# Pipe Fitters Local No. 533 Health and Welfare Plan

## Benefit Alerts

# PIPE FITTERS LOCAL NO. 533
# HEALTH AND WELFARE FUND

# BENEFIT ALERT #17

The purpose of this Alert is to announce recently approved changes to improve your dental and routine care benefits.

## DELTA DENTAL PPO

As you may be aware, in-network dental benefits are available through the Delta Dental "Premier" network. In addition to the "Premier" network, the Fund will also take part in Delta Dental's "PPO" network. The Delta Dental "PPO" network is made up of about 60% of the existing "Premier" providers, but these PPO providers offer greater discounts than the Delta Dental's non-PPO "Premier" providers. **Beginning April 1, 2010**, the Fund will offer a higher level of coverage, **90%**, for routine diagnostic and preventive dental care provided by "PPO" providers. Here is a summary of the Plan's dental benefit coverage:

| | **Delta Dental PPO** Effective 4/1/2010 | | |
|---|---|---|---|
| Co-Insurance (Plan Pays) | Delta Dental PPO | Delta Dental Premier | Non-Network Dentist |
| Class A: Diagnostic & Preventive Services | **90% (NEW!)** | 80% | 60% |
| Class B: Basic Restorative | 80% | 80% | 60% |
| Class C: Major Restorative | 80% | 80% | 60% |
| Class C: Implants | 50% | 50% | 50% |
| Class D: Orthodontic | 80% | 80% | 60% |
| Calendar Year Benefit Maximum | $1,500 per person | | |

**IMPORTANT NOTICE: Delta Dental is mailing you new ID cards** and additional information in the next few days. Prior to receiving any dental care, you are encouraged to confirm your dentist's current status with Delta Dental. To check online, please visit www.deltadental.com and click on the "Dentist Search" option. **Remember to seek out a Delta Dental "PPO" provider to get the most out of your dental coverage.**

## COLONSCOPY COVERAGE

Previously, routine colonoscopies were subject to the Plan's $300 annual routine care benefit maximum. As the cost of a routine colonoscopy can be much greater than $300, effective September 1, 2009, routine colonoscopies will be removed from the annual $300 routine care benefit and will be covered under the Plan's comprehensive medical benefits, subject to the Plan's deductible and co-insurance. This change is intended to reduce your out-of-pocket expense for colonoscopies, and leave more of your annual $300 routine care benefit available for other routine and preventive care services.

Please contact the Fund Office if you have any questions regarding this information.

Sincerely,
BOARD OF TRUSTEES
March, 2010

# PIPE FITTERS LOCAL NO. 533
# HEALTH AND WELFARE FUND

# BENEFIT ALERT #18

Effective July 1, 2010, the Pipefitters Local # 533 Health and Welfare Fund will return vision claim processing to the Fund Office. Vision care claims with a date of service on or after July 1, 2010 will no longer be processed under the Blue Cross Blue Shield provider network. Vision care claims will not be subject to any preferred provider network discount agreements or payment policies. Instead, you or your provider should file vision care claims directly with the Fund Office, at the address indicated on the enclosed vision ID card, for prompt processing. This notice supersedes all previous Alerts addressing your vision care benefits.

**IMPORTANT NOTICE:** This packet contains your family's **new vision ID cards**. Please begin using these cards for your vision care benefits received on and after July 1, 2010.

Your vision care benefit schedule is not changing. The Plan will pay 100% of your covered vision care up to the following maximums:

Maximum amount paid for exams:

a. $50 for one (1) examination by a licensed optometrist or ophthalmologist per calendar year;

Maximum amount paid for lenses:

a. $50 per pair for single vision lenses;
b. $85 per pair for bifocal lenses;
c. $95 per pair for trifocal lenses;
d. $10 per pair for color tint, if Medically Necessary;
e. $100 per set of contact lenses (or the total cost if Medically Necessary)

An Eligible Employee is covered for up to two (2) pairs of prescribed lenses (whether spectacle or contact) per calendar year; and Retirees and Dependents are covered for one (1) pair of prescribed lenses (whether spectacle or contact) per calendar year. A package of disposable contacts is treated as a pair of prescribed lenses.

Maximum amount paid for frames:

a. $75 for a pair of frames once per calendar year for Eligible Employee; and
b. $75 for a pair of frames once every two (2) calendar years for Retirees and Dependents.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
June, 2010

**PIPE FITTERS LOCAL NO. 533**
**HEALTH AND WELFARE FUND**

# BENEFIT ALERT #19

Effective January 1, 2011, the Pipefitters Local # 533 Health and Welfare Fund has contracted with LDI, Inc. to replace Express-Scripts as the Fund's Prescription Benefit Manager (PBM).

**IMPORTANT NOTICE #1:** By late-December, you will receive additional information regarding the transition to LDI, **including new prescription drug identification cards.** Please begin using these cards for prescription drug benefits on and after January 1, 2011.

Along with your new prescription drug ID cards, you will receive information on how to contact LDI, how to use their website and mail order service, and a current LDI formulary listing. As a reminder, the formulary will list those prescription brand name drugs that are considered 'preferred' and available to you for a lower co-payment than 'non-preferred' brand name prescription drugs.

**IMPORTANT NOTICE #2:** The Trustees have approved a NEW 90-Day Supply Benefit for all Walgreens retail pharmacies.

**With LDI you will now have two options to fill your 90-day prescriptions:**

- **Traditional Mail Order** – Receive a 90-day supply for 2 times your 1 month supply co-payment. If you need help getting started with LDI's mail order service, please contact LDI at 1-866-516-1121.

- **Walgreens** – The Trustees have approved a new co-payment tier (below) for 90-day prescriptions filled at any Walgreens retail pharmacy:

***NEW!***

| If your prescription is for a: | Your Co-payment: | | |
|---|---|---|---|
| | **Retail** 1 mo. supply | **Mail Order** 3 mo. Supply | **Walgreens** 3 mo. supply |
| Generic drug | $15 | $30 | **$30** |
| Brand name drug; Formulary | $30* | $60* | **$75*** |
| Brand name drug; NOT Formulary | $50* | $100* | **$125*** |

* plus the difference in the ingredient cost if your prescription is for a brand name drug when a generic is available.

## GRANDFATHERED STATUS

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
December 1, 2010

**PIPE FITTERS LOCAL NO. 533**
**HEALTH AND WELFARE FUND**

# BENEFIT ALERT #20

Effective June 1, 2011, the Board of Trustees has amended the Pipefitters Local No. 533 Health and Welfare Fund (the Plan) in conjunction with the Fund's compliance under the Patient Protection and Affordable Care Act and the Mental Health Parity Act. These plan benefit changes include the following:

## Lifetime Limits

The $2,000,000 lifetime limit on benefits has been removed and in its place is a $2,000,000 calendar year limit.

## Dependent Coverage Under the Plan

If you are an active Participant Employee, coverage for your spouse will become effective at the same time as your Eligible Employee coverage so long as your spouse's enrollment form was postmarked or otherwise positively received by the Fund Office on such date. If you get married after the date your coverage begins, coverage for your spouse will be effective as of the date of marriage as long as your spouse's enrollment form is postmarked or otherwise positively received by the Fund Office within 30 days of your date of marriage. If your spouse's enrollment form is not postmarked or otherwise positively received by the Fund Office at the same time as your Eligible Employee coverage begins or within 30 days of marriage, the spouse will become eligible for coverage for claims incurred the first day of the month after the enrollment form is postmarked or otherwise positively received by the Fund Office.

If you are an active Participant Employee, coverage for your Dependent children will become effective at the same time as your Eligible Employee coverage so long as the Dependent child's enrollment form was postmarked or otherwise positively received by the Fund Office on such date. If the Dependent child's enrollment form was not postmarked or otherwise positively received by the Fund Office on such date, the Dependent child will become eligible for coverage for claims incurred the first day of the month after the enrollment form is postmarked or otherwise positively received by the Fund Office.

Coverage will begin at birth for your newborn child as long as the Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office within 30 days of that child's birth. If you adopt a child, coverage will begin the earlier of the date the child is placed with you for adoption or the date a court order grants custody to you as long as the Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office within 30 days of

such date. If your Dependent child's enrollment form is not postmarked or otherwise positively received by the Fund Office within 30 days of birth or adoption, the Dependent child will become eligible for coverage for claims incurred the first day of the month after the enrollment form is postmarked or otherwise positively received by the Fund Office.

**Important Notice:** If you acquire a Dependent or your Dependent no longer meets the definition of a Dependent, you should immediately contact the Fund Office. **Claims for a Dependent will not be paid if a current enrollment form is not on file with the Fund Office for that Dependent.**

If you are a Retiree, the effective date of coverage for your Dependents has not changed. The rules for coverage remain the same as those on pages 8 and 9 of your current SPD.

## Increased Dependent Coverage to Age 26

Coverage for Dependent children has been extended to the end of the month in which the child turns age 26. Such extended coverage is not available if the child has employer-sponsored health care coverage available through his employer, or his spouse's employer if married. This coverage is available even if your under age 26 dependent child is married, not dependent upon you for half or more of the child's support and does not live with you.

There is one exception to the rule that coverage is not available if the child has employer-sponsored health care coverage available through his employer (or his spouse's employer if married). An unmarried child who is a full-time student over age 18, but younger than age 25 will be an eligible Dependent regardless of the availability of other employer coverage, provided that child is enrolled in an accredited educational institution and the child depends on you for support and maintenance.

## Routine Care Benefits

The Plan will cover 100% of the cost up to $300 per person per calendar year for the following Routine Care Benefits:

- Thyroid Stimulating Hormone (TSH) Test
- Pap smear
- Mammogram
- Prostate Specific Antigen (PSA) Test

In addition, eligible charges in excess of $300 will be covered subject to the Plan's standard deductible and coinsurance levels applicable to in-network and out-of-network Comprehensive Medical Benefits.

## Pediatric Vision Benefits

The $50 calendar year maximum for vision exams by a licensed optometrist or ophthalmologist has been removed for Covered Persons under age 19. The dollar maximums remain unchanged for Covered Persons age 19 and older. The maximum amount paid for lenses and frames remains unchanged for all Covered Persons regardless of age. All Vision Benefits remain subject to the current exclusions as well as the requirement of Medical Necessity.

## Pediatric Dental Benefits

For Covered Persons under age 19, benefits paid for diagnostic and preventative dental care, basic dental care, and major dental care will no longer be limited to or counted towards the $1,500 calendar year maximum. However, the $1,500 calendar year maximum for Orthodontia and Dental Implants shall remain for all Covered Persons regardless of age. Dental benefits for Covered Persons age 19 and over remain unchanged.

## Medical Supplies and Equipment

The $5,000 limit has been removed on the rental or purchase (whichever costs less) of certain medical supplies and durable medical equipment prescribed by a Physician. Covered supplies remain limited to those that are Medically Necessary for the treatment of a Sickness or injury and subject to the current rules regarding the Allowable Charge.

## Mental Health Care and Substance Abuse Treatment

Mental health care and substance abuse treatment benefits will be paid at the same coinsurance rates as Comprehensive Medical Benefits. This means the Plan will pay 85% for In-Network services and 60% for Out-of-Network services for inpatient and outpatient treatment for Mental Health and Substance Abuse as long as the treatment is provided from a duly-licensed Physician, Nurse Practitioner, Mental Health Care Provider, or alcohol or drug dependence counselor. Outpatient treatment provided as the result of a referral from the Medical Review Office of the Employee Assistance Program remains covered at 100%.

The previous 30 day limit for inpatient treatment for Mental Health Care and Substance Abuse as well the 45 day limit for outpatient treatment for Mental Health Care and Substance Abuse have been removed. The $7,500 calendar year maximum for inpatient treatment for Substance Abuse has also been removed.

All Mental Health Care and Substance Abuse Treatment remains subject to the requirement of Medical Necessity. In addition, Coverage remains limited to treatment that is provided by a duly-licensed Physician, Nurse Practitioner, Mental Health Care Provider, or alcohol or drug dependence counselor.

## Grandfathered Status

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
April 15, 2011

**PIPE FITTERS LOCAL NO. 533**
**HEALTH AND WELFARE FUND**

# BENEFIT ALERT #21

Effective June 1, 2011, the Board of Trustees has amended the Pipefitters Local No. 533 Health and Welfare Fund (the Plan). These plan benefit changes include the following:

**Dependent Coverage Under the Plan for Active Employees:**

If you are an active Participant Employee, coverage for your spouse will become effective at the same time as your Eligible Employee coverage so long as your spouse's enrollment form was postmarked or otherwise positively received by the Fund Office on such date.

**IMPORTANT NOTICE #1:** If you get married after the date your coverage begins, coverage for your spouse will be effective as of the date of marriage as long as your spouse's enrollment form is postmarked or otherwise positively received by the Fund Office **within 90 days** of your date of marriage.

If your spouse's enrollment form is not postmarked or otherwise positively received by the Fund Office at the same time as your Eligible Employee coverage begins or within 90 days of marriage, the spouse will become eligible for coverage for claims incurred the first day of the month after the enrollment form is postmarked or otherwise positively received by the Fund Office.

If you are an active Participant Employee, coverage for your Dependent children will become effective at the same time as your Eligible Employee coverage so long as the Dependent child's enrollment form was postmarked or otherwise positively received by the Fund Office on such date. If the Dependent child's enrollment form was not postmarked or otherwise positively received by the Fund Office on such date, the Dependent child will become eligible for coverage for claims incurred the first day of the month after the enrollment form is postmarked or otherwise positively received by the Fund Office.

**IMPORTANT NOTICE #2:** Coverage will begin at birth for your newborn child as long as the Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office **within 90 days** of that child's birth.

If you adopt a child, coverage will begin the earlier of the date the child is placed with you for adoption or the date a court order grants custody to you as long as the Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office within 90 days of such date. If your Dependent child's enrollment

form is not postmarked or otherwise positively received by the Fund Office within 90 days of birth or adoption, the Dependent child will become eligible for coverage for claims incurred the first day of the month after the enrollment form is postmarked or otherwise positively received by the Fund Office.

**Important Notice #3:** If you acquire a Dependent or your Dependent no longer meets the definition of a Dependent, you should immediately contact the Fund Office. **Claims for a Dependent will not be paid if a current enrollment form is not on file with the Fund Office for that Dependent.**

**If you are a Retiree, the effective date of coverage for your Dependents has <u>not</u> changed.** The rules for coverage remain the same as those on pages 8 and 9 of your current SPD.

## <u>Grandfathered Status</u>

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
November 7, 2011

**PIPE FITTERS LOCAL NO. 533**
**HEALTH AND WELFARE FUND**

# BENEFIT ALERT #22

The Board of Trustees has amended the Pipefitters Local No. 533 Health and Welfare Fund (the Plan) to provide for the following benefit improvements:

**Prescription Drug Benefit:**
The therapeutic drug class designed to lower cholesterol levels known as "statin" drugs currently includes the following generic drugs:

- **Simvastatin** (generic Zocor)
- **Atorvastatin** (generic Lipitor)
- **Lovastatin**
- **Pravastatin**

Effective December 9, 2011, the Plan will offer a new tier of reduced Participant copayments for all generic "statin" drugs:

| **If your prescription is for a:** | **Your Co-payment:** | | |
|---|---|---|---|
| | **Retail** 1 mo. supply | **Mail Order** 3 mo. Supply | **Walgreens** 3 mo. supply |
| **Generic "statin" drug *(NEW!)*** | **$10** | **$20** | **$20** |
| Other Generic drugs | $15 | $30 | $30 |
| Brand name drug; Formulary | $30* | $60* | $75* |
| Brand name drug; NOT Formulary | $50* | $100* | $125* |

* plus the difference in the ingredient cost if your prescription is for a brand name drug when a generic is available.

To get started with LDI's mail order service, please contact LDI at 1-866-516-1121.

**IMPORTANT NOTICE #1:** The Plan has reduced the member copayments for all generic "statin" drugs, commonly prescribed to lower or maintain cholesterol levels. The reduced copayment levels for all generic "statin" drugs are now in effect.

**Erectile Dysfunction Drugs:**
The Plan's coverage limit of six (6) dosages (pills or injections) per calendar month for treatment of sexual dysfunction is removed when such dosages are prescribed:

1) As rehabilitation treatment after prostate surgery in connection with prostate cancer, effective April 1, 2011; or
2) In connection with benign prostatic hyperplasia (BPH), effective December 1, 2011.

**IMPORTANT NOTICE #2:** Before filling a prescription for erectile dysfunction drugs that exceeds 6 dosages per calendar month you will need to contact LDI at 1-866-516-1121 for authorization.

## GRANDFATHERED STATUS

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
December, 2011

**PIPE FITTERS LOCAL NO. 533**
**HEALTH AND WELFARE FUND**

# BENEFIT ALERT #23

## GET THE MOST OUT OF YOUR PPO

Don't let this happen to you! Some participants have used surgery centers or other service providers recommended by their in-network doctor, only to learn after the fact that the surgery center or service provider was out-of-network. That cost the participants more money because the fees charged were not discounted like in-network fees plus the participants had to pay out-of-network deductibles and co-payments.

Here's another trap: You may have selected an in-network surgeon who is performing a surgery in an in-network hospital. That does NOT mean that the anesthesiologist will be in-network.

Your best bet is to check directly with Blue Cross and Blue Shield using the phone number listed on your ID card to determine whether the facility or service provider that your doctor is recommending is in-network by following these steps:

1. When you get a referral from your doctor, YOU should ensure that the referral doctor is in-network.
2. Certain procedures can be performed at facilities other than your doctor's office or a hospital. It is YOUR responsibility to ensure that the facility where the procedure is being performed is an in-network provider.
3. Please be aware that certain hospitals may use independent specialty contractor doctors rather than staff doctors. A hospital may be in-network; however certain providers in that hospital may not be in-network. For example, an anesthesiologist at a hospital may not be in-network although the hospital is in-network. In these instances you may get a separate bill from the independent contractor provider who will not necessarily be in-network.

**IMPORTANT NOTICE:** To keep your costs as low as possible, YOU need to ask for in-network service providers at every level of service. It is up to you to look out for your own interests. Do not assume that your in-network doctor will be doing this for you. You can ask the doctor, but he or she may not know, or may be misinformed. **Your PPO is where you need to go to get the correct answer.**

You should remember that the Fund's money is your money. By saving the Plan money, we are able to provide better benefits, and it helps to lessen the need to add a higher contribution rate, which may ultimately decrease your paycheck. There are certain things that you can do to help, such as using in-network service providers, and using the mail-order prescription drug service or generic prescription drugs whenever possible. **If you feel you are overcharged by a provider, please call the provider and ask for an itemized bill of your expenses.** Being aware of your benefits under this Plan will help you make good choices when making your healthcare decisions.

## GRANDFATHERED STATUS

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
March, 2012

# PIPE FITTERS LOCAL NO. 533
# HEALTH AND WELFARE FUND

# BENEFIT ALERT #24

The purpose of this notice is to remind you of some important Plan benefits and notify you of a change the Plan's Board of Trustees.

**Reminder #1 – Routine Care Benefit**

The Plan will cover 100% of the cost up to $300 per person per calendar year for the following Routine Care Benefits:

- Thyroid Stimulating Hormone (TSH) Test
- Pap smear
- Mammogram
- Prostate Specific Antigen (PSA) Test

In addition, eligible charges in excess of $300 will be covered subject to the Plan's standard deductible and coinsurance levels applicable to in-network and out-of-network Comprehensive Medical Benefits. Routine Care Benefits are available to Employees, Retirees, Dependent spouse's of Employees, and Dependent spouse's of Retirees.

**Reminder #2 – Concentra Wellness Benefit**

If you are an Eligible Employee or Retiree, then we will pay **100%** of the cost for you and your spouse to get a comprehensive Wellness Physical Exam from Concentra only. We have contracted with Concentra to perform this service. The following schedule applies to this benefit:

Co-Payment *(We pay)*..... 100%
Co-Payment *(You pay)*..... 0%

Frequency of Exam:

Eligible Employee or Retiree and Spouse ages 18 to 30.....1 exam every 5 years
Eligible Employee or Retiree and Spouse ages 31 to 35.....1 exam every 3 years
Eligible Employee or Retiree and Spouse ages 36 to 40.....1 exam every 2 years
Eligible Employee or Retiree and Spouse age 41 and over..... 1 exam per year

**Reminder #3 – Non-Covered Prescription Drug Discount**

Although certain prescription drugs may not be covered by the Plan (for example, proton pump inhibitors and non-sedating antihistamines), Plan Participants are still eligible for discounted pricing of non-covered prescription drugs when they are purchased directly through the LDI mail-order pharmacy. To purchase prescription drugs through the LDI mail-order pharmacy, you must submit a complete claim form to LDI, along with your original prescription and the appropriate payment for the prescription. Claim forms are available on the LDI website at www.LDIRx.com, or you may contact LDI at (314) 652-1121 or 1-866-516-1121. Once the discount has been applied, you are responsible for 100% of the cost of any non-covered prescription drug.

**Updated List of the Board of Trustees**

The current Trustees for the Plan are:

Union Trustees:

Robert A. Welch, Trustee
Pipe Fitters Local Union No. 533
8600 Hillcrest Rd.
Kansas City, MO 64138

Ronald Talley, Trustee
Pipe Fitters Local Union No. 533
8600 Hillcrest Rd.
Kansas City, MO 64138

Chris Parrino, Trustee
1320 NW 3rd St.
Blue Springs, MO 64104

Employer Trustees:

Michael Gossman, Trustee
P1 Group, Inc.
2151 Haskell Ave., Bldg #1
Lawrence, KS 66046

Michael Palmer, Trustee
18070 S. Bond Avenue
Bucyrus, KS 66103

William Alexander, Trustee
Alexander Mechanical Contractors
4251 North Kentucky Ave
Kansas City, MO 64161

**GRANDFATHERED STATUS**

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313.

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. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
January, 2013

**PIPE FITTERS LOCAL NO. 533**
**HEALTH AND WELFARE FUND**

# BENEFIT ALERT #25

The purpose of this notice is to remind you that the Pipefitters Local No. 533 Health and Welfare Plan's ("Plan") Retiree self-payment rates are subject to change each June 1 based upon the formula adopted by the Plan's Board of Trustees in 2008.

For Participants who retire on or after June 1, 2008, Retiree self-payments are based upon a "Base Rate" established as of June 1 each year. This "Base Rate" is then reduced by a variable level of Plan subsidy based upon the Participant's years of service and age at retirement. Once you retire, the Plan subsidy percentage does not change until you and/or your spouse (if married) become Medicare-eligible. Please note, Retirees who retired prior to June 1, 2008 are not subject to this formula

If you are a Participant who retired on or after June 1, 2008, your Retiree self-payment rate is calculated as follows:

**The Base Rate Equals:** 140 x the Contribution Rate as of June 1, adjusted -33% for Retiree single coverage and +33% for Retiree plus Spouse/Family coverage (i.e. coverage for a Retiree and at least one Dependent).

**The Plan Subsidy Equals:** The "Base Rate" is reduced by a Plan subsidy based upon the Retiree's age at retirement and years of service. The Plan subsidy amount is calculated as follows:

- **If you are 55 or 56 years old when you retire:** Your Plan subsidy will equal 1.33% per Year of Service, up to 30 years, and an additional subsidy of 0.25% for each Year of Service over 30 up to 35. The Plan subsidy requires a minimum of 15 years of service. Your Plan subsidy will not change until you and/or your spouse (if married) become eligible for Medicare.

- **If you are 57, 58 or 59 years old when you retire:** Your Plan subsidy will equal 1.66% per Year of Service, up to 30 years, and an additional subsidy of 0.25% for each Year of Service over 30 up to 35. The Plan subsidy requires a minimum of 15 years of service. Your Plan subsidy will not change until you and/or your spouse (if married) become eligible for Medicare.

- **If you are at least 60 years old when you retire or if you are retired due to Disability:** Your Plan subsidy will equal 2.00% per Year of Service, up to 30 years, and an additional subsidy of 0.25% for each Year of

Service over 30 up to 35. The Plan subsidy requires a minimum of 10 years of service. Your Plan subsidy will not change until you and/or your spouse (if married) become eligible for Medicare.

**Additional Self-Pay Discount once you are eligible for Medicare:** You will receive an additional 33% discount if you and all of your Dependents are Medicare eligible. If you or your spouse is Medicare eligible (i.e. only one of you is Medicare eligible), you will receive an additional 16.5% (rather than 33%) discount.

Please note that the Plan's premiums are not considered vested benefits. This means that the Board of Trustees has the authority to decrease the Plan subsidy and/or change the Retiree self-payment calculation as it may deem appropriate in its sole and exclusive discretion.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
March, 2013

## GRANDFATHERED STATUS

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

**PIPE FITTERS LOCAL NO. 533**
**HEALTH AND WELFARE FUND**

# BENEFIT ALERT #26

The Board of Trustees would like to remind you of the Pipefitters Local No. 533 Health and Welfare Plan's ("Plan") provisions regarding coordination of benefits with Medicare. It is extremely important that you read and understand all of the information in this Benefit Alert. The failure to understand the information in this Benefit Alert could create a serious financial hardship for you.

**General Information regarding the Plan's Coordination of Benefits:**

The Plan's coordination of benefit rules limit the duplication of benefits when a Covered Person has coverage under more than one health plan. Because Medicare is considered another health plan, these coordination of benefits rules apply when you become eligible for Medicare.

To understand the Plan's coordination of benefits rules, there are two definitions you need to know about. You need to know (1) the definition of "Primary Plan"; and (2) the definition of "Secondary Plan."

The plan that pays benefits first is called the "Primary Plan." The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses.

The "Secondary Plan" may reduce the benefits it pays so that no more than 100% of the allowable expense is paid through the combined coverage of the plans.

The rules that determine when the Plan is primary and when Medicare is primary are explained below.

**Coordination with Medicare:**

**Important Notice #1:** If Medicare would be the Primary Plan for you or your Dependents, but you (or your Dependents) have not enrolled in Medicare Parts A and B, the Plan will reduce the benefits it pays by the amount that would have been paid by Medicare Parts A and B. Failure to enroll in Medicare Part B could create a serious financial hardship for you.

The following chart summarizes when Medicare will be the Primary Plan for you and your Dependents. You should look at the categories on the left-column of the chart and see which one describes you and/or your Dependent(s). Some of these descriptions contain an * at the end of the description. **If you fit into a category with an *, it means you should be enrolled in Medicare Parts A and B. If you are in a category with an * and you are not enrolled in Medicare Parts A and B, the Plan will reduce the amount of benefits it pays by the amount that would have been paid by Medicare Parts A and B.** In other words, if you are in a category with an *, the Plan will only pay 20% of the cost of services normally covered by Medicare Part B and only the Medicare inpatient hospital deductible amount if you are hospitalized, and you will be responsible for any remaining charges.

This chart is solely for the purpose of providing a summary of the rules regarding the Plan's coordination of benefits with Medicare. The chart is not intended to (and should not be used to) inform you of the rules regarding when and if you are eligible for Medicare. For a more detailed description regarding the Plan's coordination of benefits with Medicare you should contact the Fund Office. For information regarding whether you are eligible for Medicare, contact the Center for Medicare and Medicaid Services at 1-800-MEDICARE or www.MyMedicare.gov.

| If you are… | Your Primary Plan will be… | Your Secondary Plan will be… |
|---|---|---|
| An Eligible Employee and you are eligible for Medicare based on disability or age | This Plan | Medicare |
| A Dependent of an Eligible Employee and you are eligible for Medicare based on disability or age | This Plan | Medicare |
| A new Retiree, you are not yet making Retiree self-payments (i.e. you are still covered by the Plan because of your hours worked during a Qualified Period), and you are eligible for Medicare based on disability or age | This Plan | Medicare |
| A Dependent of a new Retiree who is not yet making Retiree self-payments (i.e. the Retiree is still covered by the Plan because of hours worked during a Qualified Period) and you are eligible for Medicare based on disability or age | This Plan | Medicare |
| A Retiree, you make Retiree self-payments, and you are eligible for Medicare based on disability or age ***** | Medicare | This Plan |
| A Dependent of a Retiree who makes Retiree self-payments and you are eligible for Medicare based on disability or age***** | Medicare | This Plan |
| A qualified beneficiary (i.e. you are covered by COBRA) and you are eligible for Medicare based on disability or age***** | Medicare | This Plan |
| A Covered Person, you are eligible for Medicare based on End Stage Renal Disease, and you have been eligible for Medicare for less than 31 months | This Plan | Medicare |
| A Covered Person, you are eligible for Medicare based on End Stage Renal Disease, and you have been eligible for Medicare for more than 30 months***** | Medicare | This Plan |

The Plan does not coordinate with Medicare Part D, and the rules in this Benefit Alert do not apply to Medicare Part D. You should only enroll in Medicare Part D if you want to have your prescription drug coverage provided through Medicare and not through this Plan. If you enroll in Medicare Part D, you will no longer be eligible for prescription drug benefits from the Plan.

**Important Notice #2:** Once you enroll in Medicare, it is important that the Fund Office and your providers (for example, your doctor and hospital) know that you have Medicare Coverage. This means that as soon as you become eligible for Medicare you must provide the Fund Office with a copy of your Medicare card. This also means that each time you go to the doctor or hospital you need to show them both your Medicare card and your Pipefitters Local No. 533 Health and Welfare Plan card.

Please know that the reason your Plan coverage changes when Medicare becomes your Primary Plan is because it allows the Plan to save money without reducing your health coverage (so long as you enroll in Medicare). This is because if Medicare is your Primary Plan and you enroll in Medicare Parts A and B, the government will pay expenses that the Plan would pay in the absence of these rules. Additionally, the combination of coverage you will receive by Medicare and this Plan will provide you greater overall coverage than you had prior to the time you became eligible for Medicare.

Remember the Plan's money is your money. By saving the Plan money, we are able to provide better the best benefits possible. Plus, it helps lessen the need for higher Retiree premiums or higher contribution rates.

If you have any questions, please contact the Fund Office at (816) 361-0206.

Sincerely,

Board of Trustees
March 2013

## GRANDFATHERED STATUS

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

# PIPE FITTERS LOCAL NO. 533
# HEALTH AND WELFARE FUND

# BENEFIT ALERT #27

The Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Plan ("Plan") has adopted a couple of changes to the Plan's prescription drug benefits that will become effective on May 1, 2013. These changes were adopted to help each Covered Person receive the most appropriate treatment for his or her condition; to reduce the possibility that a Covered Person will experience adverse side effects and complications that are often associated with certain prescription drugs; and to manage the Plan's prescription drug benefits.

The prescription drug benefit changes are directed at a category of drugs referred to as "specialty drugs". The purpose of this notice is to provide you general information regarding specialty drugs, to inform you of the Plan's changes to the prescription drug benefits, and to remind you of some important Plan rules and programs for specialty drugs.

**General Information Regarding Specialty Drugs:**

Specialty Drugs are oral and injectable prescription drugs that treat chronic, complex conditions (for example, hepatitis C, multiple sclerosis, and rheumatoid arthritis) and have the following characteristics:

- They are typically (but not always) injectable drugs administered by a healthcare professional and are often not carried in stock at retail pharmacies;
- They have a high risk of adverse side effects and complications, especially when the physician's prescribed course of care is not followed;
- They need frequent dosage adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; and
- They are more expensive than non-specialty prescription drugs. The average 30-day supply of a specialty drug costs the Plan over $3,000.

Examples of Specialty Drugs include Humira, Enbrel, Neulasta, and Epogen. For a complete list of what the Plan is considering Specialty Drugs, please contact LDI at (866) 516-4121 or visit www.LDIRx.com.

**Changes in the Plan's Prescription Drug Benefits Effective May 1, 2013:**

The following changes will go into effect on May 1, 2013:

- The Plan has added an exclusion to the list found on pages 32 and 33 of your Summary Plan Description. **The new exclusion provides that no benefits are payable under the Prescription Drug Program for Specialty Drugs unless the Specialty Drug is Medically Necessary.**

A Specialty Drug is considered Medically Necessary if:

- It is required to treat an injury or Sickness and the absence of the drug could cause adverse consequences for the person in need of the prescription drug;
- It is appropriate and necessary for the treatment of the injury or Sickness;
- It is in accordance with standards of good medical practice within the organized medical community; and
- It is the most appropriate level of treatment that can be provided safely for the patient.

