Joint Plumbing Industry Board
Plumbers Local Union No.1 Trust Funds

Welfare Fund • **Trade Education Fund** • **Additional Security Benefit Fund** • **401(k) Savings Plan**

Michael Apuzzo, Co-Chairman - Labor **Walter Saraceni,** Administrator **Eugene S. Boccieri** Co-Chairman - Management

February 2017

SUMMARY OF MATERIAL MODIFICATIONS NUMBER 3 (SMM#3)

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

IMPORTANT! This Summary of Material Modifications ("SMM") describes changes to the SPD for the Plumbers Local Union No.1 Welfare Fund (the "Welfare Fund" or the "Fund") issued in October 2014. These changes are effective January 1, 2017, unless noted otherwise.

SPD Pg.133 / Replace Trustee List – Effective January 1, 2017

Names, Titles and Addresses of the Plan Trustees:

Union Trustees		Employer Trustees
Michael Apuzzo, Co-Chairman Plumbers Local Union No. 1 50-02 Fifth Street Long Island City, NY 11101		**Eugene S. Boccieri, Co-Chairman** Duo Plumbing & Heating Corp. 88 Kreischer Street Staten Island, NY 10309
Freddy Delligatti Plumbers Local Union No. 1 50-02 Fifth Street Long Island City, NY 11101		**Louis J. Buttermark** Louis Buttermark & Sons, Inc. 16 New Dorp Lane Staten Island, NY 10306
Daniel Lucarelli Plumbers Local Union No. 1 50-02 Fifth Street Long Island City, NY 11101		**Vito M. Giachetti** Giachetti Plumbing & Heating Corp. 58 Tiemann Place New York, NY 10027
Paul O'Connor Plumbers Local Union No. 1 50-02 Fifth Street Long Island City, NY 11101		**Thomas Maniuszko** Total Service Ltd. 116-04 Atlantic Avenue Richmond Hill, NY 11419
Alternate Union Trustees		**Alternate Employer Trustee**
		Stewart O'Brien Association of Contracting Plumbers 44 West 24th Street, 12th Floor New York, NY 10001

SPD Pg. 106 / Add to Empire BCBS Appeals Section Effective January 1, 2016

EXTERNAL REVIEW OF CERTAIN TYPES OF CLAIMS / Empire Blue Cross Blue Shield Appeal Process:

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem BlueCross BlueShield
Attn: Grievances and Appeals
PO Box 1407
Church Street Station
NY, NY 10008-1407

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

SPD Pg. 1109/ Replace CVS/Caremark Appeals Section Effective January 1, 2016

EXTERNAL REVIEW OF CERTAIN TYPES OF CLAIMS / CVS/Caremark Appeal Process:

Review of Denial of Pre-Service Clinical Claims. CVS/Caremark will provide the first-level review of appeals of Pre-Service Clinical Claims. Such Claims will be reviewed against pre-determined medical criteria relevant to the drug or benefit being requested. If the first-level appeal is denied, you may appeal CVS/Caremark's decision and request an additional second-level Medical Necessity review. The review of whether the requested drug or benefit is Medically Necessary will be conducted by an Independent Review Organization ("IRO").

For purposes of Prescription Drug Claims and Appeals, the definition of Medical Necessity is Medications, health care services or products are considered Medically Necessary if:

- Use of the Medication, service or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- Use of the medication, service or product is based on recognized standards for the health care specialty involved;

- Use of the medication, service, or product represents the most appropriate level of care for member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are preformed; and
- Use of medication, service or product is not solely for the convenience of the member, member's family, or provider.

Review of Administrative Denials. If CVS/Caremark determines that the request for a drug or benefit cannot be approved based on the terms of the Plan, including single source and/or multi-source drugs selected by the Board of Trustees, the determination will constitute an Administrative Denial. CVS/Caremark provides a single level of appeal for Administrative Denials. Upon receipt of such an appeal, CVS/Caremark will review the request for a particular drug or benefit against the terms of the Plan, including the single source or multi-source drugs selected by the Board of Trustees.

Timing of Review: Pre-Authorization Review – CVS/Caremark will make a decision on a Pre- Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS/Caremark will make a decision on the Claim within 72 hours.

Pre-Service Clinical Claim Appeal – CVS/Caremark will make a decision on a first-level appeal of a claim denial rendered on a Pre-Service Clinical Claim within 15 days after it receives the appeal. If CVS/Caremark renders an Adverse Benefit Determination (upholds the denial) on the first-level appeal of the Pre-Service Claim, you may appeal that decision by providing the information described above. A decision on the second-level appeal will be made (by the IRO) within 15 days after the new appeal is received. If you are appealing a denial of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first-and second-level appeals, combined).

Administrative Denial or Post-Service Claim Appeal – CVS/Caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim or on an Administrative Denial within 60 days after it receives such appeal.

Scope of Review: If you appeal CVS/Caremark's denial of a Pre-Service clinical Claim, and request an additional second-level Medical Necessity review by an IRO, the IRO shall:

- Consult with an appropriate health care professional who was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual);
- Identify the health care professional, if any, whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination; and
- Provide for an expedited review process for Urgent Care Claims.

Notice of Adverse Benefit Determination: Following the review of a member's Claim, CVS/Caremark will notify the member of any denial of an appeal in writing. (Decisions on Urgent Care Claims will be also be communicated by telephone or fax.) This notice will include:

- The specific reason or reasons for the denial;
- Reference to pertinent Plan provision on which the denial was based;
- A statement that the member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the denial/determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request; and
- If the denial is based on a Medical Necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

Authority as Claims Fiduciary: CVS/Caremark shall serve as the claims fiduciary solely for the purpose of adjudicating appeals relating to the coverage of prescription drug benefits. CVS/Caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties, subject to available judicial review.

SPD Pg. 44/ WHCRA Notification

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

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

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

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

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

SPD Pg. 126 / HIPAA Privacy Notice reminder

Notice of Availability of HIPPA Privacy Notice

The Privacy Rule under the Health Insurance Portability and Accountability Act, commonly known as "HIPAA", requires the Plumbers Local No. 1 Welfare Fund (the "Fund") to follow certain procedures to protect the privacy of your Protected Health Information ("PHI") maintained by the Fund. The Fund's Privacy Notice describes how the Fund uses and discloses PHI and discusses important federal rights that you have regarding your PHI. You can access the Fund's Privacy Notice by visiting www.ualocal1funds.org. You may also request a copy of the Privacy Notice by submitting a written request to the Fund Office at 50-02 Fifth Street, 2nd Floor, Long Island City, NY 11101.

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