **Claims** link and entering the dates and patient's name.

Sign up for electronic delivery of EOBs statements by checking the "**Paperless Preferences**" box.

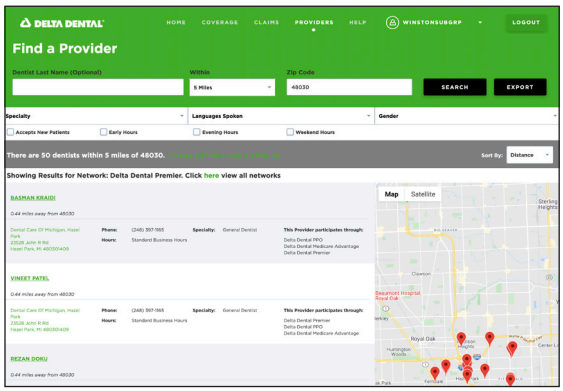




Find a dentist

Use the **Find a Provider** link to select your Delta Dental network and find a participating dentist near you.

Nationwide, three out of four dentists participate in of Delta Dental networks, which means members have lots of choices nearby.



dencap DENTAL PLANS

Welcome to the DENCAP family!

From routine checkups to major services, your plan helps protect both your smile and your budget.

Pipefitters Local 636 - Smile Smarter, Spend Less!

Get the smile support you deserve with our all-in-one dental plan. From routine care to braces, we've got you covered. Sign up today and keep your teeth in top shape!

Pipefitters Local 636 Plan	
Primary maximum per member	**$1,500 benefit**
Specialty maximum per member	**$500 benefit**
Preventive (Cleanings, exams and most x-rays)	100%†
Basic (Fillings, etc.)	75%†
Major (Endo, perio, oral surgery at a general dentist)	70%†
Specialty coverage per member (At a specialty office)	50%
Ortho (adults 19+) **(under 19)**	**$1,200 benefit** **$1,800 benefit**

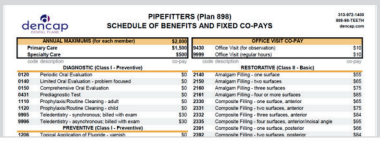
† PERCENTAGES are APPROXIMATE, see co-payments as listed on the Schedule of Benefits and Fixed Co-Pays.

Why Choose DENCAP?

- **Higher benefit coverage than other plans**
- **Live, local customer service**
- **No deductibles, no waiting periods**
- **Choose from our wide network of dentists**

Cost Clarity - Right Upfront!

A schedule of benefits helps members know their expected out of pocket costs at the dentist.


dencap

PIPEFITTERS (Plan 898)
SCHEDULE OF BENEFITS AND FIXED CO-PAYS

ANNUAL MAXIMUMS (for each member)	
Primary Care	$1,500
Specialty Care	$500

OFFICE VISIT CO-PAY	
9430	Office Visit (for observation)
9986	Office Visit (regular hours)

code	description	co-pay
	DIAGNOSTIC (Class I - Preventive)	
0120	Periodic Oral Evaluation	$0
0140	Limited Oral Evaluation - problem focused	$0
0150	Comprehensive Oral Evaluation	$0
0431	Prediagnostic Test	$0
1110	Prophylaxis/Routine Cleaning - adult	$0
1120	Prophylaxis/Routine Cleaning - child	$0
9985	Teledentistry - synchronous; billed with exam	$30
9986	Teledentistry - asynchronous; billed with exam	$30
	PREVENTIVE (Class I - Preventive)	
1206	Topical Application of Fluoride - varnish	$0

code	description	co-pay
	RESTORATIVE (Class II - Basic)	
2140	Amalgam Filling - one surface	$65
2150	Amalgam Filling - two surfaces	$65
2160	Amalgam Filling - three surfaces	$75
2161	Amalgam Filling - four or more surfaces	$85
2330	Composite Filling - one surface, anterior	$65
2331	Composite Filling - two surfaces, anterior	$75
2332	Composite Filling - three surfaces, anterior	$84
2335	Composite Filling - four surfaces, anterior/incisal angle	$98
2391	Composite Filling - one surface, posterior	$68
2392	Composite Filling - two surfaces, posterior	$84

For More Plan Information

Want all the details? Scan the QR code with your smart phone to head to your Pipefitters Local 636 landing page:

Link: dencap.com/pipefitters-local-636

PIPEFITTERS (Plan 898)
SCHEDULE OF BENEFITS AND FIXED CO-PAYS

313-972-1400
888-98-TEETH
dencap.com

ANNUAL MAXIMUMS (for each member)	$2,000
Primary Care	$1,500
Specialty Care	$500

code	description	co-pay
	DIAGNOSTIC (Class I - Preventive)	
0120	Periodic Oral Evaluation	$0
0140	Limited Oral Evaluation - problem focused	$0
0150	Comprehensive Oral Evaluation	$0
0431	Prediagnostic Test	$0
1110	Prophylaxis/Routine Cleaning - adult	$0
1120	Prophylaxis/Routine Cleaning - child	$0
9995	Teledentistry - synchronous; billed with exam	$30
9996	Teledentistry - asynchronous; billed with exam	$30
	PREVENTIVE (Class I - Preventive)	
1206	Topical Application of Fluoride - varnish	$0
1208	Topical Application of Fluoride - excluding varnish	$0
1330	Oral Hygiene Instructions	$0
	RADIOGRAPHS (Class I - Preventive)	
0210	Intraoral - complete series	$0
0220	Periapical - first radiographic image	$0
0230	Periapical - each additional radiographic image	$0
0240	Intraoral - occlusal radiographic image	$0
0270	Bitewing - single radiographic image	$0
0272	Bitewings - two radiographic images	$0
0273	Bitewings - three radiographic images	$0
0274	Bitewings - four radiographic images	$0
0330	Panoramic Radiographic Image	$0
	ADJUNCTIVE SERVICES (Class II - Basic)	
0470	Diagnostic Casts (each)	$48
1351	Sealant - per tooth	$0
1353	Repair to Sealant - per tooth	$0
1510	Fixed Space Maintainer - unilateral per quadrant	$127
1516	Fixed Space Maintainer - bilateral, upper	$158
1517	Fixed Space Maintainer - bilateral, lower	$158
1520	Removable Space Maintainer - unilateral per quadrant	$158
1526	Removable Space Maintainer - bilateral, upper	$174
1527	Removable Space Maintainer - bilateral, lower	$174
1551	Re-cement or Re-bond Bilateral Space Maintainer - upp	$25
1552	Re-cement or Re-bond Bilateral Space Maintainer - low	$25
1553	Re-cement or Re-bond Unilateral Space Maintainer - per quadrant	$25
2940	Protective Restoration (sedative filling)	$40
9110	Palliative (Emergency) Treatment - minor procedure	$47
9215	Local Anesthesia	$23
9230	Inhalation of Nitrous Oxide	$25
9239	IV Moderate (Conscious) Sedation/Analgesia - first 15 minute increment	50%
9243	IV Moderate (Conscious) Sedation/Analgesia - each subsequent 15 minute increment	50%
9310	Consultation (second opinion)	$62
9910	Application of Desensitizing Medicament	$26
9930	Treatment of Complications, Post-Surgical - unusual	$49
9944	Hard Occlusal Guard (night guard) - full arch	$400
9945	Soft Occlusal Guard (night guard) - full arch	$400
9946	Hard Occlusal Guard (night guard) - partial arch	$400
9951	Occlusal Adjustment - limited	$74

SPECIALTY CARE

- Endodontics - Oral Surgery - Periodontics - Pedodontics -
Approved referral from DENCAP is required

DENCAP pays 50% of our specialist's fees up to the Specialty Care Annual Maximum for covered services; you are responsible for the remaining balance.

