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 5 (SMM#5)

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 Modification describes changes to the SPD for the Plumbers Local Union No.1 Welfare Fund (the "Welfare Fund") issued in June 2013. These changes are effective April 1, 2017.

SPD Pg. 59 - 65 / Replace Entire Section – Effective April 1, 2017

DENTAL BENEFITS

The Plan has established an arrangement with Cigna Dental Services (Cigna), which provides a panel of dentists in the **Cigna DPPO Advantage Network**, a dental PPO plan. When you choose a network dentist, your coverage includes a wide range of eligible services. Your Plan includes coverage for preventive dental care services, including cleanings, X-rays and more, at no additional cost to you up to the limits of the Plan. Cigna DPPO Advantage Network dentists have agreed to offer services at lower negotiated rates, so you and the Fund will save money when you use an in-network dentist.

You don't need an ID card, a primary care dentist or a referral to receive care from a specialist.

If you use an out-of-network provider, dental charges will be the difference between the Billed Charges and the Plan's reimbursement. Cigna sets the reimbursement rate at the maximum allowable charge by looking at costs for similar services in your geographic area. The out-of-network provider may not accept Cigna's maximum allowable charge reimbursement as payment in full. If this happens, you will have to pay any amount above the maximum allowable charge. Pretreatment Review is available on a voluntary basis when extensive work in excess of $200 is proposed.

Benefits are limited to $3,000 per calendar year for each Eligible Employee, Spouse and Adult Child age 19 or older through the end of the month in which the Child turns age 26. These annual benefit amounts are subject to the Plan's limitations and exclusions. Annual maximum amounts do not apply to covered Children under age 19. For expenses over $200, Pretreatment Review is recommended. Contact Cigna at (800) 244-6224 or go to www.mycigna.com for more information about Pretreatment Reviews.

For Children under age 19, the lifetime orthodontic maximum does not apply. A lump-sum payment of up to the $3,000 orthodontic benefit may be paid by the Plan upon receipt of a paid bill for covered orthodontic services from an out-of-network provider of an amount equal to or greater than this limit.

DENTAL BENEFIT SUMMARY

Covered Service	Network Provider	Out-of-Network Provider
Calendar Year Maximum $3,000 (Class I, II, III, IX Expenses)	(Class I Applies) (No maximum for dependent Children under age 19)	(Class I Applies) (No maximum for dependent Children under age 19)
Calendar Year Deductible Per Individual	$0	$0
Dental Plan Reimbursement Levels	Based on Contracted Fees	Based on maximum allowable charge (for location of service rendered)
Additional Member Responsibility	None	Yes, the difference between Billed Charges and the Plan reimbursement
Student/Dependent Age	26/26	
Class I Expenses - Preventive & Diagnostic Care Oral Exams Cleanings Routine X-Rays Fluoride Application (Up to age 19 only) Sealants Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-Rays Emergency Care to Relieve Pain	100%, No Deductible	100%, No Deductible (up to maximum allowable charge) Additional member responsibility for the difference between Billed Charges and the Plan reimbursement
Class II Expenses - Basic Restorative Care Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Major Periodontics Minor Periodontics Root Canal Therapy / Endodontics Relines, Rebases and Adjustments Repairs - Bridges, Crowns and Inlays Repairs - Dentures Brush Biopsy	100%, No Deductible	100%, No Deductible (up to maximum allowable charge) Additional member responsibility for the difference between Billed Charges and the Plan reimbursement
Class III Expenses - Major Restorative Care Crowns / Inlays / Onlays Dentures Bridges Stainless Steel / Resin Crowns	100%, No Deductible	100%, No Deductible (up to maximum allowable charge) Additional member responsibility for the difference between Billed Charges and the Plan reimbursement
Class IV Expenses - Orthodontia Coverage for Eligible Children up to age 19 Only Lifetime Maximum $3,000*	100%, No Orthodontia Deductible (*No maximum for dependent Children under age 19. Dependent Children age 19 – 26 not eligible)	100%, No Orthodontia Deductible (up to maximum allowable charge) (*No maximum for dependent Children under age 19. Dependent Children age 19 – 26 not eligible) Additional member responsibility for the difference between Billed Charges and the Plan reimbursement

Covered Service	Network Provider	Out-of-Network Provider
Class IX Expenses - Implants Applies Toward Plan Calendar Year Max	100% 1 per Calendar Year	100% 1 per Calendar Year Additional member responsibility for the difference between Billed Charges and the Plan reimbursement.
Pretreatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed	

IMPORTANT CLAIMS REMINDER:

- **For dental services provided on or before March 31, 2017:** Claims must be submitted to Dental Delivery Services, Inc. (DDS, Inc.). All claims to DDS, Inc. must be submitted on or before March 31, 2018 or *they will not be covered.*
- **For dental services provided on or after April 1, 2017:** Claims should be submitted to Cigna Dental Services (Cigna). Claims must be submitted within 18 months of the beginning service date.

