

Privacy Laws –

Please be aware that due to Federal, State and HIPAA Privacy Regulations, the Plan can not discuss any detailed Health & Welfare or Pension information with your spouse or any other family member/person. We must speak directly to **you** concerning these matters. We realize this is a great inconvenience when you are working, however, the Plans must stay in compliance with Federal and State regulations. You may complete an authorization to disclose information form to release information to your spouse or other person. Please complete the attached Release form if needed.

PARTICIPANT, SPOUSE AND DEPENDENT: PLEASE READ THIS NOTICE CAREFULLY.

The Plumbers & Steamfitters Local Union 52 Health & Welfare Plan believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Plumbers & Steamfitters Local Union 52 Health & Welfare Plan, PO Box 211105, Montgomery, AL 36121-1105, 334-272-0240. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

**BLUE CROSS BLUE SHIELD OF
ALABAMA**

HEALTH

BENEFIT BOOKLETS

**ARE AVAILABLE ON OUR
WEBSITE:**

www.ualocal52.org

Click the Health & Welfare tab.

Scroll down and you will see documents on the right side of the page.

The Women's Health and Cancer Rights Act of 1998

Recent changes in federal law affect your insurance coverage. This is to provide notice as required under federal law.

The Women's Health and Cancer Rights Act of 1998 (Women's Health Act) provides new protection for breast cancer patients who elect breast reconstruction in connection with a medically necessary mastectomy.

As a result of this legislation, health plans currently offering mastectomy coverage must also provide coverage for associated reconstructive surgery.

Under this health plan, coverage will be provided to a member who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

- 1 reconstruction of the breast on which the mastectomy was performed;
- 2 surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- 3 prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for other medical and surgical benefits.

Benefits became effective October 21, 1998, when the Act was signed into law.

If you have any questions about your benefits, please contact the Blue Cross and Blue Shield of Alabama Customer Service Center. 1-800-292-8868

RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance carriers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or carrier may pay for a shorter stay if the attending provider (for example, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and carriers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or carrier may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you have any questions about your benefits, please contact the Blue Cross and Blue Shield of Alabama Customer Service Center at 1-800-292-8868 or the Plan Office at 334-272-0240.

**** Please note: The following is only applicable for those who are currently covered by Medicare or if you become covered by Medicare and are covered under the Local 52 Health Plan. ****

CREDITABLE DRUG COVERAGE NOTICE 01/01/2019

Plumbers & Steamfitters Local Union 52 Health & Welfare Plan for Plan Year: Important Notice 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 your employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your employer has determined that the prescription drug coverage offered by your employer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st●

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current employer group coverage may be affected. For example, you and your dependents may not be able to keep your current employer coverage if you join a Medicare drug plan.

If you decide to join a Medicare drug plan and drop your current employer group coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us at the address and/or telephone number at the top of this notice for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact our office at the address and/or telephone number at the top of this notice for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

● Visit www.medicare.gov

● Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help ● Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

**LOCAL 52
HEALTH AND WELFARE FUND**

**NOTICE ABOUT HEALTH INSURANCE MARKETPLACE AND
YOUR HEALTH COVERAGE**

The Trustees of the Plumbers & Steamfitters Local 52 Health and Welfare Plan ("Fund") are providing you this notice to help clear up any questions you may have about how the Health Insurance Marketplace ("Marketplace") affects your health coverage under the Fund. On **October 1, 2013**, open enrollment will begin for the Marketplace (formerly referred to as the "Exchange"), which is one of the central aspects of the Health Care Reform law known as the Affordable Care Act ("ACA"). Each state will have a Marketplace offering Qualified Health Plans ("QHPs") that may be purchased by individuals and small businesses. Coverage under QHPs purchased in the Marketplace becomes effective **January 1, 2014**.

ACA requires your employer to provide you with a notice about the Marketplace and your ability to purchase health coverage through the Marketplace before open enrollment begins. However, the required model notice is not specifically tailored to a multiemployer plan arrangement. As a result, you may find the Notice confusing.

