

U.A. Plumbers Local Union #68
GROUP PROTECTION PLAN

P.O. Box 8726
Houston, Texas 77249
713.869.2592 ♦ Fax: 713.862.4877 ♦ Toll Free: 800.833.2980

*** * * * * IMPORTANT NOTICE * * * * ***

Any/All of the following documents **MUST** be provided before **ANY** claims can be processed **OR** for the Fund to show eligibility in the Claims Office:

- Completed **ENROLLMENT CARD** (including Social Security Number of each family member) This can be found on our website www.plu68benefitfunds.com
- Completed **CLAIM FORM***, including Spouse Information. If the spouse has other coverage please fill out the Insurance verification form found on our website. This form must show effective date, whom is covered on the policy, and what type of coverage is provided. Forms can be found at www.plu68benefitfunds.com
- Copy of **CERTIFIED MARRIAGE DOCUMENTS** and/or **CERTIFIED FULL DIVORCE DECREE**
- Copy of **BIRTH CERTIFICATE** on all **DEPENDENT CHILDREN**. If your enrolling step children, please send all applicable documents on whether or not the child has coverage through their father (for example, divorce decrees, notarized document, or court documents)
- Copy of **CHECK STUBS** at the end of each month for the first **6 MONTHS** to provide eligibility for your coverage. Contractors have 40 days from the end of the month to submit hours to the Fund Office.

***Note:** You must submit a "new" claim form every calendar year for eligible members of the household. All information can be faxed or emailed to:

Website: www.plu68benefitfunds.com and **Email:** benefits@plu68.com

**ALL ELIGIBLE EMPLOYEES ARE REMINDED THAT THEY
MUST NOTIFY THE FUND OFFICE WHEN:**

1. Upon initial coverage, Eligible Employees are required to furnish the Fund Office with a certified copy of their marriage license, divorce decree and/ or birth certificates for each Dependent.
2. There is a change of address. This **MUST** be sent in writing to the Fund Office.
3. New dependents are to be covered (Provide certified birth certificates after 30 days from birth and/or certified birth facts from hospital for the first 30 days of birth). Must be a form of legal documentation.
4. There is a divorce / legal separation (give date). Please provide copies of court certified divorce papers.
5. There is a marriage. Provide certified copy of marriage certificate and/ or court-issued statement of informal marriage.
6. There is a death. Provide a certified copy of death certificate.

****This can be located on the website
www.plu68benefitfunds.com****

LAST NAME (PRINT ALL INFORMATION)		FIRST NAME IN FULL		MIDDLE INITIAL	DATE CARD IS SIGNED	
SOCIAL SECURITY NUMBER		LOCAL UNION NO.	DATE OF BIRTH		DATE OF MARRIAGE	
HOME ADDRESS — NUMBER AND STREET			APT.	CITY AND ZIP CODE		TELEPHONE NUMBER
I hereby designate as my beneficiary to receive any death benefit payable under the Pension Fund:						
FULL NAME		RELATIONSHIP		ADDRESS IF NOT SAME AS YOURS		
I hereby designate as my beneficiary to receive any death benefit payable under the Group Protection Fund:						
FULL NAME		RELATIONSHIP		ADDRESS IF NOT SAME AS YOURS		
LIST YOUR WIFE AND ALL DEPENDENT CHILDREN — ELDEST FIRST						
NAME		DATE OF BIRTH		SOCIAL SECURITY NUMBER		
		WIFE				
		BOY	GIRL			
YOUR SIGNATURE						

GROUP PROTECTION AND PENSION PLANS OF
 UA PLUMBERS LOCAL UNION NO. 68

Please complete and return this form to the Fund office by phone, email, or fax.

ANNUAL CLAIM FORM. ONE PER FAMILY

**U.A. PLUMBERS!
LOCAL UNION #68**

CLAIM FORM *GROUP INSURANCE*
MUST BE FILLED OUT EVERY YEAR
FOR EACH ELIGIBLE MEMBER IN
HOUSEHOLD

Mail completed form to:
U. A. Plumbers Local Union #68
Group Protection Plan
P.O. Box 8726
Houston, Texas 77249
(713) 869.2592 Fax # 713-862-4877
Email: benefits@plu68.com



TO BE COMPLETED BY EMPLOYEE

♦ ANSWER ALL QUESTIONS THAT APPLY

♦ SIGN WHERE INDICATED BY (☒)

EMPLOYEE NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	LAST 4 SOCIAL SECURITY NO.
COMPLETE HOME ADDRESS	CITY	ZIP	TELEPHONE NO.	
EMAIL ADDRESS	CELL NUMBER	<input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED		

