PIPEFITTERS LOCAL 636 RETIREE INSURANCE FUND PLAN

2024

PREFACE

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

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

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ARTICLE 1 – DEFINITIONS

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

Active Employee means a Journeyman, Apprentice, Residential Refrigeration Journeyman, Residential Refrigeration Apprentice, Mechanical Equipment Tradesman, Mechanical Equipment Serviceman, New Service Journeymen, Senior Maintenance Engineer, Union Employee, Education Fund Employee, Office Employee, Working Principal, or other person on whose account an Employer has made Contributions to the Pipefitters Local 636 Insurance Fund.

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

Autism Spectrum Disorder means any pervasive developmental disorders as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

Association means the Mechanical Contractors Association of Detroit.

Children or Child means:

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

(1) is a Participant's natural child or adopted child;

(2) has been placed with a Participant for adoption;

(3) is a Participant's step-child; or

(4) a child for whom the participant is legal guardian.

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

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

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

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

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

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

Consent to Out of Network Services means:

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

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

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

(b) the Plan receives notice of such consent.

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

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

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

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

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

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

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

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

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

Dependent means a Participant's Spouse and Children.

Disability means a physical or mental condition resulting from a non-occupational injury or

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

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

Emergency Services with respect to an Emergency Medical Condition means:

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

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

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

Employer means:

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

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

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

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

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

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

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

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

(a) Appropriate with regard to the standards of good medical practice and not Experimental or Investigational;

(b) Not primarily for convenience of the patient or Provider;

(c) Medically proven to be effective treatment of the condition; and

(d) The most appropriate supply or level of service which can be safely provided. When applied to inpatient care, this means that the medical symptoms or condition requires that the services cannot be safely or adequately provided on an outpatient basis. When applied to Prescription Drugs, this means the Prescription Drug is cost effective compared to alternative Prescription Drugs that produce comparable effective clinical results.

Mental Health Benefits means benefits for mental disorders, illnesses, and conditions as defined by generally recognized independent standards of current medical practice and in the International Classification of Diseases (ICD-10). Mental Health Benefits do not include benefits for conditions related to Autism Spectrum Disorder, ADD, ADHD, developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems, or intellectual disability.

Participant means a Pensioner, or Surviving Spouse entitled to coverage under the Fund.

Pensioner means

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

(1) Was an Active Employee as of January 1, 2000, did not incur a Break In Service as defined under the Pipefitters Local 636 Defined Benefit Pension Fund after January 1, 2000, and was eligible for benefits under the Pipefitters Local 636

Insurance Fund at least one month in each of the five consecutive years immediately preceding the date upon which he received his first pension check (the purpose of this Rule is to establish that the Pensioner was available for work as a pipefitter through the Union for contributing contractors during the five calendar year period indicated); or

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

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

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

(2) that:

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

(B) he has had continuous coverage under either the Pipefitters Local 636 Insurance Fund or his Spouse's comprehensive insurance plan from the time he became ineligible for benefits under the Pipefitters Local 636 Insurance Fund until the time he made an application for benefits as Pensioner; or

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

(d) An individual who:

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

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

(3) was eligible for benefits under the Pipefitters Local 636 Insurance Fund at least one month in each of the ten consecutive years immediately preceding the date upon which he separated from employment in the pipefitting industry and in the month immediately preceding such separation;

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

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

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

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

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

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

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

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

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

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

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

(f) Was a Mechanical Equipment Tradesman or Mechanical Equipment Serviceman who is not eligible for an early, normal, or disability pension from the Pipefitters Local 636 Defined Benefit Pension Plan but otherwise meets all other requirements necessary to meet the definition of Pensioner under (a), (b), (c), (d), or (e), above.

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

Plan Administrator means the Trustees of the Fund.

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

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

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

Serious and Complex Condition means

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

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

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

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

Surviving Spouse means either (1) person who was married to the Participant on the date of the Participant's death, or (2) an individual whose coverage as a Surviving Spouse under the Pipefitters Local 636 Insurance Fund terminated because he/she became Medicare eligible or eligible for a benefit from the Pipefitters Local No. 636 Defined Benefit Pension Plan or its predecessor Plumbers Local No. 98 and Pipefitters Local No. 636 Pension Fund, provided there is no lapse of coverage between termination of coverage from the Pipefitters Local 636 Insurance Fund and coverage under this Fund.

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

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

ARTICLE 2 – ELIGIBILITY RULES

2.1 Pensioner

A person who meets the definition of Pensioner set forth in Article 1, and his Dependents, are eligible for coverage under the Fund.

(a) Self-Payments

Self-payments must be made for this coverage. The monthly rates for Pensioners are as established by the Trustees from time to time. Information regarding current rates is available at the Fund Office. The Trustees are authorized and reserve the right to change this rate at any time. Payment must be made by way of an assignment of a portion of the benefit that the Pensioner is receiving or will receive from the Pipefitters Local No. 636 Defined Benefit Pension Plan or its predecessor, Plumbers Local No. 98 and Pipefitters Local No. 636 Pension Fund. This assignment is voluntary and revocable at any time; however, coverage will be lost upon such revocation. If a Pensioner chooses not to make such an assignment, he/she will be offered COBRA continuation coverage.

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

(b) Other Coverage

If a Pensioner is eligible for comprehensive group health plan or health insurance through his or her Spouse (in other words, has "Other Coverage"), and neither the Pensioner nor his Spouse have to pay a premium or other amount to obtain this

Other Coverage, then no coverage will be provided under this Plan other than the coverage under Section 3.3.

