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

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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.

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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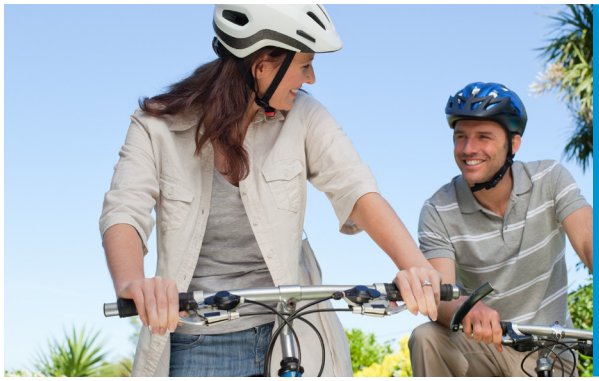
Healthy Companion, continued



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

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 #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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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 #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: • Hemoglobin/Complete Blood Count (CBS • Metabolic screening • 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: • Fecal occult blood test; • Flexible sigmoidoscopy; • Colonoscopy; and • 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: • Catch-up for Hepatitis B • Catch-up for varicella • Catch-up for measles, mumps, and rubella • Tetanus boosters as necessary, including tetanus, diphtheria and pertussis; diphtheria and tetanus; and tetanus only • Pneumococcal vaccine • Influenza virus vaccine • Meningococcal vaccine • Catch-up for Hepatitis A • HPV vaccine • Zoster vaccine • Polio vaccine • Haemophilus Influenza Type b (Hib) vaccine

ADDITIONAL SERVICES	COVERAGE DETAILS & LIMITATIONS
Immunizations (Childhood)	• At least 5 doses of vaccine against diphtheria, pertussis, tetanus; • At least 4 doses of vaccine against polio, Haemophilus Influenza Type b (Hib); • At least 3 doses of vaccine against Hepatitis B; • 2 doses of vaccine against measles, mumps, and rubella; • 2 doses of vaccine against varicella; • At least 4 doses of vaccine against pediatric pneumococcal (PCV7); • 1 dose of vaccine against influenza; • At least one dose of vaccine against Hepatitis A; • 3 doses of vaccine against Rotavirus; and • 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 1 mo. supply	**Mail Order** 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 #36

ALERT!!! IMPORTANT CHANGES ARE COMING TO YOUR HEALTH COVERAGE!

In the next few weeks you will receive important documents regarding various benefit design and eligibility changes coming in 2017 that will affect your coverage from the Pipe Fitters Local No. 533 Health and Welfare Fund (the "Plan"). It is extremely important that you read and understand all of the information contained in those documents.

The documents will include forms that you are required to complete and submit to the Fund Office to remain covered by the Plan! Please lookout for an envelope marked **"URGENT"** which will be mailed to you by mid-December and will describe the 2017 changes.

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

Sincerely,

BOARD OF TRUSTEES
November 28, 2016

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]

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.

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* Out-of-network: $300 a person/$600 a family*	In-network: $600 a person/$1,200 a family* 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* Out of-network: $300 a person/$600 a family*	In-network: $300 a person/$600 a family* 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** Out-of-network: $400 a person/$800 a family**	In-network: $150 a person/$300 a family** 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; • Allowable Charges paid for Prescription Drug Benefits, Dental Benefits, or Vision Benefits; and • 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 • 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; • Allowable Charges paid for Prescription Drug Benefits, Dental Benefits, or Vision Benefits; and • 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 • 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; • Allowable Charges paid for Prescription Drug Benefits, Dental Benefits, or Vision Benefits; and • 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 • 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.

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 NO. 533
HEALTH AND WELFARE FUND

BENEFIT ALERT #39 – Free CardioScans Effective September 1, 2017

The Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Plan ("Plan") values the health of its Covered Persons and has partnered with St. Luke's to provide Covered Persons free CardioScans.

A CardioScan is a special type of CT scan that can detect hard calcified plaque in the coronary arteries, which can indicate heart disease. Beginning September 1, 2017, the Plan will cover 100% of the cost of CardioScans (normally $50) for Covered Persons who meet St. Luke's following general screening criteria:

- Age 40 or older, or younger if the adult has known heart risk factors, for example family history of heart disease;
- No CardioScanin the past 3 years; and
- Has not had a previous heart stent or bypass surgery.

Upon request of the Fund Office, Covered Persons meeting this criteria will receive a certificate in their name which can be used to obtain a free CT CardioScan from St. Luke's Hospital. Once you receive your certificate, you can contact St. Luke's to schedule your CardioScan. Please bring the certificate with you at the time of your scheduled screening, as St. Luke's will consider the certificate as your method of payment for the CardioScan.

Please refer to the enclosed St. Luke's Cardio Scan brochure to learn more.

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

Sincerely,

BOARD OF TRUSTEES
July, 2017

PIPE FITTERS LOCAL NO. 533
HEALTH AND WELFARE FUND

BENEFIT ALERT #40

The Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Fund ("Plan") is pleased to announce that effective April 1, 2018, the Plan will cover a 90-day supply of Maintenance Medication that is purchased at a Walgreens pharmacy in the same manner that the Plan covers Maintenance Medication that is purchased through the LDI mail order pharmacy. The Plan's new rules regarding Maintenance Medication (i.e. the rules that will become effective on April 1, 2018) are explained in greater detail below. Please review this Benefit Alert in its entirety and keep it with your Summary Plan Description ("SPD") for future reference.

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

- The term "**Maintenance Medication**" means a contraceptive (i.e. birth control) or a prescription drug that is taken on a regular basis to treat a chronic health condition, such as high blood pressure, high cholesterol or diabetes. 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.

- The term "**Generic Drug**" means a prescription drug that meets <u>all</u> of the following criteria:

    - It produced by two or more generic drug manufacturers;
    - It is not in its initial Federal Drug Administration ("FDA") exclusivity period (this period is generally six months); and
    - It is considered a generic drug by LDI's industry-standard database, Medi-Span.

- The term "**Non-Preferred Drug**" means a prescription drug that is neither a Generic Drug nor a Formulary Brand name drug.

<u>New Plan Coverage for Maintenance Medications Purchased at Walgreens</u>
Prior to April 1, 2018, the Plan would only cover Maintenance Medication if the medication was filled through the LDI mail order pharmacy or met one of the exceptions included in the bullet points below. Effective April 1, 2018, the Plan will cover Maintenance Medications if the medication is either (1) filled through the LDI mail order pharmacy **<u>OR</u>** (2) a 90-day supply of medication that is filled at a Walgreens pharmacy. This means that effective April 1, 2018, the exclusion described in number one of Benefit Alert #35 is amended to provide that **no benefits are payable under the Prescription Drug Program for Maintenance Medication unless the medication meets <u>one</u> of the following criteria**:

- The Maintenance Medication is filled through the LDI mail order program;
- The Maintenance Medication is a 90-day supply of medication that is filled at a Walgreens pharmacy; ***NEW!***
- 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 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 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 or at a Walgreens pharmacy so long as the Maintenance Medication is otherwise covered by the Plan.
- The Maintenance Medication is purchased at a retail pharmacy, other than Walgreens, 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.

Based on the new rules described above, effective April 1, 2018, the following copayment chart replaces the charts found on page 31 of your SPD, Benefit Alert #19, Benefit Alert #22 and Benefit Alert #35:

If your prescription is for a:	**Your Copayment**		
	Retail 1 mo. supply	**Mail Order** 3 mo. supply	**Walgreens** 3 mo. supply (only applies to Maintenance Medications)
Generic "statin" Drug	$10	$20	$20
Other Generic Drug	$15	$30	$30
Brand name drug; Formulary	$30*	$60*	$60*
Non-Preferred Drug; NOT Formulary; NOT Generic drug	$50*	$100*	$100*

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

The only difference between the chart above and the chart found in Benefit Alert #35 is that the chart above includes a Walgreens copayment column that will apply to a 90-day supply of Maintenance Medication that is purchased at a Walgreens pharmacy on and after April 1, 2018.

If your doctor prescribes you a Maintenance Medication and you intend to have it filled through the LDI mail order program, 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.

NOTE: This section does <u>not</u> apply to Specialty Drugs. Please refer to Section 4 of Benefit Alert #35 for a description of the rules regarding Specialty Drugs.

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

Sincerely,

BOARD OF TRUSTEES
February, 2018

PIPE FITTERS LOCAL NO. 533
HEALTH AND WELFARE FUND

BENEFIT ALERT #41

The Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Fund ("Plan") has adopted changes to the Plan's Comprehensive Medical Benefits and Prescription Drug Benefits. 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.