DEPENDENT SECTION ** Age 19 to 26 Complete annual Dependent Enrollment Form**

NAME OF DEPENDENT	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
NAME OF DEPENDENT	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
NAME OF DEPENDENT	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
NAME OF DEPENDENT	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
NAME OF DEPENDENT	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
NAME OF DEPENDENT	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH

SPOUSE SECTION (MUST BE COMPLETED IN ALL CASES)

Name:	Last 4 Social Security No	DATE OF BIRTH
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Has your spouse been employed in the past twelve months: Yes No

Employer:	Address:
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DO YOU, YOUR SPOUSE, OR DEPENDENT(S) HAVE ANY OTHER INSURANCE, INCLUDING MEDICAID, OTHER THAN THE UA PLUMBERS! LOCAL UNION #68 GROUP PROTECTION PLAN?

A. Group Insurance, or any other arrangement of coverage for individuals in a group?	<input type="checkbox"/> Yes <input type="checkbox"/> No	B. Any coverage for dependents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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GIVE NAME, ADDRESS AND PHONE NUMBER OF INSURANCE COMPANY OR ORGANIZATION PROVIDING BENEFITS/SERVICES FOR ___SELF___SPOUSE___CHILD

INSURED:	NAME & ADDRESS OF INSURANCE / ORGANIZATION	PHONE NUMBER	POLICY NO. OR IDENTIFICATION NO.
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EMERGENCY CONTACT INFORMATION

Name	Phone Number	Email
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I / WE jointly certify that the above information is true and correct. I / WE hereby authorize all doctors, dentists, psychologists, pharmacists, hospital or other institutions providing care, treatment, consultation, drugs, or supplies to furnish U.A. Plumbers LU #68 Group Protection Plan with full information regarding history, physical or mental condition, consultation, treatment or psychotherapy rendered - including a copy of their records. I / WE authorize any insurance carrier, service plan, union, trust fund, or employer to furnish U.A. Plumbers LU #68 Group Protection Plan to release any information relevant to a determination of the applicability of an implementation of a coordination of benefits provision to any insurance carrier, service, plan, union, trust fund or employer requesting such information.

LU68-GROUP MEDICAL 05/04
By signing this I accept Plan coverage for Dental and Vision benefits, in addition to Medical benefits described in the Plan. I understand, that if for any reason I desire to not accept Dental and Vision benefits, I may contact the Fund Office to record my choice to not accept the Dental and Vision benefits of the Plan.

Date	Employee's Signature (Required)	Spouse's Signature
	☒	☒

U.A. PLUMBERS

LOCAL UNION NO. 68

19-26 ADULT CHILDREN

CLAIM FORM

Email: benefits@plu68.com



Mail completed form to:

U. A. Plumbers Local Union No. 68

Group Protection Plan

P.O. Box 8726

Houston, Texas 77249

(713)869-2592 Fax # (713-862-4877)

Member name _____

Member Identification _____

Adult dependent full name _____

Dependent Employer _____

Dependent Employer's address and phone number _____

Does dependent's Employer offer health insurance for which this dependent is eligible, even if not enrolled in that coverage?..... Yes _____ No _____

Was this insurance elected? _____ if so, what is the insurance? _____

Is dependent married? Yes _____ No _____

If married, is dependent eligible for health insurance through his/her spouse's Employer's plan, even if not enrolled in that coverage?..... Yes _____ No _____

Was this insurance elected? _____ if so, what is the insurance? _____

The undersigned member and dependent referenced above do certify that the information we have provided is correct and complete. We understand that omissions and/or incorrect statements made may lead to termination of Eligibility; repayment of any benefits paid out due to dependent's ineligibility or other legal action. We authorize any insurance carrier, service plan, union, trust fund, or employer to furnish U.A. Plumbers Local Union No. 68 Group Protection Plan any information relevant to a determination of Eligibility for coverage under this Plan. I/WE hereby authorize all doctors, dentists, psychologists, pharmacists, hospital or other institutions providing care, treatment, consultation, drugs or supplies to furnish U.A. Plumbers LU #68 Group Protection Plan with full information regarding history, physical or mental condition, consultation, treatment or psychotherapy rendered-including a copy of their records.