If the Pensioner or his Spouse do have to pay a premium or other amount to obtain Other Coverage, the Pensioner may elect to "opt out" of coverage under this Plan on a one time only basis (for example, if the premium for the Other Coverage is less than the self-payment required by the 636 Plan, the Pensioner may "opt out" of the 636 Plan).

If the Other Coverage involuntarily terminates (i.e. other than upon the request of the Pensioner or his Spouse), the Pensioner and his Dependents will become eligible for benefits under this Plan provided a request for Plan coverage is made within 30 days after the Pensioner involuntarily loses the Other Coverage and provides proof that he has had continuous health coverage from date Plan benefits terminated until the date of such request. Coverage will be effective the first of the month following the date such request is received.

(c) Receipt of a Disability Pension Benefit

If a Pensioner receiving a disability pension benefit from the Pipefitters Local No. 636 Defined Benefit Pension Plan returns to work covered by the Collective Bargaining Agreement, he shall be eligible to continue coverage by making self-payments to maintain coverage under this Plan for the first three months following his return to employment (and only for the months that he is so employed), or until he reestablishes eligibility as an Active Employee in the Pipefitters Local 636 Insurance Fund, whichever occurs first. Once eligibility is established in the Pipefitters Local 636 Insurance Fund, coverage will terminate under this Plan.

2.2 Dependents

(a) General Rules

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

(b) Effect of Divorce on Dependent Coverage

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

A Participant's former Spouse is entitled to continue coverage under the Fund pursuant to COBRA Continuation Coverage. In the event that the Judgment of Divorce requires the Participant to provide health insurance coverage for his

former spouse, it is the Participant's responsibility to arrange for this coverage. A divorced spouse cannot be covered as a Dependent under the Fund.

(c) Initial Enrollment of New Dependents

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

(d) Open Enrollment

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

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

(1) Coverage involuntarily terminates when:

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

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

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

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

Following the death of a Participant who has no Surviving Spouse, an election may be made by any individual on behalf of the deceased Participant's Children for continuation of coverage under this Plan. This election must be made promptly after the death of the Participant. A monthly payment must be made for this coverage. The monthly rates are as established by the Trustees from time to time. Information regarding current rates is available at the Fund Office. The Trustees are authorized and reserve the right to change this rate at any time.

2.3 Surviving Spouse

A Surviving Spouse who desires to continue eligibility for insurance under the Fund must notify the Fund Office of her election to continue such coverage for herself and any Dependents promptly after the death of the Participant. A monthly payment must be made for this coverage. The monthly rates for Surviving Spouses are as established by the Trustees from time to time. Information regarding current rates is available at the Fund Office. The Trustees are authorized and reserve the right to change this rate at any time. For a Spouse who is not receiving a benefit from Pipefitters Local No. 636 Defined Benefit Pension Plan or its predecessor, Plumbers Local No. 98 and Pipefitters Local No. 636 Pension Fund, payment must be received by the Fund Office on or before the first day of each month.

A Surviving Spouse who is receiving or will receive a pension from Pipefitters Local No. 636 Defined Benefit Pension Plan or its predecessor, Plumbers Local No. 98 and Pipefitters Local No. 636 Pension Fund, must make his/her self-payment by way of an assignment of a portion of the benefit that the Surviving Spouse is receiving or will receive from the Pipefitters Local No. 636 Defined Benefit Pension Plan or its predecessor, Plumbers Local No. 98 and Pipefitters Local No. 636 Pension Fund. This assignment is voluntary and revocable at any time; however, coverage will be lost upon such revocation.

If a self-payment is not made as indicated above, a Surviving Spouse will not be permitted to resume eligibility by making self-payments. Upon such termination, the Surviving Spouse will be offered COBRA continuation coverage. **A Surviving Spouse is not entitled to disability or death benefits.**

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

2.4 Medicare Eligibility

The Fund provides coverage for Medicare eligible Participants and Dependents under a Medicare Policy set forth in Article 14. In the event a Medicare eligible Participant or Dependent does not obtain Medicare when eligible to do so, the Fund will not provide coverage that would have been covered by Medicare or the Medicare Policy.

(a) Pensioners, Spouses and Surviving Spouses

In order for a Pensioner, or his Spouse, who is age 65 years or older to obtain maximum health benefits, he or she should apply for and obtain Parts A and B of Medicare. (Part A is for hospitalization benefits and is provided by Medicare automatically. Part B is for medical insurance and must be elected and paid for by the Pensioner or his Spouse.) **In other words, the Plan will not pay for expenses payable by Medicare, including expenses that would have been paid by the Medicare Policy under Article 14.**

Therefore, it is strongly recommended that a Pensioner have Part B coverage for himself and his Spouse when each reaches 65 years of age. It is the Participant and Spouse's responsibility to timely obtain Medicare Part B coverage. It is recommended that a Pensioner or his Spouse contact the Social Security Administration at least four months before they will reach age 65.

(b) Disability

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

(c) Dialysis Patients

After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Covered Person receiving such treatment should contact the

Social Security Administration as soon as possible to obtain information regarding Medicare eligibility and take appropriate steps to become eligible for Medicare benefits. Once eligibility could have been obtained, even if it is not, the Plan will be primary (i.e. will provide benefits) only to the extent required by the Medicare Secondary Payer rules.

2.5 Termination

A Participant's eligibility will terminate the first day of the first month following the month in which eligibility is lost.