Improved Coverage for Telehealth Visits Provided by Amwell

Prior to January 1, 2018, a Covered Person was required to pay a $10.00 copay for a telehealth visit provided by American Wellness ("Amwell"). Effective January 1, 2018, a Covered Person is no longer required to pay a copay for a telehealth visit provided by Amwell. This means that effective January 1, 2018, the Plan will pay 100% of the Allowable Charge for a telehealth visit provided by Amwell (i.e. you will not have to pay a copay, deductible or cost-sharing amount for a telehealth visit 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 visits, contact the Fund Office.

Coverage for Nurse Practitioner Retail Clinic Visits

Prior to January 1, 2018, after a Covered Person paid a $10.00 copay, the Plan would pay 100% of the Allowable Charge for an in-network Nurse Practitioner Retail Clinic Visit. Effective January 1, 2018, the copay was increased to $15.00. This means that effective January 1, 2018, after a Covered Person has paid a $15.00 copay, the Plan will pay 100% of the Allowable Charge for an in-network Nurse Practitioner Retail Clinic Visit.

NOTE: Once you have met your Comprehensive Medical Benefit annual out-of-pocket maximum, the Plan will pay 100% of the Allowable Charge for in-network Nurse Practitioner Retail Clinic Visits (i.e. you will no longer have to pay a $15.00 copay for an in-network Nurse Practitioner Retail Clinic Visit). Refer to Benefit Alert 37 for

more information about the Plan's Comprehensive Medical Benefit annual out-of-pocket maximum. Refer to page 3 of your SPD or contact the Fund Office for information regarding the type of clinics that are considered Nurse Practitioner Retail Clinics.

Coverage for 3-D Mammograms NEW!

Prior to September 1, 2016, the Plan would not cover charges for 3-D Mammograms because these Mammograms were considered experimental and investigational. Effective September 1, 2016, the Plan will cover charges for a 3-D Mammogram that is provided to a Covered Person that is at least 40 years old regardless of whether or not the 3-D Mammogram is considered experimental, investigational, or not Medically Necessary, so long the 3-D Mammogram is ordered by a physician and performed in tandem with a 2-D Mammogram. The Plan's standard deductibles and coinsurance rates will apply to 3-D Mammograms that are covered by the Plan on and after September 1, 2016.

New Program for Specialty Drugs that have Manufacturer Assistance Available

Effective June 1, 2017, the Plan implemented LDI's Variable Specialty Copay Program. Based on the Plan's implementation of this program, a specific copay will apply to each Specialty Drug that has manufacturer assistance available and is included on the List of Drugs Subject to LDI's Variable Specialty Copay Program. Enclosed is a copy of the List of Drugs Subject to LDI's Variable Specialty Program as of May 1, 2018. If you are prescribed a Specialty Drug that both has manufacturer assistance available and is included on this list, the deductible for prescription drugs and the copays listed on page 31 of your SPD do not apply and the new, drug-specific copay is applied. LDI will apply available copay assistance and coupons from pharmaceutical manufacturers to offset this copay amount. The copay assistance that is provided by a pharmaceutical manufacturer does not count towards your Prescription Drug Benefit annual out-of-pocket maximum that is described in Benefit Alert #37.

For example, manufacturer assistance is available for the Specialty Drug "Xeljanz" and Xeljanz is included on the List of Drugs Subject to LDI's Variable Copay Program. If your doctor prescribes you Xeljanz, your copay for Xeljanz is $1,000. Before you actually pay this $1,000 copay, LDI will apply a $1,000 Xeljanz manufacturer coupon. After LDI applies this coupon, your final out-of-pocket cost for Xeljanz will be $0 (i.e. you will not actually have to submit the $1,000 copay to LDI since LDI received the $1,000 from the manufacturer of Xeljanz). The $1,000 will not be applied to your $2,550 per person/$5,100 per family Prescription Drug Benefit annual out-of-pocket maximum since you did not actually pay this $1,000.

NOTE: The enclosed List of Drugs Subject to LDI's Variable Specialty Program is subject to change. Contact the Fund Office for an updated copy of this list.

New Plan Exclusion

Effective January 1, 2018, a new exclusion was added to the list found on pages 35 and 36 of your SPD. The new exclusion provides that the Plan will not cover charges for expenses incurred for infusions or injections of any of the Specialty Drugs that are included on the List of Specialty Drugs that are Only Covered by the Plan if Purchased at a Blue Cross and Blue Shield of Kansas City Designated Specialty Provider. For purposes of this exclusion, a "designated Blue Cross and Blue Shield of Kansas City specialty pharmacy or designated home infusion vendor" is a specialty pharmacy, home infusion vendor or hospital that has entered into a contract with Blue Cross and Blue Shield of Kansas City to provide specialty drugs at a specified rate. To find out if an entity is considered a designated pharmacy or home infusion vendor, please call the Blue Cross and Blue Shield of Kansas City prior authorization number on the back of your ID card.

Enclosed is a copy of the List of Specialty Drugs that are Only Covered by the Plan if Purchased at a Blue Cross and Blue Shield of Kansas City Designated Specialty Provider. The enclosed list contains the Specialty Drugs that are included on the list on May 1, 2018 and is subject to change. Contact the Fund Office for an updated copy of this list.

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

Sincerely,

BOARD OF TRUSTEES
April, 2018

SPECIALTY DRUGS SUBJECT TO LDI'S VARIABLE SPECIALTY COPAYMENT PROGRAM

Drug Name	Your Copayment (*before* Manufacturer's Assistance is applied)*	Drug Name	Your Copayment (*before* Manufacturer's Assistance is applied)*
Actemra	$1,250	Nplate	$833
Adcirca	$800	Nutropin AQ NuSpin	$833
Advate	$1,000	Odefsey	$500
Adynovate	$1,000	Odomzo	$1,250
Afinitor	$1,250	Olysio	$4,167
Alimta	$3,500	Omnitrope	$417
Alprolix	$1,000	Orencia	$833
Atripla	$500	Otezla	$750
Avastin	$2,083	Perjeta	$2,083
Baraclude	$400	Praluent	$458
BeneFix	$1,000	Prezcobix	$625
Betaseron	$1,208	Prezista	$625
Cimzia	$917	Prolia	$750
Combivir	$200	Promacta	$1,250
Complera	$500	Pulmozyme	$333
Copaxone	$1,000	Rebif	$708
Cotellic	$2,083	Recombinate	$1,000
Daklinza 30 or 60 mg	$5,000	Remicade	$3,333
Daklinza 90 mg	$10,000	Rescriptor	$200
Descovy	$300	Retrovir	$200
Edurant	$625	Reyataz	$625
Eloctate	$1,000	Risperdal Consta	$458
Emtriva	$300	Saizen	$200
Enbrel	$1,000	Sandostatin LAR Depot	$1,250
Entyvio	$3,333	Selzentry	$200
Epclusa	$7,333	Signifor LAR	$1,250
Epivir	$200	Simponi	$1,667
Epzicom	$200	Somatuline Depot	$1,667
Erbitux	$3,500	Sovaldi	$8,333
Evotaz	$625	Sprycel	$2,667
Exjade	$1,250	Stelara	$5,000
Extavia	$600	Stribild	$500
Farydak	$1,250	Sustiva	$625
Follistim AQ	$300	Synagis	$165
Forteo	$750	Tafinlar	$1,250
Gammagard	$417	Tasigna	$1,250
Gammaplex	$167	Tecentriq	$2,083
Genotropin	$417	Tivicay	$500
Genvoya	$500	Triumeq	$500
Gilenya	$1,000	Trizivir	$200
Glatopa	$750	Truvada	$300
Gleevec	$2,500	Tybost	$50
Gonal-F	$200	Tykerb	$1,250
Harvoni	$9,333	Vectibix	$833
Hizentra	$417	Venclexta	$2,083
Humatrope	$200	Viekira	$8,332
Humira	$1,000	Viracept	$200
Imatinib	$700	Viread	$300
Intelence	$625	Vitekta	$300
Isentress	$567	Vivitrol	$500
Jadenu	$1,250	Votrient	$1,250
Kaletra	$100	Xeljanz	$1,000
Lexiva	$200	Xgeva	$833
Lupaneta Pak	$250	Xolair	$833
Lupron Depot	$300	Zepatier	$5,460
Lupron Depot-PED	$167	Ziagen	$200
Mekinist	$1,250	Zortess	$600
Norditropin	$250	Zykadia	$1,250
Norvir	$100		

* Final out-of-pocket cost <u>will be $0</u> for these drugs after LDI applies available manufacturer's assistance.