OFFICE VISIT CO-PAY		
9430	Office Visit (for observation)	$10
9999	Office Visit (regular hours)	$10

code	description	co-pay
	RESTORATIVE (Class II - Basic)	
2140	Amalgam Filling - one surface	$55
2150	Amalgam Filling - two surfaces	$65
2160	Amalgam Filling - three surfaces	$75
2161	Amalgam Filling - four or more surfaces	$85
2330	Composite Filling - one surface, anterior	$65
2331	Composite Filling - two surfaces, anterior	$75
2332	Composite Filling - three surfaces, anterior	$84
2335	Composite Filling - four surfaces, anterior/incisal angle	$95
2391	Composite Filling - one surface, posterior	$66
2392	Composite Filling - two surfaces, posterior	$84
2393	Composite Filling - three surfaces, posterior	$109
2394	Composite Filling - four surfaces, posterior	$125
	PROSTHETIC REPAIR (Class II - Basic)	
2910	Re-cement Partial Coverage Restoration	$72
2915	Re-cement Indirectly Fabricated or Prefab Post and Core	$72
2920	Re-cement or Re-bond crown	$72
5410	Adjustment to Complete Denture - upper	$60
5411	Adjustment to Complete Denture - lower	$60
5421	Adjustment to Partial Denture - upper	$60
5422	Adjustment to Partial Denture - lower	$60
5511	Repair to Broken Complete Denture Base - lower	$127
5512	Repair to Broken Complete Denture Base - upper	$127
5520	Replace Missing/Broken Teeth - denture, per tooth	$110
5611	Repair Resin Partial Denture Base - lower	$125
5612	Repair Resin Partial Denture Base - upper	$125
5621	Repair Cast Partial Framework - lower	$160
5622	Repair Cast Partial Framework - upper	$160
5630	Repair or Replace Broken Clasp - per tooth	$160
5640	Replace Missing/Broken Teeth - partial, per tooth	$115
5650	Add Tooth to Existing Partial Denture	$143
5660	Add Clasp to Existing Partial Denture - per tooth	$170
5730	Reline Complete Upper Denture - in office	$223
5731	Reline Complete Lower Denture - in office	$223
5740	Reline Partial Upper Denture - in office	$208
5741	Reline Partial Lower Denture - in office	$208
5750	Reline Complete Upper Denture - lab	$262
5751	Reline Complete Lower Denture - lab	$262
5760	Reline Partial Upper Denture - lab	$260
5761	Reline Partial Lower Denture - lab	$260
6930	Re-cement or Re-bond Fixed Partial Denture	$100
	ENDODONTICS (Class III - Major)	
3110	Pulp Cap - direct	$50
3120	Pulp Cap - indirect	$50
3220	Therapeutic Pulpotomy	$120
3310	Root Canal Therapy - anterior tooth	$465
3320	Root Canal Therapy - premolar tooth	$515
3330	Root Canal Therapy - molar tooth	$640
3346	Retreat of Previous Root Canal Therapy - anterior tooth	$505
3347	Retreat of Previous Root Canal Therapy - premolar tooth	$585
3348	Retreat of Previous Root Canal Therapy - molar tooth	$685
3410	Apicoectomy Surgery - anterior tooth	$520
3421	Apicoectomy Surgery - premolar tooth, first root	$530
3425	Apicoectomy Surgery - molar tooth, first root	$650
3426	Apicoectomy Surgery - each additional root	$245
3430	Retrograde Filling - per root	$165

LAB WORK AND PRECIOUS METALS

Additional charges may apply for lab work and precious metals for procedures involving crowns, bridges, prosthodontics, space maintainers, appliances and any repairs to such items.

PIPEFITTERS (Plan 898)
SCHEDULE OF BENEFITS AND FIXED CO-PAYS

313-972-1400
888-98-TEETH
dencap.com

code	description	co-pay
	PROSTHODONTICS (Class III - Major)	
5110	Complete Upper Denture	$1,000
5120	Complete Lower Denture	$1,000
5130	Immediate Upper Denture	$1,050
5140	Immediate Lower Denture	$1,050
5211	Upper Partial Denture - resin base	$1,050
5212	Lower Partial Denture - resin base	$1,050
5213	Upper Partial Denture - cast metal framework with resin base, including clasps, rests, and teeth	$1,030
5214	Lower Partial Denture - cast metal framework with resin base, including clasps, rests and teeth	$1,030
5225	Upper Partial Denture - flexible base, including any clasps, rests and teeth	$1,030
5226	Lower Partial Denture - flexible base, including any clasps, rests and teeth	$1,030
5820	Interim Partial Denture - upper	$420
5821	Interim Partial Denture - lower	$420
5850	Tissue Conditioning - upper	$136
5851	Tissue Conditioning - lower	$136
6010	Endosteal Implant in Conjunction with Denture	NCB
6012	Endosteal Implant in Conjunction with Denture	NCB
6210	Pontic - cast high noble metal	$615
6211	Pontic - cast predominantly base metal	$577
6212	Pontic - cast noble metal	$572
6240	Pontic - porcelain fused to high noble metal	$656
6241	Pontic - porcelain fused to predominantly base metal	$590
6242	Pontic - porcelain fused to noble metal	$617
6245	Pontic - porcelain/ceramic	$714
6740	Retainer Crown - porcelain/ceramic	$714
6750	Retainer Crown - porcelain fused to high noble metal	$656
6751	Retainer Crown - porcelain fused to predominantly base metal	$577
6752	Retainer Crown - porcelain fused to noble metal	$617
6780	Retainer Crown - 3/4 cast high noble metal	$623
6781	Retainer Crown - 3/4 cast predominantly base metal	$640
6782	Retainer Crown - 3/4 cast noble metal	$654
6783	Retainer Crown - 3/4 porcelain/ceramic	$686
6790	Retainer Crown - full cast high noble metal	$627
6791	Retainer Crown - full cast predominantly base metal	$573
6792	Retainer Crown - full cast noble metal	$584
	PERIODONTICS (Class III - Major)	
0180	Comprehensive Periodontal Evaluation	$32
4210	Gingivectomy/Gingivoplasty - 4+ teeth/spaces per quad	$297
4211	Gingivectomy/Gingivoplasty - 1-3 teeth/spaces per quad	$138
4212	Gingivectomy/Gingivoplasty - access for restorative procedure, per tooth	$97
4240	Gingival Flap Procedure - 4+ teeth/spaces per quad	$368
4241	Gingival Flap Procedure - 1-3 teeth/spaces per quad	$315
4249	Clinical Crown Lengthening - hard tissue	$442
4260	Osseous Surgery - 4+ teeth/spaces per quad	$499
4261	Osseous Surgery - 1-3 teeth/spaces per quad	$410
4341	Perio Scaling and Root Planning - 4+ teeth per quad	$64
4342	Perio Scaling and Root Planning - 1-3 teeth per quad	$58
4355	Full Mouth Debridement	$38
4381	Site Specific Therapy, generic - per tooth	$45
4910	Periodontal Maintenance	$51
4921	Gingival Irrigation - per quad	$7

ORTHODONTICS (Class IV - Orthodontics)

Approved referral from DENCAP to an in-network Orthodontist is required

Continuous coverage is required for the duration of the treatment

Up to Age 19, $1800 benefit / Over age 19, $1200 benefit (Lifetime benefit)

- 12 to 24 months standard orthodontic treatment; Interceptive Ortho is not covered

code	description	co-pay
	CROWNS (Class III - Major)	
2390	Crown - resin-based composite, anterior	$244
2542	Onlay - metallic, two surfaces	$651
2543	Onlay - metallic, three surfaces	$653
2544	Onlay - metallic, four surfaces	$667
2642	Onlay - porcelain/ceramic, two surfaces	$672
2643	Onlay - porcelain/ceramic, three surfaces	$644
2644	Onlay - porcelain/ceramic, four surfaces	$657
2662	Onlay - resin-based composite, two surfaces	$641
2663	Onlay - resin-based composite, three surfaces	$645
2664	Onlay - resin-based composite, four surfaces	$647
2740	Crown - porcelain/ceramic	$930
2750	Crown - porcelain fused to high noble metal	$789
2751	Crown - porcelain fused to predominantly base metal	$643
2752	Crown - porcelain fused to noble metal	$680
2780	Crown - 3/4 cast high noble metal	$781
2781	Crown - 3/4 cast predominantly base metal	$649
2782	Crown - 3/4 cast noble metal	$689
2783	Crown - 3/4 porcelain/ceramic	$923
2790	Crown - full cast high noble metal	$919
2791	Crown - full cast predominantly base metal	$680
2792	Crown - full cast noble metal	$739
2799	Crown - interim	$219
2930	Crown - prefabricated stainless steel, primary tooth	$190
2931	Crown - prefabricated stainless steel, permanent tooth	$189
2932	Crown - prefabricated resin	$202
2933	Crown - prefabricated stainless steel with window	$190
2950	Core Buildup - including any pins	$135
2952	Post and Core in Addition to Crown	$200
2954	Prefabricated Post and Core in Addition to Crown	$160
	ORAL SURGERY (Class III - Major)	
7111	Extraction - coronal remnants (primary tooth)	$38
7140	Extraction - erupted tooth or exposed root	$25
7210	Surgical Removal of an Erupted Tooth	$67
7220	Removal of Impacted Tooth - soft tissue	$89
7230	Removal of Impacted Tooth - partially bony	$124
7240	Removal of Impacted Tooth - completely bony	$191
7241	Removal of Impacted Tooth - complicated	$284
7250	Surgical Removal of Residual Tooth Roots	$106
7280	Surgical Access of an Unerupted Tooth	$252
7285	Incisional Biopsy of Oral Tissue - hard	$197
7286	Incisional Biopsy of Oral Tissue - soft	$125
7287	Exfoliative Cytological Sample Collection	$84
7310	Alveoloplasty in Conjunction with Extractions - 4+ teeth/spaces per quad	$114
7311	Alveoloplasty in Conjunction with Extractions - 1-3 teeth/spaces per quad	$125
7320	Alveoloplasty not in Conjunction with Extractions - 4+ teeth/spaces	$175
7321	Alveoloplasty not in Conjunction with Extractions - 1-3 teeth/spaces	$175
7471	Removal of Lateral Exostosis	$269
7472	Removal of Torus Palatinus	$321
7473	Removal of Torus Mandibularis	$297
7510	Incision and Drainage of Abscess - intraoral soft tissue	$83

Benefits are subject to change.