The following are examples of when a Specialty Drug will not be considered Medically Necessary:

- The Specialty Drug may be prescribed in too large a quantity. For example, the FDA recommends that one dose of the Specialty Drug, "Humira", be taken every two weeks for Plaque Psoriasis. If you have Plaque Psoriasis and your doctor prescribes you one dose of Humira every week (rather than every two weeks), the prescription for weekly use of Humira will not be considered Medically Necessary. If this occurs, you can ask your doctor to either change the dose to one dose every other week or send supporting documentation to LDI which explains why one dose every week is Medically Necessary.

- There may be a different, non-Specialty Drug that would likely provide the same or better results as the Specialty Drug. For example, both a common drug "Methotrexate" and a Specialty Drug "Enbrel" treat Rheumatoid Arthritis. Enbrel has a higher risk of adverse side effects and complications and is more expensive than Methotrexate. For these reasons, it is typically recommended that you try Methotrexate before you take Enbrel. If you have Rheumatoid Arthritis and your doctor prescribes you Enbrel before you have tried Methotrexate, the Enbrel will not be considered Medically Necessary. In this instance, if you try Methotrexate and it does not successfully treat your Rheumatoid Arthritis, your doctor should write you a new prescription for Enbrel and contact LDI to request a new determination of whether Enbrel is now considered Medically Necessary.

- The Specialty Drug may be prescribed for an off-label use. For example, the Specialty Drug "Prolia" is FDA-approved for the treatment of postmenopausal osteoporosis in women. If you are a 30-year old female with osteoporosis, you are not postmenopausal, and your doctor prescribes you Prolia, it will not be considered Medically Necessary.

- The Specialty Drug may not be approved by the FDA for the condition which it is prescribed to treat. For example, the Specialty Drug "Sandostatin" is FDA-approved to treat a hormonal disorder called Acromegaly. Sandostatin is not FDA-approved to treat hypoglycemia. If you have hypoglycemia and your doctor prescribes you Sandostatin to treat your hypoglycemia, the Sandostatin will not be considered Medically Necessary.

**<u>Important Notice #1:</u>** You are encouraged to talk to your doctor about this rule and make sure that (s)he is prescribing the most appropriate drug for your condition.

- **The Plan will require prior-authorization for all newly-prescribed Specialty Drugs on and after May 1, 2013.** The purpose of this required prior-authorization is to assure the prescription drug is Medically Necessary. This process typically should take only a couple of days.

  To request prior-authorization, you or your doctor should contact LDI at 1-866-516-3121. Your local pharmacy also may initiate the prior-authorization process by calling LDI. However, the quickest way to start the Specialty Drug prior authorization review process is to have your doctor contact LDI directly before you head to the pharmacy. The more active you are at getting the process underway with your doctor, the quicker the process will move along.

  Generally, the request for prior-authorization is considered a Pre-Service Claim. If you disagree with the decision made on your request for prior-authorization, you may appeal it to the Board of Trustees. See the enclosed Prescription Drug Benefits Pre-Service Claims and Appeals Procedures for the Pipefitters Local No. 533 Health and Welfare Plan for additional information regarding Pre-Service Claims and appeals.

**<u>Important Notice #2</u>**: **These rules do <u>not</u> apply to the following:**

- Specialty Drugs that a Covered Person is already taking as of May 1, 2013. A Specialty Drug is considered a drug that you are already taking if you have filled a prescription for that drug within the past 120 days. This means that if you have filled a prescription for a Specialty Drug within the 120 days prior to May 1, 2013, these rules do not apply to re-fills of that Specialty Drug.

- Urgent Care Claims. An Urgent Care Claim is a pre-service claim with respect to which the application of the time period for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the Specialty Drug. For example the Specialty Drug "Enoxaparin" is used to prevent blood clots after surgery, and it must be available to a patient before (s)he can be discharged from the hospital. If you have surgery and are prescribed Enoxaparin, the Plan will cover 7 doses of Enoxaparin regardless of whether it is considered Medically Necessary. This means you will not need prior-authorization for the 7 doses of Enoxaparin. If your prescription is for more than 7 doses, the additional doses are subject to the Medical Necessity and prior-authorization requirements. In other words, the 7 doses of Enoxaparin immediately after surgery are considered Urgent Care Claims. Because those 7 doses will get you through the urgency, any additional doses are not considered Urgent Care Claims.

**Important Plan Rules and Programs for Specialty Drugs:**

- Specialty Drugs are limited to a 30-day supply.

- If you are taking a Specialty Drug, you may enroll in LDI's Specialty Pharmacy Program. To enroll in the Specialty Pharmacy Program, contact LDI at 1-866-516-3121.

  If you chose to enroll in the Specialty Pharmacy Program, you can take advantage of the following:

  **Excellent Service and Education**. This voluntary Program provides:

  - Personal attention from a team of pharmacists, nurses, and certified pharmacy technicians. You will be assigned a clinic coordinator who will provide you education that is specific to your condition, instructions on how to take your medication properly, and answers to any of your questions or concerns;
  - Easy access to pharmacists and other health experts; and
  - Informative condition-specific materials and training.

  **Enhanced Convenience**: This voluntary Program provides:

  - A single, reliable, source for your specialty medication needs;
  - Easy ordering;
  - Convenient delivery to the location of your choice (such as your home or your physician's office); and
  - Helpful follow-up calls to remind you when it is time to refill your prescription. During these calls, your clinical coordinator will ask if you have had any changes to your medication therapy or experienced any side effects.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
April, 2013

## GRANDFATHERED STATUS

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

# PIPE FITTERS LOCAL NO. 533
# HEALTH AND WELFARE FUND

# BENEFIT ALERT #28

The Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Plan ("Plan") has amended the Plan as follows:

- Effective March 1, 2013, if you have designated your spouse as your beneficiary, the beneficiary designation will automatically become null and void upon divorce.
- Effective June 7, 2013, if you are an active Participant Employee, you may waive your Dependent's coverage from the Plan.

The purpose of this notice is to explain these changes and notify you of a change in the Plan's Board of Trustees.

**Automatic Revocation of Beneficiary Designation upon Divorce**

Effective March 1, 2013, the Plan has been amended to automatically cancel the designation of your spouse as the beneficiary of your Death Benefits and your Accidental Death and Dismemberment Benefits in the event you are divorced. The cancellation is effective as of the date of your divorce. If you get divorced and you want your ex-spouse to remain your beneficiary, you must file a new Beneficiary Designation Form with the Fund Office after your divorce. If you designate your spouse and another individual as your beneficiaries, only the portion of the beneficiary designation that relates to your spouse will automatically become null and void upon divorce. Beneficiary Designation Forms are available at the Fund Office.

**Waiver of Coverage for Dependents of Active Employees**

Effective June 7, 2013, the Plan has been amended to allow an active Participant Employee to waive his or her Dependent(s) coverage from this Plan.

If you waive coverage for a Dependent, and subsequently you would like to reinstate coverage for that Dependent, you must submit a new enrollment form to the Fund Office. Your Dependent will again become eligible for coverage for claims incurred the first day of the month after the new enrollment form is postmarked or otherwise positively received by the Fund Office. **Claims for your Dependent will not be paid if a new enrollment form is not on file with the Fund Office.**

The following chart summarizes the documents that you must submit to the Fund Office to waive coverage for a Dependent. The waiver of coverage will be effective the first day of the month after all of the required documents are received by the Fund Office.

| If your Dependent is… | You must submit… |
|---|---|
| Your Spouse | A Waiver of Health Care Coverage signed by you **and** a Waiver of Health Care Coverage signed by your spouse. |
| Your Dependent Child who is at Least 18 Years Old | A Waiver of Health Care Coverage signed by you **and** a Waiver of Health Care Coverage signed by your Dependent child. |
| Your Dependent Child who is Under Age 18 | A Waiver of Health Care Coverage signed by you **and** a Waiver of Health Care Coverage signed by your Dependent child's other parent. |

Waivers of Health Care Coverage are available at the Fund Office.

**Updated List of the Plan's Board of Trustees**

The current Trustees for the Plan are:

Union Trustees:

Chris Parrino, Trustee
1320 NW 3rd St.
Blue Springs, MO 64104

Ronald Talley, Trustee
Pipe Fitters Local Union No. 533
8600 Hillcrest Rd.
Kansas City, MO 64138

Luke Moylan, Trustee
PO Box 107
Fontana, KS 66026

Employer Trustees:

Michael Gossman, Trustee
P1 Group, Inc.
2151 Haskell Ave., Bldg #1
Lawrence, KS 66046

Michael Palmer, Trustee
18070 S. Bond Avenue
Bucyrus, KS 66103

William Alexander, Trustee
Alexander Mechanical Contractors
10301 N. Dalton Ave.
Kansas City, MO 64154

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
July 2013

## GRANDFATHERED STATUS

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

# PIPE FITTERS LOCAL NO. 533
# HEALTH AND WELFARE FUND

# BENEFIT ALERT #29

Effective October 1, 2013, the Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Plan ("Plan") has amended the Plan to add a self-payment option for Eligible Employees who do not have enough hours to maintain coverage under the Plan. This new self-payment option replaces the Plan's out-of-work coverage.

The purpose of this notice is to explain this new self-payment option.

## Self-Payment Option

Prior to October 1, 2013, if you did not work enough hours to maintain your coverage as an Eligible Employee, the only way you could continue to receive coverage from the Plan was if you were eligible for out-of-work coverage. You were only eligible for out-of-work coverage if you remained ready, willing, and available for work, remained on the "out-of-work list" and paid an "out-of-work" premium for each month of coverage. If you were not eligible for out-of-work coverage, and you were not eligible for Retiree coverage, the only way you could remain covered by the Plan was if you elected COBRA continuation coverage.

Effective October 1, 2013, the Plan has replaced out-of-work coverage with a new self-payment option. Under the new self-payment option, if you do not work enough hours to maintain your coverage as an Eligible Employee, you can continue to receive coverage from the Plan for up to 18 consecutive months if you pay a premium for each month of coverage. You are eligible for this coverage regardless of whether or not you are on the "out-of-work list". The rules regarding eligibility for coverage under the new self-payment option are explained in greater detail below in the Sections titled, "Eligibility to Make Self-Payments Effective October 1, 2013", "Self-Payment Premium Amount and Due Date" and "Termination of Eligibility and Coverage from the Plan".

If you are currently covered by the Plan through out-of-work coverage, the rules regarding how this impacts your coverage are explained in greater detail below in the Section titled, "Participant's Currently Receiving Out-of-Work Coverage".

## Eligibility to Make Self-Payments Effective October 1, 2013

If you do not work sufficient hours to maintain your coverage as an Eligible Employee, you can continue to receive coverage from the Plan for up to 18 consecutive months if you pay a premium for each month of coverage and meet all of the following requirements:

- You must be covered by the Plan the month immediately preceding the date that you begin receiving coverage through making self-payments (i.e. you cannot have a lapse in coverage);
- You cannot be working in the plumbing and pipefitting industry in the Kansas City metropolitan area (the area covered by your Collective Bargaining Agreement) for an employer who does not contribute to the Plan;

- You must self-pay the premium in accordance with the Section below titled, "Self-Payment Premium Amount and Due Date"; and
- You cannot be receiving benefits from the Pipe Fitters Local No. 533 Pension Plan or the Plumbers & Pipefitters National Pension Fund.

## Self-Payment Premium Amount and Due Date

The self-payment premium is the dollar amount required for you to receive a month of coverage from the Plan. The Board of Trustees has the authority to establish and change the self-payment premium as it may deem appropriate in its sole and exclusive discretion. The current self-payment premium is $100 a month for single coverage and $200 a month for family coverage (family coverage means coverage for an Eligible Employee and at least one Dependent).

The self-payment premium is due on the first day of the month for which you intend to receive coverage. Your coverage will terminate if the self-payment premium is not received by the Fund Office by the fifth business day of the month. Coverage may not be reinstated following termination of coverage for failure to make timely self-payments unless you work enough hours to regain coverage as an Eligible Employee (or elect COBRA continuation coverage).

## Coverage for Your Dependents While You Are Making Self-Payments

If you are covered by the Plan through making self-payments, you may also elect coverage for your Dependent(s). You may not elect coverage for your Dependent(s) if you are not making self-payments for yourself.

If you decide to make self-payments to remain covered by the Plan as an Eligible Employee, and you do not elect coverage for your Dependent(s), you may not subsequently obtain coverage for any Dependent(s) who could have been enrolled at the time you began making self-payments. This means that if you elect to continue coverage under the Plan by making self-payments, you must also make an affirmative election at that time to cover your Dependent(s).

If you begin making self-payments, and subsequently a person becomes your Dependent through marriage, birth, adoption, placement for adoption or a court order, that Dependent will be entitled to a 30 day special enrollment period beginning on the date of the marriage, birth, adoption, placement for adoption or date a court order is entered. This means that if the Dependent's enrollment form is postmarked or otherwise positively received by the Fund Office within 30 days of the marriage, birth, adoption, placement for adoption, or date a court order is entered, the Dependent will be covered effective 12:01 a.m. on the date of such event. If the Dependent's enrollment form is not postmarked or otherwise positively received by the Fund Office within 30 days of the marriage, birth, adoption, placement for adoption, or the date a court order is entered, you may not subsequently obtain coverage for the Dependent.

## Termination of Eligibility and Coverage from the Plan

If you are covered by the Plan through making self-payments, your eligibility and coverage from the Plan will terminate as of 12:01 a.m. on the earliest of the following dates:

- The first day of the calendar month that you do not self-pay the premium in accordance with the Section above titled, "Self-Payment Premium Amount and Due Date";
- The first day of the calendar month following the 18th consecutive month that you have received coverage from the Plan by making self-payments;
- The effective date of your Retiree coverage under the Plan;
- The first day of the calendar month that you begin receiving benefits from the Pipe Fitters Local 533 Pension Plan or the Plumbers & Pipefitters National Pension Fund; or
- The first day that you perform work in the plumbing and pipefitting industry in the Kansas City metropolitan area (the area covered by your Collective Bargaining Agreement) for an employer who does not contribute to the Plan.

If your eligibility and coverage are terminated, you may only regain coverage from the Plan if you work enough hours to regain coverage as an Eligible Employee or elect COBRA continuation coverage.

## Participant's Currently Receiving Out-of-Work Coverage

If you are receiving out-of-work coverage on October 1, 2013, you may remain covered by the Plan if you meet all of the requirements in the Section above titled, "Eligibility to Make Self-Payments Effective October 1, 2013". However, the number of months that you have received out-of-work coverage will count towards the 18 consecutive months that you are allowed to continue coverage through making self-payments.

The following examples show how this works:

Example 1:
Joe Pipefitter began receiving out-of-work coverage from the Plan on October 1, 2012. If Joe meets the eligibility requirements to receive coverage through making self-payments, Joe can remain covered by the Plan until March 31, 2014. Beginning April 1, 2014, Joe is no longer eligible to make self-payments to the Plan.

Example 2:
Joe Pipefitter began receiving out-of-work coverage from the Plan on January 1, 2012. Effective October 1, 2013, Joe is no longer eligible to make self-payments to the Plan because he has already received coverage from the Plan through making premium payments for longer than 18 consecutive months. On October 1, 2013, Joe Pipefitter can elect to continue coverage under the Plan through COBRA.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
September 2013

## GRANDFATHERED STATUS

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

# PIPE FITTERS LOCAL NO. 533
# HEALTH AND WELFARE FUND

# BENEFIT ALERT #30

Effective July 1, 2014, the Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Plan ("Plan") will expand the Plan's wellness services to include the Blue Cross and Blue Shield of Kansas City Health Companion Program and a no-cost 24 hour nurse hotline service.

## BLUE KC HEALTHY COMPANION™ PROGRAM

The Trustees recognize having a chronic illness can be stressful and confusing. If you or any of your family members have one or more of the following listed chronic health conditions, not only must you manage your condition(s) medically, but also you still have to handle life's everyday activities. To help you cope with your condition(s) and feel your best, the Plan is making the Blue KC Healthy Companion™ program available so that you have access to free, easy-to-use educational materials, as well as online tools and resources via www.BlueKC.com.

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Disease
- Heart Failure
- High Blood Pressure
- Metabolic Syndrome
- Stress
- Anxiety

Although the Healthy Companion™ program is not meant to provide a cure or treatment for chronic illness, the free informational assistance can help you become familiar with your symptoms and learn ways to manage them better. If you have recently been diagnosed with one of the above conditions and would like to sign up for the Healthy Companion™ program and receive immediate support, call 816-395-2076 or 866-859-3813. You can also send an email to HealthyCompanion@BlueKC.com.

If, at some time, Blue Cross and Blue Shield of Kansas City identifies you as an individual that has been diagnosed with one of the above conditions, you will automatically be enrolled in the Healthy Companion™ program and an educational welcome packet will be sent to you. Your doctor may be informed of your participation in the program, and a nurse may contact you to answer any questions that you have and provide you with support and assistance. While Healthy Companion™ is offered to provide an additional layer of support and resources, you always have the option to opt out of the program if you decide it is not for you.

**BLUE KC 24-HOUR NURSE LINE: 877-852-5422**
Registered nurses are now available to answer your questions 24 hours a day, 7 days a week at no charge to you. You can call the Blue KC 24-hour nurse line, 877-852-5422, and speak to a Care Advisor if you need information on care options, treatment alternatives, home remedies, or even recommendations on where to seek care. It does not matter if you need advice regarding a simple medical matter or an urgent care concern, a Care Advisor will be available to help. Via the 24-hour nurse line, you can also access an audio health library, covering topics on adult, pediatric, and women's health issues. A Blue KC flyer is enclosed that provides more information about the 24-hour nurse hotline.

**SAVE THE DATE!** On **Saturday, October 11, 2014**, the Plan will host a wellness fair at the Pipe Fitters Local No. 533 Union Hall for all Participants and their spouses. Free flu shots, health screenings and prizes will be offered. We hope you can all make it! Look for more information about the wellness fair to come soon.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
May 2014

## GRANDFATHERED STATUS

This group health Plan believes this coverage 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 preventative 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.

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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. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

# Nurse Line Benefits

## Care Advisors are Here to Help You

Registered nurses are ready to take your call 24 hours a day… 365 days a year!

Call us 24 hours a day, 7 days a week, 365 days a year to help you with symptoms or answer a health-related question.

Just knowing these nurses are there to support you reduces stress and anxiety and gives you confidence in your health. No matter what the situation – from simple things like a twisted ankle, to an urgent care concern – the Blue Cross and Blue Shield of Kansas City (Blue KC) 24-Hour Nurse Line is there to help.

### How can we help?

Here are just a few of the many other ways our Care Advisors can help you:

- Gain convenient access to quality care
- Become better-informed about healthcare
- Gain confidence when speaking to providers during office visits
- Become educated on self-care for non-urgent injuries and illnesses
- Improve your knowledge of drugs and medications
- Live better with healthy lifestyle tips

Plus, you'll also have 24-hour access to an Audio Health Library that contains more than 1,500 topics in English and Spanish, as well as current community health concerns and announcements. The health topics include: adult, pediatric, and women's health.

### Clinical experience

Blue KC 24-hour nurse line nurses have an average of 18 years of clinical experience. They use the latest advancements in technology to assist you in making the right choices involving health issues or concerns. Most importantly, they're available to you 24 hours a day, 7 days a week, 365 days a year.

**So call us. You'll be glad you did.**

**877-852-5422**

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

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# Healthy Companion™

BlueKC.com

## Reduce Risk Factors and Improve Your Health

### Program Components

**SUPPORT** to help you understand your disease and treatment

**EDUCATION** and **COACHING** to empower you to make lifestyle choices that can improve your overall health

**POSITIVE DIALOGUE** between you and your doctor

The Healthy Companion program at Blue Cross and Blue Shield of Kansas City (Blue KC) provides a wide array of timely information, education and one-on-one support for members with the following conditions:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Disease
- Heart Failure
- High Blood Pressure
- Metabolic Syndrome
- Stress and Anxiety (Live Well)

### Live healthy and stay healthy with Healthy Companion.

- **Healthy Companion Newsletters** - Timely articles to keep you informed.
- **Educational Resources** - A variety of reliable resources and friendly reminders about medical care and tests to help you stay healthy.
- **Clinical Support** - The level of clinical support you receive is based on your needs. Our nurses may contact you from time to time to assist with your care plan, answer questions, and provide support and encouragement.
- **Online Tools and Resources** - Our website, BlueKC.com, includes many tips and resources to help you live a healthy lifestyle.

Kansas City | healthy companion

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# Healthy Companion, continued

Healthy Companion is a comprehensive program to help our members live healthier lives.

## Blue KC believes in the value of strong relationships between patients and physicians.

Our program was designed to give you the tools and information you need to work with healthcare providers to create a care plan that is right for you. Healthy Companion updates are delivered to physicians on a routine basis. In addition, your doctor may be notified of your program participation, and when appropriate, Healthy Companion will work with healthcare providers to ensure you are receiving the best care.

## Who can participate in Healthy Companion?

Members who have been identified with any of these conditions are automatically enrolled and will receive an educational welcome packet.

If you have recently been diagnosed, and would like to sign up for immediate support, contact Healthy Companion.

### WE WELCOME YOUR CALLS.

For more information or to schedule a call with a nurse, please call 816-395-2076 or toll free 1-866-859-3813, or send an email to HealthyCompanion@BlueKC.com.

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

healthy companion

BlueKC.com

001019-2.3

# PIPE FITTERS LOCAL NO. 533
# HEALTH AND WELFARE FUND

# BENEFIT ALERT #31

The Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Fund (the "Plan") has amended the Plan as follows:

- Effective June 1, 2014, there is no longer a $2,000,000 annual limit on the amount of benefits that the Plan will pay on behalf of a Covered Person during a calendar year.
- Effective June 1, 2014, a Dependent child is eligible for coverage from the Plan even if (s)he has other health care coverage available from his or her employer (or, his or her spouse's employer if (s)he is married).
- Effective June 25, 2013, the Human Papillomavirus ("HPV") test is included in the list of Routine Care Benefits that are covered by the Plan.
- Effective June 1, 2014, Wellness Benefits received by a provider other than Concentra are included in the list of Routine Care Benefits that are covered by the Plan.

The purpose of this notice is to explain these changes and notify you that one of Concentra's facilities closed on July 1, 2014.

## Annual Limit

Effective June 1, 2014, the Plan's $2,000,000 calendar year limit has been removed.

## Expanded Definition of Dependent

Effective June 1, 2014, a Dependent child under the age of 26 is eligible for coverage from the Plan even if the Dependent child has other health care coverage available from his or her employer (or, his or her spouse's employer if married). **Please remember that if you have a new Dependent child, you must enroll that child in the Plan in accordance with the following rules:**

- **Rules for an active Participant Employee**: If you have a new Dependent child as a result of birth, adoption, placement for adoption, or a court order (including a Qualified Medical Child Support Order), your Dependent child will become covered by the Plan at 12:01 a.m. on the date of the birth, adoption, placement for adoption, or effective date of the court order as long as your Dependent child's complete enrollment application is postmarked or otherwise positively received by the Fund Office within 90 days of such event. If your Dependent child's complete enrollment application is not postmarked or otherwise positively received by the Fund Office within 90 days of such event, your Dependent child will become eligible for coverage for claims incurred the first day of the month after his or her complete enrollment application is postmarked or otherwise positively received by the Fund Office. **Claims for a Dependent child will not be paid if a complete enrollment application for that child is not on file with the Fund Office. An enrollment application is not considered complete unless it includes an enrollment**

**form and copies of all supporting documentation (e.g. a birth certificate).**

- **Rules for a Retiree**: If you have a new Dependent child as a result of birth, adoption, placement for adoption, or a court order (including a Qualified Medical Child Support Order), your Dependent child will become covered by the Plan at 12:01 a.m. on the date of the birth, adoption, placement for adoption, or effective date of the court order as long as your Dependent child's complete enrollment application is postmarked or otherwise positively received by the Fund Office within 30 days of such event. **If your Dependent child's complete enrollment application is not postmarked or otherwise positively received by the Fund Office within 30 days of such event, you may not subsequently obtain coverage for your Dependent child.**

## Concentra Wellness Benefit

The Plan was informed that on July 1, 2014, Concentra closed its Kansas City wellness division located at 14831 W 95th ST, Lenexa, KS 66215. The Plan's Wellness Benefits are still available from several Concentra locations, including Concentra's Lenexa Kansas medical center located at 14809 W 95th ST, Lenexa, KS, 66215. The Concentra Wellness Benefits covered by the Plan are detailed on the following page of this notice.

In addition to the Wellness Benefits available at Concentra, the Plan's Routine Care Benefits were expanded to cover these same Wellness Benefits when they are performed by any provider. These expanded benefits became effective on June 1, 2014 and are explained in the Section below titled, "Routine Care Benefit".

## Routine Care Benefit

Effective June 1, 2014, the Plan will cover 100% of the cost up to $300 per person per calendar year for the following Routine Care Benefits:

- Thyroid Stimulating Hormone (TSH) Test
- Pap smear
- Mammogram
- Prostate Specific Antigen (PSA) Test
- Human Papillomavirus Test
- Wellness Benefits received by a provider other than Concentra ***NEW!***

In addition, eligible charges in excess of $300 will be covered subject to the Plan's standard deductible and coinsurance levels applicable to in-network and out-of-network Comprehensive Medical Benefits. Routine Care Benefits are available to Employees, Retirees, Dependent spouse's of Employees, and Dependent spouse's of Retirees.

## Wellness Benefits

Effective June 1, 2014, the Plan's Wellness Benefits available under the Concentra Wellness Benefit and the Routine Care Benefit will include the following:

- Physical Exam:
  - Urinalysis
  - Blood Pressure
  - Height/Weight/Body Mass Index
  - Range of Motion
  - Education Session
- Snellen Vision Test and Near Vision Test
- Audiogram
- Body Fat Percentage
- Complete Blood Count
- Chem 23 Lab Test

Please note that if a routine physical and/or screening exam is not listed above, it is not covered under the Concentra Wellness Benefit or the Routine Care Benefit. In other words, if you have a routine physical or screening exam that is not specifically listed in this notice, it is not covered by the Plan. If you have questions about whether a specific test or service is covered, please contact the Fund Office.

**SAVE THE DATE!** On **Saturday, October 11, 2014**, the Plan will host a wellness fair at the Pipe Fitters Local No. 533 Union Hall for all Participants and their families. Free flu shots, health screenings and prizes will be offered. We hope you can all make it! Look for more information about the wellness fair to come soon.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
August 2014

## GRANDFATHERED STATUS

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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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313. 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. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

**PIPE FITTERS LOCAL NO. 533**
**HEALTH AND WELFARE FUND**

# BENEFIT ALERT #32 – 2014 HEALTH FAIR!

The Pipefitters Local No. 533 Health and Welfare Fund ("Plan") values the health and well-being of its participants and has partnered with HealthyFit to provide covered participants, spouses, and adult children with a free and confidential health risk assessment which includes an on-site health screening and other services available to all Covered Persons.

**Health Fair Schedule:**

| | |
|---|---|
| Date/Time: | **Saturday, October 11th 7:00 AM - 3:00 PM** |
| Address: | 8600 Hillcrest Road, Kansas City, MO 64138 |
| Location: | The Pipefitters Local No. 533 Union Hall |

**Bring the kids!**
Balloon Animals & Bounce House from 11 AM to 2 PM!

**Who will be at the Health Fair?**

All of the Plan's key service providers will be there to help you learn more about your health care benefits, including:

- **HealthyFit –** offering free health screenings and health risk assessments
  - Screenings available to all covered participants, spouses, and children age 18-25
  - **Free flu shots** – available to all covered participants and children age 6 months+
- **Blue Cross Blue Shield of Kansas City** – the Plan's PPO network;
- **LDI** – the Plan's prescription benefit manager;
- **Delta Dental** – the Plan's dental benefit network;
- **St. Luke's Lifewise EAP** – the Plan's Employee Assistance Program manager; and
- **New Directions** – the Plan's behavioral health support manager.

Representatives from the YMCA, Weight Watchers and community blood bank will also be in attendance. For the kids, a balloon artist and bounce house will be there from 11am to 2pm!

**Participation Incentives and Raffle Prizes!**

**FREE MONEY!** The Pipefitters Local Union No. 533 is sponsoring great prizes, including a **$25 Visa Gift Card** to every participant, spouse and dependent child (age 18 to 25) who completes the HealthyFit screening and health risk assessment. There will also be several raffle drawings, including a $500 Cabella gift card, Visa gift cards, gift baskets, and 2-year passes to 24 Hour Fitness!

**How do I participate?**

**Please pre-register by contacting Tracy Johnson at HealthyFit at (816) 823-6758.** Please have your medical ID card handy when you phone in to pre-register. If you pre-register by Friday, September 26, the $25 Visa Gift Card for you and your adult family members will be available at the time of the screening. Plus, you will get an extra entry towards the raffle drawings! We hope to see you all there!

**IMPORTANT:** For best results, the screening requires a 12-hour fast (no eating or drinking 12 hours prior to the screening, with the exception of water and/or one cup of black coffee). Please be sure to drink water during your 12 hour fast to ensure proper hydration. If you normally take medication, continue to take it as recommended by your doctor.

## Grandfathered Status

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Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
August, 2014

**PIPE FITTERS LOCAL NO. 533**
**HEALTH AND WELFARE FUND**

# BENEFIT ALERT #33

# MANDATORY RE-ENROLLMENT COMING

The Pipefitters Local No. 533 Health and Welfare Fund (the "Plan") will soon begin its annual re-enrollment process. During this annual re-enrollment process, each Participant must submit a new enrollment form to the Fund Office.

**IMPORTANT NOTICE: In early October you will be mailed your 2015 re-enrollment notice and form. Please be on the lookout for this mailing, as it will contain additional information and the form you will need to complete and submit to the Fund Office by December 31, 2014. On February 1, 2015, the Plan will stop paying benefits on behalf of anyone who has not submitted a 2015 enrollment form to the Fund Office.**

**Don't forget to register for the Plan's October 11, 2014 Health Fair!**

- Free health screenings – **$25 Visa Gift card** for each participating adult!
- Free flu shots
- Plan vendors, including Blue Cross Blue Shield of Kansas City, LDI and others
- Great raffle prizes

The 2014 Health Fair is open to covered participants, spouses, and children. **To register, please contact Tracy Johnson at HealthyFit at (816) 823-6758.** Representatives from the Fund Office will be on hand at the Health Fair if you would like to complete and submit your re-enrollment forms at that time.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
September, 2014

## Grandfathered Status

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**PIPE FITTERS LOCAL NO. 533**
**HEALTH AND WELFARE FUND**

# BENEFIT ALERT #34

***SAVE THE DATE!***
**Wellness Fair**
**Saturday, Nov. 14**

Effective January 1, 2015, the Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Fund (the "Plan") has improved the Plan's wellness, routine and preventive care benefits by adding coverage for the preventive care benefits that non-grandfathered health plans are required to cover under the Patient Protection and Affordable Care Act ("Affordable Care Act"). These new preventive care benefits include both preventive care medical benefits and preventive care prescription drug benefits.

The Plan's new preventive care medical benefits are explained in greater detail below in the section titled "Routine Preventive Care Medical Benefits". These new Routine Preventive Care Medical Benefits replace the Plan's Routine Care Benefits, Concentra Wellness Benefits, and Well Child Benefits.

The Plan's new preventive care prescription drug benefits are explained in greater detail in the section titled, "Routine Preventive Care Prescription Drug Benefits" which begins on page 8 of this Benefit Alert.

## Routine Preventive Care Medical Benefits *NEW!*

Effective January 1, 2015, the Plan covers the Routine Preventive Care Medical Benefits listed in this section. These Routine Preventive Care Medical Benefits are available to all Covered Persons (i.e. they are available to Employees, Retirees, Dependent spouses and Dependent children, subject to the age limitations for particular services that are listed below).

