PIPE FITTERS LOCAL UNION NO. 211
WELFARE TRUST

Benefit Resources Inc.
P.O. BOX 87549 - HOUSTON, TEXAS 77287
(866) 236-3148 - LOCAL (713) 643-9300- FAX (866) 316-4794

October 5, 2021

Dear Participant:

Enclosed please find information pertaining to the Pipefitters Local Union 211 Welfare Trust:

1. Demographic Form
2. Spousal Affidavit
3. Summary of Benefits Coverage (SBC)
4. SavRx Prescription Services Brochure
5. Non- Creditable Coverage Notice
6. Women's Health and Cancer Rights Information
7. Premium Assistance under Medicaid and Children's Health Insurance Program (CHIP) information
8. Vision Benefits Information
9. Notice of Privacy Practice

Additionally, please find enclosed Beneficiary Designation forms for the Pipefitters Local Union 211 Defined Contribution Retirement Plan.

Please review, complete, sign, and submit the completed form and any required documentation via fax to:

FAX - 1-866-316-4794

If you have any questions concerning the required documentation, please do not hesitate to contact the Administrative Fund Office at:

(866) 236-3148 toll-free
(713) 643-9300 local line

Thank you,

Administrative Fund Office

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October 5, 2021

RE: 2022 Mandatory Annual Demographic Forms Requirement

Dear Participant:

The Trust Fund requires all participants to complete an annual demographics enrollment form. Enclosed is your annual demographics enrollment form that must be completed and returned to the Fund Office by December 15, 2021. If your annual demographics form is not received, eligibility for your dependent(s) will not be sent to Trust Fund vendors.

SPOUSAL AFFIDAVIT: The Board of Trustees require all spouses who are enrolled in the plan and have the ability to obtain coverage through their own employer, to enroll in their employer plan. The attached certification form must be completed and turned in with the annual demographics form. If an enrolled spouse fails to enroll in their employer's plan, the spouse will be terminated from the plan. **Please note that Blue Cross Blue Shield will still require other insurance information upon receipt of the first claim for any eligible dependent.**

1. Complete 2022 Annual Demographic Form
2. If recently married, provide a certified copy of your marriage certificate and you must complete the Spousal affidavit. **If your spouse works, they are required to enroll in their employer medical plan. If you spouse works and are not provided medical coverage through their employer, you must submit a letter on company letterhead from their employer stating no insurance is provided.**
3. If common law married, provide a copy of your court approved common law marriage form and **Spousal affidavit, please see item 2 above.**
4. If enrolling your biological child(ren) for the first time, a copy of their certified birth certificate. Their birth certificate must list participant name
5. If enrolling adopted child(ren) for the first time, a copy of their certified birth certificate and a copy of the court document showing you have adopted the child(ren) being enrolled
6. If enrolling step-child(ren) for the first time, a copy of their birth certificate, copy of other insurance information, divorce decree (if applicable) from spouse's previous marriage to determine who should provide primary coverage. If step-child(ren) were not from a previous marriage, a notarized document certifying that your spouse is responsible for medical care of the step-child(ren) being enrolled.

All documentation must be received by the fund office no later than December 15, 2021. If documentation is not received coverage for your dependent(s) will not be provided during the calendar year 2022 until all documentation is received.

Please review, complete, sign, and submit the completed form and any required documentation via fax to:

FAX - 1-866-316-4794

If you have any questions concerning the required documentation, please do not hesitate to contact the Administrative Fund Office.

Thank you,
Administrative Fund Office

2022 ANNUAL ENROLLMENT / DEMOGRAPHIC INFORMATION REQUEST

FOR MEMBER AND / OR DEPENDENT(S)

TOLL FREE NUMBER
866.236.3148
LOCAL AREA NUMBER
713.643.9300

RETURN COMPLETED INFORMATION TO: →

PIPE FITTERS LOCAL 211 WELFARE TRUST FUND
P.O. Box 87549
Houston Texas 77287

This form must be completed and signed by the Member & Spouse before any claims will be processed.
All questions must be answered.

SECTION ONE - MEMBER INFORMATION ❑ ***Check here if Change of Address***

Name	Street Address City State Zip		
Date of Birth	Social Security Number	Home Phone Number	Local Union #
Email Address:			
Do you consent to receive information by email?		□ Yes □ No	
Marital Status □ Single □ Married □ Divorced □Widowed			
If applicable: Date of marriage:		Date of divorce:	

SECTION TWO - SPOUSE INFORMATION *SPOUSAL AFFIDAVIT REQUIRED

Spouse's Name	Mailing Address □Check if same as above		
Date of Birth	Social Security Number	Sex: □ Male □ Female	
Is Spouse covered under any other Dental, Vision or Group Health Plan?			□ Yes □ No
If Yes, You must complete Section 3 (Other Insurance Information, below)			
Check all that apply: □Dental □ Vision □ Medical			
Are you, your spouse or any eligible dependent(s) covered under Medicare?			
□ Yes □ No If Yes, who is covered by Medicare?			
Effective Date of Medicare :			