Limitations and Exclusions found at:
dencap.com/general-policies

dencap
DENTAL PLANS

FAQ's - For Pipefitters Local 636 Members

Q: What is a DHMO?

A: A DHMO (Dental Health Maintenance Organization) is an insurance model where the emphasis is on preventive dentistry and containing costs on other necessary dental care.

Q: Are there any out-of-network benefits?

A: You must seek services within the DENCAP Network to use your plans benefits. There are no out-of-network benefits unless it's an out- of-town emergency.

If you are out of the DENCAP service area (5O or more miles away from your Primary Care Dentist), DENCAP will reimburse you or your covered dependent for 50% of the amount up to $100.00 for those emergency services which relieve severe pain or discomfort and are covered benefits.

Q: What if I have a dental emergency?

A: Dental emergencies can be handled by your DENCAP Primary Care Dentist. Often there are after hour emergency numbers given on a dentist's answering service. If you are unable to get a hold of your DENCAP Dentist after hours, please call DENCAP at 800-451-5918.

Q: How do I assign myself to a dental office location?

A: To assign yourself to an in-network dental office location, you must notify DENCAP over the phone or by email. You can obtain a paper copy of our provider directory by calling us at (800) 451-5918 or viewing it online at dencap.com.

Q: May I change my dental office location?

A: Yes! Changes are allowed as needed to ensure that you are completely satisfied with your dental experience. Members can change their dental location with a two-week notice by mail, phone, email, or fax.

Q: What can I do if I have a question about my dental bill?

A: First, contact your DENCAP Primary Care Dentist's billing department to see if there was an error in billing. If you still have concerns, please call DENCAP.

Q: Will I receive an ID card?

A: We will send you an ID card after your enrollment process is complete. If you lose your card, you may contact us for a replacement but it is not necessary to have a card to use your dental benefits.

TruHearing®

1-855-739-8049 | TTY: 711

Address your hearing loss for less.

Thanks to Pipefitters Local 636 Insurance Fund you have access to tremendous savings through TruHearing®. This includes a hearing exam ($0 copay[1]) and a hearing aid allowance up to $3,000 every 3 years.

Rob is wearing a Signia® Active Pro hearing aid.

Hearing aid tier	Average retail price/aid	TruHearing price	Fund allowance	**Member cost**
Premium	$3,330	$1,799	$1,500	**$299**
Advanced	$2,750	$1,399	$1,399	**$0**
Standard	$2,150	$999	$999	**$0**
Basic	$2,000	$699	$699	**$0**
Value	$1,900	$499	$499	**$0**
TruHearing Premium	$3,250	$1,449	$1,449	**$0**
TruHearing Advanced	$2,720	$1,149	$1,149	**$0**

Your hearing aid purchase includes

- Risk-free **60-day** trial period
- **1 year** of follow-up visits
- **80 free batteries** per non-rechargeable hearing aid
- Full **3-year manufacturer** warranty

Call TruHearing to get started.

1-855-739-8049 | TTY: 711

Hours: 8am–8pm, Monday–Friday

TruHearing®

1-855-739-8049 | TTY: 711

The right hearing aids can change your life.

Research shows that addressing hearing loss can impact your overall health and well-being, including improvements in[2]

- Mental and emotional health
- Relationship with spouse or partner
- Work performance

Sarah is wearing TruHearing Advanced RIC hearing aids.

The best tech for less.

Enhanced speech clarity
to understand voices above background noise

Bluetooth® streaming
from your phone for convenient calls, music, movies, and more

Potential tinnitus relief
since treating your hearing loss may be an effective tinnitus treatment

Give us a call.
Your dedicated Hearing Consultant will answer any questions you might have, check your coverage with the fund, and schedule an appointment with a TruHearing provider near you. (Teleaudiology options may also be available.)

Go to your appointment.
Your local hearing health provider will perform a hearing exam and, if needed, recommend hearing aids that best fit your hearing loss, budget, and lifestyle.

Get the support you need.
Follow-up care from your provider ensures your hearing aids feel right and perform properly, and ongoing support from TruHearing will help you get comfortable with your new hearing aids.

Schedule an appointment

1-855-739-8049 | TTY: 711

Hours: 8am–8pm, Monday–Friday

Learn more

TruHearing.com/UA636

These hearing benefits are subject to change at the fund's discretion.

[1] Must be performed by a TruHearing provider.

[2] MarkeTrak 2022.

 Hearing aid pricing based on a February 2024 survey of national average hearing aid prices. Follow-up provider visits included for one year following hearing aid purchase. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing Hearing Consultant.

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Summary of Vision Plan Benefits – Choice Plan
For Group# V5030-0001, 0002, 0003, 0004, 0005, 0006, 0007, 0099
Pipefitters Local 636 Insurance Fund

This Summary of Vision Plan Benefits is part of, and should be read in conjunction with, your Group Vision Certificate. Your Group Vision Certificate will provide you with additional information about your DeltaVision coverage, including information about exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the Provider's network participation.

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services

We will provide vision care Benefits according to the Schedule listed below. This Summary lists the vision care Benefits to which Covered Persons are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. Administrative Services for the adjudication of claims and the payment of Benefits under this Plan will be provided by Vision Service Plan Insurance Company ("VSP"), using a VSP network of Providers. VSP is sometimes referred to as the claims administrator for this Plan. If Benefits are available for Out-of-Network Provider services, as indicated by the reimbursement provisions below, Benefits may be received from any licensed eye care provider whether an In-Network or Out-of-Network Provider. This Summary forms a part of the Contract to which it is attached.

In-Network Providers are those Providers who have agreed to participate in the VSP Choice Network.

When Covered Services are received from In-Network Providers, the Benefit amounts shown in the In-Network Benefit column below are applicable, subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Covered Services are received from Out-of-Network Providers, the Covered Person is reimbursed for such Benefits according to the schedule in the Out-of-Network Provider Benefit column below, less any applicable Copayment. The Covered Person pays the Provider the full fee at the time of service and submits an itemized bill to the claims administrator for reimbursement. Discounts do not apply for Benefits obtained from Out-of-Network Providers.

Copayment

Benefits received from In-Network Providers and Out-of-Network Providers may require Copayments.

There shall be a Copayment of $10 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $25 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Lens Enhancements, if covered under this Certificate, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

BENEFITS – IN-NETWORK AND OUT-OF-NETWORK PROVIDERS

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $45*	Available once each 12 months**
Retinal Screening	Covered for a maximum fee of $39	Included in exam	Available once every 12 months**

Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated.

*Less any applicable Copayment.
**Beginning with the first date of service.

Coverage for retinal imaging as an enhancement to the eye examination.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
LENSES			Available once each 12 months**
Single Vision	Covered in full *	Up to $30.00*	
Lined Bifocal	Covered in full *	Up to $50.00*	
Lined Trifocal	Covered in full *	Up to $65.00*	
Lenticular	Covered in full *	Up to $100.00*	

Benefits for lenses are per complete set, not per lens.

Polycarbonate lenses are covered in full for dependent children up to age 26.

Standard Progressive Lenses covered in full.

*Less any applicable Copayment.
**Beginning with the first date of service.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance of $130.00*	Up to $70.00*	Available once each 24 months**

Benefits for lenses and frames include reimbursement for the following necessary professional services:

1. Prescribing and ordering proper lenses;
2. Assisting in frame selection;
3. Verifying accuracy of finished lenses;
4. Proper fitting and adjustments of frames;
5. Subsequent adjustments to frames to maintain comfort and efficiency;
6. Progress or follow-up work as necessary.

*Less any applicable Copayment.
**Beginning with the first date of service.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Necessary			Available once each 12 months**
Professional Fees/Materials	Covered in full*	Up to $210.00*	
Elective	Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a maximum $60.00 Copayment.		Available once each 12 months**
	Materials Up to $130.00	Professional Fees/Materials Up to $105.00	

*Less any applicable Copayment.
**Beginning with the first date of service.

Necessary Contact Lenses are a Covered Services when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Provider or Out-of-Network Provider. Review and approval by Delta Dental's claims administrator is not required for the Covered Person to be eligible for Necessary Contact Lenses.

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.
When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
LOW VISION			
Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing (Includes evaluation, diagnosis and prescription of vision aids where indicated.)	Covered in full	Up to $125.00	*
Supplemental Aids	75% of amount up to $1000.00*	75% of amount up to $1000.00*	*

*Maximum benefit for all Low Vision services and materials is $1000.00 (excluding Copayment) every two (2) years.

