



PIPEFITTERS LOCAL 636
FRINGE BENEFIT FUNDS
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TO: Pipefitters Local 636 Retiree Insurance Fund Participants
FROM: The Board of Trustees of the Pipefitters Local 636 Retiree Insurance Fund
RE: Summary of Material Modification - KEEP WITH YOUR SUMMARY PLAN DESCRIPTION
DATE: April 2026

Please read this Notice carefully as it contains important information about changes to the Pipefitters Local 636 Retiree Insurance Fund Plan document (the Plan). This Notice should be read carefully and attached to your Pipefitters Local 636 Retiree Insurance Fund Summary Plan Document (SPD).

Please contact the Fund Office if you have any questions about the changes described in this Notice.

Unless stated otherwise, the following changes are effective beginning December 1, 2025.

1. RECISSION OF COVERAGE – FRAUD AND INTENTIONAL MISREPRESENTATION OF MATERIAL FACT

The Plan, like most health plans, provides that when coverage was provided as a result of fraud or an intentional misrepresentation of material fact by a Participant or Dependent, or an individual seeking coverage on behalf of such Participant or Dependent, the Plan may rescind, or retroactively cancel coverage.

Effective December 1, 2025, the Plan has been amended to clarify that failing to inform the Fund office of: (1) a divorce; (2) lapsed Union membership required to maintain Pensioner status; (3) that a Participant or Dependent is covered under another health plan; or (4) any other event which makes a Participant or Dependent ineligible for coverage are events considered a fraud or intentional misrepresentation of material fact.

2. NEW AND UPDATED DEFINITIONS

The Plan provides definitions for “Autism Spectrum Disorder,” and “Mental Health Benefits.” The definition of Autism Spectrum Disorder has been deleted, and the definition for Mental Health Benefit has been updated as follows:

Mental Health Benefit(s) means a benefit(s) with respect to items or services for mental health conditions.

In addition, definitions for the “DSM,” “Habilitation Services,” “IDC,” “Mental Health,” “MHPAEA,” “Rehabilitation (Therapies),” “Substance Use Disorder,” and “Substance Use Disorder Benefit” were added to the Plan, as follows:

DSM means the most current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, which is currently the Fifth Edition, Text Revision published in March 2022. Any subsequent version of the DSM will be considered the most current version beginning on the first day of the Plan Year that is one year after the date the subsequent version is published.

Habilitation Services are medically necessary health care services and health care devices that assist an individual in partially or fully acquiring, or improving skills and functioning, to the maximum extent practicable. The Plan only covers Habilitation Services that are necessary to address a mental health condition or substance use disorder.

ICD means the most current version of the World Health Organization's International Classification of Diseases adopted by the Department of Health and Human Services which is the 10th Revision, Clinical Modification adopted for the period beginning on October 1, 2015. Any subsequent version of the ICD adopted through 45 CFR § 162.1002 will be considered the most current version beginning on the first day of the Plan Year that is one year after the date the subsequent version is adopted.

Mental Health means a condition, except a Substance Use Disorder, listed in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the ICD or that are listed in the most current version of the DSM.

MHPAEA means the Mental Health Parity and Addiction Equity Act, as amended, and the regulations promulgated thereunder.

Rehabilitation (Therapies) are medically necessary health care services (including the following therapies: occupational, physical, speech, or respiratory therapies) to restore or improve any of the following:

- (a) movement or function;
- (b) skills, or
- (c) speech,

which were impaired due to any of the following:

- (d) an acute episode of disease, injury, or trauma; or
- (e) a congenital anomaly,

and that is expected to achieve a measurable improvement within a reasonable timeframe (usually 4 – 6 months).

Substance Use Disorder are those disorders that either (1) fall under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the ICD; or (2) are listed as Substance-Related and Addictive Disorder (or equivalent category) in the most current version of the DSM.

Substance Use Disorder Benefit means any benefit(s) with respect to items or services for Substance Use Disorders.