The Plan will pay the following percentages for Routine Preventive Care Medical Benefits:

- For Routine Preventive Care Medical Benefits provided by an in-network provider on an outpatient basis, the Plan will pay 100% of the cost.
- For Routine Preventive Care Medical Benefits provided by an out-of-network provider on an outpatient basis, the Plan will pay 100% of the cost up to $300 per Covered Person per calendar year. After the first $300, the Plan will pay 60% of the Allowable Charge after the Covered Person has met his or her deductible (in other words, out-of-network services over $300 per calendar year are subject to the Plan's standard out-of-network deductible and coinsurance levels).
- For the childhood immunizations listed below, the Plan will pay 100% of the cost regardless of whether they are provided by an in-network or out-of-network provider.

- For well child exams provided to a child under the age of 7, the Plan will pay 100% of the Allowable Charge regardless of whether the exam is provided by an in-network or out-of-network provider.

The following services are Routine Preventive Care Medical Benefits when they are provided on an outpatient basis*:

| **ADDITIONAL SERVICES** | **COVERAGE DETAILS & LIMITATIONS** |
|---|---|
| Abdominal aortic aneurysm screening (Men) | One-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked. |
| Additional examinations, testing and services:<br>• Hemoglobin/Complete Blood Count (CBS<br>• Metabolic screening<br>• Hearing exams | |
| Alcohol misuse (Screening and counseling) | Clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. |
| Anemia screening (Pregnant women) | Routine screening for iron deficiency anemia in asymptomatic pregnant women. |
| Bacteriuria screening (Pregnant women) | Screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later. |
| Blood pressure screening in adults | Screening for high blood pressure in adults age 18 years and older. |
| BRCA risk assessment and genetic counseling/testing | Primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing. |
| Breast cancer screening | Screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older. |
| Breastfeeding support, supplies, and counseling† | Interventions during pregnancy and after birth to promote and support breastfeeding. |

| ADDITIONAL SERVICES | COVERAGE DETAILS & LIMITATIONS |
|---|---|
| Cervical cancer screening | Annual screening for cervical cancer in adult women. |
| Chest x-ray | |
| Chlamydial infection screening (Nonpregnant women) | Screening for chlamydial infection in all sexually active nonpregnant young women age 24 years and younger and for older nonpregnant women who are at increased risk. |
| Chlamydial infection screening (Pregnant women) | Screening for chlamydial infection in all pregnant women age 24 years and younger and for older pregnant women who are at increased risk. |
| Cholesterol abnormalities screening (Men 35 and older) | Screening men age 35 years and older for lipid disorders. |
| Cholesterol abnormalities screening (Men younger than 35) | Screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease. |
| Cholesterol abnormalities screening (Women 45 and older) | Screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease. |
| Cholesterol abnormalities screening (Women younger than 45) | Screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease. |
| Colorectal cancer exams and laboratory tests consisting of a digital rectal exam and the following:<br>• Fecal occult blood test;<br>• Flexible sigmoidoscopy;<br>• Colonoscopy; and<br>• Double contrast barium enema | |
| Colorectal cancer screening | Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary. |
| Contraceptive methods and counseling† | All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity. |
| Dental caries prevention (Preschool children) | Primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than age 6 months whose primary water source is deficient in fluoride. |

| ADDITIONAL SERVICES | COVERAGE DETAILS & LIMITATIONS |
|---|---|
| Depression screening (Adolescents) | Screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. |
| Depression screening (Adults) | Screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. |
| Diabetes screening | Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg. |
| Electrocardiogram (EKG) | |
| Falls prevention in older adults (Exercise or physical therapy) | Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. |
| Gestational diabetes mellitus screening† | Screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation. |
| Glucose screening | |
| Gonorrhea prophylactic medication (Newborns) | Prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum. |
| Gonorrhea screening (Women) | Clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors). |
| Gonorrhea testing | |
| Healthy diet counseling | Intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians. |
| Hearing loss screening (Newborns) | Screening for hearing loss in all newborn infants. |
| Hemoglobinopathies screening (Newborns) | Screening for sickle cell disease in newborns. |

| ADDITIONAL SERVICES | COVERAGE DETAILS & LIMITATIONS |
|---|---|
| Hepatitis B screening (Pregnant women) | Screening for hepatitis B virus infection in pregnant women at their first prenatal visit. |
| HIV† Counseling | Counseling and screening for HIV infection for all sexually active women. |
| HIV screening (Nonpregnant adolescents and adults) | Clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened. |
| HIV screening (Pregnant women) | Clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown. |
| HPV testing † | |
| Hypothyrodism screening (Newborns) | Screening for congenital hypothyroidism in newborns. |
| Immunizations | Covered Immunizations are limited to the age ranges and gender recommended by the Advisory Committee on Immunization Practices and/or adopted by the Center for Disease Control:<br>• Catch-up for Hepatitis B<br>• Catch-up for varicella<br>• Catch-up for measles, mumps, and rubella<br>• Tetanus boosters as necessary, including tetanus, diphtheria and pertussis; diphtheria and tetanus; and tetanus only<br>• Pneumococcal vaccine<br>• Influenza virus vaccine<br>• Meningococcal vaccine<br>• Catch-up for Hepatitis A<br>• HPV vaccine<br>• Zoster vaccine<br>• Polio vaccine<br>• Haemophilus Influenza Type b (Hib) vaccine |

| ADDITIONAL SERVICES | COVERAGE DETAILS & LIMITATIONS |
|---|---|
| Immunizations (Childhood) | • At least 5 doses of vaccine against diphtheria, pertussis, tetanus;<br>• At least 4 doses of vaccine against polio, Haemophilus Influenza Type b (Hib);<br>• At least 3 doses of vaccine against Hepatitis B;<br>• 2 doses of vaccine against measles, mumps, and rubella;<br>• 2 doses of vaccine against varicella;<br>• At least 4 doses of vaccine against pediatric pneumococcal (PCV7);<br>• 1 dose of vaccine against influenza;<br>• At least one dose of vaccine against Hepatitis A;<br>• 3 doses of vaccine against Rotavirus; and<br>• Such other vaccines and dosages as may be prescribed by the State Department of Health |
| Intimate partner violence screening (Women of childbearing age†) | Clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse. |
| Lead testing | |
| Lung cancer screening | Annual screening for lung cancer with low-dose computed tomography in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. |
| Mammograms (if ordered by a Physician) | Includes those performed at the direction of a Physician in a mobile facility certified by CMS. |
| Newborn hearing screening, audiological assessment, and follow-up, and initial amplifications | |

| ADDITIONAL SERVICES | COVERAGE DETAILS & LIMITATIONS |
|---|---|
| Obesity screening and counseling (Adults) | Screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions. |
| Obesity screening and counseling (Children) | Clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status. |
| Osteoporosis screening (Women) | Screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors. |
| Pelvic exams and pap smears | Includes those performed at the direction of a Physician in a mobile facility certified by Centers for Medicare and Medicaid Services (CMS). |
| Phenylketonuria screening (Newborns) | Screening for phenylketonuria in newborns. |
| Physician Examinations | |
| Prostate exams and prostate specific antigen (PSA) tests | |
| Rh incompatibility screening (First pregnancy visit) | Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. |
| Rh incompatibility screening (24–28 weeks' gestation) | Repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative. |
| Sexually transmitted infections counseling† | High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) in all sexually active adolescents and for adults at increased risk for STIs. |
| Skin cancer behavioral counseling | Counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer. |
| Syphilis screening (Nonpregnant persons) | Clinicians screen persons at increased risk for syphilis infection. |
| Syphilis screening (Pregnant women) | Clinicians screen all pregnant women for syphilis infection. |
| Thyroid Stimulating hormone screening | |

| ADDITIONAL SERVICES | COVERAGE DETAILS & LIMITATIONS |
|---|---|
| Tobacco use counseling and interventions (Nonpregnant adults) | Clinicians ask about tobacco use and provide tobacco cessation interventions for those who use tobacco products. |
| Tobacco use counseling (Pregnant women) | Clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke. |
| Urinalysis | |
| Visual acuity screening in children | Vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors. |

* If these Routine Preventive Care Medical Benefits are provided on an inpatient basis, they will be subject to the Plan's standard deductible and coinsurance levels.

† Indicates services that are provided as part of the Affordable Care Act's Preventive Services for Women.

## I. Routine Preventive Care Prescription Drug Benefits

Effective January 1, 2015, the Plan covers 100% of the cost of the Routine Preventive Care Prescription Drug Benefits listed in this section when they are purchased at an in-network pharmacy. The Plan does not cover any charges for prescription drugs purchased at an out-of-network pharmacy.

The Routine Preventive Care Prescription Drug Benefits listed in this section are available to all Covered Persons (i.e., they are available to Employees, Retirees, Dependent spouses and Dependent children, subject to the age limitations for particular medications that are listed in the chart below).

| INCLUDED SERVICES | COVERAGE DETAILS & LIMITATIONS |
|---|---|
| Colonoscopy Bowel Preparations | Men and Women ages 50 to 75. |
| Contraceptives (birth control) | Generic medications, as well as brands with no generic equivalent are considered Routine Preventive Care Benefits. Brand medications with a generic equivalent are not a Routine Preventive Care Benefit and remain covered subject to the Plan's standard deductible and co-payment unless your physician has indicated "Dispense as Written" on your prescription. If your physician has indicated "Dispense as Written" on your prescription, the Plan will cover 100% of the cost of a brand medication. |
| Erythromycin Ophthalmic Ointment | Infants under one year of age. |

| INCLUDED SERVICES | COVERAGE DETAILS & LIMITATIONS |
|---|---|
| Falls prevention in older adults: vitamin D | Men and women age 65 and older. |
| Folic acid supplementation (Rx and OTC) | Women capable of pregnancy ages 13 to 60 up to 100 per 30 day supply |
| Iron supplementation in children | Children ages 6 to 12 months. |
| Oral fluorides | Children ages 6 months to 6 years. |
| Aspirin | Men and women, ages 45 to 79 up to 100 per 30 day supply, and up to 30 per 30 day supply for pregnant women at high risk for preeclampsia after 12 weeks of gestation. |
| Raloxifene and tamoxifen: Breast Cancer prevention in high risk Women | One per day (for up to 5 years) |
| Tobacco use cessation drugs (Rx and OTC) | Subject to quantity limit for up to two quit attempts per calendar year. Tobacco use cessation drugs in excess of two quit attempts per year are not a Routine Preventive Care Benefit and remain covered subject to the Plan's standard deductible and co-payment. |

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
August 2015

## GRANDFATHERED STATUS

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313. 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. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

# PIPE FITTERS LOCAL NO. 533
# HEALTH AND WELFARE FUND

# BENEFIT ALERT #35

Effective June 1, 2016, the Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Fund (the "Plan") has adopted five changes to the Plan's prescription drug benefits. The purpose of this notice is to explain these changes and provide you an updated list of the Plan's Board of Trustees.

## 1. Mandatory Mail Order Program for Maintenance Medication

Effective June 1, 2016, a new exclusion was added to the list found on pages 32 and 33 of your Summary Plan Description. The new exclusion provides that **no benefits are payable under the Prescription Drug Program for Maintenance Medication unless the medication is filled through the LDI mail order program** or meets one of the following exceptions:

- The Maintenance Medication is an initial prescription. A medication is considered an initial prescription if it is for a supply of 34-days or less and it was not filled two or more times since June 1, 2016. This means that the Plan will cover the first two fills of a 34-day (or less) supply of a Maintenance Medication that you purchase at a retail pharmacy after June 1, 2016. This exception applies to each Maintenance Medication that you are prescribed. For example, if you take one medication for high blood pressure and another medication for high cholesterol, the Plan will cover the first two 34-day (or less) fills of your high blood pressure medication and the first two 34-day (or less) fills of your cholesterol medication that you purchase at a retail pharmacy after June 1, 2016.

- The Maintenance Medication is prescribed to a Covered Person who lives in a long-term care facility. This means that if you live in a long-term care facility, the Plan will cover Maintenance Medication even if it is not filled through the mail order program so long as the Maintenance Medication is otherwise covered by the Plan.

- The Maintenance Medication is purchased at a retail pharmacy due to extenuating circumstances. Extenuating circumstances are unusual and unexpected circumstances that cause a Covered Person to fill a Maintenance Medication at a retail pharmacy. This means that such circumstances rarely occur. For purposes of this exception, only LDI and/or the Board of Trustees have the authority to determine whether or not certain circumstances are considered extenuating circumstances.

A prescription drug is considered a Maintenance Medication if it is taken on a regular basis to treat a chronic health condition, such as high blood pressure, high cholesterol or diabetes, or it is a contraceptive (i.e., birth control). For purposes of this definition, a medication that is a controlled substance is not a Maintenance Medication even if it is taken on a regular basis to treat a chronic health condition.

If your doctor prescribes you a Maintenance Medication, you should ask your doctor to give you two prescriptions at once: one for a 30-day supply and one for a 90-day supply (with appropriate refills). You can then take your 30-day prescription to a retail pharmacy and have your 90-day prescription filled through the mail order program. To fill your 90-day prescription through the mail order program, you must submit a prescription, claim form, and payment to LDI. For more information about the mail order program you can call LDI at 1-866-516-3121 or visit the website www.ldirx.com.

To help you get started with the mail order process, LDI will provide you one free 90-day supply of each generic medication that you fill through the mail order program during the period of June 1, 2016 through May 31, 2017. This means that you will not have to pay for the first 90-day generic prescription that you fill through the mail order program. This free refill applies to each generic medication that you fill between June 1, 2016 and May 31, 2017. For example, if you use the mail order program for the first time on July 1, 2016 to fill a 90-day prescription for a generic high blood pressure medication and a 90-day prescription for a generic high cholesterol medication, you will not have to pay for either of these medications.

NOTE: This Section does not apply to Specialty Drugs. Refer to Section 4 of this Benefit Alert for a description of the new rules regarding Specialty Drugs.

**2. 34-Day Supply Limit for Non-Maintenance Medication Purchased at a Retail Pharmacy**

Effective June 1, 2016, the language in the middle of page 31 of your Summary Plan Description was changed to read, "***Important***: Your purchase of non-Maintenance Medication at a retail pharmacy is limited to a 34-day supply."

**This means that effective June 1, 2016, the Plan will only cover a 90-day supply of medication if the medication is filled through the LDI mail order program**. This also means that the following copayment chart replaces the charts found on page 31 of your Summary Plan Description, Benefit Alert 19, and Benefit Alert 22:

| **If your prescription is for a:** | **Your Copayment** | |
|---|---|---|
| | **Retail**<br>1 mo. supply | **Mail Order**<br>3 mo. supply |
| Generic "statin" drug | $10 | $20 |
| Other Generic drug | $15 | $30 |
| Brand name drug; Formulary | $30* | $60* |
| Brand name drug; NOT Formulary | $50* | $100* |

* Plus the difference in the ingredient cost if your prescription is for a brand name drug when a generic is available.

The only difference between the chart above and the chart found in Benefit Alert 22 is that the Walgreens copayment column was removed because the Plan will no longer cover a 90-day supply of medication unless the medication is filled through the LDI mail order program.

To fill your 90-day prescription through the mail order program, you must submit a prescription, claim form, and payment to LDI. For more information about the mail order program you can call LDI at 1-866-516-3121 or visit the website www.ldirx.com.

To help you get started with the LDI mail order process, LDI will provide you one free 90-day supply of each generic medication that you fill through the mail order program during the period of June 1, 2016 through May 31, 2017. For more information about the free refill, see the second to last paragraph of Section 1 of this Benefit Alert.

## 3. Step Therapy for Diabetes and Cholesterol Medication

Effective June 1, 2016, a new exclusion was added to the list found on pages 32 and 33 of your Summary Plan Description. The new exclusion provides that **no benefits are payable under the Prescription Drug Program for medication prescribed to treat diabetes or high cholesterol unless the medication meets the criteria of (a) or (b) below.**

**(a) The Medication Meets the Step Therapy requirements.** A medication meets the Step Therapy requirements if it is the most cost-effective medication available to treat a disease or condition. This means that if your doctor prescribes you a new medication to treat diabetes or high cholesterol, the Plan will only cover a generic medication. If a generic medication does not safely and effectively treat your condition, the Plan will cover a formulary brand medication. If the formulary brand medication does not safely and effectively treat your condition, the Plan will cover a non-formulary brand medication.

If your doctor prescribes you a new medication to treat diabetes or high cholesterol, LDI will make sure you follow these steps to ensure that your medication is covered by the Plan:

- **Step One**: Have your doctor prescribe you a generic medication. If you try the medication for at least 60 days and it does not work or you have a medical condition that prevents you from trying the medication for at least 60 days (for example, your physician provides sufficient documentation to LDI to support you are allergic to the available generic medications), you may go to step two.

- **Step Two**: Have your doctor prescribe you a formulary brand medication. If you try the medication for at least 60 days and it does not work, or you have a medical condition that prevents you from trying the medication for at least 60 days (for example, your physician provides sufficient documentation to LDI to support you are allergic to the available formulary brand medications), you may go to step three.

- **Step Three**: Have your doctor prescribe you a non-formulary brand medication.

**(b) The medication is a medication that the Covered Person is already taking as of June 1, 2016**. A medication prescribed to treat diabetes is considered a medication that you are already taking if you have filled a prescription for that medication within the past 180 days. A medication prescribed to treat high cholesterol is considered a medication that you are already taking if you have filled a prescription for that medication within the past 120 days. **This means that if you have filled a prescription for a medication to treat diabetes within the 180 days prior to June 1, 2016 or you have filled a medication to treat high cholesterol within the 120 days prior to June 1, 2016, the Step Therapy requirements do not apply to refills of that medication.** In the event that you stop taking your medication within the 120 or 180 day time frame, then Step Therapy requirements will apply.

## 4. Mandatory Mail Order for Specialty Drugs

Effective June 1, 2016, a new exclusion was added to the list found on pages 32 and 33 of your Summary Plan Description. The new exclusion provides that **no benefits are payable under the Prescription Drug Program for Specialty Drugs unless the Specialty Drug is purchased at the LDI Specialty Pharmacy** or meets one of the following exceptions:

- The Specialty Drug is a limited distribution drug and it is not available at the LDI Specialty Pharmacy. For example, if you have asthma, your doctor prescribes you Xolair, and the Xolair is not available at the LDI Specialty Pharmacy, the Plan will cover the Xolair even if it is not purchased at the LDI Specialty Pharmacy.

- The Specialty Drug is an immediate need drug. For example, if you have surgery and your doctor prescribes your Enoxaparin to prevent blood clots after the surgery, the Plan will cover seven doses of Enoxaparin regardless of whether or not it is purchased at the LDI Specialty Pharmacy. If your prescription is for more than seven doses, the additional days require approval from LDI.

For more information about the Plan's coverage of Specialty Drugs, refer to Benefit Alert 27, call LDI at 1-866-516-3121, or visit the website www.ldirx.com.

## 5. Mandatory Mail Order and Medical Necessity Requirement for New to Market Drugs

Effective June 1, 2016, a new exclusion was added to the list found on pages 32 and 33 of your Summary Plan Description. The new exclusion provides that **no benefits are payable under the Prescription Drug Program for New to Market Drugs unless the New to Market Drug is Medically Necessary and it is purchased at the LDI Pharmacy.**

A drug is considered a New to Market Drug if LDI has not yet reviewed the drug and assigned it to LDI's formulary by the LDI Formulary Management Committee. This exclusion is designed to allow LDI proper time to evaluate new pharmaceutical

products to ensure that these products are safe, cost-effective, and evaluated for possible inclusion in LDI's preferred brand formulary. These products are often expensive and are frequently used to treat conditions that may already have established treatment guidelines. For at least the first six months after the product has received approval from the FDA, LDI will require prior authorization on New to Market Drugs and will only cover the drug if it is deemed Medically Necessary and is being prescribed in compliance with the FDA's approved use.

A New to Market Drug is considered Medically Necessary if it meets all of the following criteria:

- It is required to treat an injury or Sickness and the absence of the drug could cause adverse consequences for the person in need of the prescription drug;
- It is appropriate and necessary for the treatment of the injury or Sickness;
- It is in accordance with standards of good medical practice within the organized medical community; and
- It is the most appropriate level of treatment that can be provided safely for the patient.

For more information about New to Market Drugs you can call LDI at 1-866-516-3121.

## 6. Updated List of the Board of Trustees

The current Trustees for the Plan are:

Union Trustees:

Chris Parrino, Trustee
Pipe Fitters Local Union No. 533
812 NW Park Rd.
Blue Springs, MO 64015-1524

Ronald Talley, Trustee
Pipe Fitters Local Union No. 533
8600 Hillcrest Rd.
Kansas City, MO 64138

Luke Moylan, Trustee
Pipe Fitters Local Union No. 533
PO Box 107
Fontana, KS 66026

Employer Trustees:

Michael Gossman, Trustee
P1 Group, Inc.
2151 Haskell Ave., Bldg #1
Lawrence, KS 66046

William Alexander, Trustee
Alexander Mechanical Contractors
4251 North Kentucky Ave
Kansas City, MO 64161

Harold Mitts, Trustee
10955 Lowell Ave, Ste. 350
Overland Park, KS 66210

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
June 2016

## GRANDFATHERED STATUS

This group health Plan believes this coverage 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313. 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. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

# PIPE FITTERS LOCAL NO. 533
# HEALTH AND WELFARE FUND

# BENEFIT ALERT #37

Effective January 1, 2017, the Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Fund (the "Plan") has adopted changes to the Plan's Comprehensive Medical Benefits, Prescription Drug Benefits, and self-pay rates. The purpose of this Benefit Alert is to explain those changes. Please review this Benefit Alert in its entirety and keep it with your Summary Plan Description ("SPD") for future reference.

## 1. Increased Deductible for Comprehensive Medical Benefits

Effective January 1, 2017, the Comprehensive Medical Benefit calendar year deductible for Eligible Employees and Dependents of Eligible Employees is increased to $600 per person and $1,200 per family. The amount of Allowable Charges paid to both in-network and out-of-network providers are applied to the deductible (i.e. the $600 and $1,200 includes Allowable Charges for services provided by both in-network and out-of-network providers). This means that if you are an Eligible Employee or a Dependent of an Eligible Employee, you will pay the first $600 of Allowable Charges per calendar year; however, your family will not pay more than a total of $1,200 in deductibles in the same calendar year. Any copay amounts that you pay for Nurse Practitioner Retail Clinic visits and American Wellness ("Amwell") telehealth services do not count towards your deductible.

The Comprehensive Medical Benefit calendar year in-network and out-of-network deductibles for Retirees and Dependents of Retirees have not changed.

The chart on the following page compares the Plan's current deductible for Comprehensive Medical Benefits to the Plan's deductible for Comprehensive Medical Benefits that will become effective on January 1, 2017:

[see chart on following page]

| If you are… | Your Current Deductible for Comprehensive Medical Benefits is… | Effective January 1, 2017 your Deductible for Comprehensive Medical Benefits is… |
|---|---|---|
| **An Eligible Employee or a Dependent of an Eligible Employee** | In-network: $300 a person/$600 a family*<br><br>Out-of-network: $300 a person/$600 a family* | In-network: $600 a person/$1,200 a family*<br><br>Out-of-network: $600 a person/$1,200 a family* |
| **A Retiree (or Dependent of a Retiree) who submitted an application for pension benefits after December 29, 2006 or whose pension effective date was after March 31, 2007** | In-network: $300 a person/$600 a family*<br><br>Out of-network: $300 a person/$600 a family* | In-network: $300 a person/$600 a family*<br><br>Out-of-network: $300 a person/$600 a family* |
| **A Retiree (or a Dependent of a Retiree) who submitted an application for pension benefits that was received by the Fund Office before December 30, 2006 and your pension effective date was before April 1, 2007** | In-network: $150 a person/$300 a family**<br><br>Out-of-network: $400 a person/$800 a family** | In-network: $150 a person/$300 a family**<br><br>Out-of-network: $400 a person/$800 a family** |

*Allowable Charges for services provided by an in-network provider count towards both your in-network deductible and your out-of-network deductible, and Allowable Charges for services provided by an out-of-network provider likewise count towards both your in-network deductible and your out-of-network deductible. This means that once you have met your in-network deductible you have also met your out-of-network deductible and vice versa.

**Allowable Charges for services provided by an in-network provider count towards both your in-network deductible and your out-of-network deductible, and Allowable Charges for services provided by an out-of-network provider likewise count towards both your in-network deductible and your out-of-network deductible.

## 2. Increased Cost-Sharing for In-Network Comprehensive Medical Benefits

Prior to January 1, 2017, all Covered Persons (i.e. all Eligible Employees, Retirees, and Dependents) are required to pay 15% of the Allowable Charge for Comprehensive Medical Benefits provided by an in-network provider. Effective January 1, 2017, the amount that an Eligible Employee and his or her Dependents are required to pay for Comprehensive Medical Benefits provided by an in-network provider is increased to 20%. This means that if you are an Eligible Employee or a Dependent of an Eligible Employee and you have met your calendar year deductible, the Plan will pay 80% of the Allowable Charge for Comprehensive Medical Benefits provided by an in-network provider and you will pay the other 20%. Once you have reached the Comprehensive Medical Benefit annual out-of-pocket maximum described in number three below, the Plan will pay 100% of the Allowable Charge for Comprehensive Medical Benefits provided by an in-network provider.

The amount that a Retiree and his or her Dependents are required to pay for Comprehensive Medical Benefits provided by an in-network provider has not changed.

## 3. New Comprehensive Medical Benefit Annual Out-of-Pocket Maximum

The term "Comprehensive Medical Benefit annual out-of-pocket maximum" means the dollar amount of Allowable Charges that a Covered Person must pay in a single calendar year before the Plan begins to pay 100% of the cost of covered Comprehensive Medical Benefits provided by an in-network provider. As explained in greater detail in (a), (b), and (c) below, the dollar amount of a Covered Person's Comprehensive Medical Benefit annual out-of-pocket maximum depends on whether the Covered Person is an Eligible Employee (see (a) below); a Retiree who submitted an application for pension benefits after December 29, 2006 or whose pension effective date was after March 31, 2007 (see (b) below); or a Retiree who submitted an application for pension benefits before December 30, 2006 and the effective date of the pension was before April 1, 2007 (see (c) below).

### (a) Comprehensive Medical Benefit Annual Out-of-Pocket Maximum for Eligible Employees and Dependents of Eligible Employees

Effective January 1, 2017, the Comprehensive Medical Benefit annual out-of-pocket maximum for Eligible Employees and Dependents of Eligible Employees is $4,600 per person and $9,200 per family. This means that if you are an Eligible Employee or a Dependent of an Eligible Employee and you have paid out-of-pocket Allowable Charges of $4,600 in a calendar year for covered services or your family has paid out-of-pocket Allowable Charges of $9,200 in a calendar year for covered services, the Plan will pay 100% of the Allowable Charge for Comprehensive Medical Benefits provided by an in-network provider and Emergency Services (as defined in number four of this Benefit Alert) provided by an out-of-network provider during the remainder of the calendar year.

The following Allowable Charges do not count towards your Comprehensive Medical Benefit annual out-of-pocket maximum (i.e. amounts paid for the following services do not count towards the $4,600 per person/$9,200 per family Comprehensive Medical Benefit annual out-of-pocket maximum):

- Allowable Charges paid for services provided by an out-of-network provider, unless those services are Emergency Services, as defined in number four of this Benefit Alert; and
- Allowable Charges paid for Prescription Drug Benefits, Dental Benefits, or Vision Benefits.

The following chart compares the Plan's current Comprehensive Medical Benefit annual out-of-pocket maximum for Eligible Employees and Dependents of Eligible Employees to the Plan's new Comprehensive Medical Benefit annual out-of-pocket maximums.

| | **Current Comprehensive Medical Benefit Annual Out-of-Pocket Maximum** | **NEW Comprehensive Medical Benefit Annual Out-of-Pocket Maximum Effective January 1, 2017** |
|---|---|---|
| **The Dollar Amount of the Comprehensive Medical Benefit Annual Out-of-Pocket Maximum is…** | $3,300 per person*. There is no family Comprehensive Medical Benefit annual out-of-pocket maximum. | $4,600 per person and $9,200 per family. |
| **The Allowable Charges that do NOT count towards the Comprehensive Medical Benefit Annual Out-of-Pocket Maximum are…** | • Allowable Charges paid for services provided by an out-of-network provider, unless those charges were applied to your deductible;<br>• Allowable Charges paid for Prescription Drug Benefits, Dental Benefits, or Vision Benefits; and<br>• Allowable Charges paid for Nurse Practitioner Retail Clinic Visits. | • Allowable Charges paid for services provided by an out-of-network provider, unless those services are Emergency Services; and<br>• Allowable Charges paid for Prescription Drug Benefits, Dental Benefits, or Vision Benefits. |
| **Once you reach the Comprehensive Medical Benefit Annual Out-of-Pocket Maximum, the Plan pays 100% of the Allowable Charge for…** | All covered Comprehensive Medical Benefits provided by an in-network provider except for Nurse Practitioner Retail Clinic Visits. You are still required to pay a $10.00 copay for in-network Nurse Practitioner Retail Clinic Visits. | All covered Comprehensive Medical Benefits provided by an in-network provider and Emergency Services provided by an out-of-network provider. |

*This number equals the current $300 deductible plus 15% of the next $20,000 of in-network Allowable Charges that an Eligible Employee or a Dependent of an Eligible Employee is required to pay during a calendar year before the Plan pays 100% of the Allowable Charge for services provided by an in-network provider during the rest of the year as explained on pages 20-22 of your SPD.

**(b) Comprehensive Medical Benefit Annual Out-of-Pocket Maximum for Retirees who Submitted an Application for Pension Benefits after December 29, 2006 or whose Pension Effective Date was after March 31, 2007 and Dependents of these Retirees**

Effective January 1, 2017, the Comprehensive Medical Benefit annual out-of-pocket maximum for Retirees who submitted an application for pension benefits after December 29, 2006 or whose pension effective date was after March 31, 2007 ("Post 2006 Retirees") and Dependents of these Retirees is $3,300 per person and $6,600 per family. This means that if you are a Post 2006 Retiree or a Dependent of a Post 2006 Retiree and you have paid out-of-pocket Allowable Charges of $3,300 in a calendar year for covered services or your family has paid out-of-pocket Allowable Charges of $6,600 in a calendar year for covered services, the Plan will pay 100% of the Allowable Charge for Comprehensive Medical Benefits provided by an in-network provider and Emergency Services (as defined in number four of this Benefit Alert) provided by an out-of-network provider during the remainder of the calendar year.

The following Allowable Charges do not count towards your Comprehensive Medical Benefit annual out-of-pocket maximum (i.e. amounts paid for the following services do not count towards the $3,300 per person/$6,600 per family Comprehensive Medical Benefit annual out-of-pocket maximum):

- Allowable Charges paid for services provided by an out-of-network provider, unless those services are Emergency Services, as defined in number four of this Benefit Alert; and
- Allowable Charges paid for Prescription Drug Benefits, Dental Benefits, or Vision Benefits.

The following chart compares the Plan's current Comprehensive Medical Benefit annual out-of-pocket maximum for Post 2006 Retirees and Dependents of Post 2006 Retirees to the Plan's Comprehensive Medical Benefit annual out-of-pocket maximum that will become effective for these Retirees and their Dependents on January 1, 2017:

[see chart on following page]

| | **Current Comprehensive Medical Benefit Annual Out-of-Pocket Maximum** | **NEW Comprehensive Medical Benefit Annual Out-of-Pocket Maximum Effective January 1, 2017** |
|---|---|---|
| **The Dollar Amount of the Comprehensive Medical Benefit Annual Out-of-Pocket Maximum is…** | $3,300 per person*. There is no family Comprehensive Medical Benefit annual out-of-pocket maximum. | $3,300 per person and $6,600 per family. |
| **The Allowable Charges that do NOT count towards the Comprehensive Medical Benefit Annual Out-of-Pocket Maximum are…** | • Allowable Charges paid for services provided by an out-of-network provider, unless those charges were applied to your deductible;<br><br>• Allowable Charges paid for Prescription Drug Benefits, Dental Benefits, or Vision Benefits; and<br><br>• Allowable Charges paid for Nurse Practitioner Retail Clinic Visits. | • Allowable Charges paid for services provided by an out-of-network provider, unless those services are Emergency Services; and<br><br>• Allowable Charges paid for Prescription Drug Benefits, Dental Benefits, or Vision Benefits. |
| **Once you reach the Comprehensive Medical Benefit Annual Out-of-Pocket Maximum, the Plan pays 100% of the Allowable Charge for…** | All covered Comprehensive Medical Benefits provided by an in-network provider except for Nurse Practitioner Retail Clinic Visits. You are still required to pay a $10.00 copay for in-network Nurse Practitioner Retail Clinic Visits. | All covered Comprehensive Medical Benefits provided by an in-network provider and Emergency Services provided by an out-of-network provider. |

*This number equals the current $300 deductible plus 15% of the next $20,000 of in-network Allowable Charges that a Post 2006 Retiree and a Dependent of a Post 2006 Retiree is required to pay during a calendar year before the Plan pays 100% of the Allowable Charge for services provided by an in-network provider during the rest of the year as explained on pages 20-22 of your SPD.

