SAGINAW PLUMBERS & PIPEFITTERS U.A. LOCAL NO. 85
FRINGE BENEFIT FUNDS
P.O. Box 1350 ● Troy, MI. 48099-1350
(248) 641-4985 (800) 582-6181

«FIRST_NAME» «MI» «LAST_NAME»
«ADDRESS_1»
«ADDRESS_2»
«CITY», «STATE» «ZIP»

OPEN ENROLLMENT 2026

Dear Participant,

Open Enrollment has begun for the 2026 benefit period. In 2026, you have the choice of the Blue Cross PPO Plan or the Core Plan. The Core Plan is available to those participants that are eligible for benefits through a spouse. Our records indicate that you are currently enrolled in the Core Plan through the Fund.

Please review the coverage options that are available to you and your family. If you wish to change your enrollment selection, you must notify the Benefit Office with your choice of coverage no later than **December 5, 2025**.

Our goal is to provide you with optimum member satisfaction. If you have any questions regarding your healthcare benefits, as always, please feel free to contact the Benefit Office at (248) 641-4985 or toll free at (800) 582-6181.

Sincerely,

Eligibility Department
Saginaw Plumbers & Pipefitters U.A. Local No. 85 Fringe Benefit Funds

SAGINAW PLUMBERS & PIPEFITTERS
U.A. LOCAL NO. 85 FRINGE BENEFIT FUNDS
P.O. Box 1350 • Troy, MI 48099-1350
(248) 641-4985 (800) 582-6181

To: **Active Participants in the CORE Benefit Program, and their Spouses and Dependents in the Saginaw Plumbers & Pipefitters Local 85 Health and Welfare Fund (the "Plan")**

Re: **Open Enrollment, Annual Notices, and Upcoming Benefit Changes**

Date: **November 2025**

WHAT IS THIS NOTICE ABOUT?

The Board of Trustees is pleased to provide you with the enclosed materials:

→ **Summary of Benefits and Coverage (SBC):** Enclosed is the 2026 Summary of Benefits and Coverage (SBC), which outlines several benefits available to you under the Plan. Please share the SBC with your family members who are eligible for coverage under the Plan. The Patient Protection and Affordable Care Act (PPACA) requires that all group health plans provide participants and beneficiaries with the SBC annually. The SBC provides a general description of some of the Plan's benefits and costs. The PPACA requires use of a form template and has strict rules on the format and content of the SBC. For this reason, the SBC does not cover all of the benefits provided by the Plan. We recommend you refer to the Plan's Summary Plan Description (SPD) for a more complete description of the benefits provided by the Plan, as well as the eligibility rules.

→ **Annual Open Enrollment:** Enclosed is the annual Open Enrollment Form. If your spouse or dependent child (under age 26) are not currently receiving health coverage under the Plan, you may enroll them during the month of November. If you wish to change your coverage to the prescription drug-only plan, you may also do so this November. To enroll your spouse and/or child for coverage beginning in January 2026 or if you wish to switch to the prescription drug-only plan in January 2026, please complete the enclosed form and return it to the Plan Office no later than November 30, 2025. If the Plan Office does not receive the form by November 30, 2025, your spouse and/or child will not be covered, and you will not be able to change your coverage for 2026. You must then wait until the next open enrollment period in November 2025 to enroll your spouse and/or child or change your coverage in 2026.

→ **Protections against Surprise Billing:** As a result of the No Surprises Act (the NSA), you now have protections against "surprise billing" from out-of-network providers in certain circumstances. The intent of the NSA is to provide greater transparency for health plan participants to better understand billing practices and prevent surprise billing (or balance billing) in certain situations. Specifically, the NSA provides that: 1) your cost sharing for out-of-network emergency facilities is to be the same cost-sharing as in-network emergency facilities; 2) if you go to an in-network facility (for either emergency or non-emergency service), your cost-sharing for out-of-network providers within that facility will be no more than your in-network cost sharing amount; and 3) cost-sharing for out-of-network air ambulance services will also be limited to cost-sharing for in-network air ambulance services. The Plan has been updated to reflect these changes. Hospitals and doctors are also required to provide you with notice of your rights and protections under the NSA. If you receive a balance bill after receiving these services covered by the NSA (for example, you are charged the out-of-network cost-sharing for an emergency air ambulance), you may be able to appeal this charge under the Plan's claims and appeals procedures, which are outlined in the Summary Plan Description.