Specialty Drugs that are Only Covered by the Plan if Purchased at a Blue Cross and Blue Shield of Kansas City Designated Specialty Provider

Drug Name	
Actemra	Imfinzi
Acthar	Kalbitor
Advate, Helixate fS, Kogenate FS, Kovaltry, Recombinate	Lemtrada
Adynovate	Lumizyme
Aldurazyme	Mozobil
Alphanate/VWF Complex/Human	Not otherwise classified clotting factor
AlphaNine SD, Mononine	Novoeight
Alprolix	NovoSeven Rt
Aralast, Prolastin Zemaira	Nuwiq
Avastin	Obizur
Bavencio	Ocrevus
Bebulin, Profilnine	Orencia
BeneFIX, Ixinity	Perjeta
Benlysta	RiaSTAP
Berinert	Rituxan
Blincyto	Rituxan Hycela
Cerezyme	Rixubis
Cinryze	Ruconest
Coagadex	Soliris
Corifact	Spinraza
Elaprase	Stelara
Eloctate	Synagis
Entyvio	Tretten
Fabrazyme	Vimizim
Feiba, Feiba NF	Vonvendi
Glassia	Vpriv
Haegarda	Vyxeos Liposome
Hemofil M, Koate-DVI, Monoclate-P	Wilate
Herceptin	Xyntha
Humate-P	Yervoy
Idelvion	

PIPE FITTERS LOCAL NO. 533
HEALTH AND WELFARE FUND

BENEFIT ALERT #42

Effective January 1, 2018, the Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Fund (the "Plan") amended the Plan to provide that the Plan will pay 100% of the Allowable Charge for a telehealth visit that is provided by American Well ("Amwell"). This means that effective January 1, 2018, you do not have to pay a copay, deductible or cost-sharing amount for a telehealth visit that is provided by Amwell. The purpose of this Benefit Alert is to remind you of this benefit improvement. Please review this Benefit Alert in its entirety and keep it with your Summary Plan Description ("SPD") for future reference.

What is a Telehealth Visit Provided by Amwell?
As described in Benefit Alert 37 and Benefit Alert 41, 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.

If you have a telehealth visit and during the visit Amwell determines that you need a different level of care (e.g. they determine that you need to go to a doctor's office), Amwell will direct you to that level of care and neither you nor the Fund will be charged for the telehealth visit.

How To Register
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.

Technical Assistance:
For help creating an online account, call or email the Amwell support team at 1-855-818-DOCS (3627) or support@americanwell.com.

The attached document is meant to provide a guide for you to determine the appropriate provider for your health care needs as well as illustrate the average cost per visit charged to the Plan when you receive treatment from an In-Network provider. Charges will vary by provider.

For more information regarding the Plan's coverage of telehealth visits, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
August 2018

KNOW YOUR COSTS

Lower Costs ⟷ Higher Costs

Telehealth Amwell	Nurse Practitioner Retail Clinic	Doctor's Office	Urgent Care Center	Emergency Room
Average Cost per Visit Charged to the Pipe Fitters Local No. 533 Health and Welfare Fund:				
$49 per visit*	$68 per visit*	$73 per visit*	$140 per visit*	$1,782 per visit*
Your Cost after the Pipe Fitters Local No. 533 Health and Welfare Fund Payment (assuming you see an In Network provider, you have met your deductible, and you have not met your annual out-of-pocket maximum):				
Actives:				
$0 copayment	$15 copayment	$14.60 co-insurance**	$28.00 co-insurance**	$356.40 co-insurance**
Retirees:				
$0 copayment	$15 copayment	$10.95 co-insurance**	$21.00 co-insurance**	$267.30 co-insurance**

* provided by Blue Cross and Blue Shield of Kansas City.

** This represents the average cost of each visit and will vary by provider.

A GUIDE FOR WHERE TO GO WHEN YOU NEED MEDICAL CARE***

Telehealth Amwell	Nurse Practitioner Retail Clinic	Doctor's Office	Urgent Care Center	Emergency Room
Access telehealth services to treat minor medical conditions. Connect with a board-certified doctor via video or phone when, where, and how it works best for you. You can schedule an appointment at www.amwell.com or through the mobile app.	Treats minor medical concerns. Staffed by nurse practioners and physician assistants. Located in retail stores and pharmacies. Often open nights and weekends.	The best place to go for routine or preventive care, to keep track of medications, or for a referral to see a specialist.	For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life-threatening, call 911 or go to the nearest emergency room. "Freestanding" emergency room (ER) locations are becoming more common in many areas. Because these ERs are not inside hospitals, they may look like urgent care centers. When you receive care at an ER, you're billed at a much higher cost than at other health care facilities
Typical Conditions Treated:				
• Colds and flu • Rashes or skin conditions • Sore throats, ear ache, sinus pain • Headaches • Stomachaches • Fever • Allergies • Acne • UTIs and more	• Colds and flu • Rashes or skin conditions • Sore throats, ear ache, sinus pain • Minor cuts and burns • Pregnancy testing • Vaccines	• General health issues • Preventive care • Routine checkups • Immunization and screenings	• Fever and flu symptoms • Minor cuts, sprains, burns, rashes • Headaches • Lower back pain • Joint pain • Minor respiratory symptoms • UTIs	• Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Shortness of breath • Chest pain • Head injury/major trauma • Blurry or loss of vision • Severe cuts or burns • Overdose • Broken bones
Your Time:				
No need to leave home or work. Use of mobile device, tablet or computer for virtual visit. Typically answered within minutes.	No appointment needed.	Appointment times required. Shorter wait times than an emergency room.	Walk in scheduling. No appointments taken and wait time will vary.	No appointments taken and wait times can be long and be up to many hours before you are seen.

***The information provided here is intended to be general information on how you can get the most out of your plan and your health care dollars. It is not intended as medical advice. You should consider all relevant factors and to consult with your treating doctor when selecting a health care professional or facility for care. During a medical emergency, go to the nearest hospital or call 911.

PIPE FITTERS LOCAL NO. 533
HEALTH AND WELFARE FUND

BENEFIT ALERT #43

Effective January 1, 2019, the Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Fund ("Plan") has hired Sav-Rx to replace CastiaRx (formerly LDI) as the Plan's Prescription Benefit Manager ("PBM"). In December, you will receive announcements and other materials regarding the transition to Sav-Rx.

IMPORTANT NOTICE: By late-December, you will receive additional information regarding the transition to Sav-Rx, **including new prescription drug identification cards.** Please begin using these cards for prescription drug benefits on and after January 1, 2019.

The change in the Plan's PBM does not change the retail pharmacies that you can use to fill your prescriptions. However, if you are currently filling your prescription(s) at the CastiaRx mail order pharmacy or the CastiaRx specialty pharmacy, you will be need to start filling these prescriptions at the Sav-Rx mail order pharmacy and/or the Sav-Rx specialty pharmacy on January 1, 2019. More information will be provided on how to transition to the new mail order program.

Should you have any questions, or need to update your address to ensure timely receipt of your new prescription drug identification card, please contact the Fund Office at (816) 361-0206.

Sincerely,

BOARD OF TRUSTEES
November 2018

PIPE FITTERS LOCAL NO. 533
HEALTH AND WELFARE FUND

BENEFIT ALERT #44

As a reminder, effective January 1, 2015, the Board of Trustees for the Pipefitters Local No. 533 Health and Welfare Fund (the "Plan") 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 preventive care benefits include both preventive care medical benefits and preventive care prescription drug benefits. The list of covered preventive care benefits was provided in Benefit Alert #34.

The purpose of this Benefit Alert is to provide you with an updated list of the preventive care benefits covered by the Plan with updates through October 2018 and to explain the rules that apply to the coverage of Routine Preventive Care Prescription Drug Benefits. The information provided in this Benefit Alert #44 replaces the information provided in Benefit Alert #34.

Routine Preventive Care Medical Benefits

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 in-network provider on an inpatient basis, the Plan will pay 100% of the cost if the provider itemizes the services rendered during the inpatient visit.*
- For Routine Preventive Care Medical Benefits provided by an out-of-network provider, 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 or by an in-network provider on an inpatient basis (if the provider itemizes the services rendered during the inpatient visit)*:

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: • Hemoglobin/Complete Blood Count (CBS • Metabolic screening • 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.
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 obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
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 interventions	Provide interventions during pregnancy and after birth to promote and support breastfeeding.
Cervical cancer screening	Screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
Chest x-ray	
Chlamydia Trachomatis testing	
Chlamydia screening (women)	Screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.