### (c) Comprehensive Medical Benefit Annual Out-of-Pocket Maximum for Retirees who Submitted an Application for Pension Benefits Before December 30, 2006 and whose Pension Effective Date was Before April 1, 2007 and Dependents of these Retirees

Effective January 1, 2017, the Comprehensive Medical Benefit annual out-of-pocket maximum for Retirees who submitted an application for pension benefits before December 30, 2006 and whose pension effective date was before April 1, 2007 ("Pre 2007 Retiree) and Dependents of these Retirees is $1,650 per person and $3,300 per family. This means that if you are a Pre 2007 Retiree or a Dependent of a Pre 2007 Retiree and you have paid out-of-pocket Allowable Charges of $1,650 in a calendar year for covered services or your family has paid out-of-pocket Allowable Charges of $3,300 in a calendar year for covered services, the Plan will pay 100% of the Allowable Charge for Comprehensive Medical Benefits provided by an in-network provider and Emergency Services (as defined in number four of this Benefit Alert) provided by an out-of-network provider during the remainder of the calendar year.

The following Allowable Charges do not count towards your Comprehensive Medical Benefit annual out-of-pocket maximum (i.e. amounts paid for the following services do not count towards the $1,650 per person/$3,300 per family Comprehensive Medical Benefit annual out-of-pocket maximum):

- Allowable Charges paid for services provided by an out-of-network provider, unless those services are Emergency Services, as defined in number four of this Benefit Alert; and
- Allowable Charges paid for Prescription Drug Benefits, Dental Benefits, or Vision Benefits.

The following chart compares the Plan's current Comprehensive Medical Benefit annual out-of-pocket maximum for Pre 2007 Retirees and Dependents of Pre 2007 Retirees to the Plan's Comprehensive Medical Benefit annual out-of-pocket maximum that will become effective for these Pre 2007 Retirees and their Dependents on January 1, 2017:

[see chart on following page]

| | **Current Comprehensive Medical Benefit Annual Out-of-Pocket Maximum** | **NEW Comprehensive Medical Benefit Annual Out-of-Pocket Maximum Effective January 1, 2017** |
|---|---|---|
| **The Dollar Amount of the Comprehensive Medical Benefit Annual Out-of-Pocket Maximum is…** | $1,650 per person*. There is no family Comprehensive Medical Benefit annual out-of-pocket maximum. | $1,650 per person and $3,300 per family. |
| **The Allowable Charges that do NOT count towards the Comprehensive Medical Benefit Annual Out-of-Pocket Maximum are…** | • Allowable Charges paid for services provided by an out-of-network provider, unless those charges were applied to your in-network deductible;<br><br>• Allowable Charges paid for Prescription Drug Benefits, Dental Benefits, or Vision Benefits; and<br><br>• Allowable Charges paid for Nurse Practitioner Retail Clinic Visits. | • Allowable Charges paid for services provided by an out-of-network provider, unless those services are Emergency Services; and<br><br>• Allowable Charges paid for Prescription Drug Benefits, Dental Benefits, or Vision Benefits. |
| **Once you reach the Comprehensive Medical Benefit Annual Out-of-Pocket Maximum, the Plan pays 100% of the Allowable Charge for…** | All covered Comprehensive Medical Benefits provided by an in-network provider except for Nurse Practitioner Retail Clinic Visits. You are still required to pay a $10.00 copay for in-network Nurse Practitioner Retail Clinic Visits. | All covered Comprehensive Medical Benefits provided by an in-network provider and Emergency Services provided by an out-of-network provider. |

*This number equals the current $150 deductible plus 15% of the next $10,000 of in-network Allowable Charges that a Pre 2007 Retiree a Dependent of a Pre 2007 is required to pay during a calendar year before the Plan pays 100% of Allowable Charge for services provided by an in-network provider during the rest of the calendar year as explained on pages 20-22 of your SPD.

## 4. Expanded Coverage for Emergency Services Provided by an Out-of-Network Provider

Effective January 1, 2017, the Plan will pay the following percentages for Emergency Services provided by an out-of-network provider:

- If you are an Eligible Employee or a Dependent of an Eligible Employee and you have met your deductible, the Plan will pay 80% of the Allowable Charge for Emergency Services provided by an out-of-network provider. Once you have met your Comprehensive Medical Benefit annual out-of-pocket maximum, the Plan will pay 100% of the Allowable Charge for Emergency Services provided by an out-of-network provider.

- If you are a Retiree or a Dependent of a Retiree and you have met your in-network deductible, the Plan will pay 85% of the Allowable Charge for Emergency Services provided by an out-of-network provider. Once you have met your Comprehensive Medical Benefit annual out-of-pocket maximum, the Plan will pay 100% of the Allowable Charge for Emergency Services provided by an out-of-network provider.

The following terms have a specific meaning when they are used in this Benefit Alert:

- The term "**Emergency Services"** means services provided in a Hospital or ambulance in connection with an Emergency Medical Condition, as that term is defined below. This includes medical screening examinations that are within the capability of a Hospital's emergency department and further examinations and treatment that are required to stabilize a Covered Person.

- The term "**Emergency Medical Condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individuals health in serious jeopardy (or, with respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy) or causing serious impairment or dysfunction to a bodily function, organ, and/or part.

## 5. New Plan Exclusions

Effective January 1, 2017, two new exclusions were added to the list found on pages 35 and 36 of your SPD. The new exclusions provide that the Plan will not cover charges for the following:

- Expenses incurred at an out-of-network skilled nursing facility, rehabilitation hospital or residential Treatment Facility.

- Expenses incurred for services provided on an inpatient basis at an out-of-network Hospital or other medical facility. This exclusion does not apply to Emergency Services, as that term is defined in number four of this Benefit Alert.

## 6. Improved Coverage for Certain Routine Preventive Care Medical Benefits Provided on an Inpatient Basis by an In-Network Provider

Prior to January 1, 2017, if a Routine Preventive Care Medical Benefit listed in Benefit Alert 34 was provided on an inpatient basis by an in-network provider, the Plan would pay 85% of the Allowable Charge for the Routine Preventive Care Medical Benefit after a Covered Person met his or her deductible. Effective January 1, 2017, if a Routine Preventive Care Medical Benefit listed in Benefit Alert 34 is provided on an inpatient basis by an in-network provider and the provider itemizes the services rendered during the inpatient visit, the Plan will pay 100% of the Allowable Charge for the Routine Preventive Care Medical Benefit regardless of whether or not a Covered Person has met his or her deductible. If the provider does not itemize the Routine Preventive Care Medical Benefit (for example, if the provider bills the Plan a certain amount for the entire day rather than a separate amount for each service rendered on that day), the Plan will pay the following percentages for the Routine Preventive Care Medical Benefit:

- If you are an Eligible Employee or a Dependent of an Eligible Employee and you have met your deductible, the Plan will pay 80% of the Allowable Charge for Routine Preventive Care Medical Benefits that are not itemized and are provided on an inpatient basis by an in-network provider. Once you have met your Comprehensive Medical Benefit annual out-of-pocket maximum, the Plan will pay 100% of the Allowable Charge for Routine Preventive Care Medical Benefits that are not itemized and are provided on an inpatient basis by an in-network provider.

- If you are a Retiree or a Dependent of a Retiree and you have met your in-network deductible, the Plan will pay 85% of the Allowable Charge for Routine Preventive Care Medical Benefits that are not itemized and are provided on an inpatient basis by an in-network provider. Once you have met your Comprehensive Medical Benefit annual out-of-pocket maximum, the Plan will pay 100% of the Allowable Charge for Routine Preventive Care Medical Benefits that are not itemized and are provided on an inpatient basis by an in-network provider.

NOTE: All of the Plan's other rules regarding Routine Preventive Care Medical Benefits remain the same. Refer to Benefit Alert 34 for more information about the Plan's coverage of Routine Preventive Care Medical Benefits.

## 7. Improved Coverage for Telehealth Benefits Provided by Amwell

Effective January 1, 2017, after a Covered Person has paid a $10.00 copay, the Plan will pay 100% of the Allowable Charge for telehealth visits provided by Amwell. This means that deductibles and cost-sharing do not apply to telehealth visits provided by Amwell.

Telehealth services provided by Amwell can take care of many common medical issues like colds, flu, fever, rash, abdominal pain, sinusitis, pinkeye, ear infection, migraines and more. You can schedule a telehealth appointment with Amwell online at

www.amwell.com or through the Amwell mobile app that is available on Apple and Android operating systems. For help creating an online account, call or email the Amwell support team at 1-855-818-DOCS (3627) or support@americanwell.com. For more information regarding the Plan's coverage of telehealth benefits, contact the Fund Office.

## 8. Increased Deductible for Prescription Drug Benefits

Effective January 1, 2017, the Prescription Drug Benefit calendar year deductible for Eligible Employees and Dependents of Eligible Employees is increased to $200 per person and $400 per family. This means that if you are an Eligible Employee or a Dependent of an Eligible Employee, you will pay the first $200 per calendar year; however, your family will not pay more than a total of $400 in Prescription Drug Benefit deductibles for the calendar year.

The Prescription Drug Benefit calendar year deductible for Retirees and Dependents of Retirees has not changed. The following chart compares the Plan's current deductible for Prescription Drug Benefits to the Plan's deductible for Prescription Drug Benefits that will become effective on January 1, 2017:

| **If you are…** | **Your Current Deductible for Prescription Drug Benefits is…** | **Effective January 1, 2017 your Deductible for Prescription Drug Benefits is…** |
|---|---|---|
| **An Eligible Employee or a Dependent of an Eligible Employee** | $100 a person/$200 a family | $200 a person/$400 a family |
| **A Retiree or a Dependent of a Retiree** | $100 a person/$100 a family | $100 a person/$100 a family |

## 9. New Prescription Drug Benefit Annual Out-of-Pocket Maximum

The term "Prescription Drug Benefit annual out-of-pocket maximum" means the maximum dollar amount of copays that a Covered Person must pay out-of-pocket in a single calendar year before the Plan begins to pay 100% for covered Prescription Drug Benefits.

Prior to January 1, 2017, the Plan does not have a Prescription Drug Benefit out-of-pocket maximum. This means there is not a limit on the amount of copays that a Covered Person could pay for Prescription Drug Benefits during a calendar year.

Effective January 1, 2017, the Plan has a Prescription Drug Benefit out-of-pocket maximum of $2,550 per person and $5,100 per family. This means that effective January 1, 2017, a Covered Person will not pay more than $2,550 in copays for Prescription Drug Benefits during a calendar year, and a family will not pay more than $5,100 in copays for Prescription Drug Benefits during a calendar year. This applies to all Covered Persons (i.e. this applies to Eligible Employees, Retirees, and Dependents of Eligible Employees and Retirees).

## 10. Increased Self-Payment Premium Amount

As explained in greater detail in Benefit Alert 29, an individual that does not work enough hours to maintain coverage from the Plan can continue to receive coverage from the Plan for up to 18 months if (s)he pays a premium for each month of coverage. As indicated in Benefit Alert 29, the current self-payment premium is $100 a month for single coverage and $200 a month for family coverage (family coverage means coverage for an Eligible Employee and at least one Dependent).

Effective January 1, 2017 (i.e. effective for coverage on and after January 1, 2017), the self-payment premium is increased to the following amounts:

- $200 a month for single coverage (i.e. coverage for the Eligible Employee and no Dependents);
- $400 a month for coverage for an Eligible Employee and at least one Dependent child;
- $600 a month for coverage for an Eligible Employee and a Dependent spouse; and
- $600 a month for coverage for an Eligible Employee, a Dependent spouse, and at least one Dependent child.

If you are currently receiving single coverage through the Plan's self-payment option, your premium will increase to $200 effective January 1, 2017. This means that your coverage from the Plan will terminate if the Fund Office does not receive your $200 premium payment by the fifth business day of January 2017 (i.e. by January 9, 2017).

If you are currently receiving family coverage through the Plan's self-payment option, you will receive an election form from the Plan next week. If you want your Dependent(s) to remain covered by the Plan, you must elect coverage for your Dependent(s) on that enrollment form. Your coverage from the Plan will terminate if the Fund Office does not receive your enrollment form and applicable premium payment in full by the fifth business day of January 2017 (i.e. by January 9, 2017). If your coverage from the Plan is terminated, your Dependent's coverage from the Plan will also terminate.

NOTE: All of the Plan's other rules regarding the self-payment option remain the same, including but not limited to the rules regarding Dependent enrollment and termination of eligibility and coverage. Refer to Benefit Alert 29 for more information about the Plan's self-payment option.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
December 2016

## GRANDFATHERED STATUS

This group health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act) through December 31, 2016. 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 preventative 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 Wilson-McShane at (816) 756-3313 or toll-free at 1-866-756-3313. 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. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

This group health Plan will transition to become a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act) as of January 1, 2017.

# PIPE FITTERS LOCAL NO. 533
# HEALTH AND WELFARE FUND

# BENEFIT ALERT #38

Effective March 31, 2017, the Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Fund (the "533 Plan") has added a Working Spouse Rule to the 533 Plan. The purpose of this Benefit Alert is to explain the Working Spouse Rule. It is extremely important that you read all of the information in this Benefit Alert and keep the Benefit Alert with your Summary Plan Description ("SPD") for future reference.

## General Information Regarding the Working Spouse Rule

The Working Spouse Rule is a rule, which provides that if an Eligible Employee's spouse is employed and (s)he has Qualifying Health Coverage available from his or her employer, the spouse is not eligible for coverage from the 533 Plan unless (s)he is enrolled in his or her employer's health plan. The Working Spouse Rule does not apply to spouses of Retirees. The Working Spouse Rule also does not apply to children. The 533 Plan's rules regarding eligibility and coverage for spouses of Retirees and Dependent children have not changed.

The following terms have a specific meaning when they are used in this Benefit Alert:

- The term **"Qualifying Health Coverage"** means an employer-sponsored health plan that provides "minimum value" (as that term is defined by the Affordable Care Act), does not cost the Eligible Employee's spouse more than $250 a month (i.e. the Eligible Employee's spouse does not have to pay more than $250 a month for the least expensive coverage option that is available from his or her employer), and is not Exempt Coverage (as that term is defined below).

- The term **"Exempt Coverage"** means any of the following:
    - COBRA coverage;
    - Coverage that does not provide medical or prescription drug benefits (e.g. a dental plan or a vision plan); or
    - Coverage that does not permit another health plan to pay benefits on a secondary basis (i.e. coverage that is not available to an Eligible Employee's spouse if the Eligible Employee's spouse has secondary coverage from another health plan).*

  *If the employer-sponsored coverage available to an Eligible Employee's spouse is a high-deductible health plan ("HDHP") combined with a Health Savings Account ("HSA"), the coverage is **NOT** considered Exempt Coverage. This means that if the employer-sponsored coverage available to an Eligible Employee's spouse is a HDHP combined with a HSA, the spouse is not eligible for coverage from the 533 Plan unless (s)he is enrolled in his or her employer's HDHP. If the Eligible Employee's Spouse is enrolled in his or her employer's HDHP, (s)he is eligible for coverage from the 533 Plan regardless of whether or not (s)he makes or receives employer and/or

employer contributions to the HSA. For more details about HSAs, refer to the Section titled "Important Information about Health Savings Accounts ("HSAs")" found on page 7 of this Benefit Alert.

- The term **"Special Enrollment Period"** means a period that an employer is legally required to permit an employee to enroll in the employer's health plan. An employee is entitled to a Special Enrollment Period under the following circumstances:
    - If an employee had coverage under another group health plan and the employee lost eligibility for the other coverage, the employee is entitled to a 30-day Special Enrollment Period. This means that if an Eligible Employee's spouse is employed and covered by the 533 Plan in January, February and March of a calendar year, the spouse is entitled to a 30-day Special Enrollment Period that begins on March 31 of that year. In other words, the Participant's spouse's employer is legally required to allow the Participant's spouse to enroll in the employer's health plan during the period of March 31 through April 29 regardless of the date of the employer's typical enrollment period. This is because the spouse will lose coverage from the 533 Plan on March 31 unless (s)he is enrolled in his or her employer's health plan.
    - If an employee gets married, the employee is entitled to a 30-day Special Enrollment Period. This means that if an Eligible Employee's spouse is employed on the date that (s)he gets married, the spouse is entitled to a 30-day Special Enrollment Period that begins on the date of his or her marriage. In other words, the Eligible Employee's spouse's employer is legally required to allow the Eligible Employee's spouse to enroll in the employer's health plan during the 30-day period that begins on the date that the Eligible Employee's spouse got married regardless of the date of the employer's typical enrollment period.

**Details Regarding the Working Spouse Rule**

As explained in (a) and (b) below, the date that the Working Spouse Rule applies to the spouse of an Eligible Employee depends on whether or not the spouse is married to the Eligible Employee on January 1 of the calendar year.

**a. Working Spouse Rule for the Spouse of an Eligible Employee that is Married to the Eligible Employee on January 1 of a Calendar Year**

If on January 1 of a calendar year, an Eligible Employee is married to a spouse that is employed **and** on March 31 of the same calendar year the Eligible Employee's spouse has Qualifying Health Coverage available from his or her employer, then effective March 31 of that year, the spouse is not eligible for coverage from the 533 Plan unless (s)he is enrolled in his or her employer's health plan.

This means that if you are an Eligible Employee on January 1 of a calendar year, the following rules will apply to your spouse if (s)he is employed on January 1 of a calendar year and (s)he has Qualifying Health Coverage available from his or her employer on March 31 of that year:

- **If your spouse is enrolled in his or her employer's health plan on March 31 of that year, the 533 Plan will provide <u>secondary</u> coverage to your spouse in accordance with the coordination of benefits rules on pages 39-41 of your SPD.** If your spouse subsequently loses eligibility for Qualifying Health Coverage from his or her employer and you submit a new enrollment form to the Fund Office, the 533 Plan will provide primary coverage to your spouse on the date that your spouse's coverage from his or her employer's health plan was terminated.

- **If your spouse is not enrolled in his or her employer's health plan on March 31 of that year, your spouse's coverage from the 533 Plan will terminate at 11:59 p.m. on March 31.** Your spouse may have his or her coverage from the 533 Plan reinstated in accordance with the following rules:

    - **If your spouse is enrolled in his or her employer's health plan on April 1 of that year, your spouse will regain coverage from the 533 Plan on April 1.** If you submit an enrollment form to the Fund Office prior to March 31 of the calendar year, which indicates that your spouse will have coverage from his or her employer's health plan effective on April 1 of that year then your spouse will automatically become covered by the 533 Plan on April 1 (i.e. you do not have to submit a new enrollment form to the Fund Office for your spouse to have coverage on April 1). This means that if your spouse does not have coverage from his or her employer's plan on March 31 of a calendar year but your spouse will have coverage from his or her employer's health plan on April 1 of that year, then your spouse will lose coverage from the 533 Plan at 11:59 p.m. on March 31 and become covered by the 533 Plan again at 12:00 a.m. on April 1.

    - **If your spouse is not enrolled in his or her employer's health plan on April 1 of that year and your spouse subsequently enrolls in his or her employer's health plan, you must submit a new enrollment form to the Fund Office**. If your new enrollment form is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your spouse became covered by his or her employer's health plan, your spouse will become covered by the 533 Plan on the same date that your spouse became covered by his or her employer's health plan. If your new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your spouse became covered by his or her employer's health plan, your spouse will become covered by the 533 Plan on the first day of the month following the date that your new enrollment form was postmarked or otherwise positively received by the Fund Office.
    - **If your spouse is no longer eligible for Qualifying Health Coverage from his or her employer, you must submit an enrollment form to the Fund Office.** If your spouse lost eligibility for Qualifying Health Coverage from his or her employer, you must submit a new enrollment form to the Fund Office. If your new

enrollment form is postmarked or otherwise positively received by the Fund Office within 90 days after the date that your spouse was no longer eligible for Qualifying Health Coverage from his or her employer, your spouse will become covered by the 533 Plan on the same date that your spouse was no longer eligible for Qualifying Health Coverage. If your new enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that your spouse was no longer eligible for Qualifying Health Coverage from his or her employer, your spouse will become covered by the 533 Plan on the first day of the month following the date that your new enrollment form was postmarked or otherwise positively received by the Fund Office.

If your spouse loses eligibility for Qualifying Health Coverage during a calendar year, the Working Spouse Rule will not apply to your spouse for the remainder of that calendar year. This means that if your spouse loses eligibility for Qualifying Health Coverage during a calendar year, and you submit a new enrollment form to the Fund Office, your spouse will have coverage from the 533 Plan for the rest of that year regardless of whether or not your spouse subsequently becomes eligible for Qualifying Health Coverage (see example #3 on page 9 of this Benefit Alert).

The rules in this Section only apply if you are covered by the 533 Plan as an Eligible Employee on January 1 of a calendar year. If you are not covered by the 533 Plan on January 1 of a calendar year, these rules do not apply to your spouse during that year. This means that if you are not covered by the 533 Plan on January 1 of a calendar year, then your spouse's eligibility for coverage from the 533 Plan during that calendar year will not depend on whether or not your spouse is enrolled in Qualifying Health Coverage that is available from his or her employer.

**IMPORTANT INFORMATION:** If your spouse is employed on January 1 of a calendar year and your spouse is eligible for, but not enrolled in, his or her employer's health plan prior to March 31 of that year, your spouse is entitled to a 30-day Special Enrollment Period that begins on March 31 of that year. This means that your spouse's employer is legally required to allow your spouse to enroll in the employer's health plan during the period of March 31 through April 29 of that year regardless of the date of the employer's typical open enrollment period. It is extremely important for your spouse to enroll in his or her employer's health plan during this Special Enrollment Period.

**NOTE: It is extremely important for your spouse to submit enrollment paperwork to his or her employer as soon as possible. This is because your spouse's employer might not allow your spouse to become covered by the employer's health plan until the first day of the month following the date that the employer receives your spouse's enrollment paperwork. For example, if your spouse submits enrollment paperwork to his or her employer on April 3, 2017, your spouse's employer might not allow your spouse to become covered by the employer's health plan until May 1, 2017. If this occurs, your spouse would not have coverage from his or her employer's plan or the 533 Plan during the period of March 31, 2017 through April 30, 2017.**

**b. Working Spouse Rule for the Spouse of an Eligible Employee that is not Married to the Eligible Employee on January 1 of a Calendar Year**

If an Eligible Employee gets married after January 1 of a calendar year (i.e. if an Eligible Employee gets married between January 2 and December 31 of a calendar year), and on the date of the Eligible Employee's marriage the Eligible Employee's spouse is employed and has Qualifying Health Coverage available from his or her employer, then the Eligible Employee's spouse is not eligible for coverage from the 533 Plan unless (s)he is enrolled in his or her employer's health plan.

This means that if you are an Eligible Employee and after January 1 of a calendar year you get married to a spouse who has Qualifying Health Coverage available from his or her employer on the date of your marriage, the following rules will apply:

- **If your spouse is enrolled in his or her employer's health plan on the date of your marriage and an enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date of your marriage, the 533 Plan will provide secondary coverage to your spouse effective on the date of your marriage in accordance with the coordination of benefits rules on pages 39-41 of your SPD.** If your spouse subsequently loses eligibility for Qualifying Health Coverage from his or her employer, the 533 Plan will provide primary coverage to your spouse on the date that your spouse's coverage from his or her employer's health plan was terminated.

- **If your spouse is not enrolled in his or her employer's health plan on the date of your marriage or an enrollment form for your spouse is not postmarked or otherwise positively received by the Fund Office within 90 days after the date of your marriage, your spouse will not have coverage from the 533 Plan on the date of your marriage.** Your spouse may subsequently become covered by the 533 Plan in accordance with the following rules:

    - **If your spouse is enrolled in his or her employer's health plan on the date of your marriage, but an enrollment form for your spouse is not postmarked or otherwise positively received by the Fund Office within 90 days after the date of your marriage,**

**the Plan will provide secondary coverage to your spouse on the first day of the month following the date that an enrollment form for your spouse was postmarked or otherwise positively received by the Fund Office.**

- **If your spouse is not enrolled in his or her employer's health plan on the date of your marriage and your spouse subsequently enrolls in his or her employer's health plan, you must submit an enrollment form to the Fund Office.** The 533 Plan will provide secondary coverage to your spouse on the first day of the month following the date that your spouse is enrolled in his or her employer's health plan and an enrollment form regarding that coverage was postmarked or otherwise positively received by the Fund Office.

- **If your spouse is no longer eligible for Qualifying Health Coverage from his or her employer, you must submit an enrollment form to the Fund Office.** If your spouse lost eligibility for Qualifying Health Coverage from his or her employer within 90 days after the date of your marriage and an enrollment form regarding the loss of eligibility for Qualifying Health Coverage was postmarked or otherwise positively received by the Fund Office within 90 days after the date of your marriage, your spouse will become covered by the 533 Plan on the date that (s)he was no longer eligible for Qualifying Health Coverage from his or her employer. If your spouse did not lose eligibility for Qualifying Health Coverage from his or her employer within 90 days after the date of your marriage or an enrollment form regarding the loss of eligibility for Qualifying Health Coverage was not postmarked or otherwise positively received by the Fund Office within 90 days after the date of your marriage, your spouse will become covered by the 533 Plan on the first day of the month following the date that the enrollment form regarding the loss of other coverage was postmarked or otherwise positively received by the Fund Office.

If your spouse loses eligibility for Qualifying Health Coverage during a calendar year, the Working Spouse Rule will not apply to your spouse for the remainder of that calendar year. This means that if your spouse loses eligibility for Qualifying Health Coverage during a calendar year and you submit a new enrollment form to the Fund Office, your spouse will have coverage from the 533 Plan for the rest of that year regardless of whether or not your spouse subsequently becomes eligible for Qualifying Health Coverage.

The rules in this Section apply regardless of whether or not you are covered by the 533 Plan as an Eligible Employee on January 1 of a calendar year. This means that if you get married after January 1 and you are covered by the 533 Plan on the date of your marriage, your spouse's eligibility for coverage from the 533 Plan will depend on whether or not your spouse is enrolled in Qualifying Health Coverage that is available from his or her employer. The rules in this Section do

not apply if you are not covered by the 533 Plan on the date of your marriage.

**IMPORTANT INFORMATION FOR NEW SPOUSES:** If you get married, your spouse is entitled to a 30-day Special Enrollment Period that begins on the date of your marriage. This means that your spouse's employer is legally required to allow your spouse to enroll in the employer's health plan during the 30-day period that begins on the date of your marriage regardless of the date of the employer's typical enrollment period. It is extremely important for your spouse to enroll in his or her employer's health plan during this Special Enrollment Period.

## Important Information about Health Savings Accounts ("HSAs")

If you are an Eligible Employee and the employer-sponsored coverage available to your spouse is a HDHP combined with a HSA, Federal Law provides that your spouse is only eligible to receive or make tax-advantaged employer and/or employee contributions to his or her HSA if (s)he is not covered by another health plan. This means that although your spouse is eligible for coverage from the 533 Plan regardless of whether or not (s)he makes or receives employer and/or employee contributions to his or her employer's HSA, your spouse is not allowed to receive tax-advantaged treatment of those contributions if (s)he is covered by the 533 Plan. The result is that your spouse has the following three options:

- Enroll in his or her employer's HDHP, have secondary coverage from the 533 Plan, and avoid the employer's HSA (i.e. do not make or receive HSA contributions);
- Enroll in his or her employer's HDHP, have secondary coverage from the 533 Plan, utilize the HSA and pay taxes (which could include excise taxes) on the HSA contributions; or
- Enroll is his or her employer's HDHP, waive coverage from the 533 Plan, and utilize the employer's HSA on a tax-favored basis. Refer to Benefit Alert 28 for information regarding the 533 Plan's rules for waiving coverage.

**NOTE: The information in this Benefit Alert is for the sole purpose of providing you a summary of the laws that govern HSA contributions. This information is <u>not</u> tax advice, and it is not intended to and cannot be used for the purpose of avoiding penalties that may be imposed under the United States federal tax laws or for the purpose of promoting, marketing, or recommending any transaction. The information in this Benefit Alert is based on the laws in effect as of January 1, 2017. These laws are extremely complicated and are subject to change. Although the Fund Office may provide certain general information regarding the tax consequences of HSA contributions, it cannot provide tax advice. For these reasons, you may wish to consult with a professional tax advisor before you determine whether or not your spouse should make and/or receive contributions to his or her employer's HSA.**

**** Please see the following pages for examples of the Working Spouse Rule. ****

**Examples of the Working Spouse Rule**

The following examples illustrate how the Working Spouse Rule works:

**Example #1:** If an Eligible Employee's spouse, Mary, is employed on January 1, 2017 and on March 31, 2017 she has Qualifying Health Coverage available from her employer and her cost for the least expensive coverage option does not exceed $250 per month, then Mary's coverage from the 533 Plan **will terminate** at 11:59 p.m. on March 31, 2017 unless Mary is enrolled in her employer's health plan. If Mary is covered by her employer's health plan, she will have secondary coverage from the 533 Plan in accordance with the coordination of benefits rules found on pages 39-41 of your SPD.

Although Mary's employer may offer coverage buy-ups for her spouse (i.e. the 533 Plan Participant) and/or her children, the Working Spouse Rule does not require Mary to elect coverage for her spouse and/or Dependent children, regardless of the cost of such available coverage. Should Mary voluntarily elect to enroll her spouse and/or children in her employer's health plan, the 533 Plan will provide coverage to Mary's spouse and children in accordance with the coordination of benefits rules found on pages 39-41 of your SPD.

**Example #2:** If an Eligible Employee is covered by the 533 Plan on January 1, 2017, the Participant's spouse, Betty, was not employed as of January 1, 2017, and on June 1, 2017 Betty starts working for a new employer and has Qualifying Health Coverage available from that employer, the Working Spouse Rule would not apply to Betty until 2018 (i.e. Betty will have coverage from the 533 Plan until March 31, 2018 regardless of whether or not she is enrolled in her employer's plan so long as Betty is otherwise eligible for coverage from the 533 Plan). If Betty is still employed on January 1, 2018 and she still has Qualifying Health Coverage available from her employer on March 31, 2018 at a cost that does not exceed $250 per month for the least expensive coverage option, then Betty's coverage from the 533 Plan **will terminate** at 11:59 p.m. on March 31, 2018 unless Betty is enrolled in her employer's health plan. If Betty is covered by her employer's health plan, she will have secondary coverage from the 533 Plan in accordance with the coordination of benefits rules found on pages 39-41 of your SPD.

Although Betty's employer may offer coverage buy-ups for her spouse (i.e. the 533 Plan Participant) and/or her children, the Working Spouse Rule does not require Betty to elect coverage for her spouse and/or Dependent children, regardless of the cost of such available coverage. Should Betty voluntarily elect to enroll her spouse and/or children in her employer's health plan, the 533 Plan will provide coverage to Betty's spouse and children in accordance with the coordination of benefits rules found on pages 39-41 of your SPD.