Date _____ Employee's Signature _____

ELIGIBILITY FORM MUST BE FILLED OUT EVERY YEAR FOR EACH

ELIGIBLE DEPENDENT IN HOUSEHOLD

U.A. Plumbers Local Union #68

Health & Welfare Fund



www.plu68benefitfunds.com
 P.O. Box 8726 · Houston, TX 77249
 Phone (713) 869-2592 · 800-833-2980 · Fax (713) 862-4877
 Email: benefits@plu68.com

COORDINATION OF BENEFIT FORM

Due to the HIPAA Privacy Notice our office can no longer verify primary insurance information on your spouse. In order to process any billings for family members that have additional insurance coverage the Fund needs the following information. Please complete and return this form before your current COB statement expires to avoid delay in processing claims.

This section must be completed by Participant.		
Your Name	Last 4Your SSN	
Your Mailing Address	City, St Zip	
Your Email Address	Your Phone No.	
Your Signature	Date	
Insured Spouse section. If other coverage has terminated, please provide a HIPAA termination letter.		
Insured Spouses Name	Insured Spouses SSN	Does carrier use the birthday rule or gender rule to determine liability?
Is there an open enrollment period? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when?	Does employee have any of the following benefits? <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Optical <input type="checkbox"/> Prescription Drug	
Name of Medical Insurance Carrier	Group Policy Number	Is coverage for self or dependent? <input type="checkbox"/> Self <input type="checkbox"/> Dependent
Effective Date of Coverage	Termination Date of Coverage	List dependents covered if applicable
Name of Dental Insurance Carrier if applicable	Group Policy Number	Is coverage for self or dependent? <input type="checkbox"/> Self <input type="checkbox"/> Dependent
Effective Date of Coverage	Termination Date of Coverage	List dependents covered if applicable
Name of Optical Insurance Carrier if applicable	Group Policy Number	Is coverage for self or dependent? <input type="checkbox"/> Self <input type="checkbox"/> Dependent
Effective Date of Coverage	Termination Date of Coverage	List dependents covered if applicable
Name of Prescription Drug Insurance Carrier if applicable	Group Policy Number	Is coverage for self or dependent? <input type="checkbox"/> Self <input type="checkbox"/> Dependent
Effective Date of Coverage	Termination Date of Coverage	List dependents covered if applicable
Name of person completing this form (printed)	Date	Signature of person completing this form

**U.A. PLUMBERS LOCAL UNION No. 68
FRINGE BENEFIT TRUST FUND
PO BOX 8726 HOUSTON, TEXAS 77249-8726
(713) 869-2592 (800) 833-2980 FAX (713) 862-4877**

DENTAL BENEFIT SUMMARY UPDATE

EFFECTIVE JANUARY 1, 2024

DEPENDENTS 18 AND UNDER:

1. The 1st prophylaxis, exam, x-rays and fluoride all performed on the same date of service is covered at 100%, no deductible of each calendar year.
2. The 2nd additional prophylaxis and exam performed on the same date of service are covered at 100%, no deductible. **There is a limit of two prophylaxis per calendar year (paid at 100%).**
3. Any additional dental procedure has a \$100 calendar year deductible then all services (**including general anesthesia**) are paid at 80% with a calendar year maximum of \$2,000 for each eligible member. **(This includes all basic and major services)** Crowns are paid on seat date.

MEMBERS AND DEPENDENTS FOR AGES 19+:

1. The 1st prophylaxis, exam, x-rays, and fluoride all performed on the same date of service is covered at 100%, no deductible of each calendar year.
2. Any additional dental procedure has a \$100 calendar year deductible then all services (including general anesthesia) are paid at 80% with a calendar year maximum of \$2,000 for each eligible member. **(This includes all basic and major services).**

Our plan does not have any waiting periods, frequencies, or clauses on any procedures. There are no age restrictions.

Ortho is covered under the same benefits. It is combined with the dental annual maximum

****Fee schedule for claims is UNITED CONCORDIA, DNOA, Dentemax, Carington or UCR**

****All dental claims are sent to Plumbers Local 68 PO Box 211042 Eagan MN 55121****

****Payer ID: PLU68 (EDI TRANSACTION ROUTING: 837D)****

Welcome to UnitedHealthcare

When it comes to finding a doctor and managing your health, simpler is always better. The UnitedHealthcare Shared Services member website offers a variety of tools and resources that make it easier than ever.