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

ARTICLE 3 – SCHEDULE OF BENEFITS

3.1 Death Benefit

(a) Insured Basic Life Benefits

Pensioners are eligible for coverage under a fully insured life insurance policy purchased by the Fund. The amount of coverage is $10,000.00. Further information, including limitations and exclusions to coverage, are set forth in the life insurance policy.

(b) Beneficiary Designation

The Death Benefit is payable to the beneficiary(ies) designated by the Pensioner on the Beneficiary Designation card. Each Pensioner shall have the right to change his beneficiary at any time by written notice, submitted directly to the Fund Office or the insurance company, and the change shall become effective on the date of receipt by the Plan or insurance company.

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

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

(c) Claims and Appeals

All claims and appeals regarding insured life insurance benefits shall be determined by the procedures set forth in the applicable life insurance policies and not pursuant to Article 7, below.

3.2 Medical, Prescription Drug, and Dental Benefits: Non-Medicare Participants

Benefits are available to all eligible Participants and their Dependents, as described below.

(a) Self-Funded Medical Benefits

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

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

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

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

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

iii. apply any cost-sharing payments with respect to such items and

services toward any in-network deductible or in-network out-of-pocket maximums the same as if the services were received in-network.

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

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

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

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

Medical coverage for Medicare eligible participants is provided as set forth in Article 14.

(b) Schedule of Benefits

Subject to the exclusions set below, the following summarizes the Medical benefits provided under the Fund (other than for Medicare eligible participants):

Medical Benefits	**In-Network**	**Out-of-Network**
Annual or Lifetime Maximum on Essential Health Benefits	None	None
Annual Deductibles - In/Out Satisfies each other	$300/person $600/family	$600/person $1,200/family
Annual Out of Pocket Co-Insurance and Co-Payment Maximums - In/Out Satisfies each other	$2,500/person $5,000/family	$5,000/person $10,000/family

2024 Annual TROOP (Total Real Out of Pocket Maximums for essential health benefits) (includes deductibles, co-insurance and co-pays for medical and Rx)– Annual TROOP to be adjusted annually to equal the Maximum Annual Limitation on Cost Sharing established by HHS	$9,450/person $18,900/ family	No TROOP limit

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

Medical Benefits	In-Network	Out-of-Network
Inpatient Care		
Facility - Inpatient Hospital (Semi-private room) Pre-Certification Required	80%*	70% UCR**
Ambulatory Surgery Center	80%*	70% UCR**
Surgery	80%*	70% UCR**
Anesthesia	80%*	70% UCR**
Assistant Surgeon	80%*	70% UCR**
In-Hospital Consultations	80%*	70% UCR**
Diagnostic Lab/X-Ray	80%*	70% UCR**
Imaging (CT/PET scans, MRI)	80%*	70% UCR**
Respiratory Therapy	80%*	70% UCR**
Acute Kidney Dialysis	80%*	70% UCR**
Maternity – Delivery/In-patient services/Birthing Center	80%*	70% UCR**
Organ Transplant Benefits	80%*	70% UCR**
Outpatient Care		
Pre-Admission testing	80%*	70% UCR**

Medical Benefits	In-Network	Out-of-Network
Surgery (All Related Expenses)[1]	80%*	70% UCR**
Diagnostic Lab/X-Ray	80%*	70% UCR**
Imaging (CT/PET scans, MRI)	80%*	70% UCR**
Rehabilitation: Occupational/Physical/ Speech/Respiratory Therapy – Limited to a combined maximum of 90 visits per member per year. All visits subject to pre-authorization	80%*	70% UCR**
Habilitation Services, except for Habilitation Services related to Autism Spectrum Disorder as set forth below.	Not covered	Not covered
Radiation and Chemotherapy	80%*	70% UCR**
Dialysis	80%*	70% UCR**
Second surgical opinion	80%*	70% UCR**
Emergency Services – For out-of-network expenses for Emergency Services for an Emergency Medical Condition, the in-network co-insurance and copayment are to be counter towards in-network out-of-pocket maximums.		
Emergency Services for an Emergency Medical Condition Facility/Physician Co-pay is waived if emergency care is for accidental injury or if admitted.	100% after $150 copay*	100% of the Recognized Amount after $150 copay*
Lab/X/Ray/ Diagnostic Testing	80%*	80% of the Recognized Amount
Ground Ambulance – limited to 2 trips per confinement	80%*	70% UCR**

[1] Prior to October 1, 2023, coverage for bariatric surgery was subject to certain limitations which were removed effective October 1, 2023. It is limited to once per lifetime per covered person.

Medical Benefits	In-Network	Out-of-Network
Air Ambulance (when Medically Necessary) For out-of-network expenses for Emergency Services for an Emergency Medical Condition, the in-network out-of-pocket maximums apply and the out of network co-insurance and copayment are to be counted towards in-network out-of-pocket maximums.	80%*	80%* of the lesser of billed charges of the Qualified Payment Amount, after deductible.
Mental Health		
Inpatient Care/ Outpatient Treatment Program	80%*	70% UCR**
Outpatient Psychotherapy	80%*	70% UCR**
Autism Spectrum Disorder	80%	70% UCR**
Alcohol/Substance Abuse		
Inpatient Care/ Outpatient Treatment Program	80%*	70% UCR**
Outpatient Psychotherapy	80%*	70% UCR**
Physician's Office/Urgent Care		
Primary care - visit for Illness/Injury	100% after $20 co-pay	70% UCR**
Urgent Care	100% after $20 co-pay	70% UCR**
Specialists & Consultations	100% after $20 co-pay	70% UCR**
Pre and Post Natal Care which is not considered a preventive service	80%*	70% UCR**
Allergy Testing/Treatment	100%*	70% UCR**
Diagnostic Lab/X-Ray	100% after $20 co-pay	70% UCR**
Colonoscopy – medically necessary (first per year covered under preventative)	80%*	70% UCR**
Surgery	100% after $20 co-pay	70% UCR**

