Dear Participants:

The Board of Trustees of the Pipe Fitters’ Welfare Fund, Local 597 ("Welfare Fund") are pleased to announce several changes to the plan of benefits under the Welfare Fund (the “Plan”). These changes include expanded coverage for infertility treatment and genetic testing as well as changes required in accordance with the Patient Protection and Affordable Care Act of 2010 ("ACA").

These changes are effective for claims incurred on or after January 1, 2020 and apply to Active Employees and retired Employees who are not yet eligible for Medicare, unless otherwise stated.

Below is a general overview of these changes, and a detailed summary of these changes is attached. Capitalized terms that are used but not defined in this notice, including the attached detailed summary, have the meaning set forth in the Welfare Fund’s Summary Plan Description and Plan Document ("SPD"). If you have any questions about these changes, please contact the Fund Office.

1. The Plan will now cover infertility treatment at 85% (PPO) and 75% (non-PPO) with a maximum benefit of $20,000 per lifetime (for no more than two cycles to achieve conception) under the Major Medical Benefit. A separate $10,000 per lifetime maximum applies under the Prescription Drug Benefit. Infertility treatment is only available to Participants and their Dependent spouses.

2. The Plan will now cover genetic testing at 85% (PPO) and 75% (non-PPO) with a maximum benefit of $2,500 per person per calendar year and $10,000 per lifetime limit under the Major Medical Benefit.

3. For PPO and non-PPO expenses, the calendar year deductible under the Major Medical Benefit will increase from $300 per person to $500 per person and from $900 per family to $1,500 per family.

4. For PPO expenses under the Major Medical Benefit, the calendar year out-of-pocket maximum will increase from $1,000 per person to $1,950 per person, and the Trustees added a calendar year family out-of-pocket maximum of $5,850.

5. For non-PPO expenses under the Major Medical Benefit, the calendar year out-of-pocket maximum will increase from $2,500 per person to $5,000 per person.

6. Several changes were made to your copayment amounts under the Prescription Drug Benefit. Please see the attached summary for more detailed information.

7. Some of these benefit changes described above resulted in the Plan losing its "grandfathered status" under the ACA. As a result, the Trustees adopted the following additional changes to comply with the ACA:
a. The deductible amount and copayments for physical, speech and occupational therapy services above the 40-visit limit for PPO expenses will count towards the PPO calendar year out-of-pocket maximum under the Major Medical Benefit.

b. Dental expense payments for Diagnostic and Preventive Services for Dependent children under age 19 will count towards the PPO calendar year out-of-pocket maximum under the Major Medical Benefit for Active Employees only.

c. The Plan will cover Preventive Services at 100% (PPO) and 75% (Non-PPO). Preventive Services are defined by federal law and may be subject to frequency and necessity limits. See the attached summary for more detail on Preventive Services.

d. The Plan will cover emergency room services at 85% from PPO and non-PPO providers.

e. The Trustees have adopted new claims and appeals procedures, specifically adding an external review process.

Please keep this notice with your SPD booklet for future reference. If you have any questions, please call the Fund Office.

Sincerely,

Board of Trustees

This notice describes certain features of the Plan and is intended to be a Summary of Material Modifications to the Plan. If you file a claim, please be sure to review the current SPD and any subsequent Summaries of Material Modifications for the applicable review periods and additional procedures. Full details are contained in the SPD, the document that establishes the provisions of the Plan. The Board of Trustees of the Welfare Fund reserves the right to amend, modify, or terminate the Plan at anytime and from time to time. Receipt of this notice does not confer or guarantee eligibility for benefits.

Pipe Fitters’ Welfare Fund, Local 597
Employer Identification Number: 36-2141703
November 2019
Pipe Fitters’ Welfare Fund, Local 597  
Summary of Material Modifications  
November 2019

Infertility Treatment

Effective for claims incurred on or after January 1, 2020, the Plan will cover infertility treatment at 85% (PPO) and 75% (non-PPO) under the Major Medical Benefit. The maximum benefit available is $20,000 per lifetime (for no more than two cycles to achieve conception) under the Major Medical Benefit and a separate $10,000 per lifetime maximum under the Prescription Drug Benefit. **Infertility treatment is only available to Participants and their Dependent spouses.**

Covered infertility treatment under the Plan include, but are not limited to the following:

a. Artificial insemination; and

b. In-vitro fertilization, intracytoplasmic sperm injection and preimplantation genetic diagnosis provided the following conditions are met:

i. For a participant whose spouse is of the opposite sex, the participant’s oocytes or donor eggs are fertilized with the participant spouse’s sperm or donor sperm, unless the spouse is unable to produce and deliver functional sperm or egg, and the inability to produce and deliver functional sperm or egg does not result from a vasectomy or another method of voluntary sterilization;

ii. The participant and his/her spouse have a history of involuntary infertility, which may be demonstrated by a history of (1) at least two years’ duration failing to result in pregnancy when the participant and the spouse are of opposite sexes; or (2) if the participant and his/her spouse are of the same sex, six attempts of artificial insemination over the course of two years failing to result in pregnancy; or

iii. The infertility is associated with any of the following: (1) endometriosis; (2) exposure in utero to diethylstilbestrol, commonly known as DES; (3) blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or (4) abnormal male factors, including oligospermia, contributing to the infertility.

Genetic Testing

Effective for claims incurred on or after January 1, 2020, the Plan will cover genetic testing at 85% (PPO) and 75% (non-PPO) under the Major Medical Benefit. The maximum benefit available is $2,500 per person per calendar year and $10,000 per lifetime.