**Example #3:** On January 1, 2017, an Eligible Employee is married and covered by the 533 Plan and his spouse, Justine, is employed by Employer X. On March 31, 2017, Justine has Qualifying Health Coverage available from Employer X. Effective 11:59 p.m. on March 31, 2017, Justine is only eligible for coverage from the 533 Plan if she is enrolled in Employer X's plan. On June 15, 2017, Justine stops working for Employer X. On July 1, 2017, Justine is no longer eligible for Qualifying Health Coverage from Employer X. On July 5, 2017, the Eligible Employee submits a new enrollment form to the 533 Fund Office, which indicates that Justine no longer has Qualifying Health Coverage available from her employer. Effective July 1, 2017, the 533 Plan will provide primary coverage to Justine. If on September 1, 2017 Justine becomes employed by Employer Y, and on October 1, 2017, Justine becomes eligible for Qualifying Health

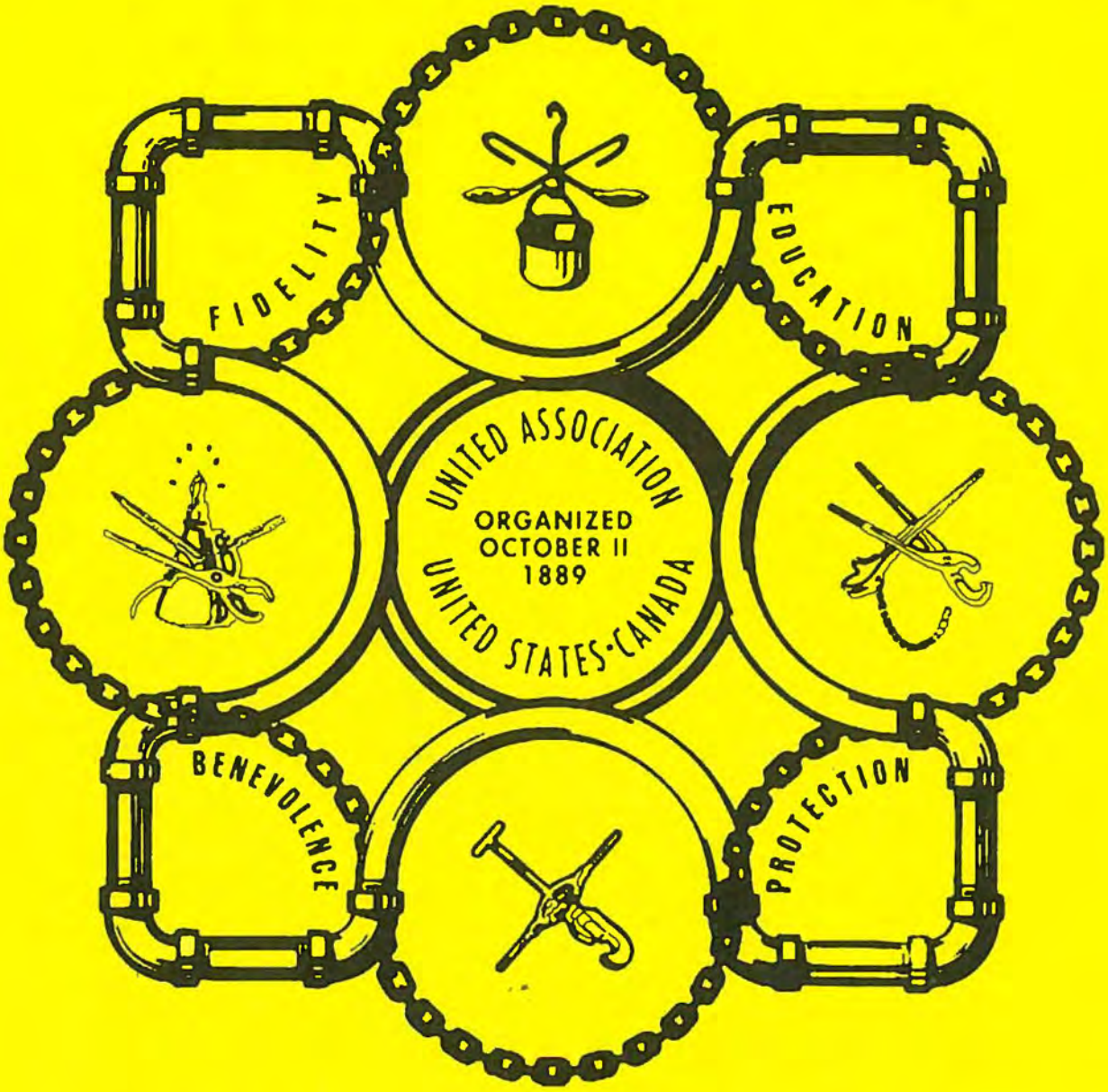
Coverage from Employer Y, Justine is still eligible for coverage from the 533 Plan until March 31, 2018 regardless of whether or not she is enrolled in Employer Y's health plan so long as Justine is otherwise eligible for coverage from the 533 Plan. If on January 1, 2018, Justine is still employed by Employer Y and on March 31, 2018, Justine still has Qualifying Health Coverage available from Employer Y, then effective at 11:59 p.m. on March 31, 2018, Justine is only eligible for coverage from the 533 Plan if she is enrolled in Employer Y's plan.

Should you have any questions, please contact the Fund Office.

Sincerely,

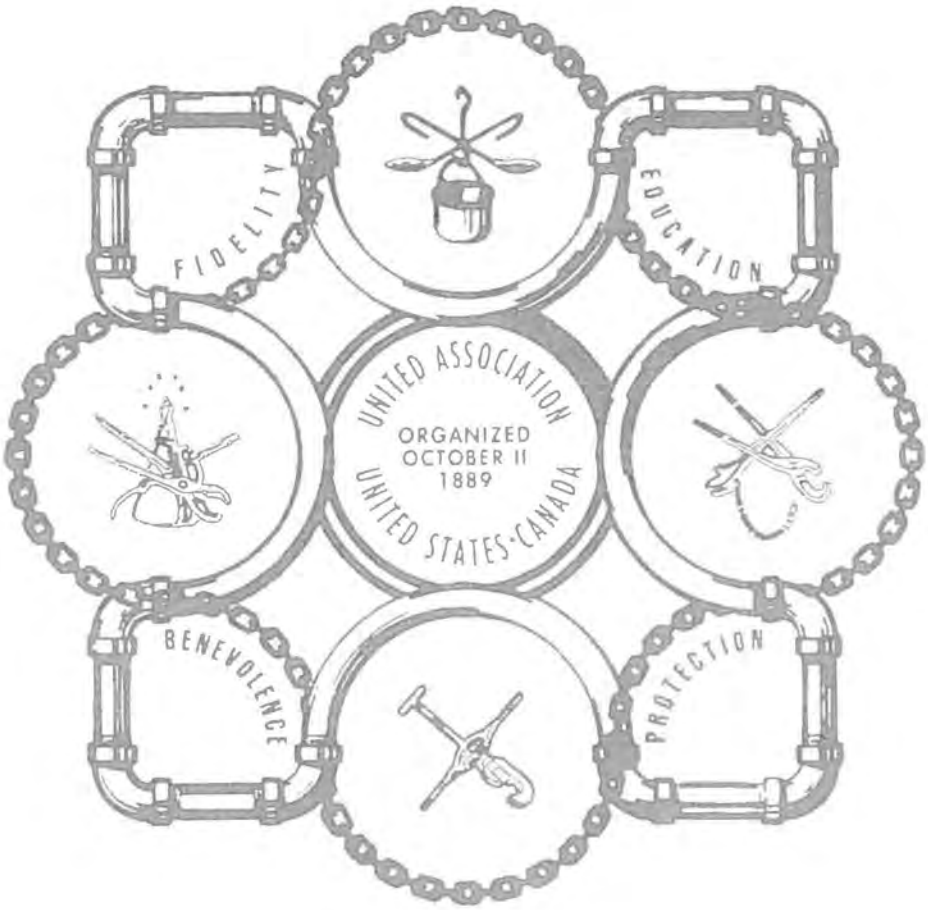
BOARD OF TRUSTEES
January, 2017

# PIPE FITTERS LOCAL UNION 533
# HEALTH AND WELFARE PLAN
# KANSAS CITY, MISSOURI




# SUMMARY PLAN DESCRIPTION

**Effective July 1, 2009**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UNITED STATES·CANADA
BENEVOLENCE
PROTECTION

## ***INTRODUCTION***

This document is your Summary Plan Description (SPD). It is a Summary of the benefits you are entitled to under the Pipe Fitters Local No. 533 Health and Welfare Plan pursuant to the Plan's governing documents. These documents include the Official Plan Document, the Restated Agreement and Declaration of Trust of the Pipe Fitters Local No. 533 Health and Welfare Fund (the Trust), and the Collective Bargaining Agreement between Pipe Fitters Association Local Union No. 533 (the Union) and the Mechanical Contractors Association of Kansas City (the Association). Under these governing documents the Board of Trustees has the power and discretion to amend, change, add to, interpret, or terminate the Plan.

This SPD incorporates the most recent Plan of benefits as restated effective July 1, 2009 and incorporates any Plan Amendments made through that date. The SPD was written in a way to help you understand your benefits under the Plan. It contains general explanations only. If something is not clear, you should contact your Plan Administrator for more specific information.

Throughout this document, certain terms are used that have very specific meanings. They are capitalized wherever they are used in the SPD. These terms are defined at the beginning of this SPD on page 1.

You should remember that the Fund's money is <u>your</u> money. By saving the Plan money, we are able to provide better benefits, and it helps to lessen the need to add a higher contribution rate, which may ultimately decrease your paycheck. There are certain things that you can do to help in this effort, such as using in-network service providers, and using the mail-order prescription drug service or generic prescription drugs whenever possible. If you feel you are overcharged by a provider, please call the provider and ask for an itemized bill of your expenses. Being aware of your benefits under this Plan will help you to make good choices when making your healthcare decisions.

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

We hope you find this SPD useful, and we hope that you and your family will enjoy the protections of the Plan for years to come.

Sincerely,

Board of Trustees

## *IMPORTANT INFORMATION REGARDING YOUR BENEFITS*

***In-Network Providers:*** Please be aware of the following situations:

1) When you get a referral from your doctor you should ensure that the referral doctor is in-network.

2) Certain procedures can be performed at facilities other than your doctor's office or a hospital. Ensure that the facility where the procedure is being performed is an in-network provider.

3) Please be aware that certain hospitals use independent specialty contractor doctors rather than staff doctors. A hospital may be in-network; however certain providers in that hospital may not be in-network. For example, an anesthesiologist at a hospital may not be in-network although the hospital is in-network. In these instances you may get a separate bill from the independent contractor provider who will not necessarily be in-network.

***Prior Authorization:*** Some services and benefits under the Plan require prior authorization from the Plan Administrator. Please carefully read each section of the Plan to determine whether a service or benefit requires prior authorization. Please contact the Plan Administrator if you have any questions regarding whether a particular service or benefit requires prior authorization.

Schedule of Benefits for Eligible Employees and Dependents
(All Benefit Amounts Listed are Per Covered Person, except the Family Deductible Maximum, as Shown Below)

| Description of Benefit | Emp'ee | Dep. | Co-Pay | Co-ins. | Plan pays | Deductible | Annual Max. | Separate Program Max. |
|---|---|---|---|---|---|---|---|---|
| **Death Bene.** | X | | n/a | n/a | $10,000 | n/a | n/a | no |
| **Loss of Time** | X | | n/a | n/a | $400/wk | n/a | n/a | 26 wk/ disability |
| **AD&D** | X | | n/a | n/a | $1,500* | n/a | n/a | no |
| **Comp. Med.**** | | | | | | | | |
| all covered charges in-network | X | X | n/a | 15% up to $20,000 | 85% up to $20,000, 100% of excess | $300, NTE $600 per family | n/a | n/a |
| all covered charges out of network | X | X | n/a | 40% up to $20,000 | 60% up to $20,000, 100% of excess | $300, NTE $600 per family | n/a | n/a |
| emergency out of network | X | X | n/a | 20% up to $20,000 | 80% up to $20,000, 100% of excess | $300, NTE $600 per family, comb. w/ in-network and out-of-network | n/a | n/a |
| WELLNESS | X | spouse only | $0.00 | 0% | 100% | none | n/a | subj. to age-based sched. |
| ROUTINE/ PREVENTIVE CARE | X | spouse only | $0.00 | 0% | 100% up to max. | none | $300 | subj. to age-based sched. |
| WELL CHILD | | child only | $0.00 | 0% | 100% | same as Comp Med. | n/a | subj. to age-based sched. |
| MED. APPLIANCES & SUPPLIES | X | X | n/a | 15% | 85% | same as Comp. Med. | $5,000 | $5,000/yr. |
| Ambulance | X | X | n/a | 15% | 85% | same as Comp. Med. | n/a | n/a |
| Hospice care | X | X | $0.00 | 0% | 100% | none | 210 days | 210 days |
| Organ Transplant | X | X | See Page 34 for explanation of benefits | | | | n/a | $1,000,000/ lifetime |
| MENTAL HEALTH | | | | | | | | |
| In-network inpatient | X | X | n/a | same as Comp. Med. | same as Comp. Med | none | 30 days | n/a |
| inpatient out of network | X | X | n/a | 40% | 60% | none | 30 days | n/a |
| outpatient in-network (no out-of-network benefits) | X | X | n/a | 50% | 50% | none | 45 visits (all MH/SA outpt) | n/a |
| outpatient in-network following amputation | X | X | n/a | 15% up to $20,000 | 85% up to $20,000, 100% of excess | none | 45 visits (all MH/SA outpt) | n/a |
| SUBSTANCE ABUSE | | | | | | | | |
| in-network inpatient | X | X | n/a | 0% | 100% up to $7,500 | none | 30 days or $7,500.00 | $7,500/yr. |
| inpatient out of network | X | X | n/a | 40% | 60% up to $7,500 | none | 30 days or $7,500.00 | $7,500/yr. |
| outpatient in-network (no out-of-network benefits) | X | X | n/a | 50% | 50% | none | 45 visits (all MH/SA outpt) | n/a |
| outpatient with EAP referral | X | | n/a | 0% | 100% | none | 45 visits (all MH/SA outpt) | n/a |
| Case Management | X | X | Provided for any participant at the discretion of, and upon request of, the Board of Trustees | | | | | |
| **Prescription Drug** | | | | | | | | |
| retail generic | X | X | $15.00 | 0% | 100% above co-pay | $100, NTE $200 per family | n/a | n/a |
| retail preferred brand name | X | X | $30.00 | 0%*** | 100% above co-pay | | n/a | n/a |
| retail non-preferred brand name | X | X | $50.00 | 0%*** | 100% above co-pay | | n/a | n/a |
| mail order generic | X | X | $30/Rx up to 90d | 0% | 100% above co-pay | | n/a | n/a |
| mail order preferred brand name | X | X | $60/Rx up to 90d | 0%*** | 100% above co-pay | | n/a | n/a |
| mail order brand name | X | X | $100/Rx up to 90d | 0%*** | 100% above co-pay | | n/a | n/a |
| **Dental** | | | | | | | | |
| In-network | X | X | n/a | 20% | 80% | none | $1,500 | $1,500/yr |
| out-network | X | X | n/a | 40% | 60% | none | $1,500 | $1,500/yr |
| dental inplants | X | X | n/a | n/a | 50% up to $1,500 dental max per year | none | $1,500 | $1,500/yr |
| **Hearing Aid** | X | X | n/a | 0% | 100% up to max. | none | n/a | $2,000/ 5 consec. calendar years |

*$1,500 principal amount; percentage paid for partial losses
**Comprehensive Medical benefits include reasonable, usual, and customary charge for medically necessary care and treatment of an injury or sickness.
***When a generic equivalent is available, the member must pay the difference in ingredient cost between the generic and the brand name.

Schedule of Benefits for Retirees and Dependents (Benefit Amounts Shown are Per Person, except for Family Deductibles where Listed)

| Description of Benefit | Ret. | Dep. | Co-Pay | Co-Ins. | Plan pays | Deductible | Annual Max. | Separate Program Max. |
|---|---|---|---|---|---|---|---|---|
| Death Bene. | X | | n/a | n/a | $10,000 | n/a | n/a | no |
| Comp. Med.* | | | | | | | | |
| all covered charges in-network for Retiree w/application for pension on or before 12/29/2006 and effective date on or before 3/31/2007 | X | X | n/a | 15% up to $10,000 | 85% up to $10,000, 100% of excess | $150, NTE $300 per family | n/a | n/a |
| all covered charges in-network for Retiree w/application for pension after 12/29/2006 or effective date after 3/31/2007 | X | X | n/a | 15% up to $20,000 | 85% up to $20,000, 100% of excess | $300, NTE $600 per family, comb. w/ in-network | n/a | n/a |
| all covered charges out of network for Retiree w/application for pension on or before 12/29/2006 and effective date on or before 3/31/2007 | X | X | n/a | 40% up to $15,000 | 60% up to $15,000, 100% of excess | $400, NTE $800 per family | n/a | n/a |
| all covered charges out of network for Retiree w/application for pension after 12/29/2006 or effective date after 3/31/2007 | X | X | n/a | 40% up to $20,000 | 60% up to $20,000, 100% of excess | $300, NTE $600 per family | n/a | n/a |
| emergency out of network for Retiree w/application for pension on or before 12/29/2006 and effective date on or before 3/31/2007 | X | X | n/a | 20% up to $10,000 | 80% up to $10,000, 100% of excess | $150, NTE $300 per family, comb. w/ in-network | n/a | n/a |
| emergency out of network for Retiree w/application for pension after 12/29/2006 and effective date after 3/31/2007 | X | X | n/a | 20% up to $20,000 | 80% up to $20,000, 100% of excess | $300, NTE $600 per family, comb. w/ in-network and out-of-network | n/a | n/a |
| WELLNESS | X | Spouse Only | $0.00 | 0% | 100% | none | n/a | subj. to age-based sched. |
| ROUTINE/ PREVENTIVE CARE | X | Spouse Only | $0.00 | 0% | 100% up to max. | none | $300 | subj. to age-based sched. |
| WELL CHILD | | | n/a | n/a | n/a | n/a | n/a | n/a |
| MED. APPLIANCES & SUPPLIES | X | X | n/a | 20% | 80% | same as Comp. Med. | $5,000 | $5,000/yr. |
| Ambulance | X | X | n/a | 20% | 80% | same as Comp. Med. | n/a | n/a |
| Hospice care | X | X | $0.00 | 0% | 100% | none | 210 days | 210 days |
| Organ Transplant | X | X | See pages for explanation of benefits | | | | n/a | $1,000,000/ lifetime |
| MENTAL HEALTH | | | | | | | | |
| in-network inpatient | X | X | n/a | same as Comp. Med. | same as Comp. Med. | none | 30 days | n/a |
| inpatient out of network | X | X | n/a | 40% | 60% | none | 30 days | n/a |
| outpatient in-network (no out of network benefits) | X | X | n/a | 50% | 50% | none | 45 visits (all MH/SA outpt) | n/a |
| outpatient in-network following amputation for Retiree w/application for pension on or before 12/29/2006 and effective date on or before 3/31/2007 | X | X | n/a | 15% up to $10,000 | 85% up to $10,000, 100% of excess | none | 45 visits (all MH/SA outpt) | n/a |
| outpatient in-network following amputation for Retiree w/application for pension after 12/29/2006 or effective date after 3/31/2007 | X | X | n/a | 15% up to $20,000 | 85% up to $20,000, 100% of excess | none | 45 visits (all MH/SA outpt) | n/a |
| SUBSTANCE ABUSE | | | | | | | | |
| In-network inpatient | X | X | n/a | 0% | 100% up to $7,500 | none | 30 days or $7,500.00 | $7,500/yr. |
| inpatient out of network | X | X | n/a | 40% | 60% up to $7,500 | none | 30 days or $7,500.00 | $7,500/yr. |
| outpatient in-network (no out of network benefits) | X | X | n/a | 50% | 50% | none | 45 visits (all MH/SA outpt) | n/a |
| Case Management | X | X | Provided for any participant at the discretion of, and upon request of, the Board of Trustees | | | | | |
| Prescription Drug | | | | | | | | |
| retail generic | X | X | $15.00 | 0% | 100% above co-pay | $100 per family | n/a | n/a |
| retail preferred brand name | X | X | $30.00 | 0%** | 100% above co-pay | | n/a | n/a |
| retail non-preferred brand name | X | X | $50.00 | 0%** | 100% above co-pay | | n/a | n/a |
| mail order generic | X | X | $30/Rx up to 90d | 0% | 100% above co-pay | | n/a | n/a |
| mail order preferred brand name | X | X | $60/Rx up to 90d | 0%** | 100% above co-pay | | n/a | n/a |
| mail order brand name | X | X | $100/Rx up to 90d | 0%** | 100% above co-pay | | n/a | n/a |
| Dental | | | | | | | | |
| In-network | X | X | n/a | 20% | 80% | none | $1,500 | $1,500/yr. |
| out-network | X | X | n/a | 40% | 60% | none | $1,500 | $1,500/yr. |
| dental implants | X | X | n/a | n/a | 50% up to $1,500 dental max per year | none | $1,500 | $1,500/yr. |
| Vision | X | X | n/a | 0% subj. to bene. max. | 100% up to bene. max. | none | varies by item | yes |
| Hearing Aid | X | X | n/a | 0% | 100% up to max. | none | n/a | $2,000/ 5 consec. calendar years |

*Comprehensive Medical benefits include reasonable, usual, and customary charge for medically necessary care and treatment of an injury or sickness.
**When a generic equivalent is available, the member must pay the difference in ingredient cost between the generic and the brand name.

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## ***DEFINITIONS OF COMMON TERMS USED IN THIS SPD***

The ***Allowable Charge*** is a reasonable charge for the covered service, product, or procedure that is the subject of the claim.

An ***Alternate Recipient*** is a person who is entitled to coverage under this Plan under a Qualified Medical Child Support Order.

***Association*** means the Mechanical Contractors Association of Greater Kansas City.

A ***Beneficiary*** is any person who is eligible to receive benefits under this Plan based on a Participant's (i.e., an Eligible Employee's or a Retiree's) participation in this Plan.

***Collective Bargaining Agreement*** means the Agreement and Contract by and between Members of Mechanical Contractors Association of Kansas City and Pipe Fitters Association Local Union No. 533 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada; as well as any other collective bargaining agreement between the Union and any other Participating Employer that sets forth benefits to be provided under this Plan or establishes any rights or obligations with respect to Participants, Beneficiaries, or contributing Employers.

***Coverage Period*** means a specified period of time for which a Covered Person is eligible to receive benefits under the terms of this Plan.

***Covered Person*** is any person who is eligible to receive benefits from this Plan, including Participants (Eligible Employees and Retirees), Dependents, and Designated Beneficiaries.

***Dentist*** is a health care provider licensed to practice dentistry by the State in which he practices.

***Dependent*** means a person who is (a) an Eligible Child or (b) the spouse (unless legally separated) of an Eligible Employee or Retiree.

***Designated Beneficiary*** is the person designated by the Participant, or by the terms of this Plan, to receive such Participant's benefits under the Death Benefit and Accidental Death and Dismemberment Benefit Programs of this Plan.

***Disability*** means an Eligible Employee will be considered to be disabled during any period when, as a result of an injury or sickness, he is unable to work at his occupation and is not performing any other work for wage or profit. A Dependent will be considered disabled during any period when, as a result of injury or sickness, (s)he is unable (because of a physical or mental condition) to engage in the normal activities of a person of the same age and gender.

***Eligible Child*** means any Dependent child of an Eligible Employee or Retiree who meets the criteria for coverage under this Plan.

***Eligible Employee*** means any Employee employed by a Participating Employer (an Employer signatory to a Collective Bargaining Agreement with the Union) who performs work covered by that Collective Bargaining Agreement, who has met the requirements to obtain coverage under this Plan, and on whose behalf contributions are made to the Plan pursuant to the Collective Bargaining Agreement. This term also refers to any regularly paid employee of the Union on whose behalf the Union makes contributions to the Plan, any regularly paid employee of the Fund, of the Pipe Fitters Local No. 533 Pension Fund, or of the Pipe Fitters Local No. 533 Training Center. See page 5 of this SPD for more in-depth eligibility rules.

An ***Emergency*** is any situation in which, due to an accident or Sickness, a person requires immediate medical care and delay could endanger the person's life, health, functioning, or could cause extreme pain that cannot be controlled without such medical care.

***Employee*** means any person employed by an Employer to perform work covered by the Collective Bargaining Agreement between the Union and the Association (or any Collective Bargaining Agreement entered into between the Union and any other individual Employer), as well as any regularly paid employee of the Fund, the Pipe Fitters Local No. 533 Pension Fund, or the Pipe Fitters Local No. 533 Training Center.

***Employer*** means any entity employing persons to perform work that is covered by the Collective Bargaining Agreement between the Union and the Association within the geographic area covered by such Collective Bargaining Agreement. (*See also* Participating Employer.)

***Fund*** means the Pipe Fitters Local No. 533 Health and Welfare Fund. (*See also* Plan.)

***Fund Office*** means any office or other physical location out of which the Fund is administered.

***Hospice*** means palliative care provided to a person with a terminal illness and his family, to provide for the basic life functions and necessities of life during this time, including pain relief, in anticipation of the Covered Person's death, related services for the Covered Person's family to assist in the transition to the person's death, and to provide grief counseling.

***Hospital*** means:

(1) an institution constituted, licensed, and operated in accordance with the laws pertaining to hospitals, which maintains on its premises all facilities necessary to provide for the diagnosis and medical and surgical treatment of injury or sickness and which provides such treatment for compensation, by or under the supervision of Physicians on an inpatient basis with continuous 24-hour nursing service by Registered Nurses; or

(2) an institution which qualifies as a hospital, a psychiatric hospital, a tuberculosis hospital, or a provider of services under Medicare, and which is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

(3) The term "Hospital" does not include an institution which is, other than incidentally, a place for rest, a place for the aged, or a nursing home.

***Medically Necessary*** (or ***Medical Necessity***) means medical care that is required to treat an injury or Sickness, and the absence of which could cause adverse consequences for the person in need of such medical care.

***Medicare*** means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

***Mental Health Care Condition*** means a physical or mental condition that causes cognitive or emotional effects, including any condition listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Ed. (DSM-IV), published by the American Psychiatric Association, or subsequent revisions thereof.

***Mental Health Care Provider*** means a person licensed by the State in which he practices to provide mental health counseling or therapy, and who has an appropriate educational degree or certificate in psychology, counseling, mental health care, or related field.

***Nurse Practitioner*** is a primary treating health care provider, and the term refers to a person who is both:

(1) a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with state law, if any is applicable; and

(2) certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

***Nurse Practitioner Retail Clinic*** is a health care facility located in either a retail store, supermarket or pharmacy that treats routine family illnesses and may provide limited preventative health care services. Such facilities are staffed primarily by licensed Nurse Practitioners or Physician Assistants.

***Participant*** is any Eligible Employee or Eligible Retired Employee who has met all prerequisites to obtain coverage under this Plan and who is enrolled for coverage under this Plan.

***Participating Employer*** is any Employer who is signatory to a Collective Bargaining Agreement with the Union, who employs persons to perform work covered by that Collective Bargaining Agreement, and who makes contributions to the Fund as required by the Collective Bargaining Agreement.

***Physician*** means:

(1) an individual, other than a Dentist, who is operating within the scope of his license and is licensed to prescribe and administer drugs or to perform surgery, or

(2) a Clinical Psychologist who holds a Ph.D. or Psy.D. in psychology, is duly licensed or certified, is working with the scope of such license or certification, and who is referred by, or working under the supervision of, a person described in clause (1) above.

***Physician Assistant*** means a person who is both:

(1) a physician assistant who is authorized by the State in which the services are furnished to practice as a physician assistant in accordance with state law, if any is applicable, and

(2) certified as a physician assistant by a recognized national certifying body that has established standards for physician assistants.

***Plan*** means the Pipe Fitters Local No. 533 Health and Welfare Plan, that is, the plan of benefits offered under the terms of the Restated Agreement and Declaration of Trust of the Pipe Fitters Local No. 533 Health & Welfare Fund.

***Plan Administrator*** means the Board of Trustees of the Pipe Fitters Local No. 533 Health and Welfare Fund. The Board of Trustees retains ultimate authority as the Plan Administrator for this Plan, but this term also refers to any person or entity responsible for carrying out the regular administrative functions and activities on behalf of the Plan.

***Plan Sponsor*** is the Board of Trustees of the Pipe Fitters Local No. 533 Health & Welfare Fund.

***Qualified Beneficiary*** is a person who is entitled to continue coverage under this Plan pursuant to COBRA continuation coverage.

***Qualifying Event*** is an event pursuant to which a Covered Person loses coverage under this Plan, and which allows the Covered Person to become a Qualified Beneficiary, and thus to continue coverage under the Plan pursuant to COBRA continuation coverage.

***Qualifying Period*** is a certain four-month block of time during which you must work the required number of hours to become eligible for coverage under the Plan, and once you are eligible it is the block of time during which you must work the required number of hours to maintain your eligibility for coverage. Also see pages 5, 6, and 7 of this SPD.

***Reasonable, Usual, and Customary Charges*** for medical services or supplies are the amount normally charged by the provider for similar services or supplies, and do not exceed the amount ordinarily charged by most providers of comparable services or supplies in the locality where the services or supplies are received.

***Registered Nurse*** means a professional nurse who is licensed, registered, or certified in the State in which he is providing health care services, and who has the right to use the title "Registered Nurse" and the abbreviation "R.N."

***Retired Employee*** (or ***"Retiree"***) means any person receiving benefits under the Pipe Fitters Local No. 533 Pension Plan who is eligible to receive benefits under this Plan.

***Sickness*** means any abnormal physical or mental condition, including physical sickness, mental illness, or functional nervous disorder, that affects the person's ability to function normally. A recurrent sickness will be considered to be one sickness. Concurrent sicknesses will be considered one sickness unless the concurrent sicknesses are totally unrelated. The term "Sickness," as used in this Plan document, shall also include pregnancy, childbirth, or resulting complications, except in the case of an Eligible Child.

***Surviving Spouse*** means the spouse of the Eligible Employee or Retiree to whom the Eligible Employee or Retiree is legally married on the date of the Eligible Employee's or Retiree's death, and only if the marriage is recognized in the State(s) of domicile of the Eligible Employee or Retiree and spouse, and only if the marriage has not been dissolved and the parties are not divorced, legally separated, subject to a decree of separate maintenance, or subject to any other legal provision separating or limiting the parties' marriage relationship.

***Treatment Facility*** means, for purposes of the Plan's provisions concerning the treatment of mental health conditions and alcohol or other substance abuse or dependency, a facility offering a treatment program certified by the Missouri Department of Mental Health, the Kansas Department of Social and Rehabilitation Services, or like agency of another State.

***Trust*** means the Agreement and Declaration of Trust made as of June 1, 1954, by and among the Union, the Association, and the Board of Trustees, as amended and restated on September 1, 2003, as the Restated Agreement and Declaration of Trust of the Pipe Fitters Local No. 533 Health and Welfare Fund, and as may be amended or restated from time to time in the future.

***Union*** means the Pipe Fitters Association Local Union No. 533 of the United Association of Journeymen and Apprentices of the Plumbing, Pipefitting, and Sprinkler Fitting Industry of the United States and Canada.

***United Association*** means the United Association of Journeymen and Apprentices of the Plumbing, Pipefitting, and Sprinkler Fitting Industry of the United States and Canada.

## ***ELIGIBILITY UNDER THE PLAN***

To understand how coverage under this Plan works, there are two key types of eligibility you need to know about. You need to know (1) how you become eligible; and (2) how you stay eligible. Your eligibility hinges on the amount of hours you work during certain time frames. You must work a certain amount during a certain time frame in order to become eligible and after that you must continue to work a certain amount during certain time frames to keep that eligibility. The time frames that are used to determine eligibility are called "Qualifying Periods." Once you work enough during a Qualifying Period that will determine your coverage for a certain amount of time called a "Coverage Period." This information is explained in more detail below:

### ***When Am I Covered?***

You become an Eligible Employee under this Plan on the first day of the Coverage Period after you have completed at least 400 hours of covered work in the matching four-month Qualifying Period for which the Plan receives contributions for you. Once you become eligible you will automatically be enrolled for coverage under this Plan on the first day of the next Coverage Period.

### ***How Do I Keep My Coverage?***

Your coverage will continue as long as you work at least 250 hours in each Qualifying Period, or at least 500 hours in two consecutive Qualifying Periods immediately preceding the Coverage Period.