To find a doctor, hospital, lab and other providers in your network visit [whyuhc.com/uhss](https://www.whyuhc.com/uhss) and follow these steps:

- 1 Click on **Find a Doctor/Hospital**
- 2 Select the network on the back of your ID card
- 3 Enter an address, city and state or zip code
- 4 Select the appropriate location and click **Continue**
- 5 Select the type of **Medical Care**, or enter a name or service and click **Search**
- 6 To locate a primary care provider, click **People**
- 7 Next, click on **Primary Care**
- 8 Choose the type of primary care provider
- 9 If you already know the doctor name, medical group or hospital you are looking for, select **All Primary Care Providers**
- 10 In the open search field, enter text and click **Filter**







Look for the blue hearts! ♥♥

Providers with this designation meet UnitedHealth Premium program criteria for providing quality and cost-efficient care.

continued ▶

Compare quick care options to help keep costs down.

Getting care at the place that may best fit your condition or situation may save you up to \$2,000 compared to an emergency room (ER) visit.* If you have a life-threatening condition, call 911 or go to the ER. For everything else, it may be best to contact your primary care provider (PCP) first. If seeing your PCP isn't possible, it's important to know your other care options, especially before heading to the ER.

Care options to consider and approximate	START HERE			
	 PCP Care from the doctor who may know you best	 Convenience care Basic conditions that aren't generally life-threatening	 Urgent care Serious conditions that aren't generally life-threatening	 Emergency room Life- and limb-threatening emergencies
Average cost*	\$160	\$100	\$180	\$2,200
Hours	Varies by location	Varies by location	Varies by location – may be open nights/weekends	24/7

● indicates the recommended place for care for the following common conditions:

Broken bone			●	●
Chest pain				●
Cough	●	●		
Fever	●	●		
Muscle strain	●	●		
Pink eye	●	●		
Shortness of breath				●
Sinus problems	●	●		
Sore throat	●	●		
Sprain	●	●	●	
Urinary tract infection	●	●		



*Source 2019: Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. (Estimated \$2,000.00 difference between the average emergency room visit, \$2,200 and the average urgent care visit \$180.) The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The choice of provider is yours. This site only serves as a general educational aid concerning provider listings and information about providers. The site is not a substitute for medical or health care advice and does not serve as a recommendation for a particular provider or type of medical or health care. If you believe you are experiencing a medical emergency, please call 911.

This directory's provider information is updated weekly and may have changed. Please check with your provider before scheduling an appointment or receiving services to confirm whether they are participating. If you think any information in this directory is inaccurate, please let us know by clicking on "Report Incorrect Information" on the specific provider's page. Check your official health plan documents to see what services and providers are covered by your health plan.

Insurance coverage provided by or through UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois or their affiliates.

U. A. PLUMBERS LOCAL UNION No.68
Fringe Benefit Trust Fund
P.O. Box 8726 * Houston, Texas 77249-8726
(713) 862-4871 * (800) 833-2980 *Fax (713) 862-4877
Email: benefits@plu68.com
Website: PLU68benefitfunds.com

November 16, 2022

Re: Plumbers Local Union No 68 Group Protection Plan

Dear Plan Participant:

The Board of Trustees of the U.A. Plumbers Local Union Number 68 Group Protection Plan (the "Plan") runs the Plan solely in the interest of you, the participants, for the exclusive purpose of providing benefits and paying expenses of the Plan. From time to time, changes are required to the Plan to ensure its continued financial stability. The Board of Trustees has found it necessary to make the following change, effective January 1, 2023.

Due to an increase in premiums and insufficient utilization, we will no longer be participating in Next Level Prime. We will continue to urge our participants to utilize Next Level Urgent Care, and anyone that does, will have their deductible and coinsurance waived, and the claim will be paid at 100%. No out-of-pocket expenses will incur. All current Plan benefits apply.

How does losing Prime affect the services offered to our members? Some services are NOT offered outside of Prime. Such as: mental health, primary care, preventive care, health coaching, telemedicine, lab, or the dietician. You will still be able to utilize Next Level Urgent Care Clinics for any and all urgent care needs.

We apologize for any inconvenience this may cause. If you have any questions regarding this change, please contact the Fund Office at (713) 869-2592.

Sincerely,
BOARD OF TRUSTEES
Plumbers Local Union No 68

Your Vision Benefits Summary



Get access to the best in eye care and eyewear with PLUMBERS LOCAL 68 and VSP® Vision Care.

Using your VSP benefit is easy.

- Create an account at vsp.com. Once your plan is effective, review your benefit information.
- Find an eye doctor who's right for you. The decision is yours to make—choose a VSP network doctor or any out-of-network provider. Visit vsp.com or call 800.877.7195.
- At your appointment, tell them you have VSP. There's no ID card necessary. If you'd like a card as a reference, you can print one on vsp.com.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Best Eye Care

You'll get the highest level of care, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.¹ Visit vsp.com to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.² Prefer to shop online? Check out all of the brands at eyeconic.com, VSP's preferred online eyewear store.