→ **Auto & Motorcycle Accidents**: Michigan changed its no-fault auto insurance laws on July 1, 2020, to allow you to

opt-out or buy reduced medical coverage on your auto policy. To opt-out or buy reduced medical coverage on your auto policy, the new law requires you to have medical coverage elsewhere for injuries related to auto accidents. THIS PLAN DOES NOT COVER CLAIMS FOR ANY INJURIES RELATED TO AUTO ACCIDENTS; THEREFORE, YOU ARE NOT ELIGIBLE TO OPT-OUT OR BUY REDUCED MEDICAL COVERAGE ON YOUR AUTO INSURANCE POLICY. For injuries incurred because of a motorcycle accident, this Plan provides coverage only after all other sources of insurance that provide coverage have been fully exhausted, and only for those amounts which were not paid by these other sources of insurance to the extent the claims are otherwise covered by this Plan.

- Injuries related to recreational vehicle accidents (such as quad sports and snowmobiles that are NOT licensed for road use) ARE covered by the Plan. Again, if you incur medical claims because of an accident involving any type of vehicle that CAN be licensed for road use in Michigan (has a license plate or equivalent road use permit), this Plan will NOT cover those medical claims.

- Be sure that you inform your insurance agent about these coverage exclusions and limitations in your Plan! When you are purchasing no-fault automobile or motorcycle insurance, BE SURE TO INCLUDE MEDICAL COVERAGE IN YOUR AUTOMOBILE AND MOTORCYCLE POLICIES, SO THAT YOU DO NOT RUN THE RISK OF HAVING NO COVERAGE FOR MEDICAL CLAIMS RESULTING FROM AN AUTOMOBILE AND LIMITED COVERAGE FOR MOTORCYCLE ACCIDENT. You may want to take this notice to your insurance agent, when purchasing that coverage, to better explain your current medical coverage to your insurance agent.

→ **Women's Health and Cancer Rights Act Annual Notice.** As required by the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), the Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call the Benefits Office at 248) 641-4985 or toll free at (800) 582-6181 for more information.

→ **Newborns' and Mothers' Health Protection Act** The Newborn's and Mothers' Health Protection Act of 1996 ("Newborn's Act") is a Federal Law that contains important protections for mothers and their newborn children concerning the length of the hospital stay following childbirth. The Plan 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 delivery by 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 child earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

→ **Optional Life Insurance Enrollment**: The Plan offers optional life insurance through MetLife. If you wish to purchase additional life insurance, you will have to complete the enclosed enrollment form and complete the medical questionnaire, as well as return the enclosed payroll deduction form to the Benefit Office.

Receipt of these documents does not constitute a determination of your eligibility, nor is it a contract. Additional limitations and exclusions may apply. If you have any additional questions about your benefits, please call the Benefit Office at (248) 641-4985 or toll free at (800) 582-6181.

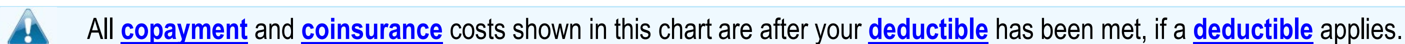
Sincerely Yours,

Board of Trustees
Saginaw Plumbers & Pipefitters Local 85 Health and Welfare Fund

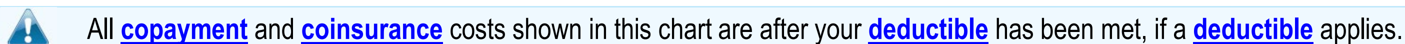
Enclosures:
-2026 Summary of Benefits and Coverage for CORE Program (SBC)
-Open Enrollment Form

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call (248) 641-4985 or (800) 582-6181. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can call (248) 641-4985 or (800) 582-6181 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	N/A	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. In-network **preventive care**, prescription drugs are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/**.
Are there other deductibles for specific services?	There are no other specific **deductibles**.	You don't have to meet specific **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For in-network providers **$4,000** person / **$8,000** family; for out-of-network providers **$8,000** person / **$16,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, self-payments, balance billed charges, dental, vision and health care this plan does not cover.	Even though you may be required to pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.bcbsm.com** or call the number on the back of your BCBSM ID card for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.


