P L U M B E R S & S T E A M F I T T E R S L O C A L 2 1
B E N E F I T F U N D S
1024 McKinley Street
Peekskill, NY 10566

PHONE (914) 737-7220 **FAX (914) 737-7299**

UNION TRUSTEES
Thomas O'Brien
Sean Carey
Don Calabrese
Jack McCrudden Jr.
Craig Strasser

FUND ADMINISTRATOR
Amir Wirr

EMPLOYER TRUSTEES
Robert Courtien
James Estabrook
Andrew Cuomo
Andrew Grundman

SUMMARY OF MATERIAL MODIFICATION TO THE PLUMBERS AND STEAMFITTERS LOCAL 21 WELFARE FUND

September 1, 2025

To: All Participants and COBRA Beneficiaries

From: The Board of Trustees

Re: Opting-Out of Medical Coverage

The Board of Trustees is committed to providing quality and affordable benefits to you and your family. This Summary of Material Modification ("SMM") describes a new feature of the active medical plan of the Plumbers and Steamfitters Local 21 Welfare Fund ("Plan", or "Fund") allowing eligible participants to opt-out of the Fund's medical benefits and retain access to their HRA account, effective January 1, 2026. You should read this SMM very carefully and retain this document with your copy of the SPD for future reference.

Opt-Out Provisions Effective January 1, 2026

Currently, when a member meets the Fund's eligibility requirements, they are automatically enrolled in the Fund's benefit program. Effective January 1, 2026, participants that meet the Fund's eligibility requirements will have the option on whether to enroll in the Fund's medical benefits. If a participant chooses to "opt-out" of the Fund's medical benefits, a portion of the Welfare Fund contribution rate will be automatically credited (on a prospective basis only) to the participant's HRA account. The amount retained by the Welfare Fund will be periodically reviewed by the Trustees and is initially set at 50% of the Welfare Fund contribution rate with a minimum amount of $4.50 per hour. Please note that the option to opt-out of the Fund's medical benefits will only be provided to those participants that meet the Fund's eligibility requirements. This means that if you are currently not eligible for Fund benefits, you will not be given the option to opt-out until you next meet the Fund's regular eligibility rules.

To opt-out of the Fund's medical benefits, a participant **must** be enrolled in other employer sponsored group health coverage, such as through a spouse's employer, that provides "minimum value" coverage under the law. In general, an employer-sponsored group health plan meets "minimum value" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. Proof of such enrollment will be required at the time of initial opt-out and during open enrollment each year. See below for more information on what constitutes proof of other minimum value group health coverage.

If a participant chooses to opt-out, they will remain eligible for the Fund's HRA account, vision, life and accidental death and dismemberment insurance, the employee assistance program and supplemental disability benefits, but only to the extent they would otherwise be eligible for the Fund's medical benefits had they not opted out. This means that if a participant opts out but then does not continue to work enough hours to maintain eligibility under the Fund's regular eligibility rules in the future, they would not be eligible for any Fund benefits.

As noted above, a participant that has opted out and is otherwise eligible based on the Fund's regular eligibility rules will continue to have access to their HRA account for reimbursement of qualified out-of-pocket medical expenses. However, the HRA will not be available to a participant's dependents unless proof of their enrollment in other employer sponsored group health coverage meeting the minimum value requirement is also provided.

In addition, a participant that has opted out will continue to be credited with hours for the purposes of meeting eligibility requirements for retiree health benefits. All other retiree health benefit eligibility rules remain the same.

Once a participant opts-out of the Fund's medical benefits, that election may not be changed (i.e., a participant may not opt back in) except during annual open enrollment for coverage in the next following calendar year (see below), or during a special enrollment period, as noted below.

The rules for entitlement to a special enrollment period are the same as detailed in the Summary Plan Description, except that a participant that has opted out of the Fund's medical benefits may also "opt back into" the Fund's medical benefits for them and their dependents if the other employer-sponsored group health coverage ends. In the case of a participant's other employer-sponsored group health coverage ending, a participant must request enrollment back into the Fund's medical plan within 30 days after such coverage ends.