Medical Benefits	In-Network	Out-of-Network
Preventive Services Required to be Covered by Law As a Retiree-only group health plan, this Plan is not subject to many of the Patient Protection and Affordable Care Act (ACA) requirements and market reforms. Nevertheless, the Plan currently covers preventive service benefits without cost-sharing in-network to the extent otherwise required under federal law. This means deductibles, co-insurance, and copayments do not apply to these benefits if provided in-network. The following is a representative list of items covered by law as preventive services as of May 1, 2023, but is not a complete list of all such items, and this list changes from time to time. For a list of items and services covered as preventive care under federal law at any given time, please visit the following websites: • U.S. Preventive Services Task Force, A & B Recommendations: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Health Resources & Services Administration Adopted-Guidelines for Women, Children, and Youth: https://mchb.hrsa.gov/programs-impact/programs/preventive-guidelines-screenings-women-children-youth • Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html Items and services covered by the Plan for preventive services will be updated and amended automatically, which may include additions to and subtractions from the representative list of covered items set forth below. Be aware that federal law may limit these benefits to certain individuals by age, sex, health history or status, and impose treatment limitations such as once per lifetime, once per year, etc. In providing these benefits, the Plan will only cover these items and services in accordance with the limitations provided by federal law. Providing all such limitations in this Plan document is not possible. Some of the representative items or services set forth below may indicate coverage once per year, etc., but that does not mean other representative preventive services do not have limitations as to timing, amounts, who is covered, etc. Contact the Fund Office if you have any questions regarding the scope of coverage for any preventive service or item.		
For Adults: • Screenings, most commonly covered annually, including the following: o Abdominal Aortic Aneurysm o Cholesterol o Colorectal Cancer (and follow-up, if required by law) o Depression o Hepatitis C	100%	Not covered

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

Medical Benefits	In-Network	Out-of-Network
○ STIs (including Chlamydia and Gonorrhea) • BRCA-Related Cancer Risk Assessment, Genetic Counseling and Genetic Testing • Obesity Prevention Counseling • Sexually Transmitted Infections Counseling • Well-Women Visits, which include pre-pregnancy, prenatal, postpartum, and interpregnancy visits		
For Pregnant Women or Women Who May Become Pregnant: • Screenings, including for the following: ○ Anxiety ○ Bacteriuria ○ Contraception ○ Gestational Diabetes ○ Rh(D) Incompatibility ○ STIs (including Chlamydia, Gonorrhea, Hepatitis B, HIV, and Syphilis) ○ Preeclampsia ○ Urinary Tract or other Infection • Breastfeeding Services and Supplies (including, but not limited to double electric breast pumps [including pump parts and maintenance] and breast milk storage supplies) • Contraception Education, Counseling, Provision of Contraceptives and Follow-Up Care (including sterilization surgery)	100%	Not covered

Medical Benefits	In-Network	Out-of-Network
• Healthy Weight and Weight Gain Behavioral Counseling • Perinatal Depression Preventive Interventions • Preeclampsia Prevention • Substance Use Assessment • Tobacco Intervention and Counseling • Well-Women Visits, which include pre-pregnancy, prenatal, postpartum, and interpregnancy visits		
For Infants, Children, Adolescents, & Young Adults (Newborn—21 years old): • Screenings, including for the following: o Anemia o Autism Spectrum Disorder o Behavioral/Social/ Emotional o Blood Pressure o Cervical Dysplasia o Depression and Suicide Risk o Developmental o Dyslipidemia o Hearing o Lead Level o Newborn Blood, Bilirubin, and Critical Congenital Heart Disease o Obesity o Scoliosis o STIs (including but not limited to Chlamydia, Gonorrhea, HIV, and	100%	Not covered

Medical Benefits	In-Network	Out-of-Network
Syphilis) ○ Tobacco, Alcohol, and Drug Use ○ Tuberculosis ○ Vision • Fluoride Varnish and Oral Fluoride Supplementation • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Doses, recommended ages, and populations may vary. • Oral Health Risk Assessment and Referral • Sudden Cardiac Arrest / Death Risk Assessment • Tobacco, Alcohol, and Drug Use Interventions • Well-Baby/Child Examinations		
Routine Services Not Required to be Covered by Law		
Routine Physicals (limited to one per calendar year)	100%	Not covered
Prostate Exam/Immunizations (limited to one per calendar year)	100%	Not covered
Routine Mammogram (limited to one per calendar year)	100%	Not Covered
Other Services		
Skilled Nursing Facility (Pre-Approval Required) – limited to 120 days per covered person per calendar year	80%*	70% UCR**
Private Duty Nursing (Pre-Approval Required)	80%*	70% UCR**
Home Health Care (Pre-Approval Required)	80%*	70% UCR**