ADDITIONAL SERVICES	COVERAGE DETAILS & LIMITATIONS
Colorectal cancer exams and laboratory tests consisting of a digital rectal exam and the following: • Fecal occult blood test; • Fecal DNA Test; • Flexible sigmoidoscopy; • Colonoscopy; and • Double contrast barium enema	
Colorectal cancer screening	Screening for colorectal cancer starting at age 50 years and continuing until age 75 years.
Contraceptive methods and counseling	All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.
Dental caries prevention (infants and children up to age 5 years)	Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. Primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
Depression screening (Adolescents)	Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Depression screening (Adults)	Screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Diabetes screening	Screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Electrocardiogram (EKG)	
Falls prevention in older adults: vitamin D	Vitamin D supplementation 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)	Screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Gonorrhea testing	

ADDITIONAL SERVICES	COVERAGE DETAILS & LIMITATIONS
Healthy diet and physical activity counseling to prevent cardiovascular disease (adults with cardiovascular risk factors)	Offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
Hemoglobinopathies screening (Newborns)	Screening for sickle cell disease in newborns.
Hepatitis B screening (nonpregnant adolescents and adults)	Screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis B screening (Pregnant women)	Screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Hepatitis C virus infection screening (adults)	Screening for HCV infection in persons at high risk for infection. Also recommends offering a 1-time screening for HCV infection to adults born between 1945 and 1965.
HIV screening	
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 parameters recommended by the Advisory Committee on Immunization Practices and/or adopted by the Center for Disease Control. • Catch-up for Hepatitis B • Catch-up for varicella • Catch-up for measles, mumps, and rubella • Tetanus boosters as necessary, including tetanus, diphtheria and pertussis; diphtheria and tetanus; and tetanus only • Pneumococcal vaccine • Influenza virus vaccine • Meningococcal vaccine • Catch-up for Hepatitis A • HPV vaccine • Zoster vaccine • Polio vaccine • Haemophilus Influenza Type b (Hib) vaccine

ADDITIONAL SERVICES	COVERAGE DETAILS & LIMITATIONS
Immunizations (Childhood)	• At least 5 doses of vaccine against diphtheria, pertussis, tetanus; • At least 4 doses of vaccine against polio, Haemophilus Influenza Type b (Hib); • At least 3 doses of vaccine against Hepatitis B; • 2 doses of vaccine against measles, mumps, and rubella; • 2 doses of vaccine against varicella; • At least 4 doses of vaccine against pediatric pneumococcal (PCV7); • 1 dose of vaccine against influenza; • At least one dose of vaccine against Hepatitis A; • 3 doses of vaccine against Rotavirus; and • 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	
Lipid cholesterol panel	
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	
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 and adolescents)	Clinicians screen for obesity in children and adolescents age 6 years and older and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.

ADDITIONAL SERVICES	COVERAGE DETAILS & LIMITATIONS
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.
Outpatient Physician Examinations	
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.
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	
Tobacco use counseling and interventions (Nonpregnant adults)	Clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco. This includes two tobacco cessation attempts per year (both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by an in-network health care provider without prior authorization.
Tobacco use counseling (Pregnant women)	Clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco. This includes two tobacco cessation attempts per year (both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by an in-network health care provider without prior authorization.

ADDITIONAL SERVICES	COVERAGE DETAILS & LIMITATIONS
Tobacco use interventions (children and adolescents)	Clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents. This includes two tobacco cessation attempts per year (both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by an in-network health care provider without prior authorization.
Tuberculosis screening (adults)	Screening for latent tuberculosis infection in populations at increased risk.
Urinalysis	
Visual screening (children)	Vision screening at least once in all children ages 3 to 5 years to detect amblyopia or its risk factors.

* If these Routine Preventive Care Medical Benefits are provided by an in-network provider on an inpatient basis and the provider does not itemize the services rendered during the inpatient visit (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), they will be subject to the Plan's standard in-network deductible and coinsurance levels.

I. Routine Preventive Care Prescription Drug Benefits

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).

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 determines that the medication is medically necessary. If your physician determines that a brand medication with a generic equivalent is medically necessary, your physician can submit a letter of medical necessity to SavRx for review. If your physician submits a letter of medical necessity to SavRx demonstrating that the brand drug is medically necessary for your prescription, the Plan will cover 100% of the cost of a brand medication.

If you are taking a "Statin" medication other than lovastatin, simvastatin or pravastatin, you will be responsible for the standard deductible and co-payment unless your physician determines that your Statin medication is medically necessary. If your physician determines that your Statin medication is medically necessary, your physician can submit a letter of medical necessity to SavRx for review. If your physician submits a letter of

medical necessity to SavRx demonstrating that your Statin medication is medically necessary, the Plan will cover 100% of the cost of your Statin medication.

INCLUDED SERVICES	COVERAGE DETAILS & LIMITATIONS
Aspirin (Rx and OTC)	Men (ages 45-79) and women (ages 55-79); Pregnant women at risk for preeclampsia
Colonoscopy Bowel Preparation	Men and Women (ages 50 to 75).
Contraceptives (birth control)	
Erythromycin Ophthalmic Ointment	Infants under one year of age.
Folic Acid (Rx and OTC)	Women capable of pregnancy.
Immunizations	Preventive vaccines per guidelines for age birth to 18 and adults
Iron (Rx and OTC)	Children ages 6 to 12 months.
Oral fluorides (Rx only)	Children ages 6 months to 6 years.
Raloxifene and Tamoxifen	Breast cancer prevention in high-risk women
Statins (lovastatin, simvastatin and pravastatin)	Men and women age 40-75 years for primary cardiovascular disease prevention
Tobacco Use Cessation Drugs (Rx and OTC)	Up to two 90-day course medications per year; Includes nicotine replacement therapy (patch, gum, inhaler, nasal spray and lozenge) and oral medications (Buproprion SR and Chantix)
Vitamin D	Men and women greater than age 64.

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

Sincerely,

BOARD OF TRUSTEES
April 2019

PIPE FITTERS LOCAL NO. 533
HEALTH AND WELFARE FUND

BENEFIT ALERT #45

The Board of Trustees of the Pipe Fitters Local No. 533 Health and Welfare Fund ("Plan") has adopted changes to the Plan's Prescription Drug Benefits. 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. NEW PHARMACY BENEFIT MANAGER: SAV-RX PRESCRIPTION SERVICES

Effective January 1, 2019, Sav-Rx Prescription Services ("Sav-Rx") replaced CastiaRx (formerly known as LDI) as the Plan's Pharmacy Benefit Manager ("PBM"). This means that Sav-Rx currently provides the services that CastiaRx used to provide.

This also means that the determination as to whether a drug is considered a Formulary Brand Drug or a Non-Formulary Brand Drug depends on whether the drug is included on Sav-Rx's formulary. Further, the determination as to whether a pharmacy is a participating pharmacy depends on whether the pharmacy is in Sav-Rx's network. To learn more about the Sav-Rx formulary or network of participating pharmacies, you can call Sav-Rx at (800) 228-3108 or visit Sav-Rx's website at www.savrx.com.

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

- The term "**Generic Drug**" means a prescription drug that is classified as a generic drug on Medi-Span's Master Drug Data Base.

- The term "**Formulary Brand Drug**" means a prescription drug that is included on Sav-Rx's formulary.

- The term "**Non-Formulary Brand Drug**" means a prescription drug that is not a Generic Drug or a Formulary Brand Drug (i.e. a prescription drug that is not included on Sav-Rx's formulary or classified as a generic drug by Medi-Span).

- The term "**Maintenance Medication**" means a prescription drug that is either a contraceptive (i.e. birth control) or is taken on a regular basis to treat a chronic health condition, (e.g. high blood pressure, high cholesterol or diabetes) and classified as a Maintenance Medication on Medi-Span's Master Drug Data Base. For purposes of this definition, a prescription drug that is considered a controlled substance is not a Maintenance Medication even if it is taken on a regular basis to treat a chronic health condition.

- The term "**Medically Necessary**" means a prescription drug that meets all the following criteria (i.e. a prescription drug is considered Medically Necessary if it meets all 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.

- The term "**Initial Prescription**" means a prescription for a one to 34-day supply of Maintenance Medication that a Covered Person has not filled more than two times since January 1, 2019 (e.g. if you are prescribed a drug for high blood pressure on January 2, 2019, the first two 34-day (or less) fills of your prescription drug are considered Initial Prescriptions).

- The term "**Extenuating Circumstances**" means unusual and unexpected circumstances that cause a Covered Person to fill a Maintenance Medication at a participating retail pharmacy that is not in Sav-Rx's Walk In Mail Order Network (i.e., a retail pharmacy that is in Sav-Rx's network but not in the Walk In Mail Order Network).

- The term "**Grandfathered Drug**" means a drug or Continuous Glucose Monitoring System ("CGMS") that a Covered Person was prescribed or had refilled during the 180-day period that ended on January 1, 2019 (i.e. the period of July 5, 2018 through December 31, 2018). A "CGMS" is considered a CGMS that was filled during the 180-day period if any component of the CGMS was prescribed, refilled, or replaced during this period. For purposes of this definition, a drug is only considered a Grandfathered Drug if the drug or CGMS has the same ingredients, dosage and strength as the drug or CGMS that the Covered Person was prescribed during the 180-day period. Once a drug or CGMS is considered a Grandfathered Drug, it will remain a Grandfathered Drug until the later of the following dates:

    - The date that a Covered Person has gone an entire year without filling a prescription for the drug or CGMS component (e.g. if a Covered Person fills a prescription for a Grandfathered Drug on February 1, 2019 and the Covered Person never fills another prescription, it will only remain a Grandfathered Drug until January 31, 2020); or
    - December 31, 2019.