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

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Covered	Not Covered	N/A
	Specialist visit	Not Covered	Not Covered	N/A
	Preventive care/screening/ immunization	Not Covered	Not Covered	N/A
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	N/A
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	N/A
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsm.com	Generic drugs	$10 co-pay for retail 30-day supply; $20 co-pay for mail order 90-day supply.	$10 co-pay plus an additional 25% of BCBSM approved amount for the drug.	Mail order drugs not covered out-of-network. Specialty drugs subject to pre-authorization and limited to a 30-day supply. Some drugs may be subject to pre-authorization and utilization review. Please call the number on the back of your BCBSM ID card for more information.
	Preferred brand drugs	$40 co-pay for retail 30-day supply; $80 co-pay for mail order 90-day supply.	$40 co-pay plus an additional 25% of BCBSM approved amount for the drug.	Mail order drugs not covered out-of-network. Specialty drugs subject to pre-authorization and limited to a 30-day supply. Some drugs may be subject to pre-authorization and utilization review. Please call the number on the back of your BCBSM ID card for more information.
	Non-preferred brand drugs	$70 co-pay for retail 30-day supply; $140 co-pay for mail order 90-day supply.	$70 co-pay plus an additional 25% of BCBSM approved amount for the drug.	Mail order drugs not covered out-of-network. Specialty drugs are subject to pre-authorization and are limited to a 30-day supply. Some drugs may be subject to pre-authorization and utilization review. Please call the number on the back of your BCBSM ID card for more information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	N/A
	Physician/surgeon fees	Not Covered	Not Covered	N/A
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	N/A
	Emergency medical transportation	Not Covered	Not Covered	N/A
	Urgent care	Not Covered	Not Covered	N/A
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	N/A
	Physician/surgeon fees	Not Covered	Not Covered	N/A


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

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	N/A
	Inpatient services	Not Covered	Not Covered	N/A
If you are pregnant	Office visits	Not Covered	Not Covered	N/A
	Childbirth/delivery professional services	Not Covered	Not Covered	N/A
	Childbirth/delivery facility services	Not Covered	Not Covered	N/A
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	N/A
	Rehabilitation services	Not Covered	Not Covered	N/A
	Habilitation services	Not Covered	Not Covered	N/A
	Skilled nursing care	Not Covered	Not Covered	N/A
	Durable medical equipment	Not Covered	Not Covered	N/A
	Hospice services	Not Covered	Not Covered	N/A
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	N/A
	Children's glasses	Not Covered	Not Covered	N/A
	Children's dental check-up	Not Covered	Not Covered	N/A

Excluded Services & Other Covered Services:

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

- Acupuncture
- Infertility treatment
- Routine foot care
- Cosmetic surgery
- Long-term care
- Weight loss programs
- Bariatric surgery
- Chiropractic care
- Private-duty nursing
- Dental care
- Routine eye care
- Hearing aids

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

- Coverage provided outside the United States. See http://provider.bcbs.com
- If you also have a balance in your Individual Account Plan (IAP), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to

submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Fund Office at (248) 641-4985 or (800) 582-6181.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al (248) 641-4985.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (248) 641-4985.]
[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (248) 641-4985.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (248) 641-4985.]