Limitations: The following dental limitations apply whether services are received from an in-network or out-of-network provider:

Procedure	Exclusions & Limitations
Exams	2 per calendar year (Does not apply to children up to age 19)
Prophylaxis (cleanings)	2 per calendar year (Does not apply to children up to age 19)
X-Rays (routine)	Bitewings – 2 per calendar year (Does not apply to children up to age 19)
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years (Does not apply to children up to age 19)
Minor Perio (non-surgical)	Various limitations depending on the service (Does not apply to children up to age 19)
Crowns and Inlays	Replacement every 5 years (Does not apply to children up to age 19)
Prosthesis Over Implants	1 per calendar year if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals No porcelain or white/tooth colored material on molar crowns or bridges
Bridges	Replacement every 5 years (Does not apply to children up to age 19)
Dentures and Partials	Replacement every 5 years (Does not apply to children up to age 19)
Relines, Rebases	Covered if more than six months after installation
Adjustments	Covered if more than six months after installation
Sealants	Limited to posterior tooth

Exclusions: The following dental exclusions apply whether services are received from an in-network or out-of-network provider:

- Services performed primarily for cosmetic reasons
- Instruction for plaque control, oral hygiene and diet
- Dental services that do not meet common dental standards
- Services that are deemed to be medical services should be submitted to the medical plan
- Services and supplies received from a hospital should be submitted to the medical plan
- Charges which the person is not legally required to pay
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
- Experimental or investigational procedures and treatment
- Any injury resulting from, or in the course of, any employment for wage or profit
- Any sickness covered under any workers' compensation or similar law
- Charges in excess of the reasonable and customary allowances
- To the extent that payment is unlawful where the person resides when the expenses are incurred

- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents)
- For charges which would not have been made if the person had no insurance
- For charges for unnecessary care, treatment or surgery
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- Illnesses or injuries due to war or any act of war, declared or undeclared, (including resistance to armed insurrection)
- Treatment of the teeth or gums, except for the repair of non-occupational injuries to natural teeth, or specifically provided dental benefits
- Medication, services or supplies not prescribed by a Physician or Dentist
- Charges in excess of the Plan's limitations
- Benefits, services, equipment and supplies that are required as a condition of employment
- Benefits, services, equipment and supplies promised by an Employer as a result of an agreement (other than an agreement to contribute to Plan)
- Hospitalization primarily for diagnostic studies and evaluations, x-ray examinations, laboratory examinations or electrocardiograms except where appropriate by virtue of Medical Necessity
- Services or supplies provided before the Eligible Employee or his or her Eligible Dependent became eligible for coverage
- Services or supplies provided after the eligibility of the Eligible Employee or his or her Eligible Dependent ends
- Any claims submitted more than 18-months after the date of treatment or service, except as otherwise approved by the Plan
- Charges for broken or missed appointments
- Treatment for intentionally self-inflicted injuries, unless the injury is the result of a medical condition
- The Plan will not pay for copayments of any kind
- Treatment for temporomandibular joint ("TMJ"), including all related expenses; Treatment for TMJ shall be covered only as a dental expense

SPD Pg. 80 / New Section in Additional Retiree Benefits Section – Effective April 1, 2017

Dental Discount Program for Medicare-Eligible Retired Participants

Medicare-eligible retired participants will have access to the Cigna*Plus* Savings dental discount program. The Cigna*Plus* Savings program is offered by Cigna Health and Life Insurance Company with network management and administrative services provided by Cigna Dental Health, Inc. The program provides discounts at certain dentists for dental care when your Cigna*Plus* ID card is presented at the time of service.

Cigna*Plus* membership also gives you access to Cigna Healthy Rewards, a program offering discounts on services, including vision, chiropractic, weight management and smoking cessation programs. With your Cigna*Plus* membership you will have access to Cigna's Identity Theft Program and Cigna's Will Preparation Services.

You can enroll for the program using the promotional code **"PlumbersL1"** at www.CignaPlusSavings.com, by calling 877-521-0244 or by mailing a completed enrollment form to Cigna Dental, 250 South Northwest Highway, Suite 340, Park Ridge, IL 60068-4244.

Members will be individually billed membership fees for the Cigna*Plus* Savings program. Membership fees are valid for a 12-month period from the effective date of enrollment, unless Cigna Dental's liability related to offering the program is altered by a state or federal law or regulation. Membership will automatically renew at the then current membership fee unless the customer provides written notice or calls the telephone number on the ID card to indicate his or her desire to cancel membership.

The Cigna*Plus* Savings program is not available in Alaska, Montana, North Dakota, South Dakota, Hawaii, Rhode Island, California, Wyoming, Idaho or Iowa. For more information on the available dental network and in-network dentists visit www.CignaPlusSavings.com.