3. CLARIFICATION – MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND REHABILITATION AND HABILITATION SERVICE BENEFITS

In light of the above, the Chart of Benefits has been updated to provide more clarity regarding: (1) the benefits covered as a mental health or substance use disorder benefit; and (2) the coverage of rehabilitation and habilitation services. Thus, the Plan now provides as follows, in Article 3, Section 3.2(b), Schedule of Benefits:

Medical Benefits	In-Network	Out-of-Network
Mental Health Benefits		
Inpatient Care Pre-Authorization required.	80%*	70% UCR**
Outpatient Treatment Program	80%*	70% UCR**
Outpatient Psychotherapy	80%*	70% UCR**
Items or services to treat Autism Spectrum Disorder (ASD), including Applied Behavioral Analysis (ABA) Therapy	80%*	70% UCR**
Substance Use Disorder Benefits		
Inpatient Care Pre-Authorization required.	80%*	70% UCR**
Outpatient Treatment Program	80%*	70% UCR**
Outpatient Psychotherapy	80%*	70% UCR**

4. BENEFIT CLARIFICATIONS TO COMPLY WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

- **Exclusions and Limitations:** The following exclusions and limitations in the Plan have been amended to clarify that the Plan does not bar coverage for those benefits that would be required to be covered to comply with the MHPAEA, assuming the Plan were subject to such law. See Section 3.2(b) of the Plan. Specifically:
 - Exclusions numbered 18 and 34 have been amended to use the proper terminology when referring to mental health conditions and substance use disorders.
 - Exclusion number 8 has been amended to explicitly address the difference in therapy benefits for rehabilitation and habilitation.
 - Exclusion number 40 has been added to clarify that caffeine and tobacco-related substance use disorders will not be covered by the Plan.

- **Nutritional Counseling:** The Plan covers Nutritional Counseling, if, assuming it were subject to the MHPAEA, such benefit would be required by law. To reflect this coverage, the Schedule of Benefits in Section 3.2(b) has been updated to provide the following:

Medical Benefits	In-Network	Out-of-Network
Other Services		
Nutritional Counseling, if, assuming Plan was subject to the MHPAEA, such benefit is required to comply with the MHPAEA	80%*	70% UCR**

- **Therapy Services:** The Plan currently covers Rehabilitation Therapies (Occupational, Speech, and Physical Therapies) to treat both medical and mental health conditions and substance use disorders; Habilitation Services are only covered to treat mental health conditions and substance use disorders (not medical conditions). This coverage has not changed, but the Plan has been amended to clarify these benefits. Thus, Article 3, Section 3.2(b), Schedule of Benefits, provides as follows:

Medical Benefits	In-Network	Out-of-Network
Outpatient Care		
Rehabilitation: Occupational / Physical / Speech / Respiratory – Combined with all Rehabilitation Therapies, limited to a combined maximum of 90 visits per member per year.	80%*	70% UCR**
Habilitation Services to treat non-mental health conditions and non-substance use disorders	Not Covered	Not Covered
Habilitation Services (including occupational, physical, and speech habilitation therapies) to treat mental health conditions and substance use disorders only.	80%*	70% UCR**

5. CLARIFICATION – GENE THERAPY EXCLUSION

The Plan excludes coverage for “Gene Therapy.” To clarify this exclusion, Section 3.2(b), Exclusion number 37, has been amended to provide that the Plan bars coverage for:

- (37) All FDA-approved Cellular and Gene Therapy products.

6. CLARIFICATION – HOSPICE CARE BENEFIT

The Plan provides coverage for Hospice Care at 100%. This coverage is not changing, but the Plan has been amended to provide clarity regarding the certification and prognosis required to use such benefit. Thus, the Schedule of Benefits in Section 3.2(b) has been amended to provide as follows:

Medical Benefits	In-Network	Out-of-Network
Other Services		
Hospice Care Must have a prognosis of 6 months or less and the patient must be certified hospice by a physician.	100%	100%

7. REMINDER – DEDUCTIBLE AND MAXIMUM OUT-OF-POCKET AMOUNTS

As a reminder, the medical in-network deductible, which is the amount paid by a covered person before the Plan pays in-network medical benefits is \$9,200 / individual and \$18,400 / family. In addition, the in-network out-of-pocket maximum, which is the maximum amount a covered person or family will pay out-of-pocket under the Plan for in-network medical and prescription drug benefits per year is \$10,600 / individual and \$21,200 / family. Once this amount is reached, the Plan will pay in-network medical and prescription drug benefits at 100%.