### ***What Happens When I Lose My Coverage and How Do I Get Coverage Back?***

If you do not work enough hours to maintain your coverage, and you do not qualify for "out-of-work" continuation coverage for three consecutive Coverage Periods, then you will have to meet the initial eligibility requirement of 400 hours within one Qualifying Period again to regain your coverage.

### ***How Do Qualifying Periods and Coverage Periods Work?***

Beginning on June 1, 2004, a Qualifying Period is a certain four-month block of time during which you must work the required number of hours to become eligible for coverage under the Plan.

Beginning on June 1, 2004, a Coverage Period is a certain four-month block of time during which you and your dependents are eligible to receive benefits under the Plan based on the work you performed during the corresponding Qualifying Period. The Coverage Period begins one month after the Qualifying Period. Below are some examples:

### ***How Do I Become Eligible?***

The work requirement Qualifying Periods, eligibility dates, and matching Coverage Periods to become eligible are as follows:

| ***Work Requirement in Qualifying Period*** | ***Initial Eligibility Date*** | ***Coverage Period*** |
|---|---|---|
| 400 hours worked from June 1 thru Sept 30 | November 1 | November 1 thru February 28 |
| 400 hours worked from Oct 1 thru Jan 31 | March 1 | March 1 thru June 30 |
| 400 hours worked from Feb 1 thru May 31 | July 1 | July 1 thru October 31 |

***How Do I Keep My Eligibility?***

The work requirement Qualifying Periods and matching Coverage Periods for keeping your eligibility are as follows:

| ***Work Requirement in Qualifying Period*** | ***Coverage Period*** |
|---|---|
| 250 hours worked from June 1 thru September 30<br>OR<br>500 hours worked from February 1 thru September 30 | November 1<br>thru<br>February 28 |
| 250 hours worked from October 1 thru January 31<br>OR<br>500 hours worked from June 1 thru January 31 | March 1<br>thru<br>June 30 |
| 250 hours worked from February 1 thru May 31<br>OR<br>500 hours worked from October 1 thru May 31 | July 1<br>thru<br>October 31 |

***What Happens to My Eligibility While I am on Leave From Work?***

***FMLA leave***: If you are on qualified leave under the Family and Medical Leave Act (FMLA), you will not lose your health benefits because of your leave. Your Employer will determine whether or not your leave qualifies as "FMLA" leave. Your Employer will also continue to make contributions to the Plan while you are on leave as if you were still working. The Plan will credit you with all hours for which it receives contributions as if you had actually worked all such hours.

***Leave due to accident or Sickness***: If you are unable to work due to an injury or Sickness you will be credited with sixteen hours per week for each week that you are absent from work because you are totally unable to work, and for which you are receiving benefits under Workers' Compensation or a similar law or program, or under the Plan's Accident and Sickness Weekly Disability Benefit. Benefits paid based on any type of partial Disability will not qualify you for the crediting of hours for eligibility purposes.

Only Eligible Employees and apprentices working toward initial eligibility are entitled to credit for hours not actually worked. You will not be credited for any additional hours beyond the date that you retire (as defined in the Pipefitters Local 533 Pension Plan), or the date that you are no longer an Eligible Employee, whichever is first to occur.

***Uniformed Service leave***: Under the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) or other applicable federal law, you and your Dependents may be entitled to continued coverage or COBRA benefits for certain periods that you are in the United States Uniformed Services. You should contact the Plan Administrator as soon as you are notified that you are being called to duty in the Uniformed Services. You should contact the Plan Administrator for more details about this issue, and to receive a copy of the Trustees' policies and procedures to be followed in the event that you are called to duty.

***What Happens to My Eligibility When Work is Unavailable?***

If you do not work enough hours to maintain your coverage as an Eligible Employee, you may continue coverage as an Eligible Employee if you pay an "Out-of-Work" premium for each month of coverage, and remain on the "out-of-work list" maintained under the Collective Bargaining Agreement between the Union and the Association. By doing this you are considered "ready, willing, and available for work."

If your out-of-work coverage terminates you are still eligible at the time of termination for COBRA continuation coverage. See page 13 of this SPD.

***RETIREE COVERAGE UNDER THE PLAN:***

***Generally:***

You may obtain Retiree coverage under this Plan after your coverage would terminate (based on hours worked or "out-of-work" coverage) if you meet the following requirements:

a. you are at least 55 (or any age if you are retired due to Disability);
b. you receive benefits under the Pipe Fitters Local No. 533 Pension Plan;
c. you make an appropriate Retiree Health Coverage Election at the time you apply for retirement;
d. you pay the appropriate Retiree premium, as determined from time to time by the Board of Trustees; and
e. you meet one of the following:
    i. You were covered under the Plan as an Eligible Employee (not under COBRA continuation coverage) for at least three of the five years immediately preceding the year you retire; or
    ii. You met the "Retirement-Qualifying Work Period Rule". You meet this rule, if you retire on or after June 1, 2006, and you had three Retirement Work Qualifying Periods during the 24 month period immediately preceding your retirement, with a Retirement Qualifying Work Period (June 1 - September 30, October 1 - January 31, and February 1 - May 31) in which you worked at least 400 hours and the Fund received contributions for you for that work.

***When is My Retiree Coverage Effective?***

Retiree coverage begins the day after your coverage as an Eligible Employee ends, assuming you have paid the appropriate premium.

If you were not covered under the Plan on the date you retired, your coverage will be effective on the first day of the month following the month you retired, assuming you have paid the appropriate premium by that date.

***How Do I Maintain My Retiree Coverage?***

You must make self-payments in order to maintain your Retiree coverage under the Plan. The Board of Trustees will determine the amount. The Board of Trustees may set different Retiree premiums for Medicare-eligible and non-Medicare-eligible Retirees and may require an additional premium for your Dependents.

Your Retiree coverage does not include Accident and Sickness Loss of Time benefits or Accidental Death and Dismemberment benefits.

***Can There Be Changes to My Retiree Coverage Under the Plan?***

Yes. We reserve the right to change or eliminate Retiree coverage or to require you to make additional contributions to continue your Retiree coverage, even if you are already disabled or have already reached age 55 at the time we make changes. We also reserve the right to establish a set of benefits that are available to you as a Retiree that are different than the benefits available to other Eligible Employees, even if the change would reduce your current Retiree benefits.

***When Will My Retiree Coverage Terminate?***

Your Retiree coverage will terminate when you regain coverage as an Eligible Employee by returning to covered work. If you return to work after being covered by Retiree coverage you may maintain your coverage before you regain Eligible Employee coverage by paying the out-of-work premium rather than the Retiree premium.

Your Retiree coverage may also terminate if you do not pay the premiums, if you choose to terminate the coverage, or on the day following the date of your death.

## ***DEPENDENT COVERAGE UNDER THE PLAN***

***Generally***:

If you are an active Participant Employee, your spouse and Dependent children are automatically covered. Dependent coverage will become effective at the same time as your Eligible Employee coverage.

Newly acquired Dependents will be covered on the date of marriage, birth, adoption, placement for adoption, effective date of a court order establishing your or your spouse's financial responsibility for a child, or the effective date of a Qualified Medical Child Support Order ("QMCSO"), as applicable.

Even though your Dependents are automatically covered, we may require you to provide information regarding your Dependents in order to make claims processing and payment faster and easier.

***Are My Dependents Automatically Covered if I Am a Retiree?***

No. If you are a Retiree, your Dependents are not automatically covered. However, you may elect coverage for your current spouse and Dependent children. This means that if you elect coverage under the Plan when you retire, you must also make an affirmative election at that time or during a special enrollment period to cover your Dependent(s). However, if you get a new Dependent after you retire through marriage, birth, adoption, or placement for adoption, then that Dependent is entitled to a 30-day special enrollment period beginning on the date of the marriage, birth, adoption, or placement for adoption.

Your Dependents may not receive coverage if you have declined Retiree coverage for yourself. Once you have declined Retiree coverage, you may not later seek to enroll yourself or any Dependents. ***Except, that your spouse will be allowed a special enrollment period if at the time you retire you provide the Plan Administrator with proof of other coverage***

***along with notice that you are declining coverage for your spouse under this Plan because (s)he has other coverage. Then when his/her other coverage terminates (s)he will be eligible to enroll in the Plan within a specified period of time.*** A spouse using other coverage shall not be treated as having a lapse in coverage under this Plan by reason of the other coverage.

You may have to pay a premium in addition to your Retiree premium for Dependent coverage.

***Who Qualifies as an Eligible Dependent?***

***Spouse***: Your spouse is only eligible for benefits if your marriage is recognized in the State where you live and intend to remain. You may not be legally separated or subject to a decree of separate maintenance in order for your spouse to be covered.

***Children***: Your child is eligible if (s)he meets the following:

(a) (s)he has one of the following relationships to you:
  (i) your son, daughter, stepson or stepdaughter;
  (ii) your eligible foster child;
  (iii) your legally adopted child or a child lawfully placed with you for legal adoption (so long as you adopt the child or the child is placed with you for adoption prior to his or her 18th birthday); or
  (iv) you have legal responsibility for the child by a court order for custody and support or maintenance (including a legal guardianship) or who is the subject of a Qualified Medical Child Support Order (QMSCO).

  *When the child is your Dependent due to guardianship or legal custody, you must provide legal documentation of the relationship before the child will be enrolled in the Plan.

  **When the child is not your natural child and the parents of the child may claim the child as a dependent on their federal income tax return, the Plan Administrator must verify that the child's natural parent is not claiming the child as a dependent and that you have a higher adjusted gross income than the highest adjusted gross income of any parent of the child.

(b) (s)he is actually financially dependent upon you (i.e. he or she has not provided over one-half of his or her own support for the calendar year);

(c) (s)he has the same principal place of abode as you for more than one-half of the year. The child is considered as having the same principal place of abode as you during periods of time when either you or the child or both are temporarily absent due to special circumstances including illness, education, business, or vacation. Additionally, if the child is your child (not step-child) and you and the child's other parent are divorced or separated and living apart, if your child does not have the same principal place of abode as you but instead has the same principal place of abode as his or her other parent, and the child receives over one half of his or her support from one or both parents then the child will be considered as having the same principal place of abode as you for purposes of this paragraph;

(d) (s)he is unmarried; and

(e) (s)he is under the age of 19, or 19-25 and a full-time student; or is permanently and totally disabled.

***Student Children***: If a child remains unmarried and financially dependent on you, (s)he will automatically remain covered through the end of the month in which (s)he turns 19; the child may continue to be covered until age 25 provided that (s)he is a full-time student at an accredited college, university, vocational-technical school, or trade school. Proof of enrollment, such as a letter from the school's registrar, is required to continue coverage past the age of 19. This student coverage will terminate at the end of the month of the last enrollment period that you have provided proof of enrollment for, or the end of the month in which the child turns 25, whichever is earlier.

A Dependent child who is covered past the age of 19 due to enrollment in school, will remain covered between enrollment periods as long as (s)he is enrolled for the next semester. (For example a college student whose Spring semester ends in May will remain covered during the Summer as long as (s)he enrolls for the Fall semester and provides proof of this enrollment to the Plan.)

***Medically Necessary Leave of Absence:*** Notwithstanding the above paragraph, a Dependent child who is covered past the age of 19 due to enrollment in a post-secondary educational institution (i.e. college students between the ages of 19 - 25), will remain covered for up to a year, unless the child's coverage would end earlier for another reason (such as a parent's termination of employment or the child's age exceeding 25), during a Medically Necessary Leave of Absence. A Medically Necessary Leave of Absence is one which begins while a Dependent child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of the Plan (i.e. the child is unable to attend school on a full-time basis due to the serious illness or injury). In order to receive coverage during a Medically Necessary Leave of Absence, you must provide the Plan Administrator with written certification by a treating Physician of the child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. A Dependent child whose benefits are continued under this section will receive the same benefits as if the child continued to be a covered student at the institution of higher education and was not on a Medically Necessary Leave of Absence.

***Disabled Children***: A disabled Dependent child may remain eligible for coverage despite his/her age, provided the other criteria are met. A disabled Dependent child will be considered disabled for purposes of receiving continued eligibility for benefits under the Plan if (s)he is unable (because of a physical or mental condition) to support himself/herself financially, as long as the Disability began before the child's coverage would otherwise have terminated.

We may require proof of the Disability in order to continue coverage past the age of 19 or 25, and may continue to require this proof from time to time.

***Adopted Children***: An adopted child is eligible for coverage on the first date that (s)he is placed for adoption with you. This child is placed with you when you assume and retain a legal obligation for total or partial support of the child in anticipation of adopting him/her. Placement terminates when your legal support obligations terminate.

An adopted child will only be eligible for coverage under the Plan if (s)he is placed with you before (s)he turns 18.

***Child Covered by a QMCSO***: A child who does not meet the eligibility criteria under this Plan may still be covered as your Dependent if the Plan receives a Qualified Medical Child Support Order ("QMCSO") from the court ordering the Plan to provide coverage to the child (as the Alternate Recipient under the QMCSO). We will determine the Order to be a QMCSO under the Plan's procedures for handling medical child support orders. You can request a copy of these procedures from the Plan Administrator, at no charge

***Will My Dependents Still Be Covered if I Die While I am Still an Active Employee?***

***Spouse***: As long as you worked at least 1,500 hours for which the Plan received contributions before your death, and your Spouse was covered by the Plan as a Dependent on the date of your death, his/her coverage will continue under the Plan. In order to continue coverage under the Plan, your spouse must elect Surviving Spouse coverage within 90 days from the date of your death. Your spouse will continue coverage under the Plan until (s)he remarries.

The Surviving Spouse will have to pay a premium in order to continue coverage under the Plan. The Plan must receive the premium within 15 days of the due date or coverage will be terminated.

The Surviving Spouse will be required to submit a sworn statement at least once per year certifying that (s)he is not remarried.

Once a Surviving Spouse has lost coverage because of failure to pay on time or remarriage, (s)he cannot again be covered under the Plan.

Neither your Surviving Spouse nor any of his/her dependents will be entitled to death benefits, accident and sickness weekly disability/loss of time benefits, or accidental death and dismemberment (AD&D) benefits.

For COBRA purposes, the Surviving Spouse suffers a "Qualifying Event" whenever his/her Surviving Spouse coverage terminates.

***Spouse's Dependents:*** If the Surviving Spouse has dependents who were also your Dependents, and they were covered under this Plan on the date of your death, then they may remain covered as long as your Surviving Spouse remains covered under this section. If your Spouse is pregnant at the time of your death, the child will be treated as your Dependent and may be covered under the Plan as well.

***Will My Dependents Still Be Covered if I Die After I Retire?***

***Spouse:*** As long as your Surviving Spouse was covered as a Dependent on the date of your death, his/her coverage under this Plan continues until the end of the month in which (s)he gets remarried. If your Surviving Spouse is using other coverage on the date of your death in accordance with the special enrollment period rules described above, (s)he will be treated as a Dependent so long as all other requirements are met. ***In order to continue coverage under the Plan your spouse must elect Surviving Spouse coverage within 90 days from the date of your death.***

The Surviving Spouse will have to pay a premium in order to continue coverage under the Plan. The Plan must receive the premium within 15 days of the due date or coverage will be terminated.

The Surviving Spouse will be required to submit a sworn statement at least once per year certifying that (s)he is not remarried.

Once a Surviving Spouse has lost coverage because of failure to pay on time or remarriage, (s)he cannot again be covered under the Plan.

For COBRA purposes, the Surviving Spouse suffers a "Qualifying Event" whenever his/her Surviving Spouse coverage terminates.

***Spouse's Dependents:*** If the Surviving Spouse has dependents who were also your Dependents, and they were covered under this Plan on the date of your death, then they may remain covered as long as your Spouse remains covered under this section. If your Spouse is pregnant at the time of your death, the child will be treated as your Dependent and may be covered under the Plan as well.

Neither your Surviving Spouse nor any of his/her dependents will be entitled to death benefits, accident and sickness weekly disability/loss of time benefits, or accidental death and dismemberment (AD&D) benefits.

## ***TERMINATION OF COVERAGE UNDER THIS PLAN***

***Generally***:

The Plan is intended to exist and provide benefits to Covered Persons indefinitely. However, under certain circumstances coverage may terminate for certain individuals, for all Covered Persons, or any group of Covered Persons. If we find it appropriate to terminate the Plan, then all Covered Persons will lose coverage under the Plan. We reserve the right to amend the Plan at any time, and these amendments may eliminate certain benefits for all Covered Persons or terminate all benefits for Certain Covered Persons, such as Retirees and Dependents.

### ***Are There Other Reasons Coverage Will Terminate?***

Except as otherwise stated in this Plan, any person who loses eligibility under the Plan will lose coverage. In addition, you may lose coverage for the following reasons

You and your covered Dependents will lose coverage the first day that you perform work in the plumbing and pipefitting industry in the Kansas City metropolitan area (the area covered by your Collective Bargaining Agreement) for an employer who does not contribute to the Plan.

You and your covered Dependents will lose coverage the date that you enter the Armed Forces on active duty, except that you have the right to extend your coverage under USERRA or other applicable law. See page 6 of this SPD.

Any person covered under this Plan who is required to make self-payments as well as all Dependents of such Covered Person, will lose coverage on the first day of the month that the Covered Person does not make the monthly payment by the due date or grace period.

A spouse covered under this Plan will lose coverage on the first day of the month following the month in which a decree of divorce, dissolution of marriage, legal separation, or separate maintenance (regardless of the terms used to describe the divorce or legal separation) is entered, or the month in which the Eligible Employee or Retiree dies, subject to the spouse's right to continue coverage as a Surviving Spouse.

***How Do I Get Certificates of Creditable Coverage From the Plan When My Coverage Terminates?***

We will issue Certificates of Creditable Group Coverage to each person who loses coverage. These Certificates provide the necessary documentation that you and your Dependents will need to reduce pre-existing condition exclusions when you enroll in a new health benefit plan.

We provide the Certificates free of charge and will give them out automatically when you or your Dependents lose coverage under this Plan, or exhaust COBRA continuation coverage. You may also request the Certificates from the Plan Administrator before you lose coverage or within 24 months after losing coverage.

## ***CONTINUATION OF COVERAGE WHEN YOU ARE NO LONGER ELIGIBLE UNDER THE PLAN***

### *NOTICE OF EMPLOYEE'S RIGHTS TO CONTINUE GROUP HEALTH COVERAGE UNDER COBRA*

***Introduction:*** This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. 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 you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. ***This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to receive it.***

The Plan Administrator of this Plan is the Board of Trustees of the Pipe Fitters Local 533 Health and Welfare Plan, 3100 Broadway, Suite 805, Kansas City, MO 64111. The phone number where you may contact the Plan Administrator is (816)756-3313 or toll free at (866)756-3313. The Board of Trustees has delegated the responsibility for carrying out the day-to-day functions of the Plan to a third party administrator listed on page 49 of this SPD. The Board of Trustees, as Plan Administrator, is responsible for administering COBRA continuation coverage, but the third party administrator's staff members can answer most of your questions and will handle the processing and administration of COBRA continuation coverage.

***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 notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and Dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

The coverage provided under COBRA continuation coverage is identical to the medical coverage provided under the Plan to similarly situated beneficiaries with respect to whom a qualifying event has not occurred. Ancillary welfare benefits, such as the death benefit, AD&D, and accident and sickness loss of time benefits may not be continued under COBRA.

If you lose coverage under the Plan due to an involuntary termination of employment between September 1, 2008 and February 28, 2010, you may be eligible to have part of your COBRA premium paid under the American Recovery and Reinvestment Act of 2009. If you are eligible to receive this benefit, you will receive additional information about how to apply with your COBRA Continuation Coverage Notice.

***Qualifying Events:*** If you will lose coverage because one of the following happens, you are considered a "qualified beneficiary" who has suffered a "qualifying event" and will be eligible for COBRA continuation coverage.

***If you are an Employee,*** you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

A. Your hours of employment are reduced (such as, you do not work sufficient hours to maintain eligibility), or
B. Your employment ends for any reason other than your gross misconduct.

***If you are the spouse of an Employee or Retiree,*** you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

A. Your spouse (i.e. the Eligible Employee or Retiree) dies;
B. Your spouse's hours of employment are reduced (that is, if the Eligible Employee does not work sufficient hours to maintain eligibility);
C. Your spouse's employment ends for any reason other than his or her gross misconduct;
D. Your spouse becomes entitled to Medicare (Part A, Part B, or both);
E. You become divorced or legally separated from your spouse.

***Your Dependent children*** will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

A. The parent-employee dies;
B. The parent-employee's hours of employment are reduced (that is, if the parent-employee does not work sufficient hours to maintain eligibility);
C. The parent-employee's employment ends for any reason other than his or her gross misconduct;
D. The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
E. The parents become divorced or legally separated; or
F. The child stops being eligible for coverage under the Plan as a "Dependent child".

We will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. We are responsible for determining that you are eligible for COBRA continuation coverage when the qualifying event is the end of employment, reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare (Part A, Part B, or both).

***For any other qualifying events*** (divorce or legal separation of the Employee and spouse or a Dependent child losing eligibility for coverage as a Dependent child), ***you must notify the Plan Administrator within 60 days after the qualifying event occurs. Send this notice in writing, along with appropriate documentation, to the Fund Office. See the chart below for appropriate documentation.***

***Procedures for Covered Employees and Qualified Beneficiaries to Furnish Notices of Qualifying Events***

It is the responsibility of an Eligible Employee or a qualified beneficiary to notify the Fund Office in writing (or by fax) of any of the following qualifying events, whether they occur while you are still working or while you are already receiving COBRA continuation coverage. The following chart describes the type of documentation you must provide as well as the time limits for notifying the Fund Office:

| ***Qualifying Event*** | ***Documentation Required*** | ***Time Limits*** |
|---|---|---|
| Divorce | Divorce Decree | Within sixty (60) days after the qualified beneficiary would lose coverage as a result of the divorce |
| Legal Separation | Legal separation decree or equivalent State court document | Within sixty (60) days after the qualified beneficiary would lose coverage as a result of the legal separation |
| Dependent child ceasing to qualify as a Dependent under the Plan | Proof of age if turning age 19, or failure to provide proof of continuing eligibility past age 19 | Within sixty (60) days after the qualified beneficiary would lose coverage as a result of no longer qualifying as a Dependent child |
| Disability Determination | Copy of Social Security Administration disability determination letter | Within sixty (60) days after: the date of the disability determination letter or the date the qualified beneficiary receives notice of this policy (receives a copy of the SPD), whichever is later |
| Change in Disability Status | Copy of Social Security determination letter | Within thirty (30) days after: the date of Social Security Administration's final determination that the individual is no longer disability or the date the qualified beneficiary receives notice of this policy (receives a copy of the SPD), whichever is later |

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 after receiving such notice. If you submit a notice of a qualifying event, and the Plan Administrator determines that you are not eligible for COBRA continuation coverage, the Plan Administrator will send you written notice of the unavailability of such coverage. For each qualified beneficiary who

elects it, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (Part A, Part B, or both), your divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment 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 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

1. ***Disability extension of 18-month period of continuation coverage:*** If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must provide the notice to the Plan Administrator within the first 60 days of COBRA continuation coverage, or if later, within 60 days from the Social Security Administration's determination of disability and before the end of the 18-month period of COBRA continuation coverage. Additionally, such notice must be accompanied with a copy of the Social Security Administration's determination letter. This notice must be sent to the Fund Office.

2. ***Second qualifying event extension of 18-month period of continuation coverage:*** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family 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 is available to the spouse and Dependent children if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, Or if the Dependent child stops being eligible under the Plan as a Dependent child, But only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

***In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund Office and must be accompanied by any appropriate documentation.***

***Applicable Premium for COBRA Continuation Coverage***

***COBRA premiums are payable monthly, and are due on the first day of the month for the month of coverage. You will have 60 days in which to elect COBRA continuation coverage, and you have 45 days from the date you elect COBRA continuation coverage to submit your initial premium payment.*** Payments must be submitted to the Fund Office, as explained more fully in the notice you will receive when you become eligible for COBRA continuation coverage.

The applicable premium is an amount determined by the Board of Trustees to be a fair and appropriate amount to cover the cost of the coverage provided to you, but will never exceed 102% of the total cost to the Plan for your coverage, except as provided for in this paragraph regarding Disability. The total cost to the Plan for your coverage is calculated on an actuarial basis by making a reasonable estimate of the cost of providing coverage for similarly situated Participants and beneficiaries. This amount may be recalculated annually. The Plan reserves the right to charge an additional premium for qualified beneficiaries who take advantage of the 11 month extension of COBRA continuation coverage for totally disabled qualified beneficiaries and family members of such qualified beneficiaries described on page 16 of your SPD. If you are eligible for the 11 month extension (to a maximum 29 months of continuation coverage), the maximum applicable premium for those additional 11 months is 150% of the total plan cost of your coverage.

***If You Have Questions***

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its staff members, or you may contact the nearest Regional or District Office of the Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

***Termination of COBRA Continuation Coverage***

Your COBRA continuation coverage will terminate on the earliest of the following events:

1. The end of the 18, 29, or 36-month maximum period as described above in this section. Since this Plan does not provide for a conversion option from group coverage under the Plan to an individual policy, you will not receive any notice prior to the termination of your COBRA continuation coverage due to exhaustion of the maximum period;
2. The date on which the Pipe Fitters Local 533 Health and Welfare Fund no longer provides any group health coverage to any members or employees;
3. The first day of the month for which you do not pay your applicable premium on time;
4. The date on which you become covered by another group health plan (after the date of your election of COBRA continuation coverage) that does not contain any exclusion or limitation with respect to any pre-existing condition which you may have;
5. The date on which you become entitled to Medicare after your election of COBRA continuation coverage; or
6. If your coverage was extended up to 29 months due to a disability, the first date of the month following the month in which the Social Security Administration determines that the qualified beneficiary is not disabled.

If your continuation coverage terminates earlier than the maximum coverage period (18, 29, or 36 months, as described above), the Plan Administrator will send you a notice of such termination.

You do not have to show that you are insurable to receive continuation coverage. Eligibility for COBRA continuation coverage is subject only to the general eligibility rules stated in this notice. If the Plan Administrator or its designee determines that you were not eligible for coverage, your coverage may be terminated retroactively.

## ***COBRA Continuation Coverage Procedures***

### ***General***

A participant or beneficiary with respect to whom a qualifying event has occurred shall be a qualified beneficiary entitled to elect COBRA continuation coverage. Any person who has properly elected continuation coverage shall remain a qualified beneficiary until continuation coverage is terminated.

### ***Notice of Qualifying Events***

Participating Employers are not required to provide notice of qualifying events to the Plan Administrator. The Plan Administrator shall determine whether a qualifying event has occurred due to the Employee's termination of employment or reduction in hours of employment, the Employee's becoming entitled to Medicare (Part A, Part B, or both), or the Employee's death.

In order to make a determination whether a qualifying event has occurred as a result of termination of employment or reduction of hours of employment, the Plan Administrator shall review the monthly Employer contribution reports to determine the number of hours to be credited to the Employee based on the number of hours worked and whether full contributions are received for all hours worked. If Employer contributions reports are submitted timely, the Plan Administrator will generally have sufficient information to determine whether an employee will lose coverage as a result of a termination of employment or reduction of hours of employment within 45 days after the last day of the qualification period in which the employee does not have sufficient hours or contributions credited to maintain coverage. The Plan Administrator shall send notice of the qualifying event and the qualified beneficiaries' rights to elect COBRA continuation coverage within 14 days after having determined that a qualifying event has occurred.

If the qualifying event is the Employee's death, the Plan Administrator shall send notice of the qualifying event and all qualified beneficiaries' rights to elect COBRA continuation coverage within 14 days after determining that a qualifying event has occurred.

The Plan Administrator shall determine whether an Employee has become entitled to Medicare and whether such entitlement constitutes a qualifying event within 30 days following the qualifying event. If the Plan Administrator determines that a qualifying event has occurred, the Plan Administrator shall send notice of the qualifying event to all qualified beneficiaries within 14 days of the determination.

An Employee must give written notice to the Plan Administrator within 60 days after the occurrence of a qualifying event that is a divorce or legal separation of the Employee (or Retiree) and spouse or a Dependent child's ceasing to meet the Plan requirements for an eligible Dependent. The notice shall be provided in writing, mailed, faxed, or delivered to the Fund Office.

The Plan will provide forms to participants and beneficiaries which may be used to provide this notice. Use of the Plan's form is not required as long as the written notice of qualifying event contains all of the necessary information and is accompanied by documentation of the qualifying event, if applicable. The Plan Administrator will then send notice of the qualified beneficiaries' rights to elect COBRA continuation coverage, or the unavailability of COBRA continuation coverage, within fourteen (14) days after receiving such notice.

***Second Qualifying Event and Disability***

If a qualified beneficiary experiences a second qualifying event while on COBRA continuation coverage that is subject to a maximum period of 18 or 29 months, the qualified beneficiary must provide written notice to the Plan Administrator within sixty (60) days of the second qualifying event in order to extend the maximum COBRA continuation coverage period to thirty-six (36) months.

If a qualified beneficiary or any member of the qualified beneficiary's family is disabled, as determined by the Social Security Administration, at any time within the first sixty (60) days of COBRA continuation coverage, the qualified beneficiary must provide written notice of such disability to the Plan Administrator within the first 60 days of COBRA continuation coverage or, if later, within 60 days from the Social Security Administration's determination that the qualified beneficiary or family member is disabled. The notice must be accompanied by a copy of the Social Security Administration's determination letter. A qualified beneficiary may, but is not required to, use a form provided by the Fund Office to provide this notice. If the Social Security Administration determines that the person's disability has ended while the person is on COBRA continuation coverage, the qualified beneficiary must provide a copy of the Social Security Administration's letter stating that the person is no longer disabled, to the Plan Administrator within thirty (30) days after the Social Security Administration's determination.

The Plan Administrator shall send notice of right to elect an extended period of continuation coverage, or notice of the unavailability of an extension of continuation coverage, within fourteen (14) days after receiving notice from the qualified beneficiary.

***Unavailability of COBRA Continuation Coverage***

When the Plan Administrator receives a notice from an Employee or beneficiary relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration regarding a covered Employee, qualified beneficiary, or other individual, and the Plan Administrator determines that the individual is not entitled to COBRA continuation coverage or an extension of COBRA continuation coverage, the Plan Administrator shall provide a notice to the person sending the notice explaining why the individual is not entitled to COBRA continuation coverage. The unavailability notice shall be sent within fourteen (14) days from receipt of the notice from the employee or other individual.

***Early Termination of COBRA Continuation Coverage***

Whenever COBRA continuation coverage is terminated prior to the latest date shown on the Election Notice (that is, prior to the end of the 18, 29, or 36-month maximum period), notice must be sent to all affected qualified beneficiaries explaining the reason for the termination, the date of termination, and any rights the qualified beneficiary may have under the Plan or under applicable

law to elect an alternative group or individual coverage. The termination notice will be provided as soon as practicable following the Plan Administrator's determination that continuation coverage shall terminate.

***Change of Premium Rate***

In the event COBRA premiums change, the Plan Administrator shall send notice of such change to all qualified beneficiaries at least one month prior to the effective date of the change.

***Deficient Premium Payment***

In the event a qualified beneficiary submits a payment for COBRA continuation coverage that is less than the full premium amount due, and the deficiency is not more than $50.00 (or the deficiency is not more than 10% of the applicable premium amount, if 10% of the premium is less than $50.00), the Plan Administrator shall provide notice of deficiency to the qualified beneficiary, demanding payment of the deficiency in full within 30 days from the date of the notice of deficiency. The deficient premium will be considered full payment until the end of the 30 day period. If the Plan Administrator fails to provide notice of the deficiency to the qualified beneficiary within 30 days after receipt of the payment, the amount paid will be deemed to constitute full payment of the applicable premium.

In the event a qualified beneficiary submits a payment for COBRA continuation coverage that is significantly less than the full amount due (that is, the deficiency exceeds the lesser of $50.00 or 10% of the applicable premium), no additional time will be granted to make up the deficiency. If the deficiency is not paid within the initial 30 day grace period, coverage will be retroactively terminated as of the first day of the month for which full payment was not made.