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

About these Coverage Examples:

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

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

- **The plan's overall deductible** **N/A**
- **Specialist *[cost sharing]*** **N/A**
- **Hospital (facility) *[cost sharing]*** **N/A**
- **Other *[cost sharing]*** **N/A**

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

Total Example Cost	**$12,710**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,700
The total Peg would pay is	**$12,710**

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

- **The plan's overall deductible** **N/A**
- **Specialist *[cost sharing]*** **N/A**
- **Hospital (facility) *[cost sharing]*** **N/A**
- **Other *[cost sharing]*** **N/A**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,100
The total Joe would pay is	**$2,800**

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

- **The plan's overall deductible** **N/A**
- **Specialist *[cost sharing]*** **N/A**
- **Hospital (facility) *[cost sharing]*** **N/A**
- **Other *[cost sharing]*** **N/A**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,800
The total Mia would pay is	**$2,810**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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«FIRST_NAME» «MI» «LAST_NAME»
«ADDRESS_1»
«ADDRESS_2»
«CITY», «STATE» «ZIP»

BENEFIT PLAN ELECTION FORM FOR ACTIVE MEMBERS

I WOULD LIKE TO CHOOSE THE FOLLOWING PLAN

☐ Community Blue PPO Preferred Plan

☐ Core Benefit Plan
(In choosing this plan, I acknowledge that I have hospital and medical coverage through other means, and that I will not have medical coverage through the U.A. Local No. 85 Health and Welfare Plan.)

Please note that the Affordable Care Act mandates that non-exempt individuals must maintain health insurance for themselves and dependents. Furthermore, such health insurance must satisfy the minimum essential coverage requirement. Coverage under the Local 85 Health and Welfare Plan's Community Blue PPO Preferred Plan does satisfy this requirement, however, coverage under the CORE Benefit Plan does not satisfy **this requirement. Prior to selection of the CORE Benefit Plan, it is strongly encouraged that you verify that your other coverage satisfies the minimum essential coverage requirement, as mandated by federal law, otherwise you may be subject to a penalty for each month of noncompliance.**

By signing this form, I acknowledge that I reviewed the enclosed information. I also acknowledge that my election ***cannot be changed*** until the next open enrollment period, which will be in the Fall 2026 for the year 2027.

If you are currently enrolled in the Community Blue PPO plan and do not wish to make any changes, nothing further is needed and you will remain in this coverage for the entire 2026 plan year. If you are moving to or from the Core Plan you must submit this form to change your election, as well as submit proof of other coverage if remaining in or electing the Core Plan.

Member's Signature: ________________________________ Date: _______________

Member's ID/SS#: ___________________________________

Enrollment Reminder

Enrollment Reminder

Open Enrollment is Here!

2026 Annual Benefits Enrollment

Scan the QR Code Below to Review your Benefit Guide: Or you can enter this link into your web browser:
Saginaw Plumbers & 85 Benefit Guide - Active CORE- Flipsnack

Scan the QR Code Below to Review your Benefit Presentation: Or you can enter this link into your web browser:
https://www.brainshark.com/usi/vu?pi=zJOzxOrwSzohk6z0

Saginaw Plumbers & Pipefitters-Local 85
P.O. Box 1350

Troy, MI 48099-1350

Recipient Name
Recipient Address

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Saginaw Plumbers & Pipefitters-Local 85
P.O. Box 1350

Troy, MI 48099-1350

Recipient Name
Recipient Address

MetLife

Metropolitan Life Insurance Company

Your life insurance claim kit

On behalf of MetLife, please accept our sincere condolences during this difficult time.

We're here to help

We recognize this may be a challenging time for you. If you have questions, or need help preparing your claim, call us at **1-800-MET-6420 (1-800-638-6420)**. Our Customer Service Center is open Monday through Thursday, 8:00 a.m. to 8:00 p.m. EST, and Friday 8:00 a.m. to 5:00 p.m. EST.

Sincerely,

MetLife
U.S. Life Insurance Claims

MetLife

State Specific Fraud Warnings – Group Product Claim Forms

Fraud Warnings

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

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

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

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

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

Kansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

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

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

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

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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

Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

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

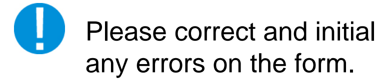
MetLife

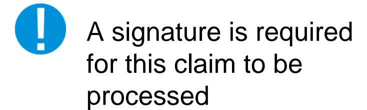
Life insurance claim form

Use this form to submit your claim for a life insurance policy payment.