2. CHANGES TO THE RULES REGARDING COVERAGE FOR MAINTENANCE MEDICATION

Prior to January 1, 2019, the Plan only covered Maintenance Medication if the medication met one of the following criteria: (i) the medication was filled through the CastiaRx mail order pharmacy; (ii) the medication was a 90-day supply of medication that was filled at a Walgreens pharmacy; or (iii) the medication met one of the exceptions included in the bullet points found on page two of Benefit Alert #40.

Effective January 1, 2019, the Plan's coverage for Maintenance Medication was expanded, and the Plan now covers a 90-day supply of Maintenance Medication that is filled at any retail pharmacy that is in Sav-Rx's Walk In Mail Order Network. The Plan will also cover a 30-90 day supply of Maintenance Medication that is filled through the Sav-Rx Mail Order Pharmacy. Based on this expansion of coverage and the Plan's transition to Sav-Rx, the exclusion described on pages one and two of Benefit Alert #40 was amended effective January 1, 2019 to provide that **no benefits are payable under the Prescription Drug Program for Maintenance Medication unless the medication meets at least one of the following criteria:**

- The Maintenance Medication is filled through the Sav-Rx Mail Order Pharmacy;
- The Maintenance Medication is a 90-day supply of medication that is filled at a retail pharmacy that is in Sav-Rx's Walk In Mail Order Network;
- The Maintenance Medication is an Initial Prescription;
- The Maintenance Medication is prescribed to a Covered Person who lives in a long term care facility (i.e. if you live in a long-term care facility, the Plan will cover your Maintenance Medication even if it is not filled through the Sav-Rx Mail Order Pharmacy or a pharmacy that is in Sav-Rx's Walk In Mail Order Network so long as the Maintenance Medication is otherwise covered by the Plan); or
- The Maintenance Medication is purchased at a participating retail pharmacy that is not in Sav-Rx's Walk In Mail Order Network (i.e., a retail pharmacy that is in Sav-Rx's network but not in the Walk In Mail Order Network) due to Extenuating Circumstances.

Based on the new rules described above, the following chart replaces the charts found on page 31 of your SPD, Benefit Alert #19, Benefit Alert #22, Benefit Alert #35 and Benefit Alert #40:

If your prescription is for a:	**Your Copayment**		
	Retail 1 mo. supply	**Mail Order** 3 mo. supply	**Sav-Rx Walk In Mail Order Network** 3 mo. supply (only applies to Maintenance Medications)
Generic "statin" Drug	$10	$20	$20
Other Generic Drug	$15	$30	$30
Formulary Brand Drug	$30	$60	$60
Non-Formulary Brand Drug	$50*	$100*	$100*

* If a Generic Drug is available and you purchase a Non-Formulary Brand Drug rather than the equivalent Generic Drug, you are required to pay the copayment listed in the chart above plus the difference between the ingredient cost of the Generic Drug and the ingredient cost of the Non-Formulary Brand Drug.

If you would like information about which pharmacies are included in the Sav-Rx Walk In Mail Order Network, you should call Sav-Rx at (800) 228-3108.

3. CHANGES IN THE MAIL ORDER PHARMACY THAT IS USED FOR SPECIALTY DRUGS

Prior to January 1, 2019, the Plan only covered a Specialty Drug if the Specialty Drug was either filled through the CastiaRx Specialty Pharmacy or met one of the exceptions included in the bullet points found on page four of Benefit Alert #35.

Effective January 1, 2019, the Plan only covers a Specialty Drug that is either filled through the Sav-Rx Mail Order Pharmacy (i.e. based on the Plan's transition to Sav-Rx, the Plan now covers Specialty Drugs that are purchased at the Sav-Rx Mail Order Pharmacy rather than Specialty Drugs that are purchased at the CastiaRx Mail Order Pharmacy) or meets one of the exceptions below. This means that based on the transition to Sav-Rx, the exclusion described in number four of Benefit Alert #35 was amended effective January 1, 2019 to provide that **no benefits are payable under the Prescription Drug Program for Specialty Drugs unless the Specialty Drug is filled through the Sav-Rx Mail Order Pharmacy or meets one of the following exceptions:**

- The Specialty Drug is not available at the Sav-Rx Mail Order Pharmacy (i.e. you are not able to purchase the Specialty Drug from the Sav-Rx Mail Order Pharmacy). For example, if you have asthma and your doctor prescribes you Xolair, and Xolair is not available at the Sav-Rx Mail Order Pharmacy, then the Plan will cover the Xolair if you purchase it at a participating retail pharmacy (i.e. a retail pharmacy that is in Sav-Rx's network).

- The Specialty Drug is an immediate need drug. For example, if you have surgery and your doctor prescribes you seven doses of Enoxaparin to prevent blood clots immediately after the surgery, the Plan will cover the seven doses of Enoxaparin if you purchase it at a participating retail pharmacy (i.e. a retail pharmacy that is in Sav-Rx's network). If your prescription is for more than seven doses, the Plan will only cover the additional (i.e. non-immediate) doses if the Specialty Drug is purchased at the Sav-Rx Mail Order Pharmacy.

4. NEW PROGRAM FOR SPECIALTY DRUGS THAT HAVE MANUFACTURER ASSISTANCE AVAILABLE

Prior to January 1, 2019, the Plan utilized CastiaRx's Variable Specialty Copay Program. Based on the Plan's utilization of this program, a specific copayment applied to each Specialty Drug that had manufacturer assistance available and was included on the List of Drugs Subject to CastiaRx's Variable Specialty Copay Program.

Effective January 1, 2019, the Plan started utilizing Sav-Rx's High Impact Advocacy ("HIA") program rather than CastiaRx's Variable Specialty Copay Program. Based on the Plan's utilization of Sav-Rx's HIA program, the copayments listed in the chart below

apply to Specialty Drugs that have manufacturer assistance available. This means that if you are prescribed a Specialty Drug that has manufacturer assistance available, neither the Plan's prescription drug benefit deductible nor the Plan's copayments that are listed on page three of this Benefit Alert apply to the Specialty Drug.

The way the HIA program works is that when you send Sav-Rx an order to fill your prescription for a Specialty Drug, Sav-Rx will apply for the manufacturer assistance that is available for that drug and then use that assistance to pay your copayment. **The result is that you will pay $0.00 for the Specialty Drug** (i.e. you will not have to pay anything for the Specialty Drug because the amount of the assistance will equal the amount of the copayment). Because you will not pay anything for the Specialty Drug, the copayment listed in the chart on the next page will not count towards your Prescription Drug Benefit Annual Out-of-Pocket Maximum (i.e. the amount the drug manufacturer pays does not count towards your Prescription Drug Benefit Annual Out-of-Pocket Maximum).

For example, if you have cancer and you are prescribed a Specialty Drug that is on Sav-Rx's HIA program list, you should order that drug from the Sav-Rx Mail Order Pharmacy. Once Sav-Rx receives the order, Sav-Rx will apply for manufacturer assistance. If the cost of the Specialty Drug is $5,000 and Sav-Rx receives manufacturer assistance in the amount of $1,000, then your copayment for the Specialty Drug is $1,000. Sav-Rx will apply the $1,000 from the drug manufacturer towards your copayment, which means you will pay $0.00 for the Specialty Drug. The $1,000 will not count towards your Prescription Drug Benefit Annual Out-of-Pocket Maximum because you will not have actually paid any portion of this amount.

The following chart lists the copayments that apply to Specialty Drugs that have manufacturer assistance available:

If the Specialty Drug is prescribed to treat…	**Your Copayment will equal…**
Multiple sclerosis, an inflammatory condition, or Cancer	20% of the cost of the drug**
Hepatitis C	25% of the cost of the drug**
Cystic fibrosis	30% of the cost of the drug**

** If the amount of the manufacturer assistance available for the Specialty Drug is less than the amount of the copayment, then your copayment will equal the amount of the manufacturer assistance that is available for the Specialty Drug. This means that the manufacturer assistance will cover your copayment and you will not pay anything for the Specialty Drug.

5. ELIMINATED SPECIAL RULES FOR "NEW TO MARKET" DRUGS

Prior to January 1, 2019, there were certain drugs that the Plan referred to as New to Market Drugs. A New to Market Drug was generally an expensive drug that was approved by the FDA during the prior six-month period (i.e. a drug was generally considered a New to Market Drug for six-months after the drug was approved by the

FDA). The Plan would only cover a New to Market Drug if the New to Market Drug was Medically Necessary and filled through the CastiaRx mail order pharmacy.