In all cases, if a participant fails to submit a request to opt back into the Fund's medical benefits within the applicable time frames, they must wait until the next open enrollment period for coverage the next following calendar year. Furthermore, if a participant opts back into the Fund's medical benefits, their entitlement to Fund benefits is based on the participant having met the Fund's regular eligibility rules for coverage.

Annual Open Enrollment Beginning November 2025

Each year participants will have an opportunity to change their opt-out election during the annual open enrollment period. Open enrollment takes place during the month of November for coverage starting January 1. Prior to the annual open enrollment period, the Fund Office will provide participants with general information about Fund benefits and instructions on how to make their election. Open enrollment guidelines are based on whether a participant is currently enrolled or opted out, but please note that participants that are opted out **must** timely submit the appropriate open enrollment materials to the Fund Office each year to remain opted out. The general guidelines are shown below.

- Currently Enrolled in the Fund's Medical Benefits (i.e., not "opted out")

  - If a participant wishes to maintain coverage, they are not required to do anything. The participant and their dependents will continue to be covered for the next following calendar year subject to the Fund's regular eligibility rules.

  - If a participant wishes to opt-out of the Fund's medical benefits, they must complete the Waiver of Participation (Opt-Out) form with the necessary proof of enrollment in other employer-sponsored group health coverage that meets minimum value criteria under the law. Acceptable proof of coverage is as follows:

- A copy of the group health insurance plan's Summary of Benefits and Coverage (SBC) and a copy of the group health insurance ID Card.

- If the above documentation is not available, a letter from the applicable employer confirming the group coverage and effective date.

Please note that proof of coverage must also be provided for the participant's dependents for the dependents to also remain eligible under the Fund's HRA benefit.

- Currently "Opted Out" of the Fund's Medical Benefits

  - If a participant wishes to remain opted out of the Fund's medical benefits, they must complete the Waiver of Participation (Opt-Out) form with the necessary proof of enrollment in other employer-sponsored group health coverage that meets minimum value criteria under the law. Acceptable proof of coverage is as follows:

    - A copy of the group health insurance plan's Summary of Benefits and Coverage (SBC) and a copy of the group health insurance ID Card.

    - If the above documentation is not available, a letter from the applicable employer confirming the group coverage and effective date.

    Please note:

    - *Proof of coverage must also be provided for the participant's dependents for the dependents to remain eligible under the Fund's HRA benefit.*

    - *Opted out participants that fail to submit a Waiver of Participation form will automatically be enrolled in the Fund's medical benefits effective the next following January 1, subject to the Fund's regular eligibility rules.*

  - If a participant wishes to opt back into the Fund's medical benefits, they **must** complete the Opt-In form and provide the necessary proof to enroll their eligible dependents.

As always, the Fund Office is available to assist you with any questions that you might have. If you have any questions, please contact the Fund Office at 914-737-7220.

Sincerely,

Board of Trustees
Plumbers and Steamfitters Local 21 Welfare Fund

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this SMM and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement is available upon request at the above address and may be inspected by you free of charge during normal business hours.

No individual other than the Board of Trustees has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.

PLUMBERS AND STEAMFITTERS LOCAL 21 WELFARE FUND

1024 McKinley Street, Peekskill, NY 10566 / Telephone: (914) 737-7220

OPT-OUT FORM ACTIVE COVERAGE

PURPOSE OF THIS FORM – This form allows eligible members and dependents to opt-out of medical benefits through the Plumbers and Steamfitters Local 21 Welfare Fund ("Fund") and maintain the right to enroll at a later date, subject to Plan requirements. This form must be properly completed, signed, and received by the Fund Office.

A. Member Information:

Last Name		First Name	Middle Initial (MI)
Mailing Address			Social Security Number
City		State	Zip Code
Gender ☐ F ☐ M	Date of Birth: (Month/Day/Year)	Email Address	Phone Number

B. Opt-Out Information: Complete this section for each person that is opting out of welfare coverage due to health coverage from another source.

