PLUMBERS LOCAL UNION NO. 1 WELFARE FUND
50-02 Fifth Street, Long Island City, N.Y. 11101

March 2016

SUMMARY OF MATERIAL MODIFICATION NUMBER 1 (SMM#1)
MES Helper

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 October 2014. These changes pertain to out-of-network provider charges in emergency situations and the availability of an external review procedure for certain types of claims. These changes are effective January 1, 2016 unless noted otherwise.

MES SPD Pg. 41 / New Section

LiveHealth Online

Talk face-to-face with your choice of board-certified doctors through your favorite mobile device or a computer with a webcam using LiveHealth Online. Doctors using LiveHealth Online provide medical advice for common health concerns like the flu, colds, allergies and more. Doctors can also send a prescription directly to a pharmacy, if needed. It's faster, easier and more convenient than a visit to an urgent care center or retail health clinic. Effective February 1, 2016, the copayment for LiveHealth Online services is $5.00.

MES SPD Pg. 2 / Replace Section

Initial Eligibility for Employees

Reciprocal Plans - This Plan also has reciprocal agreements with certain other welfare plans of U.A. Local Unions. You can continue eligibility if you provide the Fund Office with documentation of hours worked in Covered Employment for an employer outside of Local 1's jurisdiction. When contributions are received or verified by this Plan from a reciprocal Plan, you will be credited with no less than the actual hours worked for eligibility purposes under this Plan. Effective January 1, 2013, if a reciprocal Plan makes contributions at a rate that is less than this Plan's contribution rate, your credited hours will be prorated. If a reciprocal Plan makes contributions at a rate that is greater than this Plan's contribution rate, you will be credited with additional prorated hours. Contributions made to this Plan, which are forwarded to a reciprocal Plan, will not be counted for eligibility purposes in any way by this Plan. *If the prorated hours from a reciprocal Plan are not sufficient to maintain eligibility you may continue to be eligible under this Plan for up to eighteen (18) months of coverage at no cost from the date your eligibility would otherwise terminate. However, the total extension cannot exceed 50% of the length of the period during which you were eligible for benefits from this Plan, measured immediately preceding your date of travel to the outside local.* If you have a question regarding whether a certain welfare fund has a reciprocal agreement with this Plan, please call the Fund Office.

MES SPD Pg. 13 / Replace Section

Termination of Dependent Coverage

Benefits for Eligible Dependent(s) end on the earliest of the following:

- The date the Employee's eligibility terminates (see page 3);
- For the Employee's spouse and any step-child(ren), the first day of the month following the date the Employee and the step-child(ren)'s parent are divorced;
- The date a Dependent becomes an Active Eligible Employee under this Plan;
- Upon the Dependent's entry into military service;
- Upon the Dependent's eligibility and enrollment in a Medicare Part D Prescription Drug Plan or Medicare Advantage Plan.
- Six (6) months after the date of death of an Eligible Employee. If you are covered under the Surviving Spouse Continuation of Coverage, coverage will extend up to three (3) months following the death of an Eligible Retired Employee.

MES SPD Pg. 18 / Replace Section

Effect of Becoming Eligible for Medicare

Upon becoming eligible for Medicare, Medicare is the primary coverage. For maximum benefits, you ***should*** maintain coverage for Medicare Part B by self-paying the Medicare Part B premium. **Failure to elect Medicare Part B coverage will result in a reduction of benefits.** Once Medicare-eligible, you and your Eligible Dependent(s) will have retiree Medicare Wrap Around benefits under this Plan, which does not cover expenses that would be covered by Medicare Part B. See pages 72 - 73 for a description of this benefit.

Effect of Enrolling in another Medicare Part D Prescription Drug Plan

If you decide not to enroll in the SilverScript Prescription Drug Plan, and instead enroll in a different Medicare Part D prescription drug plan, you and your eligible Spouse and Dependents will lose your Welfare Fund coverage (Medicare Wrap-Around Plan for medical and hospital coverage, Prescription Drug Plan, Vision and Life Insurance Benefits).

MES SPD Pg. 20 / Replace Section

Medicare Part D Prescription Drug Coverage

Everyone with Medicare is eligible for prescription drug coverage with Medicare Part D Plans and Medicare Advantage Plans (private insurance companies). There are certain times when it's possible to enroll in a Medicare Advantage Plan. For example, you can sign up during the initial enrollment period (that is, when you first become eligible for the Medicare program or when you turn 65 years old). The enrollment period for Part D Plans will begin on October 15 and end on December 7 of each year. In addition, there is a special disenrollment period during which you can drop a Medicare Advantage Plan if you

don’t want to be a part of the plan any longer. This special disenrollment period lasts from January 1 until February 14 each year. Those who decide to drop a Medicare Advantage Plan during the special disenrollment period must switch to Original Medicare (Medicare Part A and Part B). It’s not possible to choose a new Medicare Advantage Plan at this time. If you switch to Original Medicare during this period, you'll have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage. Your coverage will begin the first day of the month after the plan gets your enrollment form. Before making your choice, be sure to get all the answers and find out what plan best fits your needs since you will be expected to remain enrolled in the plan you choose for at least one year.

A Member, Dependent and/or Surviving Spouse who is eligible for benefits under the rules of this Plan will continue to be eligible for benefits notwithstanding his/her eligibility for Medicare Part D. However