SECTION THREE - OTHER INSURANCE INFORMATION

Name of Insured	Insured's ID Number:
Policy or Plan No. Type of Coverage: □ Individual □ Family	
Name, Address and Phone No. of Insurance Company:	

I HEREBY DESIGNATE THE INDIVIDUAL NOTED BELOW TO RECEIVE ANY LIFE INSURANCE BENEFIT PAYABLE UNDER THE PIPE FITTERS LOCAL 211 WELFARE TRUST FUND:

Full Name	Relationship
Address (If not the same as yours)	

THIS FORM MUST BE DATED AND SIGNED BY YOU AND YOUR SPOUSE

I/WE jointly certify that the information above and on the back of this form is complete, true and correct. I/WE hereby authorize all doctors, pharmacists, hospitals or other Institutions rendering care and treatment to furnish **Pipe Fitters Local 211 Welfare Trust Fund** with full information regarding treatment rendered (including copies of their records). I/WE also authorize any union, trust fund, employer or insurance carrier to furnish **Pipe Fitters Local 211 Welfare Trust Fund** with information regarding benefits to which I/WE may be entitled. A copy or photocopy of this authorization shall be considered as effective and valid as the original.

Date	MEMBER'S SIGNATURE	SPOUSE'S SIGNATURE

Please provide the requested information, on the back of this form, on all family members who are covered under the Plan. Please make a copy of the back of this form if more than three dependents.

Dependent's Name Date of Birth Social Security Number Sex: ☐ Male ☐ Female	
Dependent's Address	
Relationship to Member: ☐ Child ☐ Step Child (for whose health coverage You or your eligible spouse is responsible) ☐ Foster Child or other Child of whom you are the legal guardian	Is dependent **eligible** for Health coverage through an employer (other than the employer of the dependent's parent) even if not enrolled in that coverage? ☐ Yes ☐ No If age 26 or older, then dependent is not eligible to participate in the Welfare Trust unless dependent is (i) unable to support himself because of a disability that occurred before his 26th birthday, and (ii) has never married, and (iii) is otherwise eligible under the terms of the Plan.
Dependent lives with: _______________ Has Child ever been married? ☐ Yes ☐ No If yes, date of marriage ______________	Is dependent **covered** under any other Dental, Vision or Health Plan? ☐ Yes ☐ No Check all that apply: ☐ Dental ☐ Vision ☐ Medical If yes, you must complete the following: Name of Insured Group or Plan No.
Is dependent incapable of self-support due to a disability? ☐ Yes ☐ No	Insured's ID No. Type of Coverage ☐ Family ☐ Individual Name, address, & phone number of Insurance Company:

Dependent's Name Date of Birth Social Security Number Sex: ☐ Male ☐ Female	
Dependent's Address	
Relationship to Member: ☐ Child ☐ Step Child (for whose health coverage You or your eligible spouse is responsible) ☐ Foster Child or other Child of whom you are the legal guardian	Is dependent **eligible** for Health coverage through an employer (other than the employer of the dependent's parent) even if not enrolled in that coverage? ☐ Yes ☐ No If age 26 or older, then dependent is not eligible to participate in the Welfare Trust unless dependent is (i) unable to support himself because of a disability that occurred before his 26th birthday, and (ii) has never married, and (iii) is otherwise eligible under the terms of the Plan.
Dependent lives with: _______________ Has Child ever been married? ☐ Yes ☐ No If yes, date of marriage ______________	Is dependent **covered** under any other Dental, Vision or Health Plan? ☐ Yes ☐ No Check all that apply: ☐ Dental ☐ Vision ☐ Medical If yes, you must complete the following: Name of Insured Group or Plan No.
Is dependent incapable of self-support due to a disability? ☐ Yes ☐ No	Insured's ID No. Type of Coverage ☐ Family ☐ Individual Name, address, & phone number of Insurance Company:

Dependent's Name Date of Birth Social Security Number Sex: ☐ Male ☐ Female	
Dependent's Address	
Relationship to Member: ☐ Child ☐ Step Child (for whose health coverage You or your eligible spouse is responsible) ☐ Foster Child or other Child of whom you are the legal guardian	Is dependent **eligible** for Health coverage through an employer (other than the employer of the dependent's parent) even if not enrolled in that coverage? ☐ Yes ☐ No If age 26 or older, then dependent is not eligible to participate in the Welfare Trust unless dependent is (i) unable to support himself because of a disability that occurred before his 26th birthday, and (ii) has never married, and (iii) is otherwise eligible under the terms of the Plan.
Dependent lives with: _______________ Has Child ever been married? ☐ Yes ☐ No If yes, date of marriage ______________	Is dependent **covered** under any other Dental, Vision or Health Plan? ☐ Yes ☐ No Check all that apply: ☐ Dental ☐ Vision ☐ Medical If yes, you must complete the following: Name of Insured Group or Plan No.
Is dependent incapable of self-support due to a disability? ☐ Yes ☐ No	Insured's ID No. Type of Coverage ☐ Family ☐ Individual Name, address, & phone number of Insurance Company:

Note: It may constitute fraud and/or grounds for immediate and retroactive termination of coverage to: (i) provide inaccurate or incomplete information on this form, (ii) enroll an ineligible spouse or dependent, or (iii) fail to contact the Welfare Trust once your spouse or dependent is no longer eligible to participate in the Welfare Trust Fund.