Genetic testing services are covered under the Plan, provided there is a Medically Necessary reason for conducting the test. Genetic testing services include, but are not limited to the following:

a. State-mandated newborn screening tests for genetic disorders;
b. Testing for a genetic mutation in the BRCA1 and BRCA2 genes;

c. Covered pregnant woman if the test or procedure is recommended by the American College of Obstetricians and Gynecologists and/or the American Academy of Pediatrics;

d. Pre-implantation genetic diagnosis (where one or more cells are removed from an embryo and genetically analyzed to determine whether genetic abnormalities are present) in situations where the associated in vitro fertilization procedure is also covered by the Plan;

e. Tests to determine a covered individual's sensitivity to FDA-approved drugs and tests to determine the effectiveness of an FDA-approved drug;

f. Carrier testing for certain genetic disorders (such as Cystic Fibrosis) for covered individuals in any of the following groups:

   i. Couples seeking prenatal care;

   ii. Couples who are planning a pregnancy

   iii. Persons with a family history of the genetic disorder in question;

   iv. Persons with a first degree relative identified as a carrier; or

   v. Reproductive partners of persons with the genetic disorder in question.

g. The detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered individuals who meet all of the following conditions:

   i. The testing method is considered scientifically valid for identification of a genetically linked inheritable disease;

   ii. The covered individual displays clinical features/symptoms of a genetically linked inheritable disease, or the covered individual is at direct risk (e.g., family history, first or second degree relative) for the development of a genetically linked inheritable disease (pre-symptomatic); and

   iii. The results of the test will directly impact clinical decision-making, the clinical outcome or the treatment being delivered to the covered individual.

Please be aware that genetic counseling is NOT a Covered Expense under the Plan. This means you will have to pay out-of-pocket for any genetic counseling services you receive, and these expenses will not count toward your out-of-pocket maximums (neither PPO nor non-PPO).
Calendar Year Deductible Changes

Effective for claims incurred on or after January 1, 2020, the calendar year deductible under the Major Medical Benefit will increase from $300 per person to $500 per person and from $900 per family to $1,500 per family for PPO and non-PPO expenses.

PPO Out-of-Pocket Maximum Changes

Effective for claims incurred on or after January 1, 2020, the calendar year out-of-pocket maximum under the Major Medical Benefit will increase from $1,000 per person to $1,950 per person for PPO expenses. There is also now a family out-of-pocket maximum of $5,850 for PPO expenses.

The family out-of-pocket maximum may be satisfied through any combination of individual out-of-pocket maximums. Once you meet the family out-of-pocket maximum, no further individual out-of-pocket maximum will be applied to any eligible member of your family during the remainder of the applicable calendar year.

The following PPO expenses will also count toward the PPO calendar year out-of-pocket maximum:

1. The deductible amount and copayments for physical, speech and occupational therapy services above the 40-visit limit; and

2. For Active Employees only, dental expense payments related to Diagnostic and Preventive Services for a Dependent child under age 19.

Non-PPO Out-of-Pocket Maximum Changes

Effective for claims incurred on or after January 1, 2020, the calendar year out-of-pocket maximum under the Major Medical Benefit will increase from $2,500 per person to $5,000 per person for non-PPO expenses.

Prescription Drug Benefit Changes

Effective for claims incurred on or after January 1, 2020, the Schedule of Benefits for Prescription Drugs for Active Employees and Retired Employees Not Yet Eligible for Medicare was revised as follows:

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum per Calendar Year</th>
<th>$5,000 per person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$5,000 per family</td>
</tr>
<tr>
<td>Maximum Benefits Paid under Prescription Drug Benefit</td>
<td></td>
</tr>
<tr>
<td>Infertility Treatment (Participant and Dependent spouse only)</td>
<td>$10,000 per lifetime</td>
</tr>
<tr>
<td>Your Co-Payment Amount</td>
<td>Retail (34-day supply)</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Generic</td>
<td>$10</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>20% ($25 minimum)</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>30% ($45 minimum)</td>
</tr>
<tr>
<td>Specialty (co-insurance)</td>
<td>Retail or Mail Order Co-Payments apply</td>
</tr>
</tbody>
</table>

**Preventive Services**

Effective for claims incurred on or after January 1, 2020, the Plan will cover Preventive Services at 100% (PPO) and 75% (non-PPO) before applying any deductible. Preventive services are defined by federal law and may be subject to frequency limits and medical necessity recommendations as provided by the United States Preventive Services Task Force, the Centers for Disease Control and the Health Resources and Services Administration.

The list of Preventive Services can be found at [www.healthcare.gov/coverage/preventive-care-benefits](http://www.healthcare.gov/coverage/preventive-care-benefits) and is subject to change as updated by federal regulations. For more information on Preventive Services, please contact the Fund Office.

**Emergency Room Services**

Effective for claims incurred on or after January 1, 2020, the Plan will cover emergency room services at 85% from PPO and non-PPO providers.

**Claims and Appeals Procedures**

Effective for claims filed on or after January 1, 2020, the Plan’s claims and appeal procedures have changed pursuant to the ACA. Most notably, the Plan is implementing an external review process. If your claim for benefits involves medical judgment or a rescission of coverage and is denied after you exhaust the Plan’s internal appeal procedures, you may request an external review by an independent review organization within four months of the notice of the final internal denial decision. To request a copy of the Plan’s revised claims and appeals procedures, please contact the Fund Office.

*If you have any questions about these changes or your plan of benefits, please contact the Fund Office.*