Plan Information

VSP Coverage Effective Date: 07/01/2018

VSP Provider Network: VSP Choice

PLUMBERS LOCAL 68 and VSP provide you with an affordable eyecare plan.

Visit vsp.com or call 800.877.7195 for more details on your vision coverage and exclusive savings and promotions for VSP members.

1. Brands/Promotion subject to change.

2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

©2018 Vision Service Plan.

All rights reserved. VSP, VSP Vision care for life, and WellVision Exam are registered trademarks, and "Life is better in focus." is a trademark of Vision Service Plan. Flexon is a registered trademark of Marchon Eyewear, Inc. All other company names and brands are trademarks or registered trademarks of their respective owners.

Benefit	Description	Co-pay
Your Coverage with a VSP Provider		
WellVision Exam	<ul style="list-style-type: none"> • Focuses on your eyes and overall wellness • KidsCare: Children have two, fully covered WellVision exams if needed. • Every other calendar year for Adults 	\$25 for exam and glasses
Prescription Glasses		
Frame	<ul style="list-style-type: none"> • \$230 allowance for a wide selection of frames • \$250 allowance for featured frame brands • 20% savings on the amount over your allowance • \$230 Walmart frame allowance • KidsCare: Frames for children are fully covered every calendar year • Every other calendar year for Adults • Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children 	Combined with exam
Lenses	<ul style="list-style-type: none"> • KidsCare: Additional lenses for children are fully covered when needed. Minimum prescription change required. • Every other calendar year for Adults 	Combined with exam
Lens Enhancements	<ul style="list-style-type: none"> • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements • Every other calendar year 	\$0 \$95 - \$105 \$150 - \$175
Contacts (instead of glasses)	<ul style="list-style-type: none"> • \$230 allowance for contacts • Contact lens exam (fitting and evaluation) • Every other calendar year 	Covered
Diabetic Eyecare Plus Program	<ul style="list-style-type: none"> • Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed 	\$20
Glasses and Sunglasses		
Extra Savings	<ul style="list-style-type: none"> • Extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. 	
Laser Vision Correction		
	<ul style="list-style-type: none"> • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities 	

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit vsp.com for plan details.

Exam	up to \$45	Lined Trifocal Lenses	up to \$65
Frame	up to \$70	Progressive Lenses	up to \$50
Single Vision Lenses	up to \$30	Contacts	up to \$105
Lined Bifocal Lenses	up to \$50		

HIPAA PRIVACY NOTICE

Plumbers Local No. 68 Welfare Fund

468 Link Road,
Houston, Texas 77009

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.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "Privacy Rules"), the Plumbers Local No. 68 Welfare Fund (the "Fund") is required to take reasonable steps to ensure the privacy of your health information ("Protected Health Information" or "PHI") and to inform you about:

1. The Fund's uses and disclosures of Protected Health Information,
2. Your rights to privacy with respect to your Protected Health Information,
3. The Fund's duties with respect to your Protected Health Information,
4. Your right to file a complaint with the Fund and with the Secretary of the U.S. Department of Health and Human Services ("HHS"), and
5. The person you should contact for further information about the Fund's privacy practices.

The Fund is required to maintain the privacy of your PHI, provide you with this Notice of its legal duties and privacy practices, and to follow the terms of this Notice, which is effective as of April 14, 2003. The Fund, however, reserves the right to change its privacy practices and/or the terms of this Notice at any time and to make new provisions effective for all Protected Health Information that it maintains. You will receive written notice of any changes that are made to the Fund's privacy practices and/or the terms of this Notice. You will also receive a revised Notice within 60 days after any material changes are made.

Please note that the Fund prepared this Notice so any references to "we," "our," or "us" means the Fund.

Section 1: Your Protected Health Information

Important Definitions

Protected Health Information. The term "Protected Health Information" or "PHI" includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

Business Associates. Business Associates are individuals and companies who need access to your PHI in order to act on our behalf or to provide us with services. Examples of business associates include third party administrators, managed care networks, preferred provider organizations ("PPOs"), health maintenance organizations ("HMOs"), mental health insurers, pharmacy benefits managers, attorneys, consultants and auditors. We may disclose your health information to our business associates, and we may authorize them to use or disclose your health information for any or all of the same purposes for which we are permitted to use or disclose it ourselves, as well as for their own administrative purposes. Our business associates are contractually required not to use or disclose your health information for any other purposes.