Effective January 1, 2019, the Plan no longer recognizes a special category of New to Market Drugs. Accordingly, the rules described in number five of Benefit Alert #35 were eliminated (i.e. because the Plan no longer considers certain drugs New to Market Drugs, the exclusions that applied to New to Market Drugs no longer exist).

NOTE: Although the Plan no longer has special rules for New to Market Drugs, all the Plan's other rules still apply to drugs that were first approved by the FDA during the past six months. For example, if the FDA approves a Specialty Drug in July 2019, then the drug is still subject to the Plan's rules regarding coverage for Specialty Drugs (i.e. even though the drug is no longer considered a New to Market Drug, it may still be a Specialty Drug, in which case the Plan will only cover the drug if the drug is Medically Necessary and either purchased at the Sav-Rx Mail Order Pharmacy or meets one of the exceptions described in number three of this Benefit Alert).

6. NEW EXCLUSIONS FOR CERTAIN PRESCRIPTION DRUGS

Effective January 1, 2019, five new exclusions were added to the list found on pages 32 and 33 of your SPD. **The new exclusions provide that no benefits are payable under the Prescription Drug Program for:**

(i) Fertility drugs;
(ii) Abortifacient drugs;
(iii) Drugs prescribed for a cosmetic purpose;
(iv) Drugs prescribed for weight loss; and
(v) Continuous Glucose Monitoring Systems ("CGMS") that do not meet at least one of the following criteria:

- **The CGMS is Medically Necessary, or**
- **The CGMS is a Grandfathered Drug and the CGMC (or CGMS component, as applicable) is not under a manufacturer's warranty (i.e. the Plan will not cover a CGMS or a CMGS component that the manufacturer will provide at no cost due to a warranty).**

Effective June 1, 2019 an additional exclusion was added to the list found on pages 32 and 33 of your SPD. **The new exclusion provides that no benefits are payable under the Prescription Drug Program for Growth Hormones**.

7. ADDITIONAL PRESCRIPTION DRUGS THAT ARE SUBJECT TO THE STEP THERAPY REQUIREMENTS

Prior to January 1, 2019, the Plan had Step Therapy requirements that applied to drugs that were prescribed to treat diabetes or high cholesterol. This meant that if your doctor prescribed you a new drug (i.e. a drug that you were not taking on June 1, 2016) to treat diabetes or high cholesterol, the Plan would only cover a generic drug. If the generic drug did not safely and effectively treat your condition, the Plan would cover a

formulary brand drug. If the formulary brand drug did not safely and effectively treat your condition, the Plan would cover a non-formulary brand drug.

Effective January 1, 2019, the Plan expanded the list of prescription drugs that are subject to the Step Therapy requirements. The Step Therapy requirements now apply to any drug that is prescribed to treat a condition that is described in numbers (i) through (xiv) on the top of the next page. Based on the expansion to the list of prescription drugs that are subject to the Step Therapy requirements and the Plan's transition to Sav-Rx, the exclusion described in number three of Benefit Alert #35 was amended effective January 1, 2019 to provide **that no benefits are payable under the Prescription Drug Program for drugs that are prescribed to treat one of the following conditions unless the prescription drug meets the criteria of (a) or (b) below: (i) diabetes; (ii) high cholesterol; (iii) high blood pressure; (iv) acid related stomach disease; (vi) osteoporosis; (vii) inflammatory disease; (viii) migraine headaches; (ix) overactive bladder; (x) allergies; (xi) insomnia; (xii) depression; (xiii) glaucoma; or (xiv) fibromyalgia.**

(a) The Prescription Drug Meets the Step Therapy Requirements.

A prescription drug meets the Step Therapy requirements if it is the most cost-effective prescription drug available to treat a condition. This means that if your doctor prescribes you a new drug to treat one of the conditions described in numbers (i) through (xiv) of this Section 7, the Plan will only cover a Generic Drug. If a Generic Drug does not safely and effectively treat your condition, the Plan will cover a Formulary Brand Drug. If the Formulary Brand Drug does not safely and effectively treat your condition, the Plan will cover a Non-Formulary Brand Drug.

If your doctor prescribes you a new drug to treat one of the conditions listed in numbers (i) through (xiv) above, you must follow these steps to ensure that your prescription drug is covered by the Plan:

- **Step One:** Have your doctor prescribe a Generic Drug. If you try the Generic Drug for at least 60 days and it does not work or you have a medical condition that prevents you from trying the drug for at least 60 days (e.g., you are allergic to the Generic Drug), you may proceed to Step Two.
- **Step Two:** Have your doctor prescribe a Formulary Brand Drug. If you try the Formulary Brand Drug for at least 60 days and it does not work, or you have a medical condition that prevents you from trying the Formulary Brand Drug for at least 60 days (e.g., you are allergic to the Formulary Brand Drug), you may proceed to Step Three.
- **Step Three:** Have your Physician prescribe a Non-Formulary Brand Drug.

(b) The Prescription Drug is a Grandfathered Drug.

NOTE: A prescription drug is still subject to the Plan's other rules and limitations regardless of whether the drug meets the applicable Step Therapy requirements. For example, if you are prescribed a non-sedating antihistamine for the treatment of

allergies, the Plan will not cover the non-sedating antihistamine because it is excluded from coverage.

8. NEW RULES REGARDING COVERAGE FOR OPIOIDS

Effective January 1, 2019, a new exclusion was added to the list found on pages 32 and 33 of your SPD. This exclusion provides that **no benefits are payable under the Prescription Drug Program for a drug that is classified as an opioid unless the drug meets one of the following criteria:**

- The opioid was prescribed in a dosage that is less than 90 "Morphine Equivalent Doses" ("MED"),
- The opioid was prescribed in a dosage that is between 90 MED and 200 MED and such opioid is Medically Necessary,
- The opioid was prescribed to a Covered Person who has a life expectancy of six months or less,
- The opioid was prescribed to a Covered Person who is receiving treatment for cancer, or
- The opioid is a Grandfathered Drug.

NOTE: All the Plan's other rules still apply to an opioid that meets the criteria above. For example, if a Covered Person was already taking an opioid on January 1, 2019, and that opioid is a Specialty Drug, then the opioid is still subject to the Plan's rules regarding coverage for Specialty Drugs (i.e. although the drug is not excluded from coverage based on the new rules in this Section 8 that apply to opioids, the drug is still subject to the Plan's rules that apply to Specialty Drugs, which means the Plan will only cover the drug if the drug is Medically Necessary).

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

Sincerely,

BOARD OF TRUSTEES
July 2019

PIPE FITTERS LOCAL NO. 533
HEALTH AND WELFARE FUND

BENEFIT ALERT #46

The Board of Trustees has amended the Pipefitters Local No. 533 Health and Welfare Fund (the "Plan"). The purpose of this Benefit Alert is to explain some of the past changes that have been made to the document that have not been previously communicated to you and to provide you with more comprehensive eligibility information. Please review this Benefit Alert in its entirety and keep it with your Summary Plan Description ("SPD") for future reference.

1. Participant Eligibility Under the Plan

Effective May 2, 2016, the Plan was amended to change the rules for termination of coverage. An Eligible Employee and all Dependents of that Eligible Employee will lose coverage as of the first day the Eligible Employee performs work in the plumbing and pipefitting area for an Employer (other than the Union, the Fund, the Pipefitters Local No. 533 Pension Fund, or the Pipe Fitters Local No. 533 Apprenticeship Training Fund) who does not contribute to the Plan, regardless of whether or not that work is performed in the Kansas City metropolitan area. This change effects eligibility based on hours as well as the self-pay option.

Effective February 9, 2018, the Plan was amended to change the rules for eligibility during a leave due to accident or sickness. The Plan was amended to state you must be covered by the Plan in addition to the other criteria in the Plan in order to receive the sixteen hours per week for each week that you are absent from work because you are totally unable to work.

Effective April 27, 2018, the Plan was clarified and amended to change the rules for Uniformed Service leave. The Plan was clarified so that the termination of coverage for an Eligible Employee applies when an Eligible Employee enters the Uniformed Services rather than when the Eligible Employee enters the Armed Forces on active duty. The Plan was also amended to state the termination of coverage for an Eligible Employee is on the first day of the month following the date that the Eligible Employee entered the Uniformed Services rather than the date that the Eligible Employee entered the Uniformed Services. The Plan was further clarified so that if an Eligible Employee has performed the requisite number of hours of work during the Qualifying Period(s) preceding the Coverage Period during which the Eligible Employee entered the Uniformed Services, the Eligible Employee may choose to remain covered by the Plan during the Coverage Period that (s)he entered the Uniformed Services and the two Coverage Periods following the Coverage Period that (s)he entered the Uniformed Services by using the hours that (s)he worked in the preceding Qualifying Period(s).