Things to know before you begin

- Each beneficiary submitting a claim must complete and sign a separate claim form. However, we only need one death certificate indicating the cause and manner of death.
- A signature is required for this claim to be processed.
- Please answer each question fully and accurately. If you return this form with missing or incorrect information, it will delay your claim.
- You may have to send us other documents with this claim. See the list in *Section 5: How to submit this form.*


Please correct and initial any errors on the form.


A signature is required for this claim to be processed

SECTION 1: About you

Tell us in what capacity you're making a claim ***(check one)***:

☐ Individual beneficiary or ☐ Representative of a trust, estate or Charity

Your relationship to the person who died *(check one):*

☐ Spouse/Partner ☐ Parent ☐ Child

☐ Trust/Estate Representative/Charity ☐ Other *(please explain)* ____________________

Your name *(first, middle, last) - Please print your name the way you want it to appear on your payment.*

First	Middle	Last

Maiden or other names *(if applicable)*

Mailing address *(Street number and name, apartment or suite)*	Phone number

City	State	ZIP code

Date of birth *(mm/dd/yyyy)*	Sex *(M/F)*	Social Security number	Country of Citizenship

Please complete if making a claim on behalf of a Trust, Estate or Charity

Name of Trust/Estate/Charity	Date of Trust *(mm/dd/yyyy)*

Tax Identification Number *(For the Trust, Estate, or other Charity)*

____

☐ I consent to receive claim status e-mails and text messages as indicated below. Please see the enclosed *About Electronic Statusing* for more details.

Please tell us if you would like to receive claim statuses electronically

Cell phone number	Email address

Insured Employee/Member Information

First name | Middle name | Last name

Employer name

Have you signed a document with a funeral home that authorizes us to make a payment directly to them? This document is usually referred to as a funeral home assignment.

☐ No ☐ Yes – If yes, please send us a copy of the document with this claim form.

SECTION 2: About the deceased

Name *(first, middle, last)*

First | Middle | Last

Maiden or other names *(if known, optional)*

Residence address *(Street number and name, apartment or suite)*

City | State | ZIP code

Date of birth *(mm/dd/yyyy)* | Date of death *(mm/dd/yyyy)*

Social Security number | Marital status *(check one)*
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/widower

SECTION 3: Tell us how you want to receive your claim payment

You will receive a check for your payment

Please remember to sign and date the form on the next page

Insured Employee/Member Information

First name	Middle name	Last name

Employer name

SECTION 4: Certification and signature

By signing this claim form, you certify that:

- All the information you have given is true and complete to the best of your knowledge.
- Any contributions owed by the insured will be deducted from the insurance proceeds paid to me.
- If we overpay you, we have the right to recover the amount we overpaid. This can happen if we find we've paid you more than you're entitled to under this life insurance claim, or if we paid you when we should have paid someone else. You agree to repay us the amount we overpaid. You also understand that if you do not repay us, we may take steps, including legal action, to recover the overpayment.
- You have read the Claim Fraud Warnings included with this form. **New York residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Under the penalties of perjury I certify:

1. That the number shown as my Social Security Number or Tax Identification Number in "Section 1: About you" above is my correct taxpayer identification number, and
2. That I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen, resident alien, or other U.S. person*, and
4. I am not subject to FATCA reporting because I am a U.S. person* and the account is located within the United States.

(Please note: You must cross out Item 2 above if the IRS has notified you that you are currently subject to backup withholding because you failed to report all interest or dividend income on your tax return.)

**If you are not a U.S. Citizen, a U.S. resident alien or other U.S. person for tax purposes, please cross out items 3 and 4 above, and complete and submit form W-8BEN (individuals) or W-8BEN-E (entities).*

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. You must complete this certification to avoid 24% withholding with respect to taxable amounts.