Low Vision benefits secured from Out-of-Network Providers (if covered) are subject to the same time and Copayment provisions described above for In-Network Providers. The Covered Person should pay the Out-of-Network Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what would be paid to an In-Network Provider for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their In-Network Provider or by calling the Member Services Department at 1-800-877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the enhancements.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

There are no Benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a ± .50 diopter power).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above stated allowances.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where Delta Dental or its claims administrator is required by law to pay.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.

Eligible (Certificate Holder and Eligible Dependents) – Eligibility for benefits is determined by the terms of the Pipefitters Local 636 Insurance Plan Document (the "Plan"). A summary of these provisions can be found in the Pipefitters Local 636 Insurance Fund Summary Plan Description. **IF THERE ARE ANY INCONSISTENCIES BETWEEN THE TERMS OF THE PLAN AND THE DELTA DENTAL CARE CERTIFICATE, OR ANY OTHER DOCUMENT PUBLISHED BY DELTA DENTAL, THE TERMS OF THE PLAN CONTROL**.

If you and your spouse are both eligible under this contract, you may be enrolled as both a subscriber on your own application card and as a dependent on your spouse's application card. Your dependent children may be enrolled on both application cards as well. Delta Dental will coordinate benefits.

Covered Persons choosing this vision plan are required to remain enrolled for a period of 12 months. Should a Covered Person choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Waiting Period – Eligibility for benefits is determined by the terms of the Pipefitters Local 636 Insurance Fund Plan document.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Covered Persons, you may be enrolled as both a Covered Person on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's applications as well. We will coordinate Benefits between your coverage and your Spouse's coverage.

Benefits will cease on the last day of the month in which your employment is terminated.

DELTA DENTAL® DeltaVision®

vsp vision care

Welcome to DeltaVision®

Delta Dental is committed to the whole health of our members—including eye health. That's why we've partnered with VSP® Vision Care to offer members best-in-class vision care.

See the difference.

Start taking advantage of your DeltaVision vision benefits today!

Access your benefits online

Stay informed about your dental and vision benefits in one, convenient location at www.memberportal.com.

Use our secure online tool, Member Portal, to access both your dental and vision benefits information, including eligibility information, benefits and plan coverage details, find a provider, claims information, and more.

1. Visit *www.memberportal.com*.
2. Log in with your Member Portal credentials or click the *Sign up!* link to register. You will need the primary subscriber's Social Security number or member ID number. Complete all required fields and follow the on-screen instructions to finish creating your account.
3. Member Portal features single sign-on functionality, allowing members to access their vision benefits information without creating a separate account with VSP. Click the *DeltaVision Login* button to access your vision benefits information.

How to find a VSP network doctor

Search under the VSP Choice network for any DeltaVision plan:

Online—Log in to Member Portal or visit www.vsp.com/eye-doctor to view results by city, state, ZIP code, provider's name or specialty.

Member services—Call VSP's member services team toll-free at 800-877-7195 to find a participating VSP provider.

Mobile app—Download VSP's mobile app for Apple or Android devices. To download, visit the App Store (Apple) or Google Play (Android) and search for "VSP."

Contact provider—Members should call their provider's office and ask if they participate in the VSP Choice network.

DID YOU KNOW?

Dentists and eye doctors are both trained to detect early signs of many conditions, which can lead to earlier intervention and better overall health. In fact, VSP network doctors are first to report diabetes 34 percent of the time, high cholesterol 62 percent of the time and hypertension 39 percent of the time.[1]

1 VSP, "Why VSP – Discover the benefits," web.

DELTA DENTAL DeltaVision®

vsp vision care

Frequently asked questions

Which retail chains are included?

Costco, Sam's Club Optical, Walmart Vision, Pearle Vision, Visionworks and more.

Retail chains may not show as a participating provider until the member is registered within the VSP member portal.

What percentage of network providers are accepting new patients?

All VSP network doctors must accept new VSP patients.

Does material copay apply to single vision, bifocal, trifocal and lenticular lenses?

Yes. The material copay is for lenses and/or frames.

Do our plans have any member cost differentials for disposable vs. conventional contacts?

No.

If a new DeltaVision group is coming from a prior VSP plan do their benefits reset?

Yes, even if the member recently sought treatment through their prior VSP plan, as of the effective date of the DeltaVision plan all benefits will be available.

Does VSP offer an online retail service?

Yes, through their Eyeconic.com website members have access to the following:

- In network VSP benefits on glasses, contact lenses, and/or prescription sunglasses
- Larger frame selection than physical office/ retail locations
- Try frames on virtually
    - Results in less than 5% return rate
- Add on lens enhancement options available with transparent pricing
- Ability to upload prescription
- There is no extra cost, free shipping and free returns
- The average turnaround (with standard shipping) is two business days for contacts and sunglasses, five to seven days for RX glasses
- Go to any VSP provider office to have adjustments made to frames

If a member signs on to Member Portal, will they also be able to view DeltaVision information (benefits, EOBs, etc....)?

- When a member signs into Member Portal they will be able to see their enrollment in DeltaVision, however, they will not be able to see claim or benefit specific information.
- To access claim specific or more detailed information, they will need to login to their VSP member account which can be done by visiting www.vsp.com or through a single sign on (SSO) through Member Portal.

Does Delta Dental or VSP adjudicate the vision claims?

All claims are adjudicated by VSP.

Will DeltaVision invoices be available through BMT similar to Delta Dental invoices?

Yes, however, they will be a separate invoice from the dental.

If the group has risk consolidated billing, the dental and vision billing will show on the same invoice.

More information on reverse side.

Do members need an ID card?

An ID card, or Member Vision Card, isn't required for members to receive services or care. Members simply call a VSP network provider to schedule an appointment and tell them that they're a VSP member. The network provider and VSP handle the rest. If a member wishes to have an ID card, they can create an account and log in at www.vsp.com to print one.

How do members obtain a list of VSP network providers?

- They should visit www.vsp.com or contact VSP at 800-877-7195. Clients registered for the Manage Your Plan section at www.vsp.com can download customized VSP network provider lists as PDF or Excel files.
- Members and dependents have instant access through www.vsp.com to check coverage and eligibility, find a VSP network provider and learn more about eye care wellness.

How do members collect reimbursement after visiting an out-of-network provider?

When services and/or materials are obtained from an out-of-network provider, members have two reimbursement choices:

1. Most out-of-network providers will submit a request for reimbursement on behalf of VSP members. This means members won't need to pay their entire bill upfront and will only be responsible for paying applicable copays and any balance above their out-of-network schedule.
2. Members can pay the provider directly and submit a claim to VSP for reimbursement, using the following procedure:
   A. Visit the Benefits & Claims section of www.vsp.com to begin a claim.
   B. The member should fill out the claim form completely and submit an itemized receipt or statement that includes:
      - Doctor name or office name
      - Name of patient
      - Date of service
      - Each service received and the amount paid
   C. Submit claims online at www.vsp.com or mail to:

      VSP
      PO Box 385018
      Birmingham, AL 35238-5018

Please note that claims for reimbursement must be filed within 12 months of the date of service. Members will be reimbursed according to the out-of-network reimbursement schedule.

Virtual Second Opinions
By Cleveland Clinic

Direct access to a Cleveland Clinic expert physician for peace of mind

72% of educational opinions uncover potential diagnosis changes or treatment plan modifications

The Clinic 2020 outcomes data, n=417

Through Pipefitters Local 636 Insurance Fund, you have access to The Clinic by Cleveland Clinic's Virtual Second Opinions program. The program provides you with easy, secure access to high-quality medical expertise from the comfort of home.

Through this digital health service, you can have your medical diagnosis and treatment plan reviewed by an expert physician at Cleveland Clinic and receive an educational opinion by video consultation and written report in about two weeks.

The Clinic supports you every step of the way. From collecting and reviewing medical records to identifying the best specialist for your needs, the program saves you time, trouble, and travel on your path to peace of mind — **all at no cost to you.**

What is a Virtual Second Opinion?

- A health service to have a diagnosis and treatment plan reviewed by expert physicians at the world-renowned Cleveland Clinic
- Personalized matching with one of 3,500 Cleveland Clinic expert physicians in one of over 550 advanced sub-specialties
- 100% confidential and included in your benefits package at no cost to you

We encourage you to obtain a second opinion if you are:

- Diagnosed with a serious condition
- About to make a major decision about a medical next step, such as surgery
- Considering a treatment that involves risk or has significant consequences
- Dealing with a condition or chronic illness that isn't improving or is getting worse

How it works

Live intake with nurse care manager

Records collection

Records and tests review

Expert physician matching

Expert physician review

Opinion delivered by expert physician

Get a Virtual Second Opinion from Cleveland Clinic today

Scan the QR code to the right or follow the link below to learn more, register, and download the app.
Go to: **www.clinicbyclevelandclinic.com/local-636-active**
Once prompted, enter the service key: **LOCAL636**

Cleveland Clinic is ranked one of the nation's top hospitals and No. 1 for heart care in *U.S. News & World Report*'s "2022-23 Best Hospitals" rankings.