Cigna*Plus* is not dental insurance and there is no claims process. The participant is obligated to pay for all dental care services, at the time of service, but will receive a discount for eligible services received from participating dentists. The amount of discount will vary among participating providers and those procedures not included on the negotiated fee schedule may not be subject to a discount. The discounts available under the Cigna*Plus* Savings program may not be used in conjunction with any other discount dental program or insurance program.

SPD Pg. 59 - 65 / Remove Section – Effective April 1, 2017

Dental Fee Schedule

See Dental Benefit Summary Above.

SPD Pg. 101 / Replace Dental Benefit Claim Section – Effective April 1, 2017

Dental Benefits Claims and Appeals Process

For dental services provided on or before March 31, 2017, claims must be submitted to Dental Delivery Services, Inc. (DDS, Inc.). All claims to DDS, Inc. must be submitted on or before March 31, 2018 or *they will not be covered.*

For dental services provided on or after April 1, 2017, claims must be submitted to Cigna Dental Services (Cigna) in the manner listed below. Claims must be submitted within 18 months of the beginning service date.

Cigna Dental Claims

In-Network claims. There's no paperwork for in-network care unless you exceed the annual limit. In these cases, you will just need to pay any amounts over the annual limit; your provider will submit a claim to Cigna for reimbursement of claims up to the annual limit.

Out-of-network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the Cigna website www.Cigna.com or by calling Member Services using the toll-free number 1-800-244-6224.

Cigna will consider claims for coverage under Cigna plans when proof of loss (a claim) is submitted within 18-months. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 18-months, the claim will not be considered valid and will be denied.

Claim Determination Procedures under ERISA

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the Plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. You or your authorized representative (typically, your health care professional) must request Medical Necessity determinations according to the procedures described below, in the booklet, and in your provider's network participation documents as applicable. When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the booklet, in your provider's network participation documents as applicable, and in the determination notices.

Post-Service Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed and you or your representative must provide the specified information to Cigna within 45 days after

receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

When You Have a Complaint or an Appeal

Start With Cigna Customer Services

If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call the toll-free number on your, explanation of benefits, or claim form and explain your concern to one of Cigna's Customer Service representatives. You may also express that concern in writing. If more time is needed to review or investigate your concern, Cigna will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Internal Appeals Procedure

To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write at the toll-free number on your explanation of benefits, or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

Cigna will respond in writing with a decision within 30 calendar days after an appeal is received for a post-service coverage determination. If more time or information is needed to make the determination, you will be notified in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

External Review Procedure

If you are not fully satisfied with the decision of Cigna's internal appeal review regarding Medical Necessity or clinical appropriateness, you may request that your appeal be referred to an Independent Review Organization (IRO). Each IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an external review will not affect the claimant's rights to any other benefits under the plan. There is no charge for you to initiate this external review. Cigna will abide by the decision of the IRO. In order to request a referral to an IRO, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 4 months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by Cigna's reviewer, the review shall be completed within 3 days. The external review is a voluntary program arranged by Cigna.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; a statement describing

any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a), if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal processes. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the Plan for Out-of-Network services.

SPD Pg. 25 / Replace Dental Delivery Services – Effective April 1, 2017

Other Preferred Provider Networks

Cigna Dental Services (Cigna)	*Dental Benefits*
Cigna*Plus*	*Dental Discount Program for Medicare-Eligible Participants*

The names, addresses and phone numbers of all the Preferred Provider Networks with which the Plan has arrangements are listed on page 140.

SPD Pg. 36 / Replace DDS, Inc. In Additional Medical Benefits Chart – Effective April 1, 2017

Other Preferred Provider Networks

Dental Benefits
(Offered through a Dental PPO: Cigna Dental Services)

SPD Pg. 140 / Replace Dental Delivery Services with Cigna Dental Services – Effective April 1, 2017

Source of Financing of the Plan and Identity of Any Organization through Which Benefits Are Provided:

Dental Benefits
Cigna Health and Life Insurance Company
Cigna Dental
P.O. Box 188037
Chattanooga, TN 37422-8037
Phone: (800) 244-6224
Website: myCigna.com
Group ID: 3340321

SPD Pg. 140 / Add To Section – Effective April 1, 2017

Source of Financing of the Plan and Identity of Any Organization through Which Benefits Are Provided:

Dental Benefits – Discount Program for Medicare eligible Participants
Cigna Health and Life Insurance Company, Cigna*Plus* Savings Program
Cigna Dental
250 South Northwest Highway
Suite 340
Park Ridge, IL 60068-4244
Phone: (877) 521-0244
Website: www.CignaPlusSavings.com
Group ID: PlumbersL1

SPD Pg. 43 / WHCRA Notification – Effective April 1, 2017

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. 112 / 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. 115 / 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.139 / 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. 132 / 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.