Medical Benefits	In-Network	Out-of-Network
Home Infusion Therapy	100% after $20 co-pay	70% UCR**
Hospice Care	100%	100%
Durable Medical Equipment	80%*	70% UCR **
Outpatient Diabetes Management Program (ODMP)	80%* for medical supplies; 100%* for self-management training	70% UCR **
Elective Abortion	Not Covered	Not Covered
Chiropractic Services – Limited to 24 visits per year	100% after $20 Co-Pay	Not Covered
Hair Prosthesis ("Wig") for hair loss resulting from chemotherapy/cancer treatment only.	80%* after in-network deductible; $500 maximum; once per lifetime benefit	80%* after in-network deductible; $500 maximum; once per lifetime benefit
Virtual Health Visits		
Virtual Physician	Covered same as in-person visits	Not Covered
Virtual Behavioral Health	Covered same as in-person visits	Not Covered
Virtual Specialist	Covered same as in-person visits	Not Covered
Teladoc	100%	N/A
Hearing Benefits		
Hearing aids, audiometric exam, hearing aid evaluation, fitting, hearing aid conformity test up to $3,000.00 every 3 years. Note: Effective July 1, 2024, a hearing discount program is available through TruHearing. All terms and conditions of the discounts and services available through TruHearing are governed by the summaries and/or brochures provided by TruHearing.	100% of Approved Amount	100% of Approved Amount
COVID-19		
Health Care Provider-ordered COVID-19 Testing/Facility Charges	80%*	70% UCR**

Medical Benefits	In-Network	Out-of-Network
Treatment for COVID-19	80%	70% UCR**

Pre-Certification/Medical Case Management & Utilization Review: All non-emergency hospital admissions, in-network and out of network, are subject to a pre-admission review. All emergency admissions must be reported within 48 hours of the admission. No penalty is imposed.

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

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

Exclusions:

The following services and benefits are not covered by the Plan:

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

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

(3) Charges that are not Reasonable and Customary.

(4) Services or supplies not Medically Necessary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(22) Services provided by Employer facilities.

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

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

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

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

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

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

(28) Charges for food supplements and vitamins.

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

(30) Expenses incurred for treatment of injuries, sickness, or disability incurred while the Participant or Dependent was engaged in illegal activity.

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

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

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

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

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

(36) Charges related to weight loss programs (except for weight loss drugs), unless the Covered Person:

(a) has a body mass index $\geq$ 30 kg/m^2; OR

(b) has a body mass index ≥ 27 and < 30 kg/m² and one or more of the following comorbid conditions:

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

and the program is approved as appropriate and monitored.

(37) Gene Therapy

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

(39) Bariatric surgery is covered once per lifetime per covered person.

(b) Prescription Drug Coverage

Self-funded drug coverage is administered by Aetna. The following chart sets forth applicable co-payments and co-insurances to be paid by the covered person. These amounts are based on the Aetna Formulary, which is subject to change at any time. Further, to obtain coverage certain drugs are subject to preauthorization or step therapy. Drugs subject to preauthorization may be changed from time to time and a list of such drugs is available at Fund Office.

IN-NETWORK	
	Retail (34 day Supply)
Tier 1	$10 Co-Pay ($20 Co-Pay for 35-90 day supply)
Tier 2	$40 Co-Pay ($80 Co-Pay for 35-90 day supply_
Tier 3	$80 Co-Pay ($160 Co-Pay for 35-90 dollar supply)
	Mail Order
Tier 1	$20 Co-Pay 90 day supply
Tier 2	$80 Co-Pay 90 day supply
Tier 3	$160 Co-Pay 90 day supply
Tier 4 Specialty (Must use	$150 30 Day Supply

CVS Specialty Pharmacy)	
OUT-OF-NETWORK	Not covered

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

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

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

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

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

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

Exclusions:

The following drugs are excluded under this program:

- Injectable Vitamins

- Injectable infertility drugs
- Oral Sexual Dysfunction Drugs (other than those specifically covered – *e.g.*, erectile dysfunction drugs)
- Cosmetic Drugs
- Smoking Cessation Drugs (other than those specifically covered)
- Diabetic Supplies (other than those specifically covered – *i.e.*, injectables, pumps, insulin needles and syringes, lancets and devices, glucose test strips and glucagon injectables)
- Injectable Vaccines and Immunizations (other than required preventive health immunizations)
- Injectable Growth Hormones (unless covered pursuant to a prior authorization)
- Raptiva
- Proton Pump Inhibitors (unless prescribed under step therapy and provided that a first line medication is attempted and determined ineffective before utilization of a branded PPI agent).
- Suboxone, unless prior authorization is received on an annual basis
- Certain drugs subject to coverage pursuant to approved Step Therapy programs. A list of drugs subject to Step Therapy programs is available at the Fund Office.
- Bulk Powder Compounds require a letter of Medical Necessity for plan costs greater than $200

Further, any and all exclusions under Section 3.2(a) of the Plan also apply to Drug Coverage.

Prescription drug coverage for Medicare eligible participants is provided as set forth in Article 14.

(c) Dental Benefits

(1) Self-Funded Dental Coverage

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

Participants may alternatively elect dental coverage under the Dencap DHMO, pursuant to which dental services will only be covered if the Covered Person receives treatment from a dentist in the Dencap Plan

DHMO network. The maximum benefit is $1,500 per year per Covered Person, and a lifetime orthodontic benefit of $1,350 is available. Please refer to the applicable Dencap DHMO summary of benefits for a description of the benefits available, and exclusions and limitations to coverage. As this benefit is fully insured, all claims and appeals regarding such benefits shall be determined by the procedures set forth in the Dencap Plan's summary of benefits, not pursuant to Article 7, below.