When the Fund May Disclose Your PHI

The Privacy Rules provide that the Fund may not use or disclose your PHI without your consent, unless expressly permitted by the Privacy Rules and/or HIPAA. The following is a brief description of some of the situations where the Fund may use or disclose your PHI without your consent. Please note that when using or disclosing your PHI or when requesting your PHI from another entity covered by the Privacy Rules, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

- A. **As required by law.** The Fund may use or disclose your PHI as expressly permitted or required by HIPAA, the Privacy Rules, a valid court order, or other statutory or governmental rule or regulation.
- B. **As required by HHS.** The HHS Secretary may require the disclosure of your PHI to investigate or determine the Fund's compliance with the Privacy Rules.
- C. **For treatment, payment or health care operations.** The Fund may use or disclose your PHI in order to carry out "Treatment," "Payment," or "Health Care Operations." For each of these purposes we list below examples of these kinds of uses and disclosures. These are only examples and are not intended to be a complete list of all the ways we may use or disclose of your health information within each of these two categories.

Treatment means the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Fund may disclose the name of your treating dentist to your orthodontist so that the orthodontist may ask for your dental x-rays from your dentist.

Payment includes but is not limited to the following:

- **Determining your eligibility for benefits.** For example, we may use information obtained from your employer to determine whether you have satisfied the Fund's requirements for active eligibility.
- **Obtaining contributions from you or your employer.** For example, we may send your employer a request for payment of contributions on your behalf, and we may send you information about premiums for COBRA continuation coverage.
- **Pre-certifying or pre-authorizing health care services.** For example, we may consider a request from you or your physician to verify coverage for a specific hospital admission or surgical procedure.
- **Determining and fulfilling the Fund's responsibility for benefits.** For example, we may review health care claims to determine if specific services that were provided by your physician are covered by the Fund.
- **Providing reimbursement for the treatment and services you received from health care providers.** For example, we may send your physician a payment with an explanation of how the amount for the payment was determined. Similarly, a detailed bill or an "Explanation of Benefits" ("EOB") may also be sent to you or to the primary insured that will typically include information that identifies you, your diagnosis, and the procedures you received.
- **Subrogation health claim benefits for which a third party is liable.** For example, we may exchange information about an accidental injury with your attorney who is pursuing reimbursement from another party.
- **Coordinating benefits with other plans under which you have health coverage.** For example, we may disclose information about your benefits to another group health plan in which you participate.

Health Care Operations includes, but are not limited to, the following:

- **Business Management and Administration.** This includes business planning and development, cost management, and customer service.
- **Conducting quality assessment and improvement activities.** For example, a supervisor or quality specialist may review health care claims to determine the accuracy of a processor's work.
- **Case management and care coordination.** For example, a case manager may contact home health agencies to determine their ability to provide the specific services you need.
- **Contacting you regarding treatment alternative or other benefits and services that may be of interest to you.** For example, a case manager may contact you to give you information about alternative treatments which are neither included nor excluded in the Fund's plan of benefits but which may nevertheless be available in your situation.
- **Contacting health care providers with information about treatment alternatives.** For example, a case manager may contact your physician to discuss moving you from an acute care facility to a more appropriate care setting.
- **Employee training.** For example, training of new claims processors may include processing of claims for health benefits under close supervision.
- **Accreditation, certification, licensing, or credentialing activities.** For example, a company that provides professional services to the Fund may disclose your health information to an auditor that is determining or verifying its compliance with standards for professional accreditation.
- **Securing or placing a contract for reinsurance of risk relating to claims for health care.** For example, your demographic information (such as age and sex) may be disclosed to carriers of stop-loss insurance to obtain premium quotes.
- **Conducting or arranging for legal and auditing services.** For example, your health information may be disclosed to an auditor who is auditing the accuracy of claim adjudications.
- **Formulary development.** For example, benefit utilization information may be used to develop the formulary list of prescription drugs covered by the Fund.
- **Management activities relating to compliance with privacy regulations.** For example, the Privacy Official may use your health information while investigating a complaint regarding a reported or suspected violation of your privacy.
- **Resolution of internal grievances.** For example, your health information may be used in the process of settling a dispute about whether or not a violation of our privacy policies and procedures actually occurred.
- **Sale, transfer, merger, or consolidation.** For example, your health information may be disclosed if the Fund merges with another health plan.
- **De-identification of Health Information.** We may use or disclose your health information for the purpose of creating health information that is no longer identifiable as pertaining to you. Such de-identified health data may then be used for purposes that are not described in this notice as either permitted or required.