The Marketplace **will have no effect on your coverage under the Fund**. You will continue to be a Participant of the Fund as long as you meet the eligibility requirements stated in the Summary Plan Description. Your employer will continue making contributions to the Fund on your behalf as long as you are working under a collective bargaining agreement requiring such contributions.

If you lose eligibility for coverage under the Fund due to a reduction in hours or termination of employment **after January 1, 2014**, the Marketplace may offer an attractive alternative for health coverage for you or you may choose to purchase continuation coverage offered by the Fund pursuant to the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA"). (Although permitted self-payments for those of you who are short the requisite hours in a given quarter may be a cheaper alternative to purchasing insurance through the Marketplace). The premiums to purchase a QHP in the Marketplace may be less expensive than the cost of COBRA coverage and you may qualify for a new kind of tax credit that lowers your monthly premiums in the Marketplace. You can see what your premium, deductibles, and out-of-pocket costs will be in the Marketplace before you make a decision between paying for COBRA coverage, making self-payments (if applicable), or purchasing coverage through the Marketplace.

For more information about the Marketplace, you can refer to www.healthcare.gov or call 1-800-318-2596, which is the federal government's hotline for questions about the Marketplace.

Please feel free to contact the Fund Office at 334-272-0240 X5 if you have any further questions.

Notice Of COBRA Continuation Coverage Rights
**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Plumbers & Steamfitters Local 52, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Plumbers & Steamfitters Local Union 52 Health & Welfare Plan, P.O. Box 211105, Montgomery, AL 36121-1105. You must also provide the plan with a copy of the final divorce decree or legal separation, all documentation related to the loss of dependent status of the dependent child. Other documentation may be requested by the Plan.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees

may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. For this extension to apply, evidence of disability under the Social Security Act must be provided to the Plan Administrator within the initial eighteen month continuation coverage time frame and within sixty days from the date of Social Security's determination. You must provide this notice to: Plumbers & Steamfitters Local Union 52 Health & Welfare Plan, P.O. Box 211105, Montgomery, AL 36121-1105.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

PLAN ADMINISTRATOR - The Plan Administrator is your contact as it relates to COBRA and your continuation coverage. If you have any questions regarding this notification or your continuation coverage, you may review your Plan's Summary Plan Document or contact the Plan Administrator. It is your responsibility to notify the Plan Administrator of any qualifying events and when you have a change of address. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Kay Pinckard
Plumbers & Steamfitters Local Union 52
PO Box 211105
Montgomery, AL 36121
334-272-0240

Plan Contacts:

Blue Cross Blue Shield of Alabama, (PO Box 995, Birmingham, AL 35298) at 800-292-8868
VSP at 1-800-877-7195

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 January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myallhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	INDIANA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	KANSAS – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid

<p>Website: http://chfs.ky.gov/dms/default.htm</p> <p>Phone: 1-800-635-2570</p>	<p>Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf</p> <p>Phone: 603-271-5218</p>
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
<p>Website: http://www.lahipp.dhh.louisiana.gov</p> <p>Phone: 1-888-695-2447</p>	<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</p> <p>Medicaid Phone: 609-631-2392</p> <p>CHIP Website: http://www.njfamilycare.org/index.html</p> <p>CHIP Phone: 1-800-701-0710</p>
MAINE – Medicaid	NEW YORK – Medicaid
<p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html</p> <p>Phone: 1-800-977-6740</p> <p>TTY 1-800-977-6741</p>	<p>Website: http://www.nyhealth.gov/health_care/medicaid/</p> <p>Phone: 1-800-541-2831</p>
MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
<p>Website: http://www.mass.gov/MassHealth</p> <p>Phone: 1-800-462-1120</p>	<p>Website: http://www.ncdhhs.gov/dma</p> <p>Phone: 919-855-4100</p>
MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: http://www.dhs.state.mn.us/id_006254</p> <p>Click on Health Care, then Medical Assistance</p> <p>Phone: 1-800-657-3739</p>	<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/</p> <p>Phone: 1-800-755-2604</p>
MISSOURI – Medicaid	OKLAHOMA – Medicaid and CHIP
<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</p> <p>Phone: 573-751-2005</p>	<p>Website: http://www.insureoklahoma.org</p> <p>Phone: 1-888-365-3742</p>
MONTANA – Medicaid	OREGON – Medicaid
<p>Website: http://medicaid.mt.gov/member</p> <p>Phone: 1-800-694-3084</p>	<p>Website: http://www.oregonhealthykids.gov</p> <p>http://www.hjossaludablesoregon.gov</p> <p>Phone: 1-800-699-9075</p>
NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid
<p>Website: www.ACCESSNebraska.ne.gov</p> <p>Phone: 1-855-632-7633</p>	<p>Website: http://www.dpw.state.pa.us/hipp</p> <p>Phone: 1-800-692-7462</p>
NEVADA – Medicaid	RHODE ISLAND – Medicaid

Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	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
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

OMB Control Number 1210-0137 (expires 10/31/2016)

PLUMBERS AND STEAMFITTERS LOCAL 52 HEALTH AND WELFARE PLAN

NOTICE OF PRIVACY PRACTICES

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.

The effective date of this Notice of Health Information Privacy Practices ("Notice") is September 23, 2013.

The Plumbers and Steamfitters Local 52 Health and Welfare Plan ("Plan") provides health benefits to eligible employees and their eligible dependents, as described by the Plan Document and Summary Plan Description ("SPD"), of Employers who are signatory to collective bargaining agreements with Plumbers and Steamfitters Local 52. The Plan may, on rare occasions, create, receive, use, maintain and disclose health information about eligible employees and dependents in the course of providing these health benefits.

The Plan is required by law to use appropriate safeguards to prevent the use or disclosure of Protected Health Information ("PHI"), which is defined as individually identifiable health information that is transmitted by or maintained in electronic media or other form or media.

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. This Notice does not describe in detail all of the specific uses and disclosures the Plan may make of PHI, but only attempts to describe all of the categories of uses and disclosures of PHI that the Plan may make and gives examples of those uses and disclosures.

The Plan is a fully insured benefit plan, which means that it contracts with Blue Cross Blue Shield of Alabama as an insurer and Claims Administrator ("Claims Administrator"). As such, Blue Cross Blue Shield of Alabama is a Business Associate of the Plan. Business Associates are third party service providers that help the Plan in providing health benefits. Business Associates of the Plan are held to the same privacy and security standards regarding PHI as the Plan. Therefore, the Plan may disclose PHI to Business Associates without your permission. Additionally, a Business Associate, like the Claims Administrator, may receive PHI from other third parties or create PHI.

Uses and Disclosures of PHI

The Plan does not regularly maintain PHI. Instead, the Plan contracts with Blue Cross Blue Shield of Alabama as an insurer and Claims Administrator ("Claims Administrator"). Consequently, the Claims Administrator is a Business Associate to the Plan. There are three primary circumstances under which the Claims Administrator may disclose PHI to the Trustees or when the Trustees may create, maintain or disclose PHI:

1. **Enrollment:** The Claims Administrator may inform the Trustees whether a participant is enrolled and the Plan obtains PHI in connection with enrolling the participant.

Example: A participant may complete an application to enroll in the Plan with the assistance of Plan personnel. The enrollment application will be forwarded to the Claims Administrator.

Example: The Plan may have a question as to whether a dependent of a participant has been removed from the Plan due to losing eligibility as a dependent under the terms of the Plan. The Claims Administrator may confirm the enrollment of the dependent to the Plan.

2. **Administrative Functions Necessary for Management and Operation:** The Trustees may use summary health information, such as claims history and claims expenses for management and operation of the Plan.