Questions? Call us at 844-777-0788 from 8:00 a.m. to 5:00 p.m. ET Monday through Friday.

Ulliance

No cost &
completely confidential

PIPEFITTERS LOCAL 636
LIFE ADVISOR MAP

The Ulliance Life Advisor MAP is part of your benefits package and offers total well-being services to you, spouse/live-in partner and dependents under the age of 27. This is a free and totally confidential service. Call today!

Counseling

Feeling overwhelmed with work, relationship issues, addiction, or loss? Take a breath and let our expert counselors guide you toward solutions. Choose from in-person chats, virtual video sessions, or phone calls and start making breakthroughs today!

Well-being Portal

Discover expert advice, informative articles, & insider tips to live your best life. Attend enlightening webinars and orientation videos on demand and unleash your hidden talents.

Crisis Support

You can speak with a mental health professional by phone at any time, 24 hours a day, 7 days a week—365 days a year.

Identity Theft Program

Introducing a program providing continuous surveillance of the dark web, wallet retrieval, fraud restoration support, and an online information hub. Protect up to four family members by adding their emails, phone numbers, and bank accounts.

Coaching

Tackle life's hurdles with a Life Advisor Coach, ready to chat via phone or video. Crush those career goals, save for a rainy day, or level up your self-improvement game with our pro tips and tricks.

Legal & Financial Consultations

Our experts offer support and resources to help you navigate difficult situations, including legal advice, financial planning, and debt management.

Resource Referrals

Consultants provide you with tips and tricks for tapping into community resources that are just right for you and your family.

Work/Life Materials

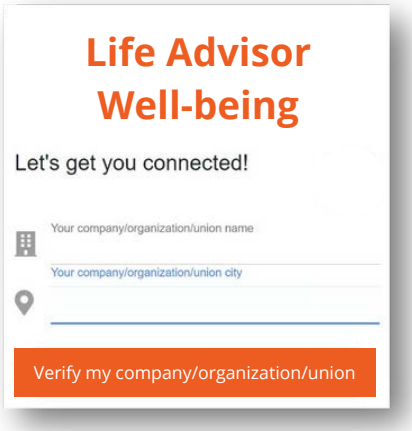
The MAP portal is like a treasure trove of helpful webinars, videos, and PDFs, all aimed at helping you nail that elusive work-life balance.

SCAN ME

LifeAdvisor.com | 800.448.8326

Ulliance Life Advisor Well-being Portal Login:
www.LifeAdvisor.com

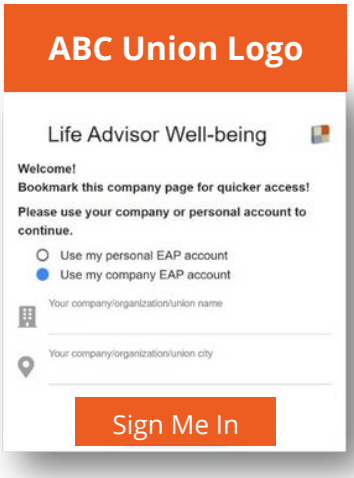
FIRST TIME LOGGING IN?



Enter your:

- Union Name
- Union City
- Click Verify

You will land on a screen with your Union LOGO:



Select:

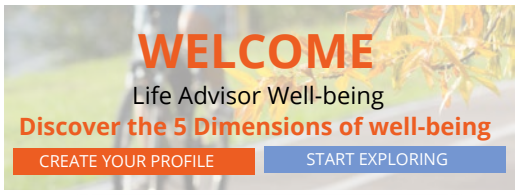
- Use my Union **MAP Account**

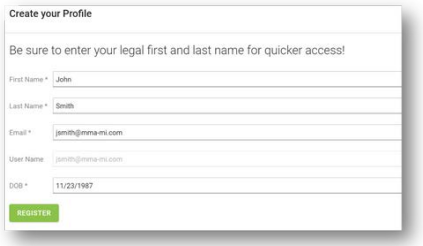
Re-enter your:

- Union Name
- Union City
- **CLICK ▶ SIGN ME IN**

Create your profile

To access the FULLY ENHANCED features for an interactive experience.





Enter your:

- First Name
- Last Name
- Date of Birth
- Email Address
- Click REGISTER

Your email address will auto-fill as your Username and a password will be sent to the email you provided.

Ulliance
Enhancing People. Improving Business.

Call us—
we're here to help...
800.448.8326

Login Today!

SCAN ME

OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The Trustees of the Pipefitters Local 636 Insurance Fund offer to all eligible, active participants, the option to purchase Optional Life and Accidental Death and Dismemberment (AD&D) Insurance coverage through Guardian. You can enroll yourself and your family in these plans, at affordable group rates, during open enrollment. You can choose Optional Life, AD&D, or both.

To select the coverage amount that is right for you and your dependents, please read this entire notice and carefully review the following enclosed documents:

- Group Enrollment Form (to be completed and returned if you elect either Optional Life or AD&D)
- Rate Chart
- Application and Authorization Agreement for Direct Payments (to be completed and returned if you elect either Optional Life or AD&D)
- Statement of Health Form/Evidence of Insurability Form (to be completed and returned only if electing above the Guarantee Issue amount)

Optional Life Coverage

You may elect to purchase coverage up to the 100% of the Guarantee Issue amount with no medical questions asked. The Guarantee Issue amounts are $150,000 for yourself, $50,000 for your spouse and $10,000 for each dependent child. However, the benefit elected for your spouse cannot exceed 50% of the benefit amount elected for yourself.

Voluntary Accidental Death & Dismemberment Coverage

Coverage up to $500,000 will be available to you and your family. This coverage can be purchased with or without the Optional Life Coverage.

TO ENROLL COMPLETE AND RETURN TO THE FUND OFFICE BY <u>DECEMBER 5, 2025</u> BOTH OF THE FOLLOWING DOCUMENTS:

- **Group Enrollment Form and Application**
- **Authorization Agreement for Direct Payments**
  Note: The cost for the Optional Life and/or AD&D benefits must be made by a deduction from your personal checking or savings account. No direct payments are permitted. The deduction will be taken from your account on or about the 10th day of each month.

If you do not enroll in either of these plans at this time, you will not be able to enroll in the future or increase your coverage without submitting a Statement of Health form. (New hires will have the opportunity to enroll upon their initial eligibility date.)

If you have any questions, please contact the Fund Administration Office at (248) 641-4936 or toll free at (888) 646-8920.

Sincerely,

BeneSys Inc., on behalf of the
PIPEFITTERS LOCAL NO. 636 INSURANCE FUND

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer/Planholder Name: PIPEFITTERS LOCAL 636 INSURANCE FUND PLAN	Group Plan Number: 00063748	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Add Employee/Member Dependents/Family Members ❑ Drop/Refuse Coverage ❑ Information Change

In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term , and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.

Class:_____ Division:_____ Subtotal Code:_____ (Please obtain this from your Employer/Planholder)

About You:	Employer/Planholder Provided Identification:	Social Security Number	
Full Legal Name-First, MI, Last Name: What is the name you go by? (optional)	_____	___ ___ ___ - ___ ___ - ___ ___ ___ ___ Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.	

Address	City	State	Zip

Gender Identity: ❑ M ❑ F Date of Birth (mm-dd-yy): ____ - ____ - ____

Phone (indicate primary): ❑ Home (____) ____ - ____
❑ Work (____) ____ - ____
❑ Mobile (____) ____ - ____

Email Address (indicate primary) ❑ Home _____ ❑ Work _____

Are you married or in a civil union? ❑ Yes ❑ No Date of marriage/civil union:____-____-_____
Do you have children or other dependents? ❑ Yes ❑ No Placement date of adopted child: ____-____-_____

About Your Job:

Job Title:

Work Status: ❑ Active ❑ Retired ❑ COBRA/State Continuation Hours worked per week: _____	Date of full time hire: _____ - _____ - _____	Annual Salary: $_____

About Your Family:

Please include the names of the Dependents/Family Members you wish to enroll. You can enroll only those Dependents/Family Members that are eligible for coverage. Please refer to the plan documents such as the group policy, member guide, or certificate to determine if a Dependent/Family Member is eligible for coverage.

If additional space is needed, please attach a separate page with this information along with your enrollment form. Each Dependent/Family Member's Social Security Number must be provided if enrolling them for Life Coverage. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a niece or a nephew.