2. New Definition of Spouse

Effective August 7, 2015, the Plan was amended to provide that a person is considered a spouse and is eligible for coverage from the Plan if the parties are legally married under the laws of a United States or foreign jurisdiction that has the legal authority to sanction marriage. Previously, the definition of spouse said you are eligible for benefits if your marriage is recognized in the State where you live and intend to remain. The definition of spouse found on page 9 of your SPD was replaced with the following definition:

"***Spouse***: Your spouse is only covered by this Plan if you are legally married under the laws of a United States or foreign jurisdiction that has the legal authority to sanction marriages, regardless of where you and your spouse live and regardless of whether you and your spouse are of the same or opposite sex."

3. Changes to the Self-Payment Option

Since October 1, 2013, a number of changes were made to the Plan's self-payment option. All of the rules are incorporated in this Section 3, which includes a complete description of the current rules regarding the Plan's self-payment option and replaces the rules found in Benefit Alert 29 and Benefit Alert 37:

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.

4. Updated Rules Regarding the Effective Date of Coverage for Dependents of Eligible Employees

a. Spouse

Effective November 20, 2015, if you are an Eligible Employee, coverage for your spouse will become effective at the same time as your coverage so long as an enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days after the date that you become covered by the Plan.

If the enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that the Eligible Employee becomes covered by the Plan, your spouse would become covered by the Plan on the first day of the month after the enrollment form is postmarked or otherwise positively received by the Fund Office.

b. Dependent Children

Effective November 20, 2015, if you are an Eligible Employee, coverage for your Dependent children will become effective at the same time as your Eligible Employee coverage so long as your Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office within 90 days after the date that the Eligible Employee becomes covered by the Plan.

If the enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days after the date that the Eligible Employee becomes covered by the Plan, the Dependent would become covered by the Plan on the first day of the month after the enrollment form is postmarked or otherwise positively received by the Fund Office.

If you add a dependent due to birth or adoption, or 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 and as listed in Benefit Alert 21.

5. Changes to Coverage for Spouses

Effective March 31, 2017, the Working Spouse Rule in Benefit Alert 38 was revised. If you are an Eligible Employee, your spouse has primary coverage under his or her parent's employer's health plan, and (s)he has coverage available from his or her employer, then your spouse is eligible for coverage from the Plan regardless of whether or not (s)he is enrolled in his or her employer's plan until March 31 of the calendar year following the calendar year that (s)he no longer has primary coverage from his or her parent's employer's health plan regardless of whether or not (s)he is enrolled in his or her employer's plan. If your spouse has primary coverage under his or her parent's employer's health plan, subsequently loses that coverage, and on March 31 of the following calendar year (s)he has qualifying coverage available from his or her employer, then effective at 11:59 p.m. on March 31 of the calendar year following the calendar year that your spouse no longer has primary coverage from his or her parent's employer's health plan, (s)he is not eligible for coverage from the Plan unless (s)he is enrolled in his or her employer's health plan.

Effective February 9, 2018, the Plan was amended to remove the statement that a Surviving Spouse was required to submit a sworn statement at least once per year certifying that (s)he is not remarried. Reminder that Surviving Spouses will still lose coverage when remarrying. The Plan was also amended to provide that the surviving spouse premium is due by the first day of the month, and unless there are extenuating circumstances as determined solely by the Board of Trustees and/or the Fund Office, a surviving spouse's coverage will terminate if his or her premium is not received by the Fund Office by the 15th day of the month. Effective January 1, 2020, the premium is due two months prior to the month in which the surviving spouse intends to receive coverage from the Plan.

9. Speech Therapy

Effective October 1, 2015, the Plan was amended to cover speech therapy for the treatment of Apraxia of Speech for a maximum of 52 sessions per calendar year.

10. Claims and Appeal Procedures

Effective January 1, 2017, the Plan adopted new claims and appeals procedures that allow for external review. Since the Plan is now a non-grandfathered plan under the Affordable Care Act, if the Plan denies an appeal and the claim involved medical judgment or a rescission of coverage, the Plan must allow the claimant to submit the appeal to an Independent Review Organization ("IRO"), which could overturn the Plan's denial. For information about the new claims and appeals procedures, contact the Fund Office.

11. Organ and Tissue Transplant Benefits

Beginning effective June 1, 2017, the Plan no longer utilized a separate, fully-insured Organ and Tissue Transplant Policy. Thereafter, all approved organ transplant benefits will be provided under the Plan's Comprehensive Medical Benefits and standard schedule of coverage, subject to the Plan's standard deductible, coinsurance and out of pocket maximums. These services must be Prior Authorized by the Plan. If the services are not Prior Authorized by the Plan, the services will be denied solely for a failure to get Prior Authorized. If it appears that you may need an Organ Transplant, the Plan encourages you to review these Covered Services with Your Physician.

Covered Organ Transplant Services
Covered Services are limited to services and supplies for Organ Transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement, and ancillary services.

Preferred Providers
Benefits will be paid at the In-Network Preferred Provider level only if Organ Transplant Services are provided at a Designated Transplant Provider.

The following apply when a human Organ Transplant is provided from a living donor to a transplant recipient:

a. When both the recipient and the donor are covered under the Plan, the Plan will cover services received by the donor and recipient.

b. When only the recipient is covered under the Plan, the Plan will cover services for both the donor and the recipient. The donor's coverage is limited to only those Benefits which are not provided by or available to the donor from any other source. This includes, but is not limited to, other health care plan coverage or any government program.

c. When only the donor is covered under the Plan, the services the Plan covers are limited to only those services which are not provided by or available to the donor from any other source. No services will be provided to a transplant recipient who is not covered under the Plan.

d. If any organ or tissue is sold rather than donated to a recipient covered under the Plan, no services will be covered if provided for the purchase price of such organ or tissue. However, other costs related to evaluation and organ "Procurement Services" are covered.

As used herein, "Procurement Services" are the services provided to match the human organ donor to the transplant recipient, surgically remove the organ from the donor and transport the organ to the location of the recipient within 24 hours after the match is made.

PIPE FITTERS LOCAL NO. 533
HEALTH AND WELFARE FUND

BENEFIT ALERT #47

The Board of Trustees of the Pipe Fitters Local No. 533 Health and Welfare Fund ("Plan") has adopted changes to the Plan's Comprehensive Medical Benefits. Additionally, the Plan has adopted temporary changes in response to the COVID-19 national emergency. 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.

The term "**National Emergency Period**" has a specific meaning when it is used in this Benefit Alert. The term "**National Emergency Period**" means the period beginning on March 18, 2020 and ending on the date that the COVID-19 public health emergency ends, as announced by the U.S. Department of Health and Human Services or another federal agency.

1. CHANGES TO TELEHEALTH BENEFITS

Effective January 1, 2020, the Amwell application ("app") and website was replaced with the Blue KC Virtual Care app and website. If you previously downloaded the Amwell app to access your medical telehealth services, you should delete it and download the Blue KC Virtual Care app. The Plan will pay 100% of the Allowable Charge for a telehealth visit provided through Blue KC Virtual Care (i.e. you will not have to pay a copay, deductible, or cost-sharing amount for a telehealth visit provided through Blue KC Virtual Care).

Further, effective during the period beginning on March 16, 2020 and ending on the date that the National Emergency Period ends, the Plan will pay 100% for any telehealth visit provided through a telehealth vendor other than Blue KC Virtual Care and any telehealth visit with a Covered Person's general physician and/or behavioral health provider (a brick and mortar physician) that is currently offering these visits rather than regular office visits. If a COVID-19 test is not ordered or prescribed during the visit, the Plan will cover 100% of the cost of the telehealth visit up to the Allowable Charge, regardless of whether the telehealth visit is with an in-network provider or out-of-network provider. If a COVID-19 test is ordered or prescribed during the telehealth visit, the Plan will pay 100% of the cost of the telehealth visit up to the lesser of the cash price listed by the provider on a public internet website or the rate negotiated with the provider, regardless of whether the telehealth visit is with an in-network provider or out-of-network provider.

2. TEMPORARY CHANGES TO PLAN COVERAGE OF COVID-19 TESTS AND RELATED TESTS

Effective during the period beginning on March 16, 2020 and ending on the date that the National Emergency Period ends, the Plan will cover COVID-19 tests and related tests in the following manner:

- For COVID-19 tests provided by an in-network provider, the Plan will pay 100% of the cost regardless of whether the test is administered, ordered, or prescribed at a doctor's office, facility, or hospital.