- **Creation of a Limited Data Set.** We may use your health information to create a "limited data set" which excludes most identifiers but may include partial addresses (city, state, and zip code), dates of birth and death, and other dates that pertain to your health care treatment. Such a "limited data set" may be disclosed for purposes of research, public health, or health care operations.
- D. *Public health purposes.*** The Fund may disclose your PHI to an authorized public health authority if required by law or for public health and safety purposes. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- E. *Domestic violence or abuse situations.*** The Fund may disclose your PHI when authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- F. *Health oversight activities.*** The Fund may disclose your PHI to a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs.
- G. *Legal proceedings.*** The Fund may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a valid court order or a subpoena or discovery request that meets the Privacy Rule's requirements. In certain situations, the Fund may be required to make reasonable efforts to notify you about a request or to obtain a court order protecting your PHI.
- H. *Law enforcement purposes.*** The Fund may disclose your PHI when required for law enforcement purposes. For example, the Fund may disclose PHI about you to law enforcement officials if there is suspicion that your death may have resulted from criminal activity.
- I. *Determining cause of death and funeral purposes.*** The Fund may disclose your PHI when it is required to be given to a coroner or medical examiner to identify a deceased person, determine cause of death or other authorized duties. The Fund may also disclose PHI to funeral directors, consistent with applicable law, as necessary for them to carry out their duties with respect to decedents.
- J. *Organ donation.*** The Fund may disclose your PHI for cadaveric organ, eye or tissue donation purposes.
- K. *Research.*** The Fund may disclose your PHI for certain research, provided that certain restrictions set forth in the Privacy Rules are met.
- L. *Health or safety threats.*** The Fund may disclose your PHI when, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- M. *Specialized government functions.*** The Fund may disclose your PHI when, consistent with applicable law, the disclosure is required for military purposes, national security, and other specialized governmental functions.
- N. *Workers' compensation programs.*** The Fund may disclose your PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.
- O. *Disclosure to the Fund's Board of Trustees.*** The Fund will also disclose PHI to the Fund's Board of Trustees for purposes related to Treatment, Payment, and Health Care Operations, and has amended the Fund's plan documents to permit this use and disclosure as required by the Privacy Rules. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

The Fund may also disclose to the Board of Trustees "summary health information," which includes claims totals without any personal identification except your zip code so the Trustees may obtain health insurance premium bids or in connection with their consideration of making amendments to the Fund's plan of benefits.

The Board will not disclose your Protected Health Information to your employer for general employment purposes.

- P. *Health-Related Services That May Be of Interest.*** The Fund or its business associates may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, you may be contacted by a case management coordinator if you suffer a serious injury or illness.
- Q. *Disclosures to Your Family and Friends.*** The Fund and/or its business associates may, in certain limited situations, disclose your PHI to your family members or friends to the extent that the disclosure is directly relevant to such persons' involvement in your care or payment for your care. Such disclosures will be made only if either of the following conditions is satisfied: (i) if you are present when the disclosure is made, you agree or do not object to the disclosure; or (ii) if you are not present or, as a practicable matter, are unable to consent at the time your PHI is disclosed, such disclosure is

in your best interest as determined in the Fund's or its business associates' professional judgment based on common practice, their experience, and the circumstances surrounding the disclosure.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

All other uses and disclosures not expressly authorized by HIPAA, the Privacy Rules and/or other applicable law will not be made without your written authorization, which you may revoke at anytime as long as you do so in writing. Written notice of your revocation must be sent to the Fund's Privacy Official at the following address:

Plumbers Local 68
468 Link Road
Houston, Texas 77009

Section 2: Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

1. Restrict the uses and disclosures of your PHI to carry out Treatment, Payment or Health Care Operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

If the Fund agrees to your request, except in certain situations such as an emergency, the Fund may not use or disclose your PHI in violation of the restriction. The Fund, however, is not required to agree to your request.

To make such a request, you must do so in writing, on a form provided by the Administrative Office, and send it to the Fund's Privacy Official, whose address is noted above.

You May Request Confidential Communications

The Fund will accommodate your reasonable requests to receive communications of PHI by **alternative means or at alternative locations**. For certain requests, the Fund may require your request to include a statement that absent such change in delivery method or location, such disclosure could endanger you.

All requests must be submitted in writing to the Fund's Privacy Official, whose address is noted above.