Spouse Address/City/State/Zip: Phone: ( ) -	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: May 06, 2024

Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

Guardian Group Plan Number: 00063748 Please print employee name:

Basic Life Coverage with Accidental Death and Dismemberment (AD&D):

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Policy Amount
Employee/Member Only
☑ $50,000
The Guarantee Issue Amount is $50,000.

* If Employee/Member is 65+ benefit reductions may apply which may change the GI amount. Please see enrollment materials for details.

Employee/Member Name your beneficiaries: (Primary beneficiary percentages must total 100%)

If additional space is needed, please attach a separate sheet of paper with this infformation along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name:_____ Social Security Number:___-___-_____%___

Date of Birth (mm-dd-yy):___-___-___
Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee/Member:_____

Name:_____ Social Security Number:___-___-_____%___

Date of Birth (mm-dd-yy):___-___-___
Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee/Member:_____

Contingent Beneficiary:_____ Social Security Number: ___-___-_____

Date of Birth (mm-dd-yy):___-___-___
Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee/Member:_____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer/Planholder maintains beneficiary information.)

Dependents/Family Members – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. ❑ Yes ❑ No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:
Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): ____ ____ ____ ____ ____-____ _____ ____
Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____
Address/City/State/Zip: _____
Phone: ( ) -

If this Basic Life coverage will replace your existing life insurance coverage through your current Employer/Planholder, provide the amount of the previous policy $_____

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

LIFE INSURANCE *continued*

Voluntary Term Life Coverage: You must be enrolled to cover your dependents/family members. *Benefit reductions apply. Please see plan administrator.*

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Employee/Member

Policy Amount *Check one box only*

❑ $25,000 ❑ $50,000 ❑ $75,000 ❑ $100,000 ❑ $125,000 ❑ $150,000
❑ $175,000 ❑ **$200,000***

*Guarantee Issue Amount. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected.

❑ I do not want this coverage

Add Voluntary Life for Spouse

Policy Amount

❑ $12,500	❑ $15,000	❑ $17,500	❑ $20,000	❑ $22,500	❑ $25,000
❑ $27,500	❑ $30,000	❑ $32,500	❑ $35,000	❑ $37,500	❑ $40,000
❑ $42,500	❑ $45,000	❑ $47,500	❑ **$50,000***	❑ $52,500	❑ $55,000
❑ $57,500	❑ $60,000	❑ $62,500	❑ $65,000	❑ $67,500	❑ $70,000
❑ $72,500	❑ $75,000	❑ $77,500	❑ $80,000	❑ $82,500	❑ $85,000
❑ $87,500	❑ $90,000	❑ $92,500	❑ $95,000	❑ $97,500	❑ $100,000

**Guarantee Issue Amount*

**The amount may not be more than 100% of the employee amount for Voluntary Life.*

❑ I do not want this coverage

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

❑ **$10,000***

**Guarantee Issue Amount*

**The amount may not be more than 100% of the employee amount for Voluntary Life.*

❑ I do not want this coverage

Voluntary Accidental Death and Dismemberment (AD&D) Coverage: Check one box only You must be enrolled to cover your dependents/family members.

Employee/Member Only

The amount of AD&D coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Policy Amount

❑ $25,000	❑ $50,000	❑ $75,000	❑ $100,000	❑ $125,000	❑ $150,000
❑ $175,000	❑ $200,000	❑ $225,000	❑ $250,000	❑ $275,000	❑ $300,000
❑ $325,000	❑ $350,000	❑ $375,000	❑ $400,000	❑ $425,000	❑ $450,000
❑ $475,000	❑ $500,000				

❑ I do not want this coverage

Spouse

Policy Amount *Check one box only*

❑ $12,500	❑ $15,000	❑ $17,500	❑ $20,000	❑ $22,500	❑ $25,000
❑ $27,500	❑ $30,000	❑ $32,500	❑ $35,000	❑ $37,500	❑ $40,000
❑ $42,500	❑ $45,000	❑ $47,500	❑ $50,000	❑ $52,500	❑ $55,000
❑ $57,500	❑ $60,000	❑ $62,500	❑ $100,000		

** The amount may not be more than 100% of the Employee/Member amount for Voluntary Accidental Death & Dismemberment.*

❑ I do not want this coverage

LIFE INSURANCE *continued*

Child(ren)

Policy Amount *Check one box only*

❑ $10,000

**The amount may not be more than 100% of the Employee/Member amount for Voluntary Accidental Death & Dismemberment.*

❑ I do not want this coverage

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

Employee/Member Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term Life,
please name below.

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

Date of Birth (mm-dd-yy):____-____-____ Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee/Member:_____

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

Date of Birth (mm-dd-yy):____-____-____ Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee/Member:_____

Contingent Beneficiary:_____ Social Security Number: ___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth (mm-dd-yy):____-____-____ Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee/Member:_____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer/Planholder maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. ❑ Yes ❑ No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): ____ ____ ____ ____ ____-____ _____ ____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: ( ) -

Signature

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
- LIFE ONLY: I understand that life insurance coverage for a dependent/family member, other than a newborn child, will not take effect if that dependent/family member is confined to a hospital or other health care facility, or is home confined, or is unable to perform two or more Activities of Daily Living (ADL's).
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- **I attest that the information provided above is true and correct to the best of my knowledge.**

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

NOTICE TO CONSUMER: THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

SIGNATURE OF EMPLOYEE/MEMBER X _____ DATE _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Pipefitters Local 636

Insurance and Retiree Funds

Active Eligible Participants Optional Life Rate Chart

Life Benefit	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
$ 25,000.00	$1.93	$2.50	$3.25	$3.75	$4.25	$6.25	$9.75	$18.25	$28.25	$54.25	$88.25	$88.25
$ 50,000.00	$3.85	$5.00	$6.50	$7.50	$8.50	$12.50	$19.50	$36.50	$56.50	$108.50	$176.50	$176.50
$ 75,000.00	$5.78	$7.50	$9.75	$11.25	$12.75	$18.75	$29.25	$54.75	$84.75	$162.75	$264.75	$264.75
$ 100,000.00	$7.70	$10.00	$13.00	$15.00	$17.00	$25.00	$39.00	$73.00	$113.00	$217.00	$353.00	$353.00
$ 150,000.00	$13.48	$15.00	$19.50	$22.50	$25.50	$37.50	$58.50	$109.50	$169.50	$325.50	$529.50	$529.50
$ 200,000.00	$15.40	$20.00	$26.00	$30.00	$34.00	$50.00	$78.00	$146.00	$226.00	$434.00	$706.00	$706.00
* Evidence of Insurability is required for benefit amounts above $200,000. Monthly premium based on member age.												

Spouse Optional Life Rate Chart

Life Benefit	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
$ 12,500.00	$0.38	$0.38	$0.63	$0.88	$1.13	$1.50	$2.13	$3.13	$4.63	$8.50	$8.50	$8.50
$ 25,000.00	$0.75	$0.75	$1.25	$1.75	$2.25	$3.00	$4.25	$6.25	$9.25	$17.00	$17.00	$17.00
$ 37,500.00	$1.13	$1.13	$1.88	$2.63	$3.38	$4.50	$6.38	$9.38	$18.88	$25.50	$25.50	$25.50
$ 50,000.00	$1.50	$1.50	$2.50	$3.50	$4.50	$6.00	$8.50	$12.50	$18.50	$34.00	$34.00	$34.00
$ 75,000.00	$2.25	$2.25	$3.75	$5.25	$6.75	$9.00	$12.75	$18.75	$27.75	$51.00	$51.00	$51.00
$ 100,000.00	$3.00	$3.00	$5.00	$7.00	$9.00	$12.00	$17.00	$25.00	$37.00	$68.00	$68.00	$68.00
* Evidence of Insurability is required for benefit amounts above $50,000. Monthly premium based on spouse age.												

Child Optional Life Rate Chart

$ 10,000.00	2.00

Premium Covers all Dependent children in the family

Active Eligible Participant Only AD&D Monthly Rate Chart

$ 100,000.00	2.00
$ 200,000.00	4.00
$ 300,000.00	6.00
$ 400,000.00	8.00
$ 500,000.00	10.00

Spouse AD&D

$100,000.00	2.00
$200,000.00	4.00
$300,000.00	6.00
$400,000.00	8.00
$500,000.00	10.00

Child AD&D (Includes one or more children for one cost)

$100,000.00	2.00
$200,000.00	4.00
$300,000.00	6.00
$400,000.00	8.00
$500,000.00	10.00

PIPEFITTERS LOCAL 636
FRINGE BENEFIT FUNDS
P.O. BOX 278
TROY, MICHIGAN 48099-0278
(248) 641-4936 (888) 646-8920

Authorization Agreement for Voluntary Life Insurance (ACH DEBITS)

Name of Participant: _____ Social Security: _____

Address: _____

City: _____ State: _____Zip:_____

Telephone Number: _____

BANK INFORMATION

The bank that you specify must be a member of the Automated Clearing House. Most banks are, and yours probably is, but if not, they will let you know what alternatives are available.