Signature of person making the claim	Date signed *(mm/dd/yyyy)*

Some services in connection with your claim may be performed by our affiliates, MetLife Global Operations Support Center Private Limited or MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your claim will be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

Insured Employee/Member Information

First name	Middle name	Last name

Employer name

SECTION 5: How to submit this form

5A. Check off the additional items you're sending with this claim form

- ☐ **A death certificate.** We require a copy of the death certificate. The funeral director taking care of the funeral arrangements can usually provide a copy of the death certificate *(indicating the cause and manner of death)*. **We only require one death certificate** – if you're aware of another claimant who's sending one, you don't have to send it.
- ☐ If you signed a document with a funeral home that authorizes us to make a payment directly to them, a copy of that document.
- ☐ If the beneficiary is the estate and you are a representative of an estate, a copy of the appointment papers issued by the courts.
- ☐ If the beneficiary is a trust and you are a trustee, a notarized statement that the trust is still in effect and you are authorized to act under the trust. If you are not the original trustee, a copy of the page naming you as the successor trustee.
- ☐ If you are submitting the claim as Power of Attorney for the beneficiary, a copy of the POA papers for the beneficiary must be provided.

5B. Submission instructions

Unless you have been advised of different instructions by the administrator/employer, return this signed claim form and the documents you've checked off above in the envelope included with this package, or mail/fax them to:

Mail:

MetLife Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100

Fax:

1-570-558-8645

Email:

Lifeclaimsubmit@metlife.com

Please note: Most claims are reviewed within five (5) business days.

If faxing, please remember to fax both front and back sides of the signed claim form. Allow two (2) hours for documents to be received.

If emailing, please be advised:
Accepted document types: Word Document, PDF and JPEG.
Maximum single attachment size: 20MB
Maximum email size: 25MB
Encrypted emails cannot be accepted

We're here to help

If you have questions, or need help preparing your claim, call us at 1-800-MET-6420 (1-800-638-6420), then press 2. Our Customer Service Center is open Monday through Thursday, 8:00 a.m. to 8:00 p.m. EST, and Friday 8:00 a.m. to 5:00 p.m. EST.

About Electronic Statusing

MetLife provides electronic statusing as a convenience to you. Please review the following terms and conditions carefully before providing (a) your agreement to them, and (b) your consent to receiving electronic statuses.

By agreeing to the terms of this Agreement, you are consenting to receive claims statuses in one or more of the following ways:

1. When a change has been made to your claim, we will send you an email advising you that we have made such a change;

Such e-mails will be sent to the current e-mail address we have on file for you. In addition, we can notify you about the availability of claim statuses by text message (SMS - Short Messaging Service). If you agree to receive notification of the availability of claim status messages by text message, you acknowledge and agree that any charges associated with your receipt of these messages are fully your obligation and are not reimbursable by MetLife or any of its affiliates. There may be other third party costs for Internet access fees or text message (SMS) charges that are not reimbursable by MetLife or any of its affiliates.

We will continue to deliver information in writing to you by U.S. mail.

2. You may withdraw your consent, change your delivery preferences, and update information we need to contact you electronically at any time by replying "stop" to a text message from us or by calling our Customer Service Department.

THE clinic BY Cleveland Clinic

Virtual Second Opinions
By Cleveland Clinic

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

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

The Clinic 2020 outcomes data, n=417

Through Saginaw Plumbers and Pipefitters Local 85 Health and Welfare Fund, you have access to The Clinic by Cleveland Clinic's Virtual Second Opinions program. The program provides you with easy, secure access to high-quality medical expertise from the comfort of home.

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

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

What is a Virtual Second Opinion?

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

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

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

How it works

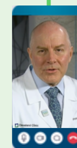
Live intake with nurse care manager

Records collection

Records and tests review

Expert physician matching

Expert physician review



Opinion delivered by expert physician

Get a Virtual Second Opinion from Cleveland Clinic today

Scan the QR code to the right or follow the link below to learn more, register, and download the app.

Go to: **www.clinicbyclevelandclinic.com/local-85**

Once prompted, enter the service key: **LOCAL85**

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

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