- For other tests provided by an in-network provider (i.e. tests for conditions other than COVID-19), the Plan will pay 100% of the Allowable Charges if the test meets both of the following criteria:
  - The test causes a provider to administer, order, or prescribe a COVID-19 test; and
  - The test is administered during the same visit in which the COVID-19 test is administered, ordered, or prescribed.

- For COVID-19 tests provided by an out-of-network provider, the Plan will pay 100% of the cost up to the lesser of the cash price listed by the provider on a public internet website or the rate negotiated with the provider, regardless of whether the test is administered, ordered, or prescribed at a doctor's office, facility, or hospital.

- For other tests provided by an out-of-network provider (i.e. tests for conditions other than COVID-19), the Plan will pay 100% of the cost up to the lesser of the cash price listed by the provider on a public internet website or the rate negotiated with the provider, if the test meets both of the following criteria:
  - The test causes a provider to administer, order, or prescribe a COVID-19 test; and
  - The test is administered during the same visit in which the COVID-19 test is administered, ordered, or prescribed.

Effective on the day immediately following the date the National Emergency Period ends, the Plan's standard cost-sharing provisions will be applied to these benefits.

3. COVERAGE OF COVID-19 VACCINES AS ROUTINE PREVENTIVE CARE MEDICAL BENEFITS

The Plan will pay 100% of the cost for Routine Preventive Care Medical Benefits provided by in-network providers on an outpatient basis. For Routine Preventive Care Medical Benefits provided by out-of-network providers 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. These rules are described in Benefit Alert 34, which also contains a list of Routine Preventive Care Benefits.

Effective January 1, 2021, the list of Routine Preventive Care Medical Benefits was updated to include federally approved COVID-19 vaccines.

Additionally, during the period that begins on January 1, 2021 and ends on the date that the National Emergency Period ends, the Plan will pay 100% of the cost of federally approved COVID-19 vaccines provided to Covered Persons by out-of-network providers. This means that the Plan will pay 100% of the cost of the vaccine even if the Covered Person has already received $300 of Routine Preventive Care Medical Benefits from out-of-network providers on an outpatient basis. This also means that the cost of federally approved COVID-19 vaccines will be disregarded when determining whether or not a Covered Person has received $300 of Routine Preventive Care Medical Benefits from an out-of-network provider. Coverage of other Routine Preventive Care Medical Benefits provided by out-of-network providers has not changed.

4. COVERAGE OF COVID-19 VACCINES AS ROUTINE PREVENTIVE CARE PRESCIPTION DRUG BENEFITS

The Plan will pay 100% of the cost for Routine Preventive Care Prescription Drug Benefits filled by in-network pharmacies. Typically, the Plan does not cover charges for Routine Preventive Care Prescription Drug Benefits filled by out-of-network pharmacies. These rules are described in Benefit Alert 34, which also contains a list of Routine Preventive Care Prescription Drug Benefits.

Effective January 1, 2021, the list of Routine Preventive Care Prescription Drug Benefits was updated to include federally approved COVID-19 vaccines.

Additionally, during the period that begins on January 1, 2021 and ends on the date that the National Emergency Period ends, the Plan will pay 100% of the cost of federally approved COVID-19 vaccines filled by out-of-network pharmacies. Coverage of other Routine Preventive Care Prescription Drug Benefits filled by out-of-network pharmacies has not changed.

5. SUSPENSION OF PLAN DEADLINES DURING THE OUTBREAK PERIOD

Effective March 1, 2020 and ending on the date sixty days after the declared end of the National Emergency Period ("Outbreak Period"), the following Plan deadlines are suspended:

- **Deadlines for Enrollment**
    - As described on page 8 of your current SPD and as listed in Benefit Alert 21, if you are an active Participant Employee and 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. This 90-day deadline is suspended during the Outbreak Period (i.e. the days in the Outbreak Period do not count towards the 90-day deadline).
    - As described on page 8 of your current SPD and as listed in Benefit Alerts 21 and 31, if you are an active Participant Employee and 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 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. This 90-day deadline is suspended during the Outbreak Period (i.e. the days in the Outbreak Period do not count towards the 90-day deadline).

- As described on pages 8 and 9 of your current SPD and as listed in Benefit Alert 31, if you are a Retiree and 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 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. This 30-day special enrollment period is suspended during the Outbreak Period (i.e. the days in the Outbreak Period do not count towards the 30-day deadline).

- **Deadlines for COBRA**
  - As described on page 17 of your current SPD, you will have 60 days in which to elect COBRA continuation coverage. This 60-day deadline is suspended during the Outbreak Period.
  - As described on page 17 of your current SPD, you have 45 days from the date you elect COBRA continuation coverage to submit your initial premium payment. This 45-day deadline is suspended during the Outbreak Period. The Plan is not obligated to pay a qualified beneficiary's claims until the qualified beneficiary pays the premium (i.e. although the deadline to pay the premium is suspended, the Plan does not actually have to start paying claims until the qualified beneficiary pays the premium).
  - As described on page 17 of your current SPD, COBRA premiums are payable monthly, and are due on the first day of the month for the month of coverage. This deadline is suspended during the Outbreak Period. The Plan is not obligated to pay a qualified beneficiary's claims until the qualified beneficiary pays the premium (i.e. although the deadline to pay the premium is suspended, the Plan does not actually have to start paying claims until the qualified beneficiary pays the premium).
  - As described on pages 14, 15, and 18 of your current SPD, for certain qualifying events (e.g. 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. This 60-day deadline is suspended during the Outbreak Period.
  - As described on page 19 of your current SPD, if a qualified beneficiary experiences a second qualifying event while on COBRA continuation coverage that is subject to a maximum 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. This 60-day deadline is suspended during the Outbreak Period.

- As described on page 19 of your current SPD, 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. This deadline is suspended during the Outbreak Period.

- **Deadlines for Claims and Appeals**
  - As described on page 45 of your current SPD, 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. This deadline is suspended during the Outbreak Period.
  - As described on page 45 of your current SPD, your 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 remain in the calendar year, within 90 days after the end of the Period of Disability. This deadline is suspended during the Outbreak Period.
  - As described on page 46 of your current SPD, your 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. This deadline is suspended during the Outbreak Period.

6. REDUCED PREMIUM FOR MEDICARE ELIGIBLE RETIREES WHO RETIRED ON OR AFTER JUNE 1, 2008

The Plan's 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. Effective January 1, 2020, this formula was changed to provide an additional discount to Medicare eligible Retirees who retired on or after June 1, 2008.

Prior to January 1, 2020, you received an additional 33% discount if you and all of your Dependents were Medicare eligible. If you or your spouse was Medicare eligible (i.e. only one of you was Medicare eligible), you would receive an additional 15% (rather than 33%) discount.

Effective January 1, 2020, the Plan was amended to provide that you will receive an additional 40% 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 20% (rather than 40%) 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.

7. ELIMINATION OF DEDUCTIBLE FOR PRESCRIPTION DRUG BENEFITS FOR RETIREES

Effective January 1, 2020, the Prescription Drug Benefit calendar year deductible for Retirees and Dependents of Retirees was eliminated. This means that if you are a Retiree or a Dependent of a Retiree, you are not required to meet a Prescription Drug Benefit calendar year deductible.

The Prescription Drug Benefit calendar year deductible for Eligible Employees and Dependents of Eligible Employees has not changed. The following chart compares the Plan's prior deductible for Prescription Drug Benefits to the Plan's deductible for Prescription Drug Benefits that became effective January 1, 2020:

If you are…	**Your Deductible for Prescription Drug Benefits was…**	**Effective January 1, 2020 your Deductible for Prescription Drug Benefits is…**
An Eligible Employee or a Dependent of an Eligible Employee	$200 a person/$400 a family	$200 a person/$400 a family
A Retiree or a Dependent of a Retiree	$100 a person/$100 a family	$0 a person/$0 a family

8. UPDATED LIST OF THE BOARD OF TRUSTEES

The Current Trustees for the Plan are:

UNION TRUSTEES

Ron Talley
Pipefitters Local No. 533
8600 Hillcrest Road
Kansas City, MO 64138

Luke Moylan
Pipefitters Local No. 533
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EMPLOYER TRUSTEES

Michael Gossman
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13605 W. 96th Terrace
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Bryan Taylor
U.S. Engineering Construction
3433 Roanoke Road
Kansas City, MO 64111

Chris Hutchings
MMC Contractors
13800 Wyandotte Street
Kansas City, MO 64145

The Board of Trustees may be contacted at the following Fund Office address and phone number:

Wilson-McShane Corporation
3100 Broadway, Suite 805
Kansas City, MO 64111
Phone: (816) 756-3313
Toll Free: (866) 756-3313

Satellite Office Maintained at:
8600 Hillcrest Rd. Suite A
Kansas City, MO 64138
Phone: (816) 361-0206

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

Sincerely,

BOARD OF TRUSTEES
January 2021