(2) Limited Implants and Orthodontia Coverage

Implants

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

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

Orthodontia

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

3.3 Benefits Available to Participants, And Their Dependents, Who Opt Out of Medical Coverage

(a) Pensioner Life Insurance

This benefit is available in the amount of $50,000.00. An additional $50,000.00 accidental death and dismemberment benefit is also provided. Both benefits are reduced if a Pensioner is above age 65. These benefits are provided pursuant to a policy of insurance purchased by the Fund. Further information, including limitations and exclusions to coverage, and coverage for dependents, are set forth in the life insurance policy. All claims and appeals regarding life insurance benefits shall be determined by the procedures set forth in the life insurance policy and not pursuant to Article 7, below. This benefit is in addition to the benefits provided under Section 3.1.

(b) Prescription Drug Benefit

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

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

(c) Vision Benefit

Vision Benefits are provided on a self-insured basis through Vision Service Plan (VSP). A description of the benefits available can be obtained from the Fund Office. To find a VSP provider, Participants can contact VSP at 1-800-877-7195 or by visiting www.vsp.com. Coverage for glasses or contact lenses up to an approved amount once every 12 months.

(d) Dental Benefits

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

(e) Health Reimbursement Account

As governed by the terms of the Pipefitters Local 636 Insurance Fund plan document, a Pensioner who opts out of coverage under the Plan will receive an additional $800.00 per year in his/her HRA, to be credited in 12 equal monthly installments, i.e. $66.66 per month.

(f) Hearing Benefit

Hearing benefits are provided as set forth in the chart of benefits in Article 3,

Section 3.2(a).

3.4 Exclusions and Limitations

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

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

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

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

(d) Expenses incurred for treatment of injuries, sickness, or disability incurred while the Participant or Dependent was engaged in illegal activity. On a one-time only basis, this provision will not exclude coverage of up to $40,000.00 for treatment of a Participant's injuries arising from a physical altercation with another Participant where, as determined in the sole and exclusive discretion of the Trustees, the physical altercation: (1) does not meet the elements of a felony offense; (2) does not result in substantial bodily injury to the other Participant that necessitated immediate medical treatment or caused disfigurement, impairment of health, or impairment of any bodily part; (3) does not relate to or arise out of a domestic assault or dispute; and (4) is not the basis of any arrest or criminal charges against the Participant;

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

(f) Any benefit otherwise excluded or limited by the terms of the insurance policies purchased by the Fund covering Participants and Dependents and/or any benefits guides describing coverage provided by the Fund, including but not limited to the Exclusions and Limitations set forth in the Blue Cross Blue Shield Benefit Guides; or

(g) Any expense which the Covered Person is not legally obligated to pay.

No claims will be paid by the Fund if they are not submitted for payment within 12 months of the date incurred.

ARTICLE 4 – COORDINATION OF BENEFITS

4.1 Application

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

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

(b) the benefits that would be payable under any other plan in the absence of a coordination of benefits provision,

would exceed such allowable expense payable under this Plan.

4.2. Coordination

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

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

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

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

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

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

(2) the plan covering the parent with custody of the dependent;

(3) the plan covering the spouse, if any, of the parent with custody of the dependent;

(4) the plan covering the parent without custody;

(5) the plan covering the spouse of the parent without custody; or

(6) if none of the foregoing applies, coordination of benefits shall be determined in accordance with the Michigan Coordination of Benefits Act (MCL §550.251, et seq.), or any successor law.

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

(1) Benefits will be coordinated with Medicare according to the Medicare Secondary Payer (MSP) Rules when applicable.

(2) The following addresses specific situations where MSP Rules are applicable:

(A) Coordination with Coverage By Virtue of Current Employment Status

In the event a Medicare-eligible Covered Person in this Plan is also eligible under any Other Plan as a dependent of an actively employed spouse:

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

(B) End Stage Renal Disease

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

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

(g) Motor Vehicle Accidents

If coverage for a motor vehicle accident is not excluded under Section 4.1(b)(24) or (26), the Fund will only provide coverage on a secondary basis. If coverage is provided on a secondary basis, this means that if the Participant or Dependent is

involved in a motor vehicle accident, the claims should first be submitted to his/her no-fault carrier (or other auto carrier) and any expenses not paid by such carrier (for example, deductibles, co-payments, etc.) will be paid by the Fund.

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

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

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

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

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

ARTICLE 5 – THIRD PARTY LIABILITY

5.1 Subrogation

(a) In General

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

claims the Covered Person may have against the third party who caused the injury. In other words, the Participant or Dependent must repay to the Plan the benefits paid on his or her behalf out of any recovery received from a third party and/or any applicable insurer.

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

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

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

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

(b) Conditions to Payment of Benefits

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

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

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

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

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

(c) Right to Pursue Claim

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

(d) Enforcement

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

At the Fund's option, it may enforce this provision by deducting amounts owed from future benefits.

5.2 Workers' Compensation

The Fund does not pay any claims covered by workers' compensation. If a Participant or Dependent receives any benefits that are properly payable by workers' compensation, then this Fund must be indemnified by the Participant or Dependent for the amount paid for such benefits. The Fund shall be indemnified out of the proceeds received from the Participant or Dependent in settlement of any workers' compensation claim. The Participant must complete any forms required by the Fund to preserve its rights under this section. At the Fund's option, it may enforce this provision by deducting amounts owed from future benefits. If the Fund authorizes the payment of benefits pending resolution of a contested worker's compensation claim, eligibility for and payment of such benefits remains subject to all other terms and conditions set forth in this Plan.