You must provide any documentation that the Welfare Trust Fund reasonably requires in order to substantiate that your spouse, child, or other dependent is eligible to participate in the Welfare Trust. Fund If you have questions regarding the eligibility of your spouse, child, or other dependent, contact the Welfare Trust Fund at (713) 643-9300 or (866) 236-3148.

Spousal Affidavit – Must be completed by Spouse

As the legal spouse of a Pipe Fitters Local 211 Trust Fund participant, in order to be covered under the medical plan during plan year starting January 1, 2022, you must sign and return this Spousal Affidavit with your spouse annual demographics form.

Please check the appropriate box below and certify that I am:

- ❑ I am not employed or I am Retired with no ability to obtain insurance coverage
- ❑ I am Self-employed with no ability to obtain insurance benefits
- ❑ I am Employed but my employer does not offer group health plan coverage. You must provide proof from your employer.
- ❑ I am enrolled in group health plan coverage through my employer.
  If you check this box, please provide the information requested below.

I also certify under penalty of perjury under the laws of the State of Texas that the foregoing is true and correct. I understand that providing false information or concealing important facts can be considered a violation of the law and punishable by a fine, imprisonment, or both and that I may be required to repay to the Plan any benefits improperly paid on my behalf.

Spouse Name (Please print): _____

Spouse Signature: _____ Date _____

Member Name (Please print):_____

Member Signature: _____ Date _____

If you have any questions about spousal eligibility status, contact Benefit Resources Inc.before signing this document. Please note:

- *The Plan reserves the right to request at any time documentation that substantiates the eligibility of an enrolled spouse.*
- *The Plan has the right to request reimbursement of any premiums and claims paid for ineligible spouses.*
- *Failure to complete this Spousal Affidavit fully and truthfully will make the spouse ineligible for Trust Fund health plan coverage during 2022*

Complete if You Have Health Plan Coverage through Your Employer

If you are enrolled in group health plan coverage through your employer, please provide the following information:

Employer Name: _____

Insurance Company: _____

Group Number and ID Number_____

Effective Date: _____

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call the plan at 1-866-236-3148 or 713-643-9300. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-236-3148 or 713-643-9300 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,250/individual, $3,600/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. However, if a family has more than 3 members, the amount that all family members pay cumulatively towards the family deductible can be used to satisfy the family deductible amount.
Are there services covered before you meet your deductible?	Yes. In-network preventive care and care received under the $300 supplemental accident benefit are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers: $5,100/individual, $10,200/family; Out-of-network providers: $10,800/individual	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com/provider/index.html for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% coinsurance	50% coinsurance	None
	Specialist visit	25% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	25% coinsurance for outpatient well-baby care (from birth up to one year) up to $500, then 90% coinsurance; 25% coinsurance for other preventive services	Age and frequency limits apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	Preauthorization required for outpatient tests or procedures involving an invasion of the body or benefits paid at 50% coinsurance.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.sav-rx.com	Generic drugs	50% coinsurance (based on the actual cost of the drug)	Not covered	Limited to 30-day supply retail and 90-day supply mail order. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Brand name drugs	50% coinsurance (based on the actual cost of the drug)	Not covered	
If you have outpatient	Facility fee (e.g., ambulatory	25% coinsurance	Not covered	Preauthorization required on all outpatient

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
surgery	surgery center)			surgical procedures or benefits paid at 50% coinsurance.
	Physician/surgeon fees	25% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	Professional/physician charges may be billed separately.
	Emergency medical transportation	25% coinsurance	50% coinsurance	Limited to transportation to/from the nearest hospital where treatment can be given.
	Urgent care	25% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	Preauthorization required or benefits paid at 50% coinsurance.
	Physician/surgeon fees	25% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Inpatient services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
If you are pregnant	Office visits	25% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. Delivery expenses are not covered for dependent children.
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Plan of care must meet specific criteria.
	Rehabilitation services	25% coinsurance	50% coinsurance	None
	Habilitation services	25% coinsurance	50% coinsurance	None
	Skilled nursing care	25% coinsurance	50% coinsurance	None
	Durable medical equipment	25% coinsurance	50% coinsurance	Benefits for the rental of durable medical equipment may not exceed the purchase price.
	Hospice services	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$10 copayment	No charge up to $50, then 100%	Limited to one eye exam per calendar year. $50 limit not applicable to pediatric eye exams for individuals under age 19.
	Children's glasses	$25 copayment, plus amounts in excess of plan's allowed amount for frames	No charge up to allowed amount of $50 for single vision lenses and up to allowed amount of $70 for frames, then 100%	Limited to one pair per calendar year. Out-of-network allowed amount is $75 for bifocals and $100 for trifocals. Dollar limits not applicable to glasses for individuals under age 19.
	Children's dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