Example: During the annual renewal with Claims Administrator, the Trustees may receive summary information regarding claims history by age group, physician or types of conditions.

Example: During the annual renewal, the Trustees may request a utilization report from the Claims Administrator in order to determine if the benefits under the plan should be modified as a cost savings measure.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.

- Underwriting, premium rating and performing related functions to create, renew or replace insurance related to the Plan; however, no genetic information will be used for this purposes
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions

- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

3. Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment activities, including making payment to or collecting payment from third parties, such as health care providers.

Example: You may need to utilize an out of state service provider and receive payment of your claims within the Blue Cross Blue Shield network of host plans. The Plan or its Claims Administrator may use PHI to ensure proper payment of the claim and proper coordination of co-pay and deductibles under the Plan.

Example: The Plan may discover that claims paid on behalf of a participant were actually the result of actions of a third party. The Plan or its Claims Administrator may pursue subrogation against the third party and require PHI to litigate its subrogation claim.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans, health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Disclosure Limits: The Plan shall limit the use and disclosures of participants PHI to the minimum necessary as follows:

- 1. Limited Data Set:** The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.
- 2. Legally Required:** The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.
- 3. Health or Safety:** When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.
- 4. Law Enforcement:** The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.
- 5. Lawsuits and Disputes:** In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.
- 6. Workers' Compensation:** The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

- 7. Personal Representatives:** The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. Individually identifiable information of a person who has been deceased for more than 50 years is no longer PHI.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

8. **Health Oversight Activities:** The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.
9. **Coroner, Medical Examiner, or Funeral Director:** The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.
10. **Organ Donation.** The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.
11. **Specified Government Functions:** In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.
12. **Business Associates:** If the Trustees disclose any participants' PHI to a Business Associate, the Trustees will require the Business Associate to protect the participants' health information as required by the Act.
13. **Employment Related:** The Trustees will not use or disclose participants' PHI for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Trust.
14. **Report of Breaches:** The Trustees will promptly report to the Claims Administrator any use or disclosure of participants' PHI that is inconsistent with the uses or disclosures allowed by HIPAA. A participant has a right to and will receive notifications of breaches of unsecured PHI.
15. **Inspection and Copying:** The Trustees will allow a participant to inspect and copy any PHI about the specific participant that is in their custody and control.
16. **Amendment:** The Trustees will amend, or allow the Claims Administrator to amend, any portion of a participant's PHI to the extent permitted or required under the Act. You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to Plan. The Plan may deny the request if it does not include a reason to support the amendment or for other valid reasons. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.
17. **Disclosure Log:** With respect to some types of disclosures, the Plan will keep a Disclosure log. The Disclosure log will go back for six years (but not before April 14, 2003). Participants have a right to see the Disclosure log. The Plan does not have to maintain the log if disclosures are for certain Plan-related purposes, such as payment of benefits or health care operations.
18. **Internal Practices:** The Trustees will make its internal practices, books, and records, relating to its use and disclosure of participants' PHI available to the Claims Administrator and to the U.S. Department of Health and Human Services.
19. **Destruction:** The Trustees will, if feasible, return or destroy all participants' PHI in their custody or control that has been received from the Claims Administrator or from any Business Associate when the participants' PHI is no longer needed to administer the Plan. If it is not feasible for the participants' PHI to be returned or destroyed, the Trustees will limit the Use or Disclosure of any PHI that cannot feasibly be returned or destroyed to those purposes that make return or destruction of the information infeasible.

Authorization to Use or Disclose PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person identified in this Notice. To the extent the Plan has taken action in reliance on your authorization, you cannot revoke your authorization.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the Plan contact person identified in this Notice. The Plan may deny your request for access. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not address privacy practices of your physicians or other health care providers with respect to your PHI that they maintain.

Complaints

If you believe that your privacy rights have been violated, you have the right to submit complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information The Plan has designated Kay Pinckard as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at 334-272-0240, P.O. Box 211105, Montgomery, AL 36121-1105.