You May Inspect and Copy PHI

You have the right to inspect and obtain copies of your PHI contained in a "designated record set" for as long as such information is maintained in a designated record set. In certain situations, however, the Fund may deny you access to your PHI. In such case, the Fund will provide you a written notice of the denial that includes the reason(s) for the denial, whether or not the decision is reviewable, a description of the review procedures if the decision is reviewable, and a description of how you may complain to the Fund or the HHS Secretary about the denial.

In most situations, the Fund must provide the PHI you request in both the form and the format you request. In certain situations, with your approval, the Fund may provide you with an explanation or summary of your PHI provided that you agree in advance to the fee that may be imposed by the Fund for such summary. If you request copies of your PHI, the Fund may impose reasonable fees for such copies covering the cost of the copies, labor, and postage.

The Fund must provide the requested access or its notice of denial within 30 days if the information you request access to is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline provided that the Fund notifies you in writing of the reason for the extension and the date which the Fund will complete its action within the applicable initial 30 or 60-day period.

To request access to your PHI that is maintained in a designated record set, you must do so in writing and submit it to the Fund's Privacy Official, whose address is noted above.

A **Designated Record Set** includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Fund or other information used in whole or in part by or for the Fund to make decisions about you.

You Have the Right to Request Amendment of Your PHI

You have the right to request that the Fund amend your PHI or a record about you that is maintained in a designated record set for as long as the PHI is maintained in a designated record set.

The Fund has 60 days after receiving your request to act on it by either making the amendment or denying your request. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denies your request to amend your PHI in whole or in part, the Fund will provide you with a written notice that provides (i) an explanation of the basis for the decision, (ii) a statement of your right to submit a written statement disagreeing with the denial and how you may file this statement, (iii) a statement that if you do not submit a disagreement, you may request your initial amendment request plus the denial to be included with any future disclosures of the PHI subject to the request, and (iv) a description of how you may complain about the denial to the Fund or the HHS Secretary. If you file a written statement of disagreement (or request that your initial amendment request serve as such), the Fund has the right to issue and file a written rebuttal to your statement, in which case, a copy will be provided to you.

All requests to amend your PHI must be submitted in writing to the Fund's Privacy Official, whose address is noted above.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will provide you with an accounting of certain disclosures by the Fund of your PHI made after April 14, 2003, and up to 6 years prior to your request. We do not have to provide you with an accounting of disclosures related to Treatment, Payment, or Health Care Operations, disclosures made to you or authorized by you in writing, or in certain other limited situations as provided for in the Privacy Rules. Generally, the accounting will include the date of the disclosure, the name of the person or entity that received the PHI and their address, if known, a brief description of the disclosed PHI and a brief statement of the reason for the disclosure.

The Fund has 60 days to provide the accounting after receipt of your request. The Fund is allowed an additional 30 days if the Fund gives you a written notice of the reasons for the delay and the date by which the accounting will be provided within the initial 60 day period.

All accounting requests must be submitted in writing to the Fund's Privacy Official, whose address is noted above. If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Fund's Privacy Official at the following address:

Plumbers Local 68
468 Link Road
Houston, Texas 77009

Your Personal Representative

You may exercise your rights described in this Notice through a personal representative. Your personal representative will generally be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This Notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose "summary health information" to the Board of Trustees for obtaining premium bids or modifying, amending or terminating the Fund. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals covered by the Fund. Identifying information will be deleted from summary health information, in accordance with HIPAA and the Privacy Rules.

Section 3: Your Right to File a Complaint with the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the Fund's Privacy Official at the address noted above. All complaints must be in writing.

You also may file a complaint with the U.S. Department of Health and Human Services at the address noted below. Your complaint must (i) be filed in writing, either on paper or electronically, (ii) include the Fund's name, (iii) contain a description of the acts or omissions you believe to be in violation of the Privacy Rules, and (iv) be filed within 180 days of when you knew or should have known that the acts or omissions giving rise to the complaint occurred. Your complaint should be filed at the following address:

Region VI
Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202

Voice Phone: (214) 767-4056
Fax: (214) 767-0432
TDD: (214) 767-8940

The Fund will not retaliate against you in any way for filing a complaint.

Section 4: If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Fund's Privacy Official at the following address:

Plumbers Local 68
468 Link Road
Houston, Texas 77009

Section 5: Conclusion

PHI use and disclosure by the Fund is regulated by HIPAA and the Privacy Rules. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice is provided to you pursuant 45 CFR §164.520 and it attempts to summarize some of the Privacy Rules and the Fund's privacy policies and procedures. The Privacy Rules and HIPAA will supersede this Notice if there is any discrepancy between the information in this Notice and the Privacy Rules and/or HIPAA.