December 2022

Pipeline Industry Pension Fund
Pipeline Industry Benefit Fund

Important Information to the Membership
Summary of Material Plan Modifications

The Board of Trustees of Pipeline Industry Pension Fund and Pipeline Industry Benefit Fund met on August 24 and November 16, 2022, and approved changes to the respective Plans as summarized below. These important pension plan and health and welfare plan changes will affect active participants, spouses, children, and retirees.

Pipeline Industry Pension Fund

The following pension improvements and changes will be implemented for participants earning pension credits and retired participants in the Pipeline Industry Pension Fund (PIPF):

In-Service Distribution Accruals Earned

1. In accordance with the provisions of the Plan prior to January 1, 2013, a retiree age 62 or older could work and receive his monthly pension benefit as an In-Service Distribution; however, accruals earned while working were limited or offset based on the benefit payments received and in most cases the retiree did not receive the full accruals for continued work. The Trustees have again temporarily suspended this offset rule extending it through December 31, 2024. If you are a retiree age 62 or older receiving an In-Service Distribution, you may continue to receive your monthly pension check and earn the full accrual of benefits based on the hours worked, with no offset for payments received through December 31, 2024.

Normal Retirement Age

2. The PIPF normal retirement age is age 65. Normal Retirement Age means the later of 1) the Participant's sixty-fifth (65th) birthday; or 2) the fifth (5th) anniversary of the date on which a Participant first commences participating under the Plan.

Disability Pension Benefit Suspension and Reinstatement

3. If your disability pension benefit is suspended because you were not approved for your Social Security Disability benefit within 24 months, upon receipt of the Social Security Award, the Trustees shall retroactively reinstate the Disability Benefit from the date of suspension, commencing on the first day of the first month following receipt of the Social Security Award, provided that the date of disability as determined under the Social Security Award is within the 24-month period.

Pipeline Industry Benefit Fund

The following benefit improvements and changes will be implemented for participants and retired participants in the Pipeline Industry Benefit Fund (PIBF):

Health Reimbursement Arrangement (HRA)

1. The Trustees have again approved the continuance of the HRA for 2023. The HRA benefit will continue to be $4,000.00 per year for active members for single or family coverage. Active members on COBRA will continue to be $4,000.00 per year for single or family coverage. Separate coverage for spouses and children who are on COBRA is $2,000.00 per year. The HRA amount for a retired member with covered dependents is $4,000.00 per year and single retired members and retired widows is $2,000.00 per year. HRA benefits are available for months with active, COBRA, or retiree coverage only.

COBRA Coverage

2. Effective March 1, 2023, COBRA rates will be as follows:

   - Single Coverage $640 per month
   - Family Coverage $1,700 per month

Eligibility Rules Amended

3. Trustees amended the Plan (effective January 1, 2023), to change initial eligibility for new journeyman participants who enter the plan on or after January 1, 2023, or who have lost eligibility for 60 months and are re-establishing eligibility from the 500-hour requirement to an 800-hour requirement. The hours must be worked within a 12-month period. Eligibility rules for helpers remain at 800 hours.

Virtual Medical Visit Option Expanded to Include Behavioral Health and Co-Payment Amounts Changing as of April 1st

4. Beginning April 1, 2023, the MDLIVE program will include the option for behavioral health visits. Co-payment for this service will be 30% of the cost of the visit. For a medical visit, the co-payment will remain around $15; however, co-payments for behavioral health will depend on the length and level of visit and the credentials of the medical provider. This co-payment will count toward your annual medical benefits deductible and out-of- pocket expense limit. It will be eligible for reimbursement under the Health Reimbursement Arrangement (HRA) by submitting your Explanation of Benefits (EOB) with a completed HRA Claim Form. Plan exclusions apply (treatment of substance abuse, etc. See the PIBF SPD at www.pibf.org, pages 53-55 for a complete list of plan exclusions). Please know that MDLIVE is experiencing high visit volumes due to COVID-19 and the cold and flu season and wait times may be longer than normal.

External Review Process

In March 2022, you were notified of the patient protections for surprise medical bills required by recent federal legislation under the No Surprises Act (NSA), effective January 1, 2022. This Notice explains that in the event you file a claim related to surprise medical billing protections as explained in the March 2022 Notice, and your claim is denied after going through the appeals process under the Plan, you are permitted to request that your adverse determination be reviewed under External Review. This Notice is only a summary of the External Review process and does not replace or modify the Plan. Please contact the Fund office if you have any questions about how these External Review procedures apply to you.

What can I do if my claim related to surprise medical billing protections is denied after appealing to the Trustees?

If your initial claim for items or services that are subject to the surprise medical billing protections is denied (you received an adverse determination as described under the "Claims Appeal Procedures" of the SPD), and you are dissatisfied with the final outcome of the Plan's internal claims and appeal process, you may be eligible to have your adverse determination further reviewed by an accredited Independent Review Organization ("IRO") in accordance with the Plan's External Review Procedures.

To request External Review, you must file a written request with the Fund office within four months of the date of the adverse benefit determination. Within 5 days of your request, the Plan will review whether you are eligible for External Review. You will be notified by the Fund office within one day of completion of review if you are eligible for External Review, or if you are not eligible, you will be notified of the reasons and permitted to perfect your request. If you are eligible, the Plan will assign your claim to the IRO that is under contract with the Fund and furnish the necessary documents and information considered by the Plan in making the adverse determination. The IRO is not bound by the Plan's decisions or conclusions reached in the internal appeal process and will notify you if any additional information must be furnished to review your claim. You will then be

notified by the IRO of its final external review decision within 45 days after the IRO receives the request for review. If an IRO reverses the Plan's adverse determination, coverage or payment will be paid immediately upon the Plan's receipt of the IRO notice.

You may also request an expedited External Review in certain circumstances such as if the adverse determination involves a medical condition for which the timeframe for completion of an expedited internal appeal under the Plan's appeals procedures, or the time frame for completing the standard external review, would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal with the Plan. Your claim will be reviewed under the standard steps described above, but the decision timeframes are shorter.

The External Review process does not apply to any other adverse determination under the Plan, but only applies to claims related to medical billing protections.

For additional information, please contact the Fund office for a copy of the Plan's External Review Procedures contained in the SPD.

Your receipt of this Notice is not a certification that you are eligible to receive any benefits under the Plan. You must satisfy the Plan's eligibility requirements to receive benefits and this is only a summary and simple description of the recent changes to the Plan. If you have any questions, please contact the Fund office.

REMINDER OF GRANDFATHERED HEALTH PLAN STATUS: *The Plan is a group health plan that believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans (for example, the requirement for the provision of preventive health services without any cost sharing). However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act (for example, the elimination of lifetime limits on benefits).*

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund office, at the address and telephone number listed above. You may also contact the Employee Benefits Security Administration,

U.S. Department of Labor at ***1-866-444-3272*** *or* ***www.dol.gov/ebsa/healthreform****. This website has a table summarizing which protections do and do not apply to grandfathered health plans.*

Sincerely,

Renée E. Vause

Renée E. Vause
Director