ARTICLE 6 – INTERPRETATION OF PLAN DOCUMENTS

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

ARTICLE 7 – CLAIM REVIEW AND APPEALS

For benefits provided under fully insured policies, and the Medicare Policy set forth in Article 14, claims and appeals will be governed solely by the procedures set forth in the documents governing such benefits, and not by the provisions under this Article.

7.1 Types of Claims Covered

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

- Urgent health claims: claims that require expedited consideration in order to avoid jeopardizing the life or health of the Claimant or subjecting the Claimant to severe pain;
- Pre-service health claims: for example, pre-certification of a hospital stay or predetermination of dental coverage;
- Post-service health claims: for example, Claimant or his Physician submits a claim after claimant receives treatment from Physician;
- Concurrent claims: claims for a previously approved ongoing course of treatment subsequently reduced or terminated, other than by plan amendment or plan termination.
- Disability Claims: initial claims for disability benefits or any rescission of coverage of a disability benefit.

7.2 Initial Submission of Claims

Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, claims should be submitted to the prescription benefit manager or the dental network provider as applicable. All other claims for benefits, including medical benefits, should be submitted to the Fund Office.

7.3 Notice That Additional Information is Needed to Process Claim

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

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

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

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

7.4 Initial Decision On A Claim

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

- For Urgent Health Claims – 72 hours after receiving initial claim, if it was complete; or 48 hours after receiving completed claim or after the 48-hour claimant deadline for submitting information needed to complete claim, whichever is earlier.
- For Pre-Service Health Claims – 15 days after receiving the initial claim. A 15-day extension permitted is Plan needs more information and it has provided notice of same to Claimant during initial 15 day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.
- For Post-Service Health Claims – 30 days after receiving initial claim. A 15-day extension is permitted if Plan needs more information and has provided notice of same to claimant during initial 30-day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.

(b) Approved Ongoing Course of Treatment

Benefits for an approved ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

7.5 Benefit Denials

Notice of a benefit denial will include the specific reasons for the denial; the specific Plan provision or provisions on which the decision was based; if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary; a description of the Plan's appeal procedures (including a statement of the Claimant's right to bring a civil action after a further denial on appeal); the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rules or guidelines do not exist; and, if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same.

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

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

With respect to benefit denials for disability claims, the benefit denial must also include the following:

(i) An explanation of the basis for disagreeing with any of the following:

- The health care professionals that treated the Claimant;
- The advice of the health professional obtained by the Plan; or
- A disability determination from the Social Security Administration.

(ii) A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.

(iii) The denial must be in a culturally and linguistically appropriate manner.

7.6 Appeals

(a) Submission of Appeals

An appeal is a written request to the Trustees setting forth issues to consider related to the benefit denial, along with any additional comments the claimant may have. A Claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. The review on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Appeals should be submitted to the Fund Office.

(b) Time for Submitting Appeals

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

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

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

(c) Notice of Decision on Appeal

The notice of a decision on appeal will include the specific reasons for the denial; the specific Plan provision or provisions on which the decision was based; a statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits; a statement of the Claimant's right to bring a civil action under ERISA §502(a); a statement describing any contractual limitation period that applies to the Claimant's right to bring an action under ERISA §502(a) and the calendar date on which such contractual limitation period expires; the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rule or similar guideline does not exist; if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same; and the following statement "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

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

Before the Fund can a notice of decision on appeal with respect to disability benefits based on a new or additional rationale, the Claimant must be provided,

free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

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

- An explanation of the basis for disagree with any of the following:
  - The health care professionals that treated the Claimant;
  - The advice of the health professional obtained by the Plan; or
  - A disability determination from the Social Security Administration.
- A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.
- The notice of decision on appeal must be in a culturally and linguistically appropriate manner.

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

- For Urgent Health Claims – 72 hours after receiving appeal.
- For Pre-Service Health Claims – 30 days after receiving the appeal if one level appeal is applicable.
- For Post-Service Health Claims:

  Medical Benefits – The Fund Office, without deference to the claim denial, shall decide the initial appeal, and inform the claimant of its decision 30 days after receiving appeal. A second appeal to the Trustees must be filed within 60 days of receipt of this first appeal denial. The Trustees shall decide this appeal at a Board Meeting.*

  Other Benefits – The Trustees shall decide the appeal at a Board Meeting.*
- For Concurrent Claims – Prior to termination of previously approved course of treatment.

- For Disability Claims – The Trustees shall decide the appeal at a Board Meeting.*

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

7.7 Discretion of Trustees

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

7.8 Limitations of Actions

No action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal.

7.9 Failure to Follow Claims Procedures

If the Plan fails to follow claims procedures with respect to any claim for benefits, the Claimant is deemed to have exhausted administrative remedies and is entitled to pursue all remedies under ERISA §502(a) on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits.

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

Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant.

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

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

7.10 Avoiding Conflicts of Interest

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

ARTICLE 8 – COBRA

8.1 Introduction

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

8.2 Nature of COBRA Continuation Coverage

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

A Pensioner is not eligible for COBRA coverage.

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

(1) Death of spouse;

(2) Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(3) Divorce from the participant.

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

(1) The parent-participant dies;

(2) The parent-participant becomes entitled to Medicare benefits (under Part A, Part B, or both);

(3) The parents become divorced; or

(4) The child stops being eligible for coverage under the plan as a "dependent child."