## ***BENEFITS UNDER THIS PLAN***

***Generally***

You will pay a deductible every year. It must be paid before we start paying for your benefits. Once you have paid your deductible, we use a cost sharing mechanism called a "co-pay" so that you and the Plan each pay for part of the benefits. There is a separate co-pay for prescription drug benefits that you will always pay and that does not count towards your deductible. This is all explained in more detail below:

***What is My Yearly Deductible?***

The amount of your deductible (both in-network and out-of-network) depends on whether you are an Eligible Employee or a Retiree as described in detail below:

***In-Network***:

a. If you are an Eligible Employee or a Retiree who submitted an application for benefits after December 29, 2006 or whose pension effective date was after March 31, 2007, you will pay the first $300 of Allowable Charges per year. This applies to every Covered Person. However, your family will not pay more than a total of $600 in deductibles for the year [Any amounts credited towards your out-of-network deductible will also count for the in-network deductible].

b. If you are a Retiree who submitted an application for pension benefits that was received by the Fund Office before December 30, 2006, the pension effective date was before April 1, 2007, and the application was approved by the Board of Trustees, you will pay the first $150 of Allowable Charges per year. This applies to every Covered Person. However, your family will not pay more than a total of $300 in deductibles for the year. [Any amounts credited towards your out-of-network deductible will also count for the in-network deductible.]

***Out-of-Network***:

a. If you are an Eligible Employee or a Retiree who submitted an application for benefits after December 29, 2006 or whose pension effective date was after March 31, 2007, you will pay the first $300 of Allowable Charges per year. This applies to every Covered Person. However, your family will not pay more than a total of $600 for in-network and out-of-network deductibles combined for the year [Any amounts credited towards your in-network deductible will also count towards your out-of-network deductibles.]

b. If you are a Retiree who submitted an application for pension benefits that was received by the Fund Office before December 30, 2006, the pension effective date was before April 1, 2007, and the application was approved by the Board of Trustees, you will pay the first $400 of Allowable Charges per year. This applies to every Covered Person. However, your family will not pay more than a total of $800 for in-network and out-of-network deductibles combined for the year. [Any amounts credited towards your in-network deductible will also count towards your out-of-network deductibles.]

Common Accident: If more than one person in your family is injured in the same accident, all the Allowable Charges will be combined, and only one deductible amount will be required to pay benefits for that accident.

***How Does Cost-sharing for the Comprehensive Medical Benefits Program Work?***

Once you have met your deductible, there is cost-sharing between you and the Plan. How costs are divided between you and the Plan is based on the Plan's total Allowable Charge for the service or treatment you receive.

***What is the Plan's total Allowable Charge?***

The Plan's total Allowable Charge is the amount the Plan has determined is generally charged for any given service or treatment.

***What happens if the bill for my treatment is more than the total Allowable Charge?***

The percentage that the Plan pays for your treatment is always a percentage of the total Allowable Charge, even if the total amount billed for your service or treatment is more than the total Allowable Charge. The Plan will never pay expenses which exceed the total Allowable Charge.

***I thought the Plan had agreements with the providers. How could a bill ever be for more than the total Allowable Charge?***

The Plan does have agreements with the providers in the Plan's network. So, when you receive treatment or services from an in-network provider, you will not be billed for more than the total Allowable Charge. However, if you use an out-of-network provider, that provider will not have an agreement with the Plan and could bill for more than the total Allowable Charge.

***Does the Plan pay a portion of every treatment or service expense I incur?***

No. Your cost-sharing arrangement with the Plan applies only to covered treatments and services. If you receive a treatment or service which is not covered by the Plan, the Plan will not pay any portion of that expense.

***How Does the Cost-sharing Work For In-Network Services After I Have Paid My Deductible for the Year?***

If you are an Eligible Employee or a Retiree who submitted an application for benefits after December 29, 2006 or whose pension effective date was after March 31, 2007, we will pay 85% of the total Allowable Charge for in-network (services, and you will pay the other 15%. Once you have incurred $20,000 in in-network Allowable Charges for a year, we will pay 100% of your in-network Allowable Charges for the rest of the year.

If you are a Retiree who submitted an application for pension benefits that was received by the Fund Office before December 30, 2006, the pension effective date was before April 1, 2007, and the application was approved by the Board of Trustees, we will pay 85% of the total Allowable Charge for in-network services, and you will pay the other 15%. Once you have incurred $10,000 in in-network Allowable Charges for a year, we will pay 100% of your in-network Allowable Charges for the rest of the year.

***How Does the Cost-sharing Work For Out-of-Network Services After I have Paid My Deductible for the Year?***

If you are an Eligible Employee or a Retiree who submitted an application for benefits after December 29, 2006 or whose pension effective date was after March 31, 2007, we will pay 60% of the total Allowable Charges for out-of-network charges for covered medical care, and you will pay the other 40%, plus any additional amount charged over the total Allowable Charge. Once you have incurred $20,000 in out-of-network charges for covered medical care, we will pay 100% of all Allowable Charges.

If you are a Retiree who submitted an application for pension benefits that was received by the Fund Office before December 30, 2006, the pension effective date was before April 1, 2007, and the application was approved by the Board of Trustees, we will pay 60% of the total Allowable Charges for out-of-network charges for covered medical care, and you will pay the other 40%, plus any additional amount charged over the total Allowable Charge. Once you have incurred $15,000 in out-of-network charges for covered medical care, we will pay 100% of all Allowable Charges.

***What if I Need medical care and There is No In-Network Provider Nearby?***

We will pay an out-of-network claim the same as an in-network claim in the event that you need medical care and the nearest in-network provider of like specialty is more than 25 miles away.

***What if I Get Emergency Treatment From an Out-of-Network Provider?***

In an Emergency situation where the circumstances of treatment are beyond your control or so serious that you do not have time to obtain treatment from a participating provider because it would endanger your life or health, and as a result you go to an out-of-network provider, we will pay 80% of the Allowable Charges for covered Emergency services.

However, you should note that beginning on the date that you could be transferred to an in-network facility or provider without risk to your health, the standard out-of-network rules will apply.

***Are Any Medical Benefits Provided at a Flat Fee Instead of Cost-Sharing?***

Yes, cost-sharing does not apply to covered services provided at Nurse Practitioner Retail Clinics. You will be charged a flat $10 co-pay per visit for all covered services provided at an in-network Nurse Practitioner Retail Clinic. Please note that most clinics will not be able to accept the $10 co-pay at the time of service and will require you to pay 100% of the expense. When this occurs, please obtain an itemized statement from the in-network provider and submit the claim to the Fund Office for reimbursement of all covered expenses over $10.

***Is There a Maximum Lifetime Amount That the Plan Will Pay?***

Yes. We will pay a lifetime maximum amount of two million dollars ($2,000,000) for benefits under this Plan. After we have paid out $2,000,000 on your behalf, you will no longer be eligible for any benefits.

***Is There Ever Case Management Under This Plan?***

Yes. When you are receiving (or reasonably anticipate that you will receive) prolonged medical care for a serious Sickness or injury, we may employ a case manager to consult with you, your Physician, and your family to help design a treatment plan that will provide the most appropriate and cost-effective medical care in the least restrictive setting. We will pay for all case management costs. The decision to employ a case manager is at our discretion.

***Three Situations You Should Be Aware Of:***

1. When you get a referral from your doctor you should ensure that the referral doctor is in-network.
2. Certain procedures can be performed at facilities other than your doctor's office or a Hospital. Ensure that the facility where the procedure is being performed is a Blue Cross and Blue Shield of Kansas City provider.
3. Please be aware that certain Hospitals use independent specialty contractor doctors rather than staff doctors. A Hospital may be in-network, however certain providers in that Hospital may not be in-network. In these instances you may get a separate bill from the independent contractor provider who will not necessarily be in-network.

## ***COMPREHENSIVE MEDICAL BENEFITS***

***Generally***:

We will pay for Medically Necessary covered medical care based on the total Allowable Charge for the service. We will pay a percentage of the total Allowable Charge, and you will pay the rest.

You are covered for Medically Necessary diagnosis and treatment (including both medical and surgical treatment, but not including chiropractic or alternative treatment) provided by a Physician, Physician Assistant, or Nurse practitioner for treatment of an injury or Sickness. This includes diagnostic services such as X-ray and lab services, as well as inpatient drugs (including oxygen and blood or blood products) that you may be given while being treated in a Hospital. This also includes charges for a professional anesthetist or anesthesiologist. Other types of treatments (both medical and surgical treatment and the supplies necessary for such treatment) may also be covered if deemed Medically Necessary and prescribed by a Physician in appropriate circumstances. The other treatments covered include but are not limited to; physical therapy, occupational therapy, radiation therapy, physical rehabilitation, cardiac rehabilitation, respiratory therapy or rehabilitation, and prosthetics and orthotics (other than foot orthotics)** Coverage for prosthetic and orthotics is limited to the initial purchase and fitting of the prosthetic or orthotic device as well as repairs or replacement when they are Medically Necessary because of a change in the physiological condition of the patient, an irreparable change in the condition of the device, or the condition of the device requires repairs and the cost of the repairs would be more than 60% of the cost of a replacement device. Additionally, you must receive prior authorization from the Plan Administrator for a prosthetic or orthotic device. If you receive authorization from the Plan Administrator, the device is Medically Necessary, and an appropriate prosthetic or orthotic device is not available in-network, then an 80% cost-sharing rate will be substituted for the 60% rate. ***Please contact your Plan Administrator prior to purchasing a prosthetic or orthotic device.***

**Foot orthotics are covered under medical supplies and durable medical equipment provided the criteria on pages 25 and 26 of this SPD are met, and subject to the limitations regarding durable supplies and medical equipment on pages 25 and 26 of this SPD.

***What If I Become Pregnant While Covered Under This Plan?***

You or your Spouse is covered for Medically Necessary expenses related to pregnancy and childbirth and follow-up Hospital care for mother and newborn for up to 48 hours after a vaginal birth, and up to 96 hours after a cesarean section. We do <u>not</u> cover pregnancy related expenses for your Dependent children.

Pregnancy is treated the same as any other Sickness under the Plan. This includes coverage for pre-natal care, post-natal care, and pregnancy complications.

***What is Covered if I Have a Mastectomy?***

The Women's Health and Cancer Rights Act of (1998) (WHCRA) is a federal law that requires coverage for mastectomies and other related services. We cover mastectomies, including all stages of reconstruction on the breast on which the mastectomy was performed, as well as surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment

of physical complications related to mastectomies including lymphedema. All of these services are considered Medically Necessary under the Plan.

***Hospital Care and Other Facilities Generally***:

We will pay for inpatient Hospital charges when it is Medically Necessary for covered medical care and no other more cost-effective arrangement is appropriate. This also applies to intensive care, confinement in a private room, and a semi-private room, wherever such is Medically Necessary. The Allowable Charge will be based on the reasonable, usual, and customary charge for that service.

Home health care services are covered when:

- They are provided in accordance with a home health care plan established by your Physician;
- They are Medically Necessary; and
- You would have to be hospitalized if the services were not available in your home.

***Is There Hospice Care for Terminal Illness Under This Plan***?

Yes. We cover the reasonable, usual, and customary charges of Hospice care for management of a terminal illness or palliative care for up to 210 days for the following services:

1. Nursing care provided by or under the supervision of a registered nurse;
2. Physical, occupational, and speech therapy;
3. Medical social services if they are under the direction of a Physician;
4. Personal care services and household services that are needed to maintain a safe and sanitary environment and that are not performed by a person who lives with the covered person or who is related to the covered person;
5. Drugs, medical supplies, and the use of medical appliances or durable medical equipment;
6. Physician services;
7. Occasional short-term (5 consecutive days or less) inpatient care in an inpatient facility ("crisis care");
8. Counseling for members of the covered person's family with respect to the care of the terminally ill individual and the adjustment of his or her death.

You are eligible for Hospice care if:

1. You have a life expectancy of six months or less;
2. The Hospice care charges are certified as a Hospice Care Program under Medicare or by the Joint Commission on Accreditation of Healthcare Organizations;
3. Your Physician approves and agrees to follow a Hospice care plan that was drafted by the Hospice program;
4. The written Hospice care plan provides that your care will be provided at home; and
5. Your Hospice care program agrees to accept the benefits under the Plan as payment in full for the services and supplies provided to you.

***What Medical Supplies and Equipment Are Covered***?

We cover some medical supplies and durable medical equipment when prescribed by a Physician. However, you should note that we will only pay up to $5,000 per person in a calendar year for

covered medical supplies or equipment that is/are Medically Necessary for the treatment of Sickness or injury. If a Medically Necessary appliance is not available through the Plan's PPO, then you will pay an 80% co-insurance rate instead of the regular 60% rate.

We will not cover any supplies that are solely for your convenience or comfort.

We will pay for whichever costs less between renting and purchasing equipment or supplies, and any charge in excess of that will not be considered part of the Allowable Charge.

***What if My Infant Needs Phenyl-Free Formula?***

We will pay for 80% of the reasonable, usual, and customary charges for the infant formula, if your Physician recommends it to treat phenylketonuria ("PKU"), or any inherited disease of amino and organic acids, up to $5,000 per person in a calendar year, after you have paid your deductible.

***Are There Special Rules for Using an Ambulance Service?***

Yes. In a non-emergency situation you should always check to see if there is an "in-network" ambulance service provider that serves your area, because if you use an ambulance service that is not in-network, you will pay for it as an out-of-network claim. If no ambulance or other appropriate medical transportation service is available "in-network", we will pay 80% of the allowable charge. In an Emergency situation, the rules that apply to all Emergency situations on page 23 of the SPD apply to ambulance services.

Ambulance services are provided to a covered person for:

1. Transport to the nearest facility for appropriate care for an Emergency medical condition;
2. Transfer of a covered person who has received Emergency care or who is an inpatient at an acute care facility to the nearest facility where appropriate care can be provided; or for transporting a covered person who is bedridden to a facility for treatment or to his or her home;
3. Transporting a respirator-dependent person; and
4. Transporting a Covered Person to and from the nearest appropriate facility for testing and/or procedures that cannot be performed at the present facility.

***Are Any Dental Services Covered Separately From the Dental Benefits Program?***

Yes. We cover treatment of your natural teeth if they are accidentally injured, or if you require cutting procedures to treat a disease of the teeth, jaw or gums. We also cover treatment of a fractured or dislocated jaw, or surgery to remove impacted teeth. We only cover tooth implantation if it is necessary because of an accident and you need bone replacement in the same area as the implant.

Effective January 1, 2009, we cover general anesthesia materials, their administration, and medical care facility charges when they are provided to the following covered persons:

1. Children age 7 and under; and
2. Individuals with medical or behavioral conditions that require hospitalization or general anesthesia when dental care is provided and who have received prior authorization from the Plan Administrator.

Any other dental services not specifically discussed here may be covered under the Dental Benefits Program (page 33 of this SPD), but are excluded from coverage under the Comprehensive Medical Benefits section.

***Are Immunizations Covered?***

We cover the Allowable Charge for immunizations that your Physician recommends, like "flu shots." We do not cover immunizations that you may get for purposes of employment or international travel. This section applies to Covered Persons age seven or over under the same cost-sharing provisions as apply to other benefits under this Comprehensive Medical Benefits Program. The Allowable Charge for these immunizations includes the charge for the immunization itself, but not the office visit to get the immunization.

Some immunizations for your Dependent child are covered under the Well Child Benefit Program (page 28 of this SPD).

## ***WELLNESS BENEFITS UNDER THIS PLAN***:

If you are an Eligible Employee or Retiree, then we will pay 100% of the cost for you and your spouse to get a Wellness Physical Exam from Concentra only. We have contracted with Concentra to perform this service. The following schedule applies to this benefit:

***Wellness Benefits:***

***Provided through Concentra only.***

Co-Payment ***(We pay)***.....100%
Co-Payment ***(You pay)*** .....0%

Frequency of Exam

Eligible Employee or Retiree and Spouse ages 18 to 30 ..... 1 exam every 5 years
Eligible Employee or Retiree and Spouse ages 31 to 35 ..... 1 exam every 3 years
Eligible Employee or Retiree and Spouse ages 36 to 40 ..... 1 exam every 2 years
Eligible Employee or Retiree and Spouse age 41 and over..... 1 exam per year

## ***ORGAN OR TISSUE TRANSPLANT***

Human organ and tissue transplant benefits are provided according to the terms and conditions set forth in a separate Organ & Tissue Transplant Policy (Transplant Policy) that has been issued to the Plan. Transplant related benefits will be provided to each covered person during the transplant benefit period specified in the Transplant Policy. Once the transplant benefit period has elapsed, all transplant-related benefits will revert back to this Plan, subject to its terms and conditions.

Transplant related benefits are only available to individuals that:

A. Are eligible for medical benefits under this Plan;
B. Meet all the terms and conditions outlined in the Transplant Policy; and
C. Have fulfilled the waiting period (if applicable) as defined in the Transplant Policy.

For further information about the Organ & Tissue Transplant benefit, including steps to obtain a specialist referral and a complete copy of the Transplant Policy, please contact the Plan Administrator.

***ROUTINE CARE BENEFITS***:

Routine Care Benefit
*Employee Co-Payment does not apply to Deductible or Out of Pocket Limits.*
Co-Payment ***(We pay)***
In Network or Out of Network.....100%
Co-Payment ***(You pay)***
In Network or Out of Network.....0%
Covered Exams
Thyroid Stimulating Hormone (TSH) Test
Pap smear
Mammogram
Prostate Specific Antigen (PSA) Test
Colonoscopy
Maximum Benefit (Calendar Year) ..... $300 per person

***These Routine Care benefits are available to Retirees and their Spouses.***

***WELL CHILD BENEFITS***:

After you have paid your child's annual deductible, we pay for 100% of the Allowable Charge for services provided or supervised by a Physician including routine well baby care, pediatric preventive services, developmental assessment, appropriate immunizations and laboratory tests. We will also provide full coverage for most routine immunizations required to place your Dependent children in a child care facility, school or similar program.

These benefits are listed below:

***Well Child Benefit (Eligible Dependents of Eligible Employees only)***
*The Co-Payment percentages apply only after your deductible has been met.*

Co-Payment ***(We pay)***
In Network or Out of Network.....100%
Co-Payment ***(You pay)***
In Network or Out of Network.....0%
Maximum Well Child Benefit
Eligible Dependent children age birth through 1 year ..... All visits per year
Eligible Dependent children ages 1 and 2 years ..... 5 visits per year
Eligible Dependent children age 3 years through 6 years.....1 visit per year
Eligible Dependent children age 7 or over .....0 visits per year

***These Well Child benefits are not available to Retirees and their Dependents.***

## ***MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT***:

***Generally***:

No benefits for mental health care or substance abuse treatment are available under other sections of this Plan except that you may receive Loss of Time Benefits while you are getting inpatient treatment, see page 37.

***What if I Receive Inpatient Treatment for Mental Health Care?***

If your inpatient treatment is Medically Necessary to treat a Mental Health Care Condition, it will be covered the same as a Hospital stay under the Comprehensive Medical Benefits Section (see page 25) as long as you get treatment from an accredited and licensed Hospital or Treatment Facility that participates in the Plan's PPO. If you receive Medically Necessary inpatient treatment for a Mental Health Care Condition at an out-of-network facility, we will pay 60% of the treatment as long as the facility is an accredited and licensed Hospital and Treatment Facility. We will only cover up to thirty days of inpatient treatment for a Mental Health Care Condition.

***What if I Receive Inpatient Treatment for Substance Abuse?***

If your inpatient treatment is Medically Necessary to treat a substance abuse problem, then we will pay for 100% of the treatment up to a $7,500 maximum per covered person, per calendar year, as long as you get treatment from an accredited and licensed Hospital or Treatment Facility that participates in the Plan's PPO. If you receive Medically Necessary inpatient treatment for a substance abuse problem at an out-of-network Hospital or Treatment Facility then we will pay for 60% of the treatment up to a $7,500 maximum per covered person, per calendar year, as long as the out-of-network facility is an accredited and licensed Hospital and Treatment Facility.

We will only cover up to thirty (30) days of inpatient care per calendar year, regardless of whether you have reached the $7,500 maximum limit for treatment.

***What if I Need Treatment for Substance Abuse and a Mental Health Condition at the Same Time***?

If you require treatment for a dual diagnosis of substance abuse and another mental health condition, then benefits will be paid under the substance abuse benefit rules. This means that there are two separate thirty day limitations, there is one thirty day maximum limitation for inpatient treatment for mental health care per calendar year and there is one thirty day maximum limitation per calendar year for treatment of substance abuse or of a dual diagnosis. The thirty day maximum limitation for a Mental Health Care Condition is not combined with the thirty day maximum limitation for substance abuse or for a dual diagnosis of substance abuse and a Mental Health Care Condition.

***What if I Need Outpatient Treatment for Mental Health Care or Substance Abuse?***

We will pay 50% of the Allowable Charges for up to 45 outpatient visits per calendar year for the treatment of substance abuse or dependency and/or other Mental Health Care Conditions (including "after care" following inpatient substance abuse treatment, when that care is not included in the charge for the inpatient treatment), as long as you get treatment from a duly-licensed Physician, Nurse Practitioner, Mental Health Care Provider, or alcohol or drug

dependency counselor, who participates in the Plan's PPO. There are no out-of-network benefits available for outpatient Mental Health Care or substance abuse treatment.

***Is Outpatient Mental Health Care Treatment After an Amputation, Including a Mastectomy Covered?***

Yes. The cost sharing for this type of treatment will be treated like outpatient treatment for medical and surgical benefits. This means that we will pay 85% and you will pay 15% for "in network" treatment. No out-of-network benefits are available, and the forty-five visit maximum applies.

***Are Any Counseling Services Covered?***

Yes. We offer you and your family comprehensive Employee Assistance Program ("EAP") services. The EAP offers short-term counseling (up to 4 visits) and/or referral and follow-up services for support in areas including family or relationship difficulties, emotional stress, alcohol or drug problems, smoking cessation, and financial or legal concerns. Services provided by the EAP are available at no cost to you or your family; however situations that require outside referral or continued counseling (beyond the 4 visits) may or may not be covered by the Plan. Please contact the Plan Administrator to determine what benefits, if any, may be available for your situation.

***Is There a Different Cost-Sharing Rule When Outpatient Treatment is Referred By the Medical Review Office of the Employee Assistance Program***?

Yes. We will pay 100% of the cost for your outpatient treatment if it is provided as the result of a referral from the Medical Review Office of the Employee Assistance Program.

***Combined Forty-five (45) Day Visit Maximum For Outpatient Treatment***:
There is a forty-five visit maximum per calendar year combined for all out-patient visits for the treatment of substance abuse or dependency and other mental health conditions, regardless of the cost-sharing rule that applies.

***PRESCRIPTION DRUG BENEFIT***

We now use a drug 'Formulary.' A Formulary is a list of *preferred* brand name drugs that is carefully designed to best serve your interests by providing quality drugs at a reasonable cost.

The type of drug prescribed by your doctor will determine how much you pay for your prescription (your co-payment). You should share the Formulary with your doctor.
***Prior Authorization and Quantity Control Program: The following two paragraphs are currently suspended, meaning the prior authorization requirements and the quantity control limits do not apply. If the suspension is lifted you will receive a Benefit Alert. Please contact the Plan Administrator if you have any questions.***

[You must receive prior authorization for a specific list of medications. If a medication is subject to prior authorization it must be reviewed by the Plan's Pharmacy Benefit Manager prior to being covered. Medications that may be subject to prior authorization include: antihypertensive drugs, biotech agents, dermatological drugs, injectable agents, proton pump inhibitors (coverage only in connection with throat, tongue, stomach, esophageal, or larynx cancer, scleroderma, and in suspended form for children up to age 7), Xolair (asthma), Zelnorm, and Lotronex.

If your prescription exceeds the quantity limit, coverage will be denied with a message to the pharmacy indicating the approved quantity allowed. The prescription can then be resubmitted for the approved quantity. Medications that may be subject to the quantity control include: pain management drugs, diabetic supplies, anti-emetics drugs, migraine therapy drugs, sedative/hypnotic drugs, and erectile dysfunction drugs.]

Here is the schedule for co-payments that you will pay to the pharmacy when you buy drugs from a retail pharmacy:

| ***If your prescription is for a:*** | ***Your co-payment:*** |
|---|---|
| Generic drug | $15 |
| Brand name drug listed on the Formulary | $30 * |
| Brand name drug NOT listed on the Formulary | $50 * |

* plus the difference in the ingredient cost if your prescription is for a brand name drug when a generic is available

***Important:*** Your purchase at a retail pharmacy is limited to a 34-day supply for each co-payment. You may purchase a 102-day supply if you pay 3 co-payments, if your doctor prescribes a 102-day supply.

***Mail Order Prescriptions***:

The Formulary also applies to purchases made through the mail order program. The co-payments schedule for mail order purchases is as follows: ***Important: You will be permitted to purchase as much as a 90-day supply with one co-payment.***

| ***If your prescription is for a:*** | ***Your co-payment:*** |
|---|---|
| Generic drug | $30 |
| Brand name drug listed on the Formulary | $60* |
| Brand name drug NOT listed on the Formulary | $100* |

* plus the difference in the ingredient cost if your prescription is for a brand name drug when a generic is available

Remember, this Prescription Drug Benefit does not cover the cost of medications that have recently become available 'over-the-counter'. ***However, coverage of legend drugs includes vitamins that are treated as legend drugs under federal law, so prescription vitamins are covered.***

***Your Benefits and Co-Payments are also listed on the chart at the beginning of this SPD.***

***High-Risk Patient Support Services:***

If you are at a higher-risk, you may be contacted by a HealthReach Care Manager. HealthReach is a specialized health education and support program that provides personal assistance to help higher-risk covered persons understand and manage specific medical conditions and minimize potential side effects of prescription drugs. HealthReach is provided at no charge to covered persons, is completely voluntary, and is confidential. HealthReach Care Managers will provide you with information and clarification to help you make informed health care decisions, but they will not make decisions for you.

***Deductible and Cost-Sharing:***

A separate deductible applies every year for expenses for Prescription Drug Program benefits. The deductible is satisfied only by prescription drug expenses.

If you are an Eligible Employee you will pay the first $100 a year. This applies to every Covered Person. However, no family will pay more than a total of $200 in deductibles for the year.

If you are a Retiree, you will pay the first $100 per year. This applies to your ***entire family*** (i.e. your family will not pay more than a total of $100 in deductibles for the year).

***Covered Expenses:***

Prescription drug expenses are expenses for legend drugs, insulin, and diabetic supplies other than those that are excluded below, that are purchased through either the Plan's direct mail prescription provider or a participating preferred retail pharmacy. Legend drugs are those that may only be obtained with a valid prescription.

***Exclusions***: No benefits are payable under the Prescription Drug Program for:

a. drugs obtained without a valid prescription;
b. non-legend or over-the-counter (OTC) drugs (that is, drugs which may be obtained without a prescription);
c. contraceptive drugs for non-spouse Dependents;
d. any expense for a prescription drug to the extent the billed charge exceeds a reasonable, usual and customary charge for such drug;
e. non-legend or over-the-counter (OTC) vitamins (that is vitamins which may be obtained without a prescription);
f. drugs provided without charge to you, or paid for, under any government program or law;
g. drugs or other pharmaceutical products for which no charge is incurred, or for which you incur no legal obligation to pay;
h. drugs or other pharmaceutical products provided to you while confined in a Hospital or other facility, or that are covered under any other section of this Plan;
i. devices (including biotechnology devices) of any type even though such devices may require a prescription order;
j. expenses incurred for more than six dosages (i.e., pills or injections) per calendar month for treatment of sexual dysfunction;

k. charges payable under Worker's Compensation, occupational disease, or similar law;

l. Non-Sedating Antihistamines, including but not limited to: Allegra, Allegra D, Clarinex, or Clarinex D; or

m. Proton Pump Inhibitors (except in connection with throat, tongue, stomach, larynx or esophageal cancer, and in suspended form for children up to age 7. Additionally, the Plan will cover Proton Pump inhibitors in connection with limited scleroderma (CREST syndrome) but only after the covered person completes a 30-day trial of an over-the-counter Proton Pump Inhibitor drug) including but not limited to: Prilosec, Nexium, Aciphex, Prevacid, and Protonix

## ***DENTAL SERVICES***

### ***Your Dental Services Generally***:

We pay for 80% of the Allowable Charges for covered dental care provided by a licensed participating Dentist up to $1,500 per person per year. There is no set deductible that you have to pay for dental care, but you will pay the other 20% of the Allowable Charge for the services. (If you use an out-of-network provider then we only pay 60% of the Allowable Charge and you will pay the other 40%.)

### ***What is Included in Covered Dental Care***?

Diagnostic and preventive dental care including:

- Routine exams and cleanings not more than twice a year;
- Bitewing and periapical X-rays as required;
- Full mouth X-rays once in any 36 consecutive months;
- Dental prophylaxis not more than twice a year including cleaning, scaling, and polishing (treatment for diseases of the gums is not included in this benefit);
- Topical fluoride applications for Covered Persons under age 19 once in a calendar year;
- Palliative emergency treatment as needed;
- Certain space maintainers for prematurely lost teeth for your Dependent children;
- Preparation of a treatment plan;
- Diagnosis of mouth, teeth, gum and jaw disorders;

Basic dental care, including:

- Restorative services including amalgam, synthetic porcelain, and plastic restorations;
- Periodontics including treatments for diseases of the gums and surgical procedures necessary for the treatment of diseases of the gums and bone supporting the teeth and periodontal splitting;
- Endodontics including pulpal therapy and root canal filling; and
- Extractions, including simple and surgical extractions and pre and post-operative care related to such surgical extractions.

Major dental care, including:

- Prosthetics including bridges, partial dentures, and complete dentures (including replacement of dentures when Medically Necessary if it has been five years since you originally got dentures or since your most recent replacement);

- Crowns and jackets when your teeth cannot be restored without a filling;
- Oral Surgery; and
- Occlusal mouth guards prescribed in connection with the treatment of Bruxism, but only when it has been five years since you originally got an occlusal mouth guard or since your most recent replacement.

Orthodontia, including all medically necessary orthodontic services (including adult orthodontia and appliances) subject to your annual $1,500 benefit maximum for all dental benefits combined. Benefits include treatment for correction of malposed teeth, the establishment of proper occlusion through the movement of teeth or their maintenance in position, and an occlusal mouthpiece in connection with the treatment of Bruxism up to one time every five years.

Dental Implants: We will pay 50% of Allowable Charges for dental implants up to a maximum of $1,500 per person per calendar year. You are responsible for the remaining 50% of Allowable Charges for dental implants as well as any charges that exceed $1,500. The charges incurred for dental implants count towards your $1,500 maximum per year. (For example, if the allowable charges for your dental implants are $3,000 we will pay $1,500 and you will pay $1,500 and you will not be entitled to any other dental benefits for the year. If the allowable charges for your dental implants are $2,000, we will pay $1,000 and you will pay $1,000 and you will still be allowed $500 more of covered dental care for the year).

***When is an "Expense Incurred" for My Dental Benefits?***

For an appliance or modification of an appliance, at the time the impression is made.
For a crown or bridge, at the time the teeth are prepared.
For a root canal, at the time the pulp chamber is opened.
For all other expenses, at the time the service or supply is provided.

***Is Oral Surgery Covered By This Plan?***

When you need oral surgery, it is covered the same as the Comprehensive Medical Benefits Program as long as the surgery is performed by a Dentist who is a member of the Plan's PPO, or a Physician who is properly certified in oral surgery.

The benefits for oral surgery do not count towards your annual dental maximum.

## ***VISION BENEFITS***

***Generally:***

We will pay for 100% of your covered vision care up to the following maximums:

Maximum amount paid for exams:

a. $50 for one examination by a licensed optometrist or ophthalmologist per calendar year;

Maximum amount paid for lenses:

a. $50 per pair for single vision lenses;
b. $85 per pair for bifocal lenses;
c. $95 per pair for trifocal lenses;

d. $10 per pair for color tint, if Medically Necessary;
e. $100 per set of contact lenses (or the total cost if Medically Necessary)

An Eligible Employee is covered for up to two pairs of prescribed lenses (whether spectacle or contact) per calendar year; and Retirees and Dependents are covered for one pair of prescribed lenses (whether spectacle or contact) per calendar year. A package of disposable contacts is treated as a pair of prescribed lenses.