	Last Name	First Name	MI	Sex	DOB	SSN/ID Number
☐ Self (Member)						
☐ Spouse						
☐ Dependent Child						
☐ Dependent Child						
☐ Dependent Child						
☐ Dependent Child						

C. Signature & Acknowledgement:

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that 50% of my Welfare Fund contribution rate will be credited to my HRA account and 50% will be retained by the Welfare Fund, with a minimum retention of $4.50 per hour. I understand that I must provide proof of alternative employer sponsored group health coverage *(a copy of the group health insurance plan's Summary of Benefits and Coverage (SBC) and a copy of the group health insurance ID Card or a letter from the applicable employer confirming the group coverage and effective date*). I understand that I must provide proof of coverage annually during open enrollment. I understand that by opting out, I only remain eligible for the HRA, as well as the Welfare Fund's vision, life, accidental death and dismemberment insurance, employee assistance program, and supplemental disability benefits, and only to the extent I would otherwise be eligible for the Fund's medical benefits had I not opted out. (*This means that I must maintain enough hours to maintain eligibility for the aforementioned*). I understand that I can only opt back into the Fund's medical benefits annually during open enrollment or if I have a qualifying event entitling me to a special enrollment period, and if I opt back in, my entitlement to Fund benefits is based on having met the Fund's regular eligibility rules. Should I lose my alternative employer sponsored group coverage, I must notify the Fund Office and opt back into the plan within 30 days of losing the coverage. I further acknowledge that the Trustees reserve the right and have the authority to amend, modify, and/or eliminate benefits, or to terminate the Plan at any time. The undersigned acknowledge that they have voluntarily chosen to opt out of medical coverage. The undersigned agrees to hold the Trustees of the Welfare Fund harmless from any and all claims, liabilities, damages, losses, or expenses arising out of or in connection with the undersigned's decision to opt out of the medical coverage. This hold harmless provision applies to any claims arising from a lack of medical coverage during the opted-out period, including but not limited to claims for medical expenses, injuries, or any other health-related issues.

Member's Signature_____ Date_____

PLUMBERS AND STEAMFITTERS LOCAL 21 WELFARE FUND

1024 McKinley Street, Peekskill, NY 10566 / Telephone: (914) 737-7220

OPT-IN FORM ACTIVE COVERAGE

PURPOSE OF THIS FORM – This form allows eligible members and dependents to opt back into medical benefits through the Plumbers and Steamfitters Local 21 Welfare Fund ("Fund"), subject to Plan requirements including the Plan's regular eligibility requirements. Members can opt-in only during the annual open-enrollment period or by having a qualifying event, such as the entitlement to a special enrollment period or the loss of their alternative employer sponsored group health coverage. This form must be properly completed, signed, and received by the Fund Office.

A. Member Information:			
Last Name		First Name	Middle Initial (MI)
Mailing Address			Social Security Number
City		State	Zip Code
Gender ☐ F ☐ M	Date of Birth: (Month/Day/Year)	Email Address	Phone Number

B. Opt-In Information: Complete this section for each person that is opting into welfare coverage. *Please provide appropriate documentation (social security card, birth certificate, marriage certificate, etc.)*

	Last Name	First Name	MI	Sex	DOB	SSN/ID Number
☐ Self (Member)						
☐ Spouse						
☐ Dependent Child						
☐ Dependent Child						
☐ Dependent Child						
☐ Dependent Child						

C. Signature & Acknowledgement:

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that I must request enrollment back into the Fund's medical plan within the applicable time period specified in the Summary Plan Description for special enrollment, or if for loss of alternative employer sponsored group health coverage, within 30 days after such coverage ends along with any required proof (e.g. termination letter from health plan or employer). I understand that if I fail to submit a request to opt back into the Fund's medical benefits within the applicable time frame, I will still be considered opted-out and I must wait until the next open enrollment period for coverage the next following calendar year even if I am eligible for benefits based on the Fund's regular eligibility rules. Furthermore, I understand that my entitlement to Fund benefits when I opt back in is based on having met the Fund's regular eligibility rules for coverage. I understand that Welfare Fund contributions will no longer be credited to my HRA account. I further acknowledge that the Trustees reserve the right and have the authority to amend, modify, and/or eliminate benefits, or to terminate the Plan at any time. The undersigned agrees to hold the Trustees of the Welfare Fund harmless from any and all claims, liabilities, damages, losses, or expenses arising out of or in connection with the undersigned's decision to opt out of the medical coverage. This hold harmless provision applies to any claims arising from a lack of medical coverage during the opted-out period, including but not limited to claims for medical expenses, injuries, or any other health-related issues.

Member's Signature_____ Date_____