8.3 When COBRA Coverage Is Available

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Plan Administrator will monitor whether a qualifying event has occurred due to Medicare eligibility.

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

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

Further, failure to timely notify the Plan of a divorce or a child losing eligibility gives the Plan the right to hold the participant and his/her spouse separately and fully liable for any benefits paid by the Plan which would not have been paid had the Plan received timely notification of such event. At its sole election, the Plan may suspend the payment of future benefits until such amount has been recovered.

8.5 How COBRA Coverage Is Provided

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

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

Coverage under the Plan will be terminated upon the occurrence of a qualifying event and will be retroactively reinstated to the date of the qualifying event once a qualified beneficiary elects COBRA continuation coverage and pays the applicable premium. See Section 8.7 below regarding the election period for COBRA coverage.

8.6 Duration of COBRA Coverage

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

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

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

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

(3) In all other events, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

(A) Disability Extension

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

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

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

(B) Second Qualifying Event Extension

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

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

8.7 The Election Period for COBRA Continuation

Qualified beneficiaries have 60 days after receipt of the Election Notice, which will be sent to each qualified beneficiaries' last known address, to elect COBRA continuation coverage. Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

8.8 Premium Payment for COBRA Coverage

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

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

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

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

8.9 Scope of Coverage

COBRA coverage only pertains to health benefits available under the Plan. Coverage for such benefits under COBRA is the same as those the qualified beneficiary had the day before coverage initially terminated. Coverage may change while on COBRA coverage due to Plan amendments that affect all participants in the plan.

8.10 Enrollment of Dependents During Period of COBRA Coverage

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

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

8.11 Qualified Medical Child Support Orders

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

8.12 Termination of COBRA Coverage

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

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

8.13 Keep the Plan Informed of Address Changes

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

8.14 Exclusions from COBRA Coverage

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

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

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

ARTICLE 9 – QUALIFIED MEDICAL SUPPORT ORDER

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

9.1 Qualified Medical Child Support Order ("QMCSO") means a medical child support order-

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

(b) clearly specifies

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

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

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

(4) the plan to which the order applies.

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

9.3 Procedures for Determining Qualified Status of Medical Support Orders.

Upon receipt of a medical child support order, the following procedures will be used when determining whether it is a Qualified Medical Child Support Order pursuant to the terms of ERISA:

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

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

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

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

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

9.4 National Medical Support Notice Deemed to be a QMCSO

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

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

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

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

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

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

9.6 The Plan will comply with any other requirements of § 609 of ERISA regarding QMCSO.

ARTICLE 10 – CHANGES TO OR TERMINATION OF COVERAGE

The Trustees reserve the right to amend, alter, or terminate any or all coverages hereunder, for any or all classes of Participants or Dependents, at any time. The Trustees also have the right to change the required self-payment amounts for any benefit or class of Participants or Dependents, including the right to impose self-payment for coverage that previously had been provided without requiring such self-payments.

ARTICLE 11 – GENDER NEUTRALITY

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

ARTICLE 12 – HIPAA PLAN SPONSOR PROVISIONS

12.1 Effective April 14, 2003, Protected Health Information ("PHI"), as defined in HIPAA, shall only be disclosed to the Plan Sponsors in accordance with the following procedures:

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

The Plan Sponsors agree to:

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

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

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

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

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

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

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

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

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

(j) Provide for adequate separation between the group health plan and the plan sponsor. To do so:

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

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

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

12.2 Effective April 20, 2005, the Plan and the Plan Sponsor will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to Electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI (1) it receives pursuant to an appropriate authorization (as described in 45 C.F.R. §164.504(f)(1)(ii) or (iii)), or (2) that qualifies as Summary Health Information and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. §164.508). If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are

incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations.

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

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

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

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

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

ARTICLE 13 – RIGHT TO RECOVER AMOUNTS PAID FOR BENEFITS DUE TO MISTAKE OR FRAUD

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

Providing false information to maintain or obtain coverage, or knowingly cooperating in any actions designed to provide false information to maintain or obtain coverage, is an example of a fraud or intentional misrepresentation of material fact. Examples of fraud or intentional misrepresentation of material fact also include, but are not limited to, failing to inform the Fund Office of: (1) a divorce, or (2) any other event which makes a Participant or Dependent ineligible for coverage.

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

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

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

Article 14 – Medicare Eligible Participants and Dependents

Medicare-eligible Participants and Dependents are provided medical and prescription drug coverage via a fully insured Medicare coordinated policy with Humana (Medicare Policy) and will be enrolled in the Medicare Policy. The terms and conditions of such coverage are set forth in the Medicare Policy. Non-Medicare eligible dependents of Medicare eligible Participants are covered under the Fund's self-insured medical and prescription drug plan set forth in Article 3.

Coverage under the Medicare Policy may be limited if such person has not timely applied for and obtained Medicare. It is the Participant's or Dependent's responsibility to timely obtain Medicare coverage. If he/she does not do so, he/she is responsible for the costs of medical expenses that otherwise would have been covered by Medicare or the Medicare Policy.

All Medicare eligible Participants and Dependents will automatically be enrolled in the Medicare Policy at the earliest enrollment opportunity after Medicare eligibility is obtained.

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

IN WITNESS WHEREOF, the Board of Trustees has approved and adopted this Pipefitters Local No. 636 Retiree Insurance Fund Plan on 7/15, 2024.

UNION TRUSTEES

EMPLOYER TRUSTEES

Christopher J. Freeman

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