Maximum amount paid for frames:

a. $75 for a pair of frames once per calendar year for Eligible Employee; and
b. $75 for a pair of frames once every two calendar years for Retirees and Dependents.

***Exclusions***: We do ***not*** pay benefits for:

a. an eye exam required by an employer as a condition of employment
b. extra charges for glasses with tinted lenses unless they are prescribed by an optometrist or ophthalmologist as Medically Necessary
c. sunglasses
d. special/unusual procedures, including but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonic lenses, and tonography
e. vision exams, lenses, or frames that were received or ordered before you became eligible for benefits under this section
f. lenses or frames ordered while covered for vision care benefits but delivered more than 60 days after your vision coverage terminated
g. procedures which constitute refractive eye surgery, including radial keratotomy, ***however, for Eligible Employees only, we will pay a lifetime maximum of $1,000.00 per eye for such procedures.***

## ***HEARING AID BENEFITS***

We will pay 100% of the cost up to $2,000.00 in any five consecutive calendar years for you to purchase a hearing aid.

## ***EXCLUSIONS***

***General Exclusions***:

We will not cover any charges for the following:

a. any charges relating to any injury or Sickness for which a Covered Person has received or is entitled to receive compensation under any Workers' Compensation or occupational disease or similar law or program, including all charges payable under Workers' Compensation, occupational disease, or similar law;
b. expenses for hospitalization or medical or surgical treatment provided at no charge to the Covered Person, or paid for, by any government agency;
c. any expenses related to an injury or Sickness caused by war or any act of war;
d. any expenses related to an injury or Sickness incurred while engaged in service with the armed forces of any nation or state;
e. expenses which neither the Covered Person nor the Eligible Employee or Retiree is required to pay;

f. expenses for routine physical or screening examinations, except as specifically provided under the Wellness and Routine/Preventive Care Benefits Programs;
g. expenses for hearing aids, except as provided under the Hearing Aid Benefit Program;
h. expenses for medical or surgical treatment rendered for cosmetic purposes as well as expenses for complications arising from such treatments;
i. expenses for services and supplies that are not Medically Necessary as well as complications arising from services and supplies that are not Medically Necessary;
j. expenses that exceed the Plan's reasonable, usual, and customary charge limitations;
k. expenses for any contraceptive devices or treatments (including surgical sterilization);
l. expenses for any product or service whose use is experimental or investigational;
m. expenses for any product or service, such as air-conditioners, water beds, and filters, the principal purpose of which is convenience or general comfort;
n. expenses for any medical or surgical treatment or examination required by an employer as a condition of employment;
o. charges made for confinement in a nursing home, long-term care facility, or any facility primarily providing personal care, assisted living, and/or general custodial services, rather than acute medical care;
p. any expense that is not incurred (an expense is incurred at the time the service or supply is actually provided) while the Covered Person is covered under this Plan, unless a Plan provision specifically provides otherwise;
q. any expense incurred for speech therapy, unless necessary because of:
    1. an injury, or
    2. a Sickness <u>other than</u>: otitis media, mental illness, or a functional nervous disorder;
r. expenses for services performed by a chiropractor;
s. expenses incurred for actual or attempted impregnation or fertilization, involving either the Covered Person or a surrogate as donor or recipient or expenses incurred for diagnosis or treatment of infertility;
t. expenses incurred for any treatment of sexual dysfunction that is not caused directly by a Sickness or injury, except for prescription drug expenses, which shall be limited to a maximum of six dosages (i.e., pills or injections) per calendar month;
u. expenses incurred for the treatment of obesity as well as expenses for complications arising from such treatment;
v. expenses incurred by a Dependent child in connection with her pregnancy, the birth of her child, or complications arising from either; or
w. any expenses for Dental or Mental Health Care and substance abuse treatment that is not specifically covered under other provisions of the Plan.

## ***<u>ANCILLARY BENEFITS</u>***:

These benefits are additional benefits that accompany your Comprehensive Medical Benefits under this Plan.

### ***What is the Death Benefit Under This Plan?***

If you are an Eligible Employee or Retiree, then you are eligible for a death benefit that will be paid to a designated beneficiary. You may designate a beneficiary to receive this benefit

on a form required by the Fund. You must file the form with the Plan Administrator before you die. You can change this beneficiary at any time before you die.

If you die on or after June 1, 2004, then your designated beneficiary will receive $10,000.

If you do not designate a beneficiary before you die, or your beneficiary has died before you, then we will pay the money in the following order until the benefit has been paid: (1) first to your Surviving Spouse; (2) if you do not have a Surviving Spouse, then to your descendants; (3) if you do not have descendants, then to your parents in equal shares; (4) if you do not have parents, then to your siblings in equal shares; and (5) if you do not have any siblings, then to your estate.

***When Can I Get Accident and Sickness Loss of Time Benefits?***

If you are prevented from working for at least one week due to injury or Sickness, then you are eligible for loss of time benefits during that time that you are unable to work. The maximum amount you will be paid is $400 gross amount per week for up to 26 weeks for any one injury or Sickness, called the "Period of Disability." If your Period of Disability lasts less than 26 weeks and ends on a partial week, then you will receive a partial week's credit for the number of days missed that week based on the weekly rate divided by seven (7).

This Period of Disability is the total amount of time that you are completely unable to perform any work in your own occupation, or any other gainful employment due to a physical or mental condition. After your initial Period of Disability, a separate Period of Disability is triggered only if you have returned to work and have actually worked for two weeks, or if you are disabled by a second separate physical or mental condition that is not related to the first condition.

You will <u>not</u> be paid Accidental and Sickness Loss of Time benefits if:

1. Your Disability lasts less than a full week.
2. Your injury or Sickness was caused by the use of alcohol or drugs, unless you are receiving inpatient treatment in an in-network treatment facility.
3. You are gainfully employed.
4. You are receiving or entitled to receive unemployment insurance/compensation payments.
5. You are receiving benefits under the Pipefitters Local No. 533 Pension Plan.
6. You are entitled to receive Worker's Compensation benefits, occupational disease benefits, or benefits under any similar law.
7. You are disabled as a direct result of an intentionally self-inflicted injury, unless your injury was the result of any physical or mental health condition.

***What if I Need Inpatient Treatment for Alcohol or Drug Use?***

If you participate in an inpatient treatment program for treatment of alcoholism or substance abuse at an in-network treatment facility, you will be eligible to receive the Loss of Time Benefits. These benefits are only available for 30 days for one inpatient program per calendar year.

If you successfully complete the program, then you will be paid Loss of Time benefits for each full week of approved inpatient stay, and you will receive pro-rated benefits for each additional portion of a week included in the program, for up to 30 days.

If you do not complete the program, then the Loss of Time benefits will only be paid for each week of the program that you completed, and you will not receive benefits for any partial weeks.

If you get this type of treatment at an out-of-network treatment facility, or if you receive outpatient treatment (whether in-network or out-of-network) you will not receive the Loss of Time benefits, even though the treatment itself may be covered under the Substance Abuse Treatment Benefit Program.

***What Accidental Death and Dismemberment (AD&D) Benefits Can I Get Under This Plan?***

If you die or lose a body part or function because of an accidental injury, or you lose a body part or function or die within 90 days after the accident, as long as your loss is due to the accident and does not come from any Sickness or other cause, you will be compensated in the principal amount of $1500 for that loss.

The following types of losses are covered under the program:

| ***If you lose:*** | ***We will pay:*** |
|---|---|
| Your life | $1500 (the principal sum) |
| Both hands or both feet | $1500 (the principal sum) |
| One hand and one foot | $1500 (the principal sum) |
| Entire sight of both eyes | $1500 (the principal sum) |
| One hand and or one foot, and entire sight in one eye | $1500 (the principal sum) |
| One hand or one foot or entire sight in one eye | $750 (half the principal sum) |

You will not receive more than $1500 for any losses resulting from one accident.
You will not receive AD & D benefits if your loss is:

a. caused by any Sickness or other physical or mental condition; or
b. caused by any type of infection, except an infection introduced through a wound sustained in an accidental injury, simultaneously with such accidental injury and not occurring as a result of later treatment or failure to treat the accidental injury; or
c. caused by or contributed to by any medical, surgical, or dental treatment, even if such treatment is provided in response to an accidental injury; or
d. caused by or resulting from your own act, regardless of your physical or mental state at the time of the act, regardless of voluntariness of the act, and regardless of whether the loss, or the act causing the loss, was intended or not; or
e. caused by ingestion of or exposure to poisons, drugs, medicines, chemicals, or other substances, regardless of the state of matter of the substance (including, but not limited to, food poisoning or exposure to carbon monoxide gas); or
f. incurred during the commission or attempted commission of a crime; or
g. incurred in connection with war, insurrections, or participation in a riot; or

h. incurred while you are serving in any military, naval, or air force of any country at war, declared or undeclared, or in any auxiliary or civilian non-combatant unit serving in a war-related capacity with any such force; or

i. incurred while traveling or flying in or on any type of aircraft, except while riding as a passenger on a regularly scheduled commercial airline operated by a common carrier or by a U.S. Government transport service.

## ***COORDINATION OF BENEFITS***:

If you or your Dependents have health care coverage under this Plan and another plan, these "Coordination of Benefits with Another Plan" rules apply because sometimes your coverage under these plans may be duplicated, meaning that both plans pay benefits for the same medical expenses. There are more detailed rules in the Plan document. Ask your Plan Administrator for more information.

### ***What if I am Covered by Another Health Plan?***

When benefits are coordinated you receive payment from both plans, but not more than your reasonably incurred medical expenses.

We coordinate with other plans such as:

a. any group or group-type insurance or group or group-type subscriber contract;
b. uninsured arrangements of group or group-type coverage;
c. group or group-type coverage through HMOs and other pre-payment, group practice, and individual practices plans;
d. the amount by which group or group-type Hospital indemnity benefits that exceed two hundred dollars ($200.00) per day;
e. the medical benefits coverage in group, group-type, and individual automobile insurance contracts;
f. the medical care component of long-term care contracts, such as coverage for skilled nursing care; and
g. individual or family insurance contracts, subscriber contracts, or coverage through closed-panel or other pre-payment, group practice, and individual practice plans.

If you are eligible to enroll in another plan, but do not enroll, the plan will only be treated as another plan with which benefits may be coordinated if there is no cost for you to enroll. If you are eligible to enroll in another plan at no cost, then that plan will be treated as another plan with which benefits may be coordinated.

The plan that pays benefits first is the "primary plan" and the plan that pays benefits second, is called the "secondary plan." There are special detailed rules to determine which plan is primary and which is secondary. These are determined by your status at the time of coverage and are briefly explained below:

### ***Eligible Employees***:

If you are covered under another plan as the employee, member, or "primary insured," then that plan will be primary and this Plan will be secondary.

If you are covered under another plan as a dependent, or as a laid -off or retired employee, then this Plan will be primary and the other plan will be secondary.

Generally, we will not take into account any benefits you are entitled to under Medicare in determining the benefits payable by this Plan. We will generally be primary for you and your Dependents while you are an active Employee, and Medicare will be secondary.

***Spouses:***

If your spouse is covered under this Plan as a Dependent and under another plan as the employee, member, or "primary insured", then that other plan will be primary and this Plan will be secondary.

If your spouse is covered under this Plan as a Dependent and is covered under another plan as a dependent, the plan that has covered your spouse the longest will be primary, unless the other plan covers your spouse as a dependent of a laid-off or retired employee, in which case that plan will be secondary and this Plan will be primary.

If your spouse is age 65 or older and is covered as a Dependent of an active Eligible Employee under this Plan, this Plan will not take into account any benefits that you are entitled to under Medicare in determining the benefits payable by this Plan. We will always be primary for your spouse while you are an active Employee, and Medicare will be secondary.

If your spouse is age 65 or older and is covered as a Dependent of a Retiree under this Plan, Medicare will be primary and this Plan will be secondary.

***Retirees***:

If you are covered under this Plan and another plan, the other plan will be primary and this Plan will be secondary. If you are age 65 or older and covered by this Plan, Medicare will be primary and this plan will be secondary.

***Your Dependent Children***:

If your child is covered as a Dependent under this Plan, and is covered as an employee, member, or "primary insured" under another plan, then that other plan will be primary and this Plan will be secondary.
If your child is covered by both parents who live together, then this Plan will follow the "birthday rule." The plan of the parent whose birthday is earliest in the calendar year will be the child's primary plan, and the plan of the other parent will be the child's secondary plan.

If your child is covered by both parents who do not live together, then the custodial parent's plan will be the child's primary plan, the plan of the child's step-parent who lives with the child will be secondary, and the non-custodial natural or adoptive parent's plan will pay after the first two plans have paid. [If the child is not covered by three plans then the order will be the same as listed here, just skipping the parent's plan that does not cover the child.]

Any plan ordered to provide coverage under a Qualified Medical Child Support Order (QMCSO) will be the child's primary plan.

If two Eligible Employees covered under this Plan share a child, then the child will be considered a Dependent of both.

***Which Plans and Programs Do Not Coordinate With This Plan?***

We do not coordinate benefits with Workers' Compensation.

We do not treat Medicare or Medicaid as another plan, but each will be coordinated under separate rules.

We do not coordinate with other insurance policies, such as school accident-type policies, and other policies which provide benefits to cover for losses other than the payment of health care expenses.

If a third party (other than "another plan") is liable for your injury or Sickness, we will not have any liability for payment of any of those medical care expenses except under the Plan's Subrogation rules. (See page 42)

***What Are The Medicare Coordination Rules?***

The Medicare rules apply to you or your Dependent when eligible for Medicare whether or not you or the eligible Dependent is enrolled.

If you are an active Employee and you or your covered Dependent is eligible for Medicare, then this Plan is primary and Medicare will be secondary.

However, if you or your covered Dependent is eligible for Medicare based on Disability or age, and are covered by this Plan's COBRA continuation coverage, or as a Retiree, then Medicare will be primary and this Plan will be secondary. When coverage under this Plan is secondary to Medicare, we will coordinate benefits by paying all remaining charges, up to the lesser amount of Medicare's total Allowable Charge or the Plan's total Allowable Charge. We will pay benefits regardless of whether you have met your deductible under Medicare.

We have special rules for persons on Medicare with End Stage Renal Disease (ESRD). Contact the Plan Administrator if you need more specific information.

For dental benefits, prescription drug benefits, or vision care benefits that are not covered by Medicare, this Plan is primary for claims filed under those benefit programs. If any of those benefits are provided by your Medicare plan, the Plan will follow the ordinary coordination of benefit rules explained in the above paragraphs.

***What Are The Medicaid Coordination Rules?***

We will pay benefits without regard to any coverage you or your Dependents may have under Medicaid. However, we will honor an assignment of rights by or on behalf of you or your Dependents as required by Medicaid.

## ***SUBROGATION***

### *What is subrogation?*

Subrogation allows the plan to "stand in your shoes" to recover benefits paid under this Plan from any other plan or person who should have properly paid those benefits. For example, if you are injured in an auto accident due to another driver's fault, and the Plan pays expenses for the treatment of your injuries, the Plan can "stand in your shoes" and make a claim to recover those expenses from either the responsible driver or the responsible driver's insurance company. In subrogation, the Plan is asserting your rights to collect against a responsible party.

### *What is reimbursement?*

With reimbursement, the Plan is not asserting your rights but instead is simply requiring repayment of the benefits paid on your behalf. For example, say you are crossing the street and are hit by a car that failed to stop for the crosswalk. The Plan pays expenses for the treatment of your injuries. You hire an attorney and file suit against the driver, eventually arriving at a settlement. Under the Plan's reimbursement provisions, the Plan must be repaid for the benefits it paid out of the proceeds of your settlement. You have asserted your rights to collect against the responsible party, but the Plan must be repaid.

Reimbursement also covers the situation where the Plan makes payment that is in excess of the maximum allowable amount of payment necessary.

### *How does the Plan collect money under the subrogation provision?*

To collect money under the subrogation provision, the Plan will send written notice to you informing you that the Plan is enforcing its rights. The Plan may then collect money directly from the other person or plan without your consent.

### *Do I get any of the money the Plan recovers in a subrogation action?*

The Plan will apply any monies collected from another plan or person to any reasonable costs and expenses the Plan incurs in collecting that money (including attorney fees) up to the amount of the award or settlement. If there is any remaining balance, that balance will be paid to you.

### *If I am injured by a third party, is there anything I have to do before the Plan will pay benefits?*

Yes. You must complete a subrogation agreement and provide any requested information to the Plan before any benefits will be paid.

### *What if I hire an attorney and my attorney negotiates a settlement?*

As discussed in the reimbursement example above, the Plan's rights to subrogation and reimbursement take priority over any other use of money you recover. This includes the payment of attorney fees and expenses. The Plan must be paid first, regardless of the amount

of your recovery, and regardless of whether that recovery comes from lawsuit or settlement. The Plan is entitled to be reimbursed from your recovery, regardless of how your recovery is characterized or paid.

***Are the Plan's rights limited by the "make whole" or "common fund" doctrines?***

No. The Plan's subrogation and reimbursement rights are not limited by the common fund doctrine or the make whole doctrine. The Plan specifically disclaims these two doctrines.

***Will the Plan pay the costs or expenses incurred in connection with recovery from another plan or person?***

No. The Plan will not be responsible for any costs or expenses incurred in connection with your recovery from any other plan or person unless the Plan agrees in writing to pay a part of those expenses.

***Are there any times the Plan will accept less than full reimbursement?***

The Board of Trustees, within its sole discretion, may decide to recover less than the full amount of reimbursement if:

- This Plan has made reasonable and diligent collection efforts appropriate under the circumstances, and
- Such decision is reasonable under the circumstances based on the likelihood of collecting monies in full or based on the expenses the Plan would incur in an attempt to collect additional funds.

***Will the Plan ever reduce my benefits to recover benefits that were overpaid?***

The Trustees may, in their discretion, elect to set-off amounts paid by the Plan in excess of benefits due against any amount owed in the future. For example, if the Plan pays $200.00 for a medical expense later determined to not be covered under the Plan, the Plan may require you to pay the next $200.00 in submitted claims to set-off the amount that was overpaid.

***Can the Plan recover overpaid benefits from anyone other than me?***

Yes. The Plan has the right to recover excess payments from any one or more of the persons it has paid (for example, a provider), from one or more persons for whom it has made payments (the person who is the subject of the medical claim), or from any other person or organization that may be responsible for the benefits or services that were provided and paid for.

***How does the Plan determine who will repay the benefits?***

The Trustees have the sole and absolute discretion to determine from whom they will recover.

***Do the subrogation and reimbursement provisions apply to any payment I receive from a responsible third party?***

Yes. If a responsible third party (or that person's insurer, or anyone else on that person's behalf) makes a payment to you as compensation for an injury or sickness, the Plan is entitled to reimbursement in an amount equal to the lesser of the amount of benefits paid by the Plan and the amount of compensation paid by the third party.

***If I receive payment for my injury and the injury still requires treatment, will that treatment be covered by the Plan?***

Whether any future treatment will be covered by the Plan will depend on the terms of your settlement agreement. If you are compensated for future medical expenses, those expenses will not be covered by the Plan.

***Do I have any responsibility to the Plan?***

Yes. You have a duty to cooperate with this Plan. As a condition of receiving benefits under this Plan, you agree that at the request of the Board of Trustees or its designee you will take any action, give any information and assistance, and execute any documents required by this Plan to enforce its subrogation and reimbursement rights. The Plan will make no payments to you or on your behalf unless you satisfy these terms.

Additionally, the Plan has the right to release or to obtain from any person any information which the Board of Trustees determines necessary to make payment for medical care, to determine and to enforce any cost sharing requirements, and to enforce the Plan's right to recovery, reimbursement and/or subrogation.

## ***HOW TO FILE A CLAIM UNDER THIS PLAN***

***Generally***:

Generally, your provider will file your claim for you, as long as you provide all of the necessary information about your coverage. Always present your Plan identification card to your provider when you receive any health care services to help him/her determine if he or she can file the claim on your behalf.

We have entered into a Preferred Provider Organization (PPO) contract with Blue Cross and Blue Shield of Kansas City (BCBSKC). Your claims will first go to BCBSKC, whose sole responsibility is to apply the appropriate discounts to your claims. The claim is then sent to the Plan Administrator who actually administers the Plan. You should contact the Fund Office if you have any questions regarding coverage.

***Where Do I File My Claim?***

You should file all your health benefit claims with Blue Cross and Blue Shield of Kansas City (BCBSKC) at the address shown on your identification card. You can file in either paper

format, using either your provider's form or a standard health claim form, or EDI compliant electronic format.

If this Plan is secondary, you should still file health benefits claims with BCBSKC at the address shown on your identification card. This includes any Medicare related claims that must be filed with this Plan.

Death benefits, AD&D, and Loss of Time benefits are administered directly by the Fund Office. Claim forms are available from, and must be returned to, the Fund Office.

Express-Scripts will handle your prescription drug claims. Participating retail pharmacies will submit your claim for you, and mail order and reimbursement claim forms are available at the Fund Office.

Dental claims must be filed with Delta Dental of Missouri on Delta Dental's claim form.

If you file the claim yourself, *always* include the following information:

Name and Social Security Number of the Participant;
Name and Date of Birth of the Patient
Patient's Relationship to Participant
Date Health Care Service Was Provided
Name and Billing Address of Provider
Tax Payer ID Number of Provider
Type of Treatment-Service Provided
Number of Units (for anesthesia and certain other claims)
Diagnosis for which Treatment was Provided
Whether treatment was result of Accident, and Details
Information on Any Other Insurance the Patient Has
Include Billing Statement or Receipt
Signature of Patient or Patient's designated representative and Provider
Your Provider Must Fill Out Part of the Form.

**See the Claim form for more specific information. You must use the correct form in order for your claim to be processed properly and timely.

**Only a written notification from the Plan Administrator (in the form of an Explanation of Benefits or other formal correspondence) will constitute notice of a benefit determination.

***When Do I Have to File My Claim?***

Your claims for payment of health care expenses must be filed by the last day of the calendar year following the calendar year in which the expense was incurred.

Claims for Loss of Time benefits must be filed within the calendar year in which the Period of Disability ended, or if less than 90 days remains in the calendar year, within 90 days after the end of the Period of Disability.

Claims for death benefits and accidental death and dismemberment (AD&D) benefits must be filed within one year from the date of death or the date of loss. If you are submitting a claim for death benefits, you must submit proof of death (such as a death certificate) with the claim. If you are submitting a claim for AD&D benefits, you must submit proof of accident (such as a police report or coroner's report) with the claim.

You can only file claims after the periods described above with the express approval of the Trustees or their designated representative. If you cannot file your claim within this period, you must send a written request to file a late claim to the Trustees that includes an explanation of the circumstances preventing timely filing.

We will process claims filed by you or your authorized representative. You may designate an authorized representative by completing and filing an Authorized Representative form that is available from the Fund Office. No form needs to be on file for your spouse, the parent or legal guardian of a minor participant, or your treating Physician to file a claim on your behalf.

***How is My Claim Processed?***

You will receive notice of all claim determinations. In some instances, if the claim is paid in full, payment of the claim will serve as your written notice of our decision. If your claim is denied, in whole or in part, or if we pay less than the total amount you are charged, you will receive a written notice that will include:

- the specific reason or reasons for the adverse benefit determination;
- reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary for you to perfect your claim, and an explanation of why that material or information is necessary;
- a description of the Plan's review (appeals) procedures and the time limits applicable to those procedures, including a statement of your right to bring a lawsuit under section 502(a) of the Employee Retirement Income Security Act (E.R.I.S.A.) following an adverse benefit determination on review;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion in full, or it will contain a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in making a determination, and that a copy of the specific rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and
- if the adverse benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limitation, the notice will contain either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of the claim, or the notice will contain a statement that such an explanation will be provided free of charge upon request.

***ONLY A FORMAL NOTICE OF BENEFIT DETERMINATION, AS DESCRIBED IN THIS SECTION, SHALL CONSTITUTE AN OFFICIAL PLAN DECISION AS TO WHETHER BENEFITS ARE AVAILABLE, SUBJECT ONLY TO APPEAL AS SET***

***FORTH BELOW. NO OTHER COMMUNICATION, WHETHER WRITTEN OR ORAL, SHALL CONSTITUTE A PROMISE TO PAY OR A GUARANTEE OF BENEFITS UNDER THIS PLAN.***

For claims for death benefits and AD&D benefits, notice of any adverse benefit determination will be sent to you within 90 days after the Plan receives your claim, unless the Plan Administrator determines that special circumstances require a 90 day extension of time for processing the claim. We will send you written notification of any extension.

For claims for loss of time benefits, notice of any adverse benefit determination will be sent to you within 45 days after the Plan receives your claim, unless the Plan Administrator determines that circumstances beyond control of the Plan require an extension. We will send you written notification of any extensions before the expiration of the 45-day period. A decision will be made within 30 days of the time the Plan notifies you of the delay. If circumstances beyond control of the Plan cause the Plan to be unable to decide the claim within the additional 30 days, the Plan may extend the time for deciding the claim for up to an additional 30 days. If another extension is required you will get another written notice from us prior to the expiration of the first 30 day extension period that tells you the reason for the extension and the date which the Plan expects to render a decision.

If an extension is necessary because we need additional material or information from you, the time period for deciding the claim will be suspended from the date we send you notice, until we receive the information or material from you. If you need more than 45 days to supply the material or information, you should request it in writing. When the Plan has received your information (or the time within which you were to have supplied the material or information has passed, if you do not provide it), we will make a decision on your claim within 30 days.

For all health care claims, your claim will be decided and notice of any adverse benefit determination will be sent to you within 30 days after we receive your claim. If the Plan Administrator determines that an extension is necessary due to matters beyond our control and send you notice within the initial 30 day period, we may extend the decision up to 15 days. If we need additional material or information from you, the time period for deciding the claim will be suspended from the date that we send you notice of this, until we receive the information or material from you. If you need more than 45 days to supply the material or information, you should request it in writing. When we have received your information (or the time within which you were to have supplied the material or information has passed, if you do not provide it), we will make a decision on your claim within 15 days.

***How Do I File an Appeal?***

If a claim is denied, in whole or in part, or if the amount approved or paid varies in any other way from the total amount claimed, and you believe that you are entitled to benefits under this Plan which you did not receive, you may appeal the determination by requesting that the Board of Trustees review the determination.

Your request must be made in writing and must explain the reasons you believe you are entitled to the benefit or portion of your claim that was denied. ***Send your written request for review to the Board of Trustees, Pipe Fitters Local 533 Health and Welfare Plan, 3100 Broadway, Suite 805, Kansas City, MO 64111.***

A request for review concerning a claim for death or AD&D benefits must be made within 60 days after you receive notice of adverse benefit determination.
All other requests for review must be made within 180 days after you receive notice of adverse benefit determination.

The Board of Trustees will provide a full and fair review of the claim and the adverse benefit determination, and will not give deference to the initial determination.

You may submit written comments, documents, records, and other information relating to the claim for benefits.

In deciding an appeal of any benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the Board shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Board of Trustees shall make a benefit determination on your appeal at the next regularly scheduled quarterly meeting after it has received your request for review unless the request for review is filed within thirty (30) days of that meeting. In such case, the Trustee's review and determination will be made at the second meeting following receipt of the request for review. If unusual circumstances (such as the need to hold a hearing) require a further extension of time, the Trustees review and determination will be made no later than the meeting following the meeting where it was determined that an extension of time is required. The Plan Administrator will provide you with written notice of any extension

The Plan Administrator will provide you written notice of the decision on review as soon as possible, but not later than five (5) days after the decision is made. The notice will include an explanation of the decision, and a statement of your rights to bring a lawsuit under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA) after you have exhausted all administrative remedies. That lawsuit must be brought within one year.

## ***YOUR PRIVACY AND PROTECTED HEALTH INFORMATION***

We take all reasonable efforts to protect the privacy and security of your information, and maintaining that privacy is a high priority. Staff members who use and access your Protected Health Information in the course of administering the Plan are bound by rules of conduct to protect that information. We have a separate "Notice of Privacy Practices" that explains in detail how this information is handled. You can obtain a copy of the Notice free of charge from the Plan Administrator.

## ***OTHER INFORMATION ABOUT THIS PLAN THAT YOU SHOULD KNOW***:

***The name of your Plan***: Pipe Fitters Local No. 533 Health and Welfare Plan.

***Employee Organization***: Pipe Fitters Local Union No. 533

***Employer Organization***: Mechanical Contractors Association of Greater Kansas City

***Plan Sponsor***: The Board of Trustees of the Pipe Fitters Local No. 533 Health & Welfare Fund.

***Employer Identification Number of Plan Sponsor***: 44-0651452

***Plan Number***: 501

***Plan Fiscal Year***: June 1 through May 31

***Type of Plan***: This is a group health plan that also provides ancillary welfare benefits.

***Type of Administrator***: The Plan is self-funded and is administered by a third-party administrator under the direction of the Board of Trustees.

***Plan Administrator***: The Board of Trustees of the Pipe Fitters Local No. 533 Health and Welfare Fund retains ultimate authority as the Plan Administrator for this Plan, but it has delegated responsibility for the day to day administration of the Plan to:

Wilson-McShane Corporation
3100 Broadway, Suite 805
Kansas City, MO 64111
Phone: (816)756-3313
Toll Free: (866)756-3313
Fax: (816)756-3659

Satellite Office Maintained at:
8600 Hillcrest Rd., Suite A
Kansas City, Missouri 64138
Phone: (816) 361- 0206

***Plan's Designated Agent for Service of Process***: Ms. Carolyn Papuga at the address for Wilson-McShane Corporation above. You may also serve process on any Trustee or the Plan Administrator.

***Board of Trustees***:

Union Trustees:

Pat Julo, Trustee
Pipe Fitters Local Union No. 533
8600 Hillcrest Rd.
Kansas City, MO 64138

Robert A. Welch, Trustee
Pipefitters Local No. 533
8600 Hillcrest Rd., Suite A
Kansas City, MO 64138

Chris Parrino, Trustee
1320 NW 3rd St.
Blue Springs, MO 64104

Employer Trustees:

Michael Gossman, Trustee
P1 Group, Inc.
2151 Haskell Ave., Bldg #1
Lawrence, KS 66046

Michael Palmer, Trustee
18070 S. Bond Avenue
Bucyrus, KS 66103

William Alexander, Trustee
Alexander Mechanical Contractors
8744 E. Alice Street
Kansas City, MO 64126

***Plan's Legal Counsel***: Blake & Uhlig, P.A.
753 State Ave., Suite 475
Kansas City, KS 66101
Ph: 913-321-8884
Fax: 913-321-2396

***Plan's Consultant***: Hans Kraabel
United Actuarial Services
11590 North Meridian St., Suite 610
Carmel, IN 46032-4529
Ph: 317-580-8670
Fax: 317-580-8651

***Plan's Accountant***: James F. Gillespie, CPA, P.A.
7270 West 98th Terrace, Suite 210
Overland Park, KS 66212
Ph: (913) 648-2130
Fax: (913) 648-2150

- You may get a complete list of the employers and employee organizations sponsoring this Plan if you submit a written request to the Plan Administrator. A list is also available for examination by you or your beneficiaries at the Fund Office.
- You may get information regarding whether a particular employer or employee organization is a Plan sponsor, and if so the sponsor's address, if you submit a written request from the Plan Administrator.

- You may also get a copy of any Collective Bargaining Agreement under which the Plan is maintained if you submit a request in writing to the Plan Administrator. A copy is also available for examination by you or your beneficiaries at the Fund Office.

## ***YOUR RIGHTS UNDER ERISA***:

As a participant in the Pipe Fitters Local 533 Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The Plan is required by Federal law to provide you with information about your rights under ERISA. ERISA provides that all plan participants shall be entitled to:

### *Receive Information About Your Plan and Benefits*

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### *Continue Group Health Plan Coverage*

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage.

### *Prudent Actions by Plan Fiduciaries*

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your

Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health or welfare benefit or exercising your rights under ERISA.

***Enforce Your Rights***

If your claim for a health or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

***Assistance with Your Questions***

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.