I request that my monthly payment for optional life and/or AD&D insurance coverage be electronically transferred from my:

Checking Account_____ **Savings Account_____**

Please only choose one option above.
Please include a voided check or deposit ticket for a savings account.

FINANCIAL INSTITUTION INFORMATION

Bank Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Your Account Number: _____

ABA Number (Bank I.D. Number): _____

YOUR AUTHORIZATION

I hereby authorize Pipefitters #636 Insurance Fund to initiate debit entries from my account indicated above. If an amount should be debited from my account in error or after my death, I authorize the appropriate credit adjustment to be made to my account.

Participant Signature: _____ Date: _____

Additional Signature: _____ Date: _____

(If joint account BOTH persons must sign this authorization)

HPA
Health Plan Advocate

PHARMACY SAVINGS PROGRAM

We are pleased to provide a Pharmacy Savings Program administered by Health Plan Advocate (HPA).

HPA assists with your prescription drug needs as your dedicated resource for questions and by connecting you to cost reduction strategies and opportunities.

Here's how it works:

- The program is available to employees and dependents enrolled in our medical plan.
- All members with prescription drugs that (1) have a retail cost of $400 or more and (2) have an available method for cost reduction (“program-eligible drug”) will automatically be included in the program. For all other prescription drugs, the plan’s standard copays as outlined in the Schedule of Benefits will apply.
- If you or one of your dependents are taking a program-eligible drug, HPA will contact you to assist with program enrollment.
- For those who respond to HPA, your final copay for your program-eligible drug(s) will be $0. Some saving methods have a “point-of-sale” copay, and this will be reimbursed to you by the plan.
- For those who choose not to respond to HPA, a copay of up to 50% will apply for your program-eligible drug(s).
- If you or your dependent has been identified as eligible for the program, be sure to respond to HPA so you can avoid the 50% prescription drug copay and take advantage of the cost reduction and advocacy benefits of this program.

HPA looks forward to assisting you. For program-related or general questions, contact them directly.

(616) 575-0211 EXT. 206
PHARMSAVINGS@HEALTHPLANADVOCATE.COM

Nonopioid directive form helps fight opioid epidemic by allowing patients to notify health professionals they don't want opioids

Patients can fill out a state form that directs health professionals and emergency medical services personnel to not administer opioids to them.

The nonopioid directive form is available to the public in response to a state law. The nonopioid directive is part of the State of Michigan's multifaceted plan to address the opioid epidemic.

The goal is to help ensure that nonopioid options for pain management are considered during medical treatment in the state. The nonopioid form is a supportive tool for patients to notify their health professionals that they are seeking alternatives for pain treatment. State officials call this "critically important" for those at risk for misusing opioids, including Michiganders with histories of opioid disorder.

A link to the directive form is located under "Additional Resources" at the bottom of the "Find Help Page" on Michigan's Opioid Addiction Resources website, michigan.gov/opioids.

The nonopioid directive can be filled out by the patient or a person's legal guardian or patient advocate. Once submitted, the directive must be included in the patient's medical records. There are exceptions in the law, such as a provision that a prescriber or a nurse under the order of a prescriber may administer an opioid if it is deemed medically necessary for treatment.

Public Act 554 of 2018 amended the Public Health Code to provide for the form, and required the Michigan Department of Health and Human Services to make it available publicly.

NONOPIOID DIRECTIVE

Michigan Department of Health and Human Services
Required by MCL 333.9145 effective 3/28/2019

MUST BE INCLUDED IN THE PATIENT'S MEDICAL RECORD

Patient Name	Date of Birth
Other names used by patient	Preferred language of patient
Emergency Contact	Name of primary care provider
Drug allergies	

The patient above must not be administered an opioid or offered a prescription for an opioid while this directive is in effect.

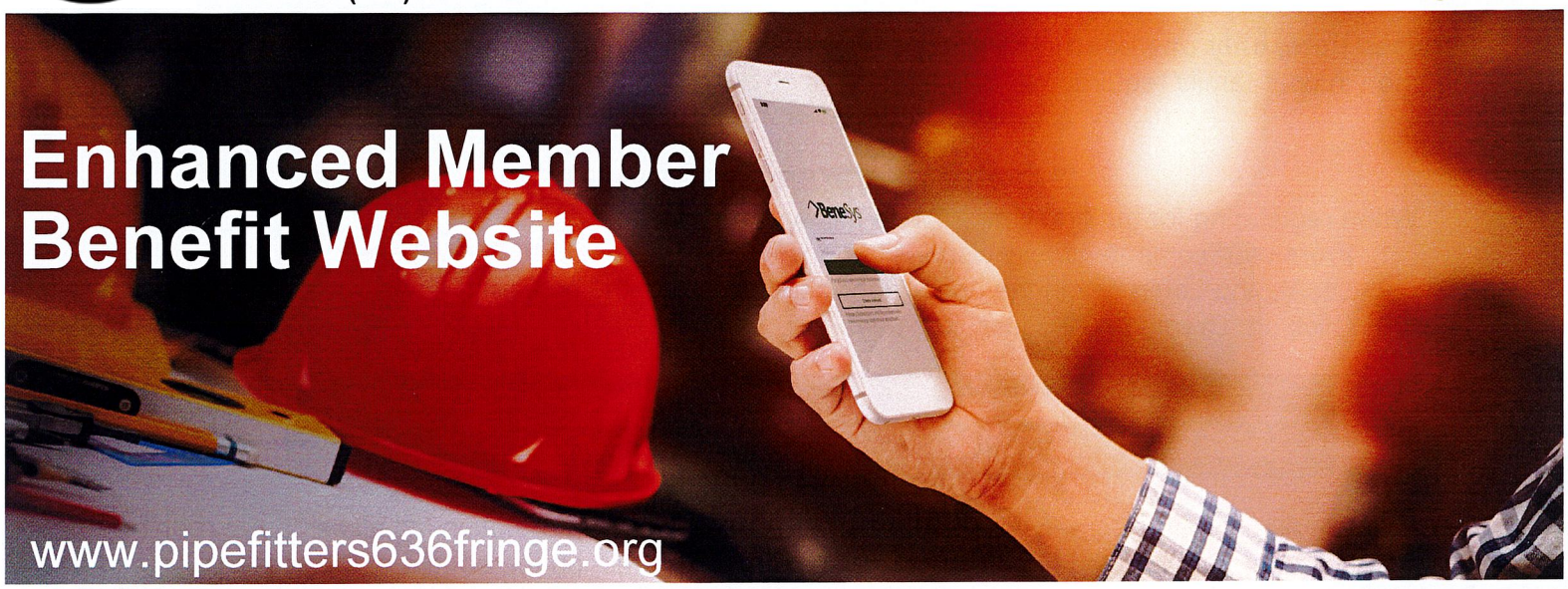
- An individual who has executed a nonopioid directive on their own behalf may revoke the directive at any time and in any way they are able to communicate their intent to revoke the form.
- A guardian or patient's advocate can revoke at any time by issuing a revocation in writing and providing notice of the revocation to the individual's health professional or their delegate.
- This directive does not apply to:
  - A patient receiving opioids for substance use disorder treatment;
  - A patient who is in hospice;
  - A patient is being treated at a hospital, or in a setting outside of a hospital in the case of an emergency, and, in the prescriber's professional opinion, the administration of the opioid is medically necessary to treat the individual.

Signature of patient, or if the patient is a minor, parent	Date
Printed name of Patient	Date
Signature of guardian or patient's advocate, if applicable	Date
Printed name of parent/guardian/patient's advocate, if applicable	Date

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

Pipefitters Local 636
Fringe Benefit Funds
P.O. Box 278
Troy, MI 48099-0278
Toll Free: (888) 646-8920

BeneSys™



Dear Member:

The Trustees of the Pipefitters Local 636 Fringe Benefit Funds would like to remind you that you have access to an enhanced member benefit website that is fully updated to provide you with a more effective way to access and manage your benefits. You may access your benefit website by visiting www.pipefitters636fringe.org. The website is device agnostic, which means it can be used on multiple devices, such as your smart phone, tablet, or computer.

Key features of the website include:

- Review covered dependents
- Review month to month healthcare coverage eligibility status
- Current dollar bank balance
- Current health reimbursement account balance
- Review accrued Defined Pension benefit
- Credited Service Years
- Cash Balance account information
- Month by month work history
- Current Supplemental Unemployment Benefit credit balance
- Medical claims history for you and your dependents
- Explanation of Benefits for process claims
- Benefit FAQs
- Frequently used forms
- And much more!

To contact a dedicated UA Service Team member at BeneSys regarding claims, eligibility, pension benefits and hours, please call:

(888) 646-8920

To access your personal benefit website, you need to register as a new user by clicking the Create an Account link at the top right-hand corner in the Login box. More detailed instructions are shown on the following page.