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

- Acupuncture
- Children's dental check-up
- Cosmetic surgery (unless because of an accidental injury, incidental to or following surgery that results from trauma, infection or other disease, or because of congenital disease or anomaly that has resulted in a functional defect)
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Mental health/behavioral health services
- Substance abuse services
- Weight loss programs (except as required under the Affordable Care Act)

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

- Bariatric surgery (for treatment of morbid obesity in certain limited circumstances)
- Chiropractic care (limited to maximum reimbursement of $500 per year)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (if medically necessary and provided by a registered nurse or licensed practical nurse)
- Routine eye care (Adult)
- Routine foot care (limited to maximum of 50 visits per year)

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross Blue Shield at 1-800-367-8309. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-810-2583.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$1,250
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$0
Coinsurance	$2,810
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,120

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

The plan's overall deductible	$1,250
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$3,750

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

The plan's overall deductible	$1,250
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$0
Coinsurance	$170
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,420

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

Sav-Rx Prescription Services

SIMPLE TIPS TO SAFELY REDUCE YOUR DRUG COSTS:

- Eliminate unnecessary drugs (and lower your risk of side effects and drug interactions) by reviewing medications with your primary care physician or pharmacist every six months.
- Talk with your doctor about cost. Let your doctor know cost and effectiveness both matter.
- Ask your doctor if a generic or a lower cost substitute is available for the medication you are currently taking.
- Shop around and compare prices in supermarket pharmacies, chain pharmacies, independent pharmacies, and mail order.
- Talk to your doctor about splitting your pills. You could save money if your doctor can prescribe a pill which is twice your dose so you could split it in half. Do not split pills without the permission of your doctor.
- Avoid free samples because they are usually brand name and more expensive in the long run.
- If you are taking a brand medication, manufacturer coupons may be available online.
- Consider asking for smaller quantities of new medications by asking your doctor to write the prescription for a small amount until you know the medication is right for you. This is especially helpful if paying cash or if you have a large copay.
- Ask your pharmacist for guidance. Pharmacists can be helpful in guiding you through suggestions and identifying other options if you are unable to afford your medications.

Sav-Rx Mail Order Pharmacy: The Sav-Rx Mail Order Pharmacy offers a convenient and cost-effective option for your long-term maintenance and specialty medications. We can reach out to your physician to obtain your mail order prescription, or you may call Sav-Rx with your prescription drug names, as well as your physician contact information and we will take care of the rest. The Sav-Rx Mail Order Pharmacy offers convenient refill options, you may request a refill by phone, online at www. savrx.com, or download the Sav-Rx App from the App Store or Google Play. Automated refills are not available from the Sav-Rx Mail Order Pharmacy, as we want to ensure you are re-ceiving only the prescriptions you need. Your payment is due at the time of your order and all orders are shipped directly to your home or office with no additional shipping charge.

Call to find out more about your prescription coverage, network locations and clinical programs. An agent will be ready to provide you with personalized, professional assistance 24/7.

1-800-228-3108

Please visit our website at:
www.savrx.com

For Organized Labor, By Organized Labor

Sav-Rx Prescription Services

RETAIL PHARMACY (UP TO 30 DAY SUPPLY)	
Generic	50%
Brand	50%
Brand with Generic	50%
SAV-RX MAIL ORDER (UP TO 90 DAY SUPPLY)	
Generic	50%
Brand	50%
Brand with Generic	50%

**Specialty medications are limited to a 30 day supply

Where may I use my Sav-Rx Card?

Retail Pharmacy: The Sav-Rx Retail Pharmacy Network includes over 72,000 pharmacies, as well as 18,000 independant pharmacies nationwide. Most pharmacies in your area are already part of the Sav-Rx Network, including all major pharmacy chain stores. It is important that you present your Sav-Rx ID Card to your pharmacy to access your benefit. To locate a pharmacy near you, please visit www.savrx.com and enter the Group printed on your ID card with your zip code.

What medications are covered?

Most maintenance medications are covered by your Plan. These include, but are not limited to insulin, blood pressure, cholesterol, pre-scription prenatal vitamins and more. Please refer to your Summary Plan Description for specific coverage rules.

Certain medicatons are excluded from coverage such as over the counter medications, mental health medications, and those used for fertility or cosmetic purposes.

Please contact Sav-Rx Prescription Services for any questions regarding your medication.

Are generics just as safe and effective as brand name medications?

Generic drugs have been approved by the Food and Drug Administration (FDA) as safe and effective. Generic drugs contain the same active ingredients in the same amounts as the brand name product. The generic version works like the brand name drug in dosage, strength, performance and use. Generics may differ in color, shape, size or flavor from the brand product; however, these differences do not effect the performance, safety or effectiveness of the generic drug.

PIPE FITTERS LOCAL UNION NO. 211
WELFARE TRUST FUND
Benefit Resources Inc.
P. O. Box 87549 - Houston, Texas 77287
(866) 236-3148 – LOCAL (713) 643-9300 - FAX (866) 316-4794
www.benefitresourcesinc.com

October 1, 2021

IMPORTANT NOTICE TO EMPLOYEES ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. The Pipe Fitters Local Union No. 211 Welfare Trust Fund (the Plan) has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Non-Creditable Coverage. This is important, because for most people, failure to enroll in Medicare prescription drug coverage when first eligible for such coverage means you will have to pay a penalty in the form of a higher premium for Medicare prescription drug coverage if you decide to enroll in this coverage later.

2. Read this notice carefully – it explains the options you have for prescription drug coverage, and can help you decide whether you want to enroll in a Medicare prescription drug plan.

WHAT DO YOU NEED TO DO:

⇨ **First:** Read this entire Notice.

⇨ **Second:** If you are eligible for Medicare, compare your current coverage through the Plan to the coverage available to you through the Medicare prescription drug plans available in your area.

⇨ **Third:** Decide whether you want to enroll in a Medicare prescription drug plan.

KEEP IN MIND:

⇨ Individuals can enroll in a Medicare prescription drug plan when they are first eligible and also from October 15 to December 7 of each year (the annual enrollment period). In addition, Medicare beneficiaries leaving or losing employer- or union-sponsored coverage may be eligible for a “special enrollment period” – this may allow enrollment in a Medicare prescription drug plan outside the regular annual enrollment period.

⇨ If you do not enroll in a Medicare prescription drug plan when first eligible you may pay a penalty in the form of a higher monthly premium for that coverage.

⇨ You may keep your current coverage with the Plan regardless of whether you enroll in a Medicare prescription drug plan.

INFORMATION ABOUT THE MEDICARE PRESCRIPTION DRUG PROGRAM

Prescription drug coverage is available to everyone with Medicare through private Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

You need to compare your current coverage with the Plan to the Medicare prescription drug plans available where you live. As you compare coverage, keep the following in mind:

- You would pay a premium to the Medicare prescription drug plan that you choose. The amount would depend on the type of coverage that you choose. For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available.

- Each Medicare prescription drug plan will cover different brand name drugs at different costs to you. Your drugs may not be covered under every plan, so you need to choose carefully. For instance, one plan might cover your current brand name medication, and another might not.

- Each Medicare prescription drug plan may have a different deductible, copayments, and other costs that you will be responsible for paying.

- Each Medicare prescription drug plan will have a different network of retail and mail order pharmacies.

YOUR CHOICES

If you are eligible for Medicare, you can choose any one of the following options:

1. You can keep your current medical and prescription drug coverage with the Plan and enroll in a Medicare prescription drug plan.

If you do this, the Fund will pay primary to Medicare for active employees and their dependents.

2. You can keep your current medical and prescription drug coverage with the Plan and not enroll in a Medicare prescription drug plan.

If you do not enroll in a Medicare prescription drug plan when first eligible, you may pay more later. You may pay a late enrollment penalty in the form of a higher monthly premium for the Medicare prescription drug coverage that you choose later.

If you wait to enroll, and if you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next October to enroll.

For more information about this notice or your current prescription drug coverage…

If you have any questions about this notice or your current prescription drug coverage, please contact the Fund Office (see the contact information below).

NOTE: You may receive this notice at other times in the future (such as before the next annual enrollment period, and if this coverage changes). You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook that Medicare publishes each fall and sends to Medicare beneficiaries. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 1, 2021

Sender: Pipe Fitters Local 211 Welfare Trust Fund

Contact: Fund Office

Address: P.O. Box 87549
Houston, TX 77287

Telephone: 713-643-9300 1-866-316-4794

As in all cases, the Plan reserves the right to modify benefits at any time, in accordance with applicable law.

This document is intended to serve as your Notice of Non-Creditable Coverage as required by law.

PIPE FITTERS LOCAL UNION NO. 211
WELFARE TRUST FUND

Benefit Resources Inc.
P. O. Box 87549 - Houston, Texas 77287
(866) 236-3148 – LOCAL (713) 643-9300 - FAX (866) 316-4794
www.benefitresourcesinc.com

October 1, 2021

Important Information Regarding the Women's Health and Cancer Rights Act of 1998

If you have had or going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: (1) all states of reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and (4) treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. Call the Fund Office at (713) 643-9300 for more information on WHCRA benefits.

Important Information Regarding the Health Insurance Portability and Accountability Act of 1996
Confidentiality of Your Protected Health Information

The privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require the Plan to protect the privacy and confidentiality of your protected health information (PHI). As described in its Notice of Privacy Practices. Recently issued government regulations have made material changes with regard to restrictions on the use and disclosure of your PHI. The updated Notice also clarifies that you will receive a notice if a breach of your PHI occurs. The Plan will not use or disclose your PHI except as is necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law, or as otherwise authorized by you.

You have certain rights under the privacy rules with respect to your PHI, including the right to receive an accounting of certain disclosures of the information the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Your rights with respect to your PHI are explained in greater detail in the Plan's Notice of Privacy Practices. The Notice also describes how the Plan uses and discloses PHI. You may obtain a copy of the Plan's Notice of Privacy Practices by writing the Fund's HIPAA Privacy Official at the office of Benefit Resources Inc., 8441 Gulf Freeway Suite 304, Houston, Texas 77017, or by calling (713) 643-9300.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid / Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

A LOOK AT YOUR VSP VISION COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM PIPE FITTERS LOCAL UNION NO. 211 WELFARE TRUST FUND AND VSP.

VSP® Vision care for life

Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

It's easy to find a nearby in-network doctor. Maximize your coverage with bonus offers and savings that are exclusive to Premier Program locations—including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

PREMIER PROGRAM

Visionworks

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

GET YOUR PERFECT PAIR

EXTRA $20 TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON LACOSTE NINE WEST

SEE MORE BRANDS AT **VSP.COM/OFFERS**.

\+

UP TO **40%** SAVINGS ON LENS ENHANCEMENTS

EXCLUSIVE MEMBER EXTRAS

Enroll today.

Contact us: **800.877.7195** or **vsp.com**

YOUR VSP VISION BENEFITS SUMMARY
PIPE FITTERS LOCAL UNION NO. 211 WELFARE TRUST FUND and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
	YOUR COVERAGE WITH A VSP PROVIDER		
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every calendar year
PRESCRIPTION GLASSES		$25	See frame and lenses
FRAME	• $140 featured frame brands allowance • $120 frame allowance • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$50 $80 - $90 $120 - $160	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
DIABETIC EYECARE PLUS PROGRAM℠	• Retinal screening for members with diabetes • Additional exams and services for members with diabetic eye disease, glaucoma, or age-related macular degeneration. Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20 per exam	As needed
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Log in to **vsp.com** to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Log in to **vsp.com** to find an in-network provider based on your plan type.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Classification: Restricted

PIPE FITTERS LOCAL UNION NO. 211 WELFARE TRUST FUND

NOTICE OF PRIVACY PRACTICES
Effective: May 1, 2020

This notice describes the medical information practices of the Pipe Fitters Local Union No. 211 Welfare Trust Fund (the "Plan"), and that of any party that assists in the administration of the Plan. Any reference in this Notice to we, us or our also refers to the Plan. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PLEASE NOTE: The vast majority of your medical information resides with our business vendors which provide services to the Plan (such as Benefit Resources Inc.). To access the information contained in their files, contact the vendor directly at the address or phone number listed on your Member ID Card.

Plan Pledge Regarding Medical Information

We understand that medical information about you and your health is personal, and we intend to protect the confidentiality of that information. The Plan, similar to your doctor, must create a record of the health care claims you or your doctor submits for payment. These records are used to administer the Plan.

This notice applies to all of the medical records we maintain. While your personal doctor or health care provider may have different policies regarding his/her use and disclosure of your medical information, this notice will tell you about the ways in which your Plan intends to use and disclose medical information about you. It also describes our obligations and your rights regarding such use and disclosure. We are required by law to ensure that medical information that identifies you is kept private to the extent possible. As a result, we are giving you this notice of our legal duties and privacy practices with respect to medical information about you, and we expect to follow the terms of this notice now and in the future.

How the Plan Uses and Discloses Medical Information

The following categories describe different ways that we use and disclose medical information. While not every use or disclosure in a category will be listed, they will describe all of the ways we are permitted to use and disclose information without your authorization.

For Treatment. The Plan may use or disclose medical information about you to help your doctors provide you with medical treatment. To that end, we may disclose your medical information to all medical providers who are involved in taking care of you.

> For example, if asked by the pharmacist, we might disclose information about your prior prescriptions if he/she needs it to determine if a pending prescription would be harmful to you in light of your other prescriptions. If asked by your doctor, we, or one of the Plan service providers, might disclose your medical history in order to help him/her provide the most appropriate treatment for your medical condition, or to help determine whether a proposed treatment is experimental, investigational, or medically necessary.

For Payment. The Plan may use or disclose information about you to determine your eligibility for benefits, pay the Plan's portion of the medical bill, determine benefit responsibility under the Plan, or coordinate Plan coverage with benefits you may be receiving from another plan. *Note, while we may use your personal information to determine your eligibility for Plan benefits, your eligibility for coverage under the Plan is not dependent upon your health status.*

For example, we may tell your health care provider about your medical history to determine whether and how much the Plan will pay for your treatment. We may also share medical information with a utilization review or pre-certification service provider to help them maximize the benefits available to you. We may share medical information with another party at our discretion to assist with the adjudication or subrogation of claims, or to another health plan to coordinate benefits.

For Health Care Operations. The Plan may use and disclose medical information about you for other necessary Plan operations.

For example, we may use your medical information to conduct quality assessment and improvement activities, underwrite the Plan's financial risks and/or other activities relating to Plan coverage. We may also use your medical information to conduct or arrange for medical review, legal services, audit services, fraud/abuse detection programs, and business planning and development such as cost management and general administrative activities.

Special Situations

The following situations describe special circumstances where the Plan may also release your medical information without your authorization.

As Required By Law. The Plan must disclose medical information about you when required to do so by federal, state or local law.

For example, we may disclose medical information to the federal Department of Health & Human Services, or the Centers for Disease Control.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

For example, we may disclose medical information about you in a proceeding regarding the licensing, or the revocation of a license, of a physician. Also, if you were to contract a serious illness that might pose a threat to public safety.

Disclosure to Other Health Plans. Should you become eligible for another health plan, your information may be disclosed to the responsible party administering that plan. This will be done to assist in treatment, payment, and health care operations. In addition, minimum necessary access to your medical information may be given to Fund personnel (such as the Trustees and the Privacy Official) for the purpose of ensuring the continued existence and administering the benefits of the Plan.

Organ and Tissue Donation. If you are an organ donor, we may release information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks. We may disclose medical information about you for public health activities, including but not limited to the following:

- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease; or,
- to notify a government authority if we believe a person has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose medical information to a federal or state health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at a hospital; and
- in the case of an emergency, to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or a medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of that person's death. We may also release medical information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information the Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To do this, you must submit your request in writing via U.S. Mail to the HIPAA Privacy Official at the address listed at the end of this Notice.

Your request must include your name, Social Security number, work and home addresses and telephone numbers in order to receive a response. You must also identify the name of the health plan to which your inquiry applies and be specific about the time period and subject for which you are requesting information. If you request a copy of the information, we may charge a fee for the costs of compiling, copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, we will tell you why and you may request a review of the denial.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, you must provide a reason for your request, and the request must be made in writing and submitted via U.S. Mail to the HIPAA Privacy Official at the address listed at the end of this Notice.

We are not required to agree to your request. We may deny the request for an amendment if it is not in writing or does not include a valid reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations. To request this list or accounting of disclosures, you must submit your request in writing via U.S. Mail to the HIPAA Privacy Official at the address listed below.

Your request must state a time period in which the disclosures occurred, but may not be longer than six years from the date of your request and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone (other than a medical provider) who is involved either in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. To request restrictions, you must make your request in writing via U.S. Mail to the HIPAA Privacy Official at the address listed at the end of this Notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We are not required to adopt special mailing instructions such as registered or certified mail.

To request confidential communications, you must make your request in writing via U.S. Mail to the HIPAA Privacy Official at the address listed at the end of this Notice. While we will not ask you the reason for your request, the Plan will only accommodate reasonable requests. Your request must specify how or where you wish to be contacted.

As a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you are not the participant and you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.*, an Explanation of Benefits, or "EOB"). *Unless* you agree that you will be responsible for benefit payments, a copy of the EOB (in which your PHI might be included) will be released to the plan participant.

Right to a Copy of This Notice. You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon your request. To request a copy of this notice, you must make your request in writing via U.S. Mail to the HIPAA Privacy Official at the address listed at the end of this Notice.

Changes to This Notice

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. You will be provided a new notice within 60 days if there is a material revision.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan. To file a complaint with the Plan, contact in writing via U.S. Mail:

HIPAA Privacy Official
Pipe Fitters Local Union No. 211 Welfare Trust
Fund c/o Benefit Resources, Inc.
P.O. Box 87549
Houston, TX 77287

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

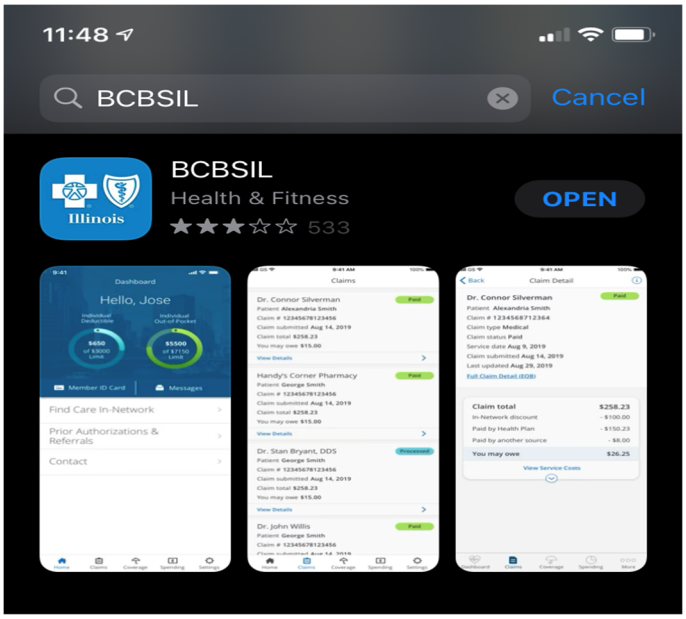
You will not be penalized for filing a complaint. For more information, you may call the Privacy Official at 866-236-3148. As with all correspondence with the Privacy Official called for in this Notice, you must identify both yourself and the Plan in which you participate in order to receive a response.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide an authorization to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care and benefits provided to you. Furthermore, you should be aware that any disclosure we make pursuant to your authorization strips that information of the protection of the Plan's privacy guidelines.

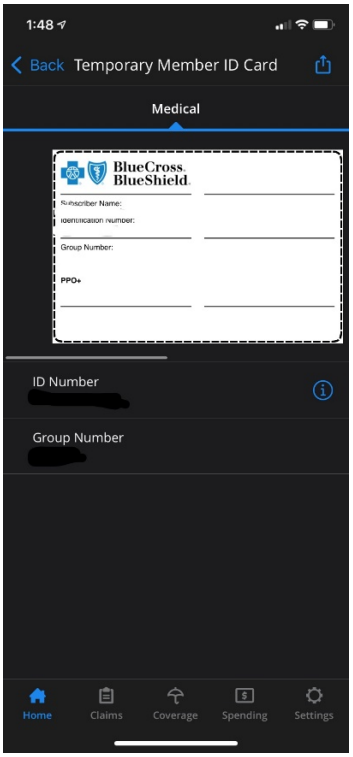
BLUE CROSS BLUE SHIELD PHONE APP.

Search BCBSIL in the app. Store.

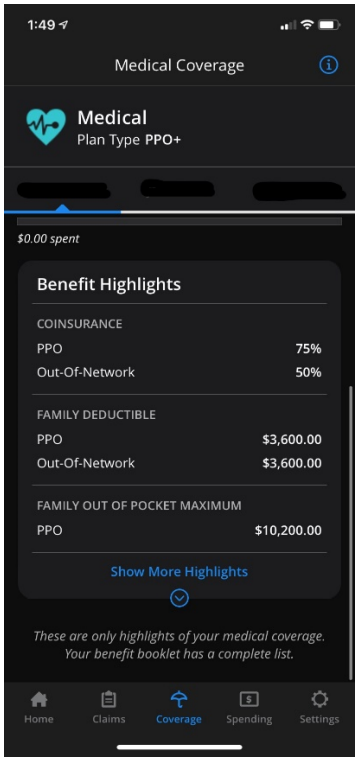


You can see all your Blue Cross Blue Shield information in one place!

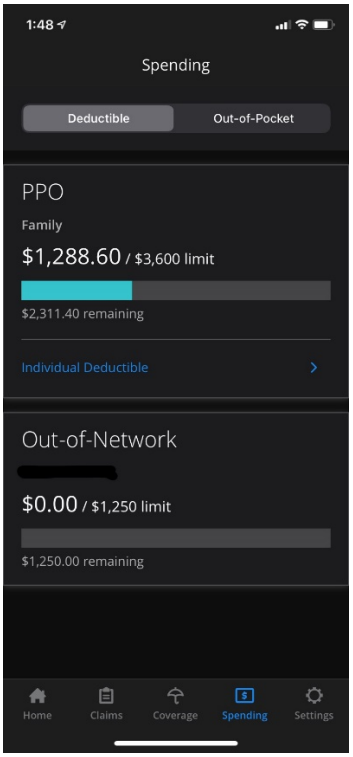
Digital id card!



See coverage!



View deductible!



PIPEFITTERS LU211 H&W TRUST

HELP HOLD YOUR INSURANCE COST DOWN!

SIGN UP FOR MD LIVE TODAY. IT'S EASY.

FROM YOUR SMART PHONE,

TEXT BCBSIL TO 635483

CLICK ON THE LINK & FOLLOW THE INSTRUCTIONS.

If you have difficulty, simply call the Customer Service number on the back of your medical card.

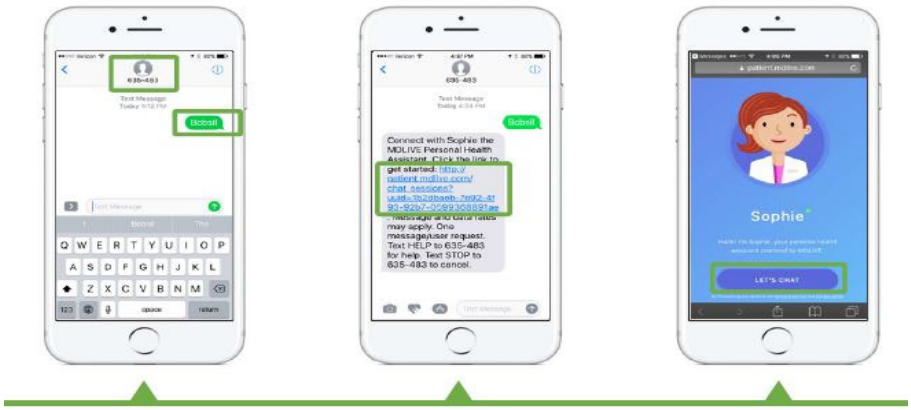
YOU CAN EXPECT

NO COST DOCTOR VISITS VIA PHONE CALL!

PRESCRIPTIONS CALLED INTO YOUR PHARMACY!

This option costs our fund much less than an urgent care or emergency room.

Helping To Save Our Members Money!



Text BCBSIL to 635483.	Tap the link to connect To Sophie.	Tap 'Let's Chat' to launch Registration with Sophie.