8. REMINDER – GROUND AND AIR AMBULANCE BENEFITS

As a reminder, the Plan provides benefits for emergency medical transportation – ground and air ambulances as follows:

Medical Benefits	In-Network	Out-of-Network
Other Services		
Ground Ambulance – limited to 2 trips per confinement. Notwithstanding, if an out-of-network ambulance takes a covered person to an in-network facility, the Fund will pay at the in-network co-insurance applied to UCR.	80%*	70%** UCR
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 the billed charges or the Qualified Payment Amount, after deductible

9. CHANGES TO HIPAA NOTICE OF PRIVACY PRACTICES TO COMPLY WITH FEDERAL LAW

Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), known as the Privacy Rule, requires group health plans, like the Pipefitters Local No. 636 Retiree Insurance Fund plan, to adopt a Notice of Privacy Practices. This Notice of Privacy Practices describes the uses and disclosures the plan can make of your protected health information (PHI) that is created, received, and maintained by the plan in the course of providing health benefits. In addition, the Notice of Privacy Practices explains the legal obligations of the plan and your legal rights regarding the PHI held by the Plan.

The Privacy Rule also requires plans to make available to all participants their Notice of Privacy Practices and, when material changes are made to such Notice of Privacy Practices, send a timely communication describing such materials changes.

Effective **February 16, 2026**, the Pipefitters Local No. 636 Retiree Insurance Fund’s Notice of Privacy Practices has been materially changed to comply with changes made by law, specifically to:

- 1. Incorporate additional protections for substance use disorder treatment records.** In relevant part, there are specific limitations on how we can use or disclose records of your identity, diagnosis, prognosis, or treatment maintained in connection with the performance of any program or activity related to substance use disorder education, prevention, training, treatment, rehabilitation, or research, which was conducted, regulated, or directly or indirectly assisted by any federal department or agency (Part 2 records).

Part 2 records, or testimony relaying the content of such records, will not be used or disclosed in any civil, administrative, criminal, or legislative proceeding against you unless based on specific written consent or a court order after notice and an opportunity to be heard is provided to you. A court order authorizing the use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

- 2. Provide information regarding redisclosure.** You should be aware that information disclosed in accordance with this notice and federal law may be subject to redisclosure and no longer protected by the limitations contained in this notice and federal law.

To request a copy of the Pipefitters Local No. 636 Retiree Insurance Fund’s updated Notice of Privacy Practices, provide your name and mailing address to the plan representative identified below, and a copy will be sent to you, free of charge.

Plan Representative: Darris Garoufalis (third-party administrator)
BeneSys, Inc.
700 Tower Drive, Suite 300
Troy, Michigan 48098
Phone Number: (248) 813-9800

The Pipefitters Local No. 636 Retiree Insurance Fund's updated Notice of Privacy Practices is also posted on the Fund's website, accessible at <https://www.ourbenefitoffice.com/Pipefitters636/Benefits/>.

10. REMINDER – PREVENTIVE SERVICES

As a reminder, the Plan covers in-network preventive services without cost-sharing to the extent required under federal law. This means deductibles, co-insurance, and copayments do not apply to these benefits if provided in-network.

Please be aware that the list of preventive services required to be covered under federal law changes periodically and 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. For a list of items and services required to be covered under federal law as a preventive service, please contact the Fund Office, or visit the following resources:

- 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 <https://www.womenspreventivehealth.org/recommendations>
- Health Resources & Services Administration Adopted Guidelines for Infants, Children, and Adolescents (the Bright Futures Periodicity Schedule): <https://www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule>
- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention: <https://www.cdc.gov/acip/vaccine-recommendations/index.html>

PLEASE CALL THE FUND OFFICE IF YOU HAVE ANY QUESTIONS ABOUT THE INFORMATION CONTAINED IN THIS NOTICE.