Every member, spouse, and dependent over the age of 18 can create their own login that will give them access to their own Protected Health Information (PHI). Each person that receives their own username and password will not have their PHI available for viewing by any other user.

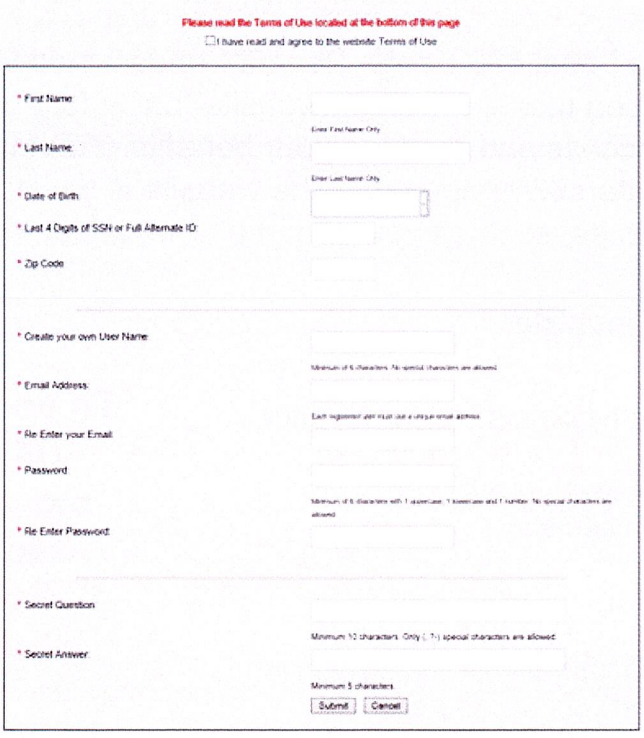
Please note, only one username and password is permitted per email address. If more than one person in your family requires website access, each must use a different email address.

HOW TO REGISTER ON THE WEBSITE

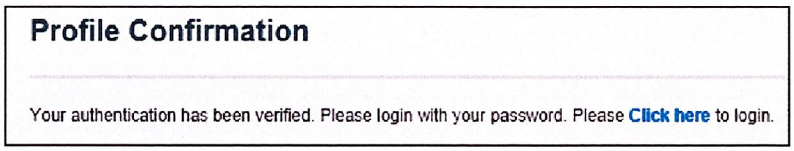
When registering for the first time, please follow these instructions:

1. From your computer, www.wspensionbenefits.org to connect to the website.
2. Locate the Login box in the upper right-hand corner of the screen.
3. Click on "Create an Account" to get started.

4. The Registration Screen will display next. Please enter all information, as all fields are required. Once all information has been entered, please click "Submit" on the bottom of the screen.



5. After registering you will receive an email notification with a link to confirm your registration. Your email address will also be used in the event you forget your user name and password.



Please contact the Benefit Office at (888) 646-8920 if you encounter any difficulty retrieving your User Name and Password, or if you have any questions regarding the Member Benefit website. You can also email the Benefit Office directly by using the "Contact Us" section of the website.

To access the website via QR Code, please scan the below with your phone:

Website Instructions and Overview

Logging in:

When accessing your account for the first time, log into **www.accountplanaccess.net/benesys**. Your initial login information is as follows:

- Username – Social Security number, without dashes
- Password – Full birth date, without slashes (mmddyyyy)

You will be prompted to update your username and password after your initial login.

Upon login, the site will take you to the "My Dashboard" page. Here you will be able to review a snapshot of your account balance, investments and recent transactional activity.

Managing your investments:

By selecting "Manage Investments" you can then elect one of the following to make changes to your account.

- Change Elections:
  - Allows you to change your investments for your future contributions. To move your current balance, select either "Move Money" or "Rebalance".
- Move Money:
  - Allows you to transfer your current money from one fund to another. To change your investments for your future contributions, select "Change Elections".
- Rebalance:
  - Allows you to rebalance your money based on your current investment elections. This will realign your ending balance in each fund according to your investment percentages.

***Each investment listed in the above selections include a link to view the fund information, including fund performance. Click the fund name to view this information.*

Once you have made your selection, the website will walk you through your transaction, from start to finish. Once you have submitted the transaction, your request will be processed as follows:

- Requests submitted prior to 2:30 p.m. EST on a business day, will be processed same day.
- Requests submitted after 2:30 p.m. EST will be processed on the next business day.
- Requests submitted on a weekend or market holiday, will be processed the next business day.

View your transactions:

You can view your recent or historical transactional activity by scrolling to the bottom of the "My Dashboard page and selecting "View Transactions". Your options to search transactional activity will include:

- Investment
- Transaction type
- Transaction status
- Start and end dates

Submitting the request will display the transactions on the bottom of the page. You can view the activity in further detail by using the dropdown selections for the individual transactions from your search.

<over>

Your account performance:

As a participant in the Plan, you are provided the funds available for investing your contributions. To assist you in making an informed decision, Investment Returns are available on the website for all funds. On the top menu bar, select Performance/Investment Returns. This election will allow you to view specific time frames of the investment returns.

Your personal Rate of Return is also available for review under "Performance". Your rate of return will be available on a monthly, quarterly and annual basis.

Your quarterly account statements and other helpful documents:

You can find several other items related to the Plan posted to the website. These items include the following:

- Quarterly statements
  - Your quarterly statement is available on the website 15 days after the calendar quarter end. Be sure to supply an email address for alerts when the statements become available.
- Fee disclosure
  - Fee disclosures are posted annually to the website and include the operating expenses, fund restrictions for each fund available to the Plan. The disclosures are also updated whenever there is an investment change to the Plan.
- Summary Plan Description
  - The Summary Plan Description is an overview of the Plan created for its participants. The SPD is updated on the website with each restatement. You are encouraged to review this document for Plan information.

Updating your email address or password:

The gear at the top right of the website screen will allow you to view your general information, email address on file or change your current password.

- Personal Information
  - Email - You can enter an email address to have on file. Using your email address. We will be able to notify you when your quarterly statement is available.
  - General - You can view your address, phone number, and birth date in this section to ensure we have the most up to date information.
  - Password Change: You can change your password as often as you like by selecting this option. You will need to enter your current password, then designate a new password. You can also change your user id or login.

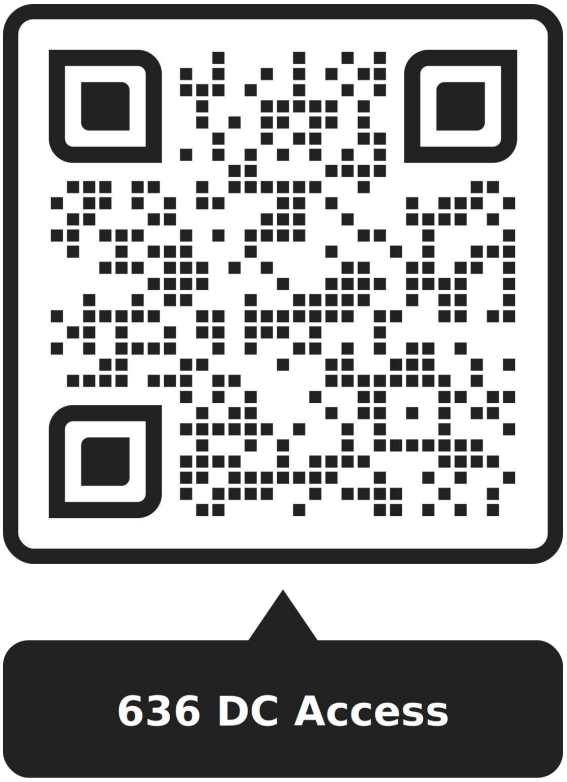
Delivery of your quarterly statements:

Putting your needs first, our system allows you to elect whether you would prefer your quarterly statements to be delivered electronically to your online account or have a paper copy mailed to your home. The statement will be securely posted to your account online. This election can be made by visiting www.accountplanaccess.net/benesys and logging into your account.

- Go to the gear on the top right of the website:
  - Select Personal Info.
  - Select the dropdown under Email
  - Update your email address. *(This will be used to send alerts to you when your statement is ready)*
  - Make your selection to receive your statements electronically – yes or no.
    - YES - your statements will be available on a quarterly basis by logging into your online account
    - NO - you will continue to receive your paper statement on a quarterly basis
  - Submit your changes.

If you need assistance or have any questions regarding the website, please contact the Fund Office.

To access the website via QR Code, please scan the below image with your phone:



PIPEFITTERS
LOCAL 636
FRINGE BENEFIT FUNDS
P.O. BOX 278
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(248) 641-4936 (888) 646-8920

To access and log in to My Wex Health Card for your HRA Information, please visit https://my.wexhealthcard.com/LoginPage.aspx?ReturnUrl=%2f or scan the below QR Code with your phone.

HRA Benefit Card