PLUMBERS LOCAL UNION NO. 1 WELFARE FUND
158-29 George Meany Boulevard
Howard Beach, N.Y. 11414

October 2014

SUMMARY OF MATERIAL REDUCTION NUMBER 1 (SMR#1)

Please place this in your Summary Plan Description (SPD) for handy reference and safekeeping.
If you do not have a Summary Plan Description, you may obtain a copy on our website at www.ualocal1funds.org or by making a written request to the Fund Office.

IMPORTANT!

This Summary of Material Reduction or SMR describes changes to the SPD for the Plumbers Local Union No.1 Welfare Fund (the "Welfare Fund") issued in June 2013.

The following Medical/Hospital benefit changes will take effect January 1, 2015:

COPAYMENTS — Empire BC/BS will provide new ID Cards

OFFICE VISITS

Office Visit Copayment
$25

EMERGENCY ROOM (waived if admitted)

Emergency Room Copayment
$100

OUT-OF-NETWORK INDIVIDUAL & FAMILY DEDUCTIBLES

INDIVIDUAL	***FAMILY***
Out-of-Network Individual Deductible	Out-of-Network Family Deductible
$2,000	$5,000

OUT-OF-NETWORK OUT-OF-POCKET COINSURANCE MAXIMUM

INDIVIDUAL	***FAMILY***
New Out-of-Network Out-of-Pocket Individual Coinsurance Maximum Effective January 1, 2015	New Out-of-Network Out-of-Pocket Family Coinsurance Maximum Effective January 1, 2015
$2,000	$5,000

The following Prescription Drug benefit changes will take effect January 1, 2015:

COPAYMENTS

Using the CVS/Caremark Retail Pharmacy Network

When you fill your prescriptions, simply present your CVS/Caremark ID card to the pharmacist.

Up to 30-day supply through CVS/Caremark network pharmacies	$10.00 co-pay for generic $30.00 co-pay for single-source $50.00 co-pay for multi-source

Maintenance Medication Co-pays

You and your eligible Dependent(s) can fill prescriptions for 84-90 day supplies of certain maintenance medications at CVS Pharmacies and pay the applicable mail order co-pay, which saves you money.

You are allowed to fill your prescriptions for 30-day supplies of your maintenance medications at any in-network retail pharmacy up to three times at the applicable retail co-pay. Starting with the fourth fill, you will pay the applicable retail co-pay ***plus*** a surcharge if you continue to fill prescriptions for 30-day supplies of maintenance medications.

Here's how the co-payments for maintenance medications work:

For Prescriptions Filled at Retail CVS Pharmacies			
	30-Day Supply (First three fills)	30-Day Supply (Fourth Fill and After)	84-90-Day Supply (First Fill and After)
Generic Medication	$10	$25 ($10 co-pay + $15 surcharge)	$25
Single-Source	$30	$50 ($30 co-pay + $20 surcharge)	$75
Multi-Source	$50	$70 ($50 co-pay + $20 surcharge)	$125
For Prescriptions Filled at Other Network Retail Pharmacies			
	30-Day Supply (First three fills)	30-Day Supply (Fourth Fill and After)	84-90-Day Supply (First Fill and After)
Generic Medication	$10	$25 ($10 co-pay + $15 surcharge)	Not Covered
Single-Source	$30	$50 ($30 co-pay + $20 surcharge)	Not Covered
Multi-Source	$50	$70 ($50 co-pay + $20 surcharge)	Not Covered

For a list of covered maintenance medications or for more information, visit CVS/Caremark online at www.caremark.com or you can call CVS/Caremark toll-free at 1 866-831-4336.

Effect of Filling Maintenance Drugs at Other Network Retail Pharmacies

For maintenance drugs, which are those for which you have a continuing, long-term prescription, supplies purchased through network pharmacies instead of CVS Pharmacies or the mail service described below will be charged a $15 surcharge for generic and a $20 surcharge for single-source or multi-source after 3 prescription fills at retail.

Using the CVS/Caremark Mail Service

You will need to complete a mail order form for you and your family member who will be utilizing the Caremark mail program. This will set up each member's profile in the mail order system with valuable information. Then simply mail the completed form, along with an original prescription written for a 90-day supply and payment. It will take approximately 14 days to receive your mail order prescription. ***It may be necessary to obtain two prescriptions from your Physician, one for a 30-day supply so you can start or continue your medication without interruption and one for the 90-day mail order supply.*** After your script has been filled the first time and you have available refills, you can re-order your mail script online at www.caremark.com, by calling Caremark Member Services or by mailing in your re-order form that you received with your prescription.

You are encouraged to use the Caremark Mail Service to order maintenance drugs.

Up to 30-day supply through CVS/Caremark mail order	$ 10.00 co-pay for up to 30-day generic $ 30.00 co-pay for up to 30-day single-source $ 50.00 co-pay for up to 30-day multi-source
Up to 60-day supply through CVS/Caremark mail order	$ 17.00 co-pay for up to 60-day generic $ 50.00 co-pay for up to 60-day single-source $ 87.50 co-pay for up to 60-day multi-source
Up to 90-day supply through CVS/Caremark mail order	$ 25.00 co-pay for up to 90-day generic $ 75.00 co-pay for up to 90-day single-source $125.00 co-pay for up to 90-day multi-source

DISPENSE AS WRITTEN ONE (DAW-1)

In New York State, pharmacists are allowed, by law, to substitute the generic version of a drug when the prescription is written for the brand – EXCEPT when a prescription is written with the Dispense as Written (DAW)-1 requirement by your physician. Effective January 1, 2015, if you choose to not purchase the generic prescription drug, and would rather purchase the Single-Source or Multi-Source brand prescription drug, you will be responsible to pay the $30.00 or $50.00 copayment plus the difference in the cost between the Single Source or Multi-Source brand prescription drug and the cost of the available generic version of that drug.

ELIGIBILITY FOR RETIRED EMPLOYEES

Eligibility Rule Effective January 1, 2015

You are considered a Retired Employee on the effective date of your Pension. If you initially retire on or after January 1, 2015 and you are receiving a pension from the Plumbers and Pipefitters National Pension Fund (sometimes referred to as the "National Pension Fund"), you will be eligible for Retiree Benefits from the Welfare Fund if you meet the following requirements. You must satisfy both the applicable Service and Age requirements. In addition, you must elect Retiree coverage at the time of retirement.

- **Service**

  1. If you first enter the industry before or after January 1, 2007, you must have been eligible for benefits from the Welfare Fund for at least ten (10) years and for at least eighty-four (84) out of the last one hundred and twenty (120) months prior to the start of your retirement. Months during which you were covered under the Welfare Fund by virtue of COBRA are not counted in determining whether you satisfy the 84 of 120 eligibility months service test.

  2. In addition to satisfying requirement 1 above, you must have at least 500 combined hours of work reported to the Welfare Fund for the last three (3) years prior to the year of retirement. If disabled, you must have had 500 hours reported during the 36-month period prior to the commencement of your disability.

  3. In addition to satisfying requirements 1 and 2 above, you must have the required Years of Pension Credit with the National Pension Fund, or one of the prior plans, as of the date shown in the following schedule:

Effective Date	Total Years of Pension Credit
January 1, 2015	15
January 1, 2016	16
January 1, 2017	17
January 1, 2018	18
January 1, 2019	19
January 1, 2020	20

- **Age** – You must be at least age 60 or age 55 and have become Totally and Permanently Disabled before age 60 under a "Contingent Early Retirement Pension-Awaiting Social Security Benefit Award."

NOTE - If you leave the industry, you may not meet the service requirement described above and will not be eligible for Retiree Continuation of Coverage Benefits. In order to become eligible for Retiree Continuation of Coverage Benefits, you must return to work and remain eligible for benefits from the Welfare Fund long enough so that you satisfy the applicable service requirement. The period that you must return to work and remain eligible as an Active Employee in order to be eligible for Retiree Continuation of Coverage Benefits will vary depending on how long you were out of the industry and the service required at the time as illustrated above.

Effect of Becoming Eligible for Medicare

Upon becoming eligible for Medicare, Medicare is the primary coverage. For maximum benefits, you ***should*** maintain coverage for Part B by self-paying the Medicare Part B premium. **Failure to elect Medicare Part B coverage will result in a reduction of benefits.** Once Medicare-eligible, you and your Eligible Dependent(s) will have retiree Medicare Wrap Around benefits under the Welfare Fund, which does not cover expenses that would be covered by Medicare Part B. See pages 78 - 80 of the SPD for a description of this benefit.

If you meet the above-described age and service requirements, you are required to make self-payments for Retiree Benefits. However, if you retire **before** age 60 and elect Retiree Continuation Coverage, you will be required to pay an amount equal to the COBRA rate in effect at the time. The Welfare Fund's rules concerning eligibility for and the cost of Retiree Benefits are summarized as follows:

- If you retire at age 55 and before age 60 under a "Contingent Early Retirement Pension-Awaiting Social Security Award" from the National Pension Fund, you will be able to continue eligibility under Extension of Eligibility During Periods of Temporary Disability and you will not be required to elect COBRA or make self-payments if you qualify for this extension.

- If you retire at age 55 and before age 60 under a "Contingent Early Retirement Pension-Awaiting Social Security Award" from the National Pension Fund, you will be required to elect COBRA and pay the COBRA rate in effect at the time, if you are not eligible for the Extension of Eligibility During Periods of Temporary Disability. However, if the Social Security Disability Award is granted, your eligibility for Retiree benefits and payments are then determined in accordance with the rules for Employees who initially retire on or after January 1, 2015.

- Retiree Continuation Coverage is available to Retired Employees from age 55 until age 65. If you meet the eligibility requirements of the Welfare Fund at age 65, the Welfare Fund's benefits coordinate with Medicare, and you will then be eligible for the Medicare Wrap Around Program. See pages 78-80 of the SPD.

- If you retire before age 60, you are not eligible for the Medicare Wrap Around Program or any other coverage from the Welfare Fund at age 65 or after. Nor are you eligible for COBRA Continuation Coverage upon reaching age 65 (unless you are within the 18-month COBRA period measured from the date of retirement).

- If you retire at age 60 or older, or at age 55 or older in the case of Total and Permanent Disability and meet the eligibility requirements of the Welfare Fund, you will be eligible for coverage from the Welfare Fund until age 65 at which time you will be covered by the Medicare Wrap Around Program. See pages 78-80 of the SPD.

- If you are eligible for benefits from the Welfare Fund based on the receipt of Workers' Compensation Benefits, your coverage will continue as described on pages 4-6 of the SPD, regardless of whether you have elected to begin receipt of a "Contingent Early Retirement Pension-Awaiting Social Security Award" from the National Pension Fund. If the Social Security Disability Award is granted, you will qualify for Retiree Coverage. If the Social Security Disability Award is denied, your eligibility for Retiree Coverage and payments will be determined in accordance with the rules for Employees who initially retire on or after January 1, 2015.

If You Retire(d)*…	Can Receive Retiree Benefits	Pays the following % of COBRA Rate
Before Age 60	Ages 55 to 64	65%
At Age 60 or older before January 1, 2015	Ages 60 to 65 then Medicare Wrap Around Program	5%
At Age 60 or older **Effective January 1, 2015 w/15 Total Years of Pension Credit** **Effective January 1, 2016 w/16 Total Years of Pension Credit** **Effective January 1, 2017 w/17 Total Years of Pension Credit** **Effective January 1, 2018 w/18 Total Years of Pension Credit** **Effective January 1, 2019 w/19 Total Years of Pension Credit** **Effective January 1, 2020 w/20 Total Years of Pension Credit**	Ages 60 to 65 then Medicare Wrap Around Program	5%
Total & Permanent Disability Retirement Before or after January 1, 2015 w/20 Total Years of Pension Credit Age 55 or Older	From Date of Disability Retirement to Medicare eligibility; then Medicare Wrap Around Program	5%
Total & Permanent Disability Retirement Retired before January 1, 2015 w/ less than 20 Total Years of Pension Credit or under Age 55	From Date of Disability Retirement to Medicare eligibility; then Medicare Wrap Around Program	33% 2015 66% 2016 100% 2017
Total & Permanent Disability Retirement Retired on or after January 1, 2015 w/ less than 20 Total Years of Pension Credit Age 55 or Older	From Date of Disability Retirement to Medicare eligibility; then Medicare Wrap Around Program	100%

*Remember you must still have been eligible for benefits from the Welfare Fund and meet all other requirements.

INDIVIDUAL COBRA RATES	***FAMILY COBRA RATES***
Monthly Premium @ 5% COBRA	***Monthly Premium @ 5% COBRA***
$33*	$90*
Monthly Premium @ 33% COBRA	***Monthly Premium @ 33% COBRA***
$218.00*	$591.00*
Monthly Premium @ 75% COBRA	***Monthly Premium @ 75% COBRA***
$496.00*	$1,343.00*
Monthly Premium @ 100% COBRA	***Monthly Premium @ 100% COBRA***
$662.00*	$1,791.00*

** These rates are effective January 1, 2015. Keep in mind that COBRA rates can change from time to time.*

Important Reminder - You must elect Retiree Continuation of Coverage at time of retirement. Failure to elect Retiree Continuation of Coverage at time of retirement will result in forfeiture of all eligibility for Retiree Coverage. Under no circumstances can you elect Retiree Coverage after expiration of the date upon which to elect such coverage.

Loss of Grandfathered Health Plan Status

As of January 1, 2015, the Welfare Fund will no longer be a “grandfathered health plan” under the Patient Protection and Affordable Care Act (PPACA). This means that additional consumer protections under PPACA will apply to the Welfare Fund. These new protections include the following:

Preventive Services

The Welfare Fund will pay 100% of the costs incurred for certain preventive services when those services are provided by an in-network provider. This means that these services will not be subject to any deductible, and you will not have to pay any cost sharing (in other words, you will not have to pay a copayment for these services). You may, however, be required to pay a copayment if the primary purpose of an office visit to a provider is not to receive the preventive service, or for a visit that is billed separately from the preventive service.

The preventive services to which this new rule applies are those that are required under PPACA. The required services include the following:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved. (For a complete list of “A” and “B” Recommendations of the Task Force, visit http://www.healthcare.gov/center/regulations/prevention/taskforce.html.)

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the guidelines supported by the Health Resources and Services Administration (HRSA).

- With respect to women, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).

To find out if a particular preventive service will be paid at 100% when provided by an in-network provider, contact the Fund Office or Empire Blue Cross at 1 (800) 553-9603. You should note that the list of preventive services required to be covered without cost sharing will change periodically as the standards change. To the extent required by law, any additional recommendations provided in the future will be covered as of the first plan year beginning on or after the first anniversary of when the recommendations are updated.

Direct Access to Obstetrical and Gynecological Care

You do not need prior authorization from the Welfare Fund or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Fund Office or Empire Blue Cross at 1 (800) 553-9603.

Hospital Emergency Room Services

The Welfare Fund will cover certain emergency services provided in hospital emergency rooms when you are suffering from an emergency medical condition. You do not have to obtain prior authorization from the Welfare Fund before seeking emergency services in a hospital emergency room. Beginning January 1, 2015, the Welfare Fund will charge you the same $100 copayment whether you obtain those services in-network or out-of-network.

Please note, however, that if you obtain those services from an out-of-network hospital, the out-of-network hospital may bill you separately if the charges exceed what the Welfare Fund allows (e.g., they may balance bill you), so this may result in higher out of pocket cost to you. Out-of-Network emergency services are also subject to the Welfare Fund's general deductible for out-of-network care and count towards the Welfare Fund's out-of-pocket maximum for out-of-network care.

For the purposes of the above rule, 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 average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

The term "emergency services" means a medical screening examination and medical treatment necessary to stabilize the person (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the person from the facility).

Out-of-Pocket Maximum Effective January 1, 2015

The Welfare Fund has an Out-of-Pocket Limit (also referred to as an Out-of-Pocket Maximum) which limits your annual cost-sharing for covered essential benefits received from in-network providers related to Hospital, Medical, and Prescription Drug copayments, deductibles, and coinsurance. The Out-of-Pocket Limit is the most you pay from January 1 through December 31 of each year before the Welfare Fund starts to pay 100% for covered essential health benefits received from in-network providers.

There is no Out-of-Pocket Limit on the use of Out-of-Network providers, except that covered emergency services performed in an Out-of-Network Emergency Room will apply to meet the In-Network Out-of-Pocket Limit.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits the Welfare Fund from imposing an annual Out-of-Pocket Limit on medical/surgical benefits and a separate annual Out-of-Pocket Limit on mental health and substance use disorder benefits. Expenses for in-network mental health and substance use disorder benefits count toward the in-network Out-of-Pocket Limit in the same manner as those for in-network medical expenses.

The Welfare Fund's In-Network Out-of-Pocket Limits for the period January 1, 2015 through December 31, 2015 are as follows:

Benefit Type	Individual	Family
Hospital/Medical	$5,100	$10,200
Prescription Drug	$1,500	$3,000

If you have Family Coverage under the Welfare Fund, once any covered member of your family meets the Individual Out-of-Pocket Limit, the Welfare Fund will pay 100% of covered essential health benefits received from in-network providers for that covered family member. All out-of-pocket costs for that covered family member will also apply towards the Family Out-of-Pocket Limit.

Please be aware that the amount of the Welfare Fund's Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.

Internal and External Review of Coverage Determinations

As you know, the Welfare Fund provides an internal appeals procedure that allows you and your family the opportunity to request review of claims determinations that you believe are incorrect. Under PPACA, beginning January 1, 2015, if your internal appeal is denied for certain reasons, you may have the right to appeal to an independent reviewer. The rules regarding independent review are currently under development at the Fund Office, and will be sent to you in a separate mailing at a later date.

Changes to the Time Limit to Bringing a Lawsuit

Effective July 1, 2014, any action by a Participant or Beneficiary for benefits following the denial of an appeal must be filed within 365 days after the date of the notice of the denial of the final appeal. Thus, for example, if a particular claim requires two levels of administrative appeal to Empire Blue Cross/Blue Shield ("Empire") and the date of Empire's denial of the second level administrative appeal was January 1, 2014, you have until January 1, 2015 to file a lawsuit for benefits. If the claim at issue only requires one level of appeal to the Welfare Fund, you would determine the period within which to file suit based on the date of the Welfare Fund's denial of the appeal. Remember that you cannot file a lawsuit until you have complied with the Welfare Fund's administrative appeal procedures. A description of the claims and procedures applicable to each type of claim is set forth in the section of your SPD entitled "How to File a Claim."

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

The Women's Health and Cancer Rights Act of 1998 (the "Act") provides that any group health plan or health insurance that provides surgical benefits with respect to a mastectomy must also provide coverage for reconstructive surgery following the mastectomy. Specifically, if you are receiving benefits in connection with a mastectomy, the Welfare Fund must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce symmetrical appearance, and
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

This coverage is subject to all of the Welfare Fund's rules regarding benefits, including the Welfare Fund's annual deductible, co-pays or coinsurance and plan maximums.

The Welfare Fund already provides coverage for the items listed above and did so prior to the enactment of the Act and will continue to provide such coverage. Nonetheless, federal law requires us to notify you of this coverage.

The Board of Trustees will continue to work with the Welfare Fund's consultants in exploring ways to continue to provide quality and affordable health benefits to you and your families. If you have any questions, please contact the Plumbers Local Union No. 1 Welfare Fund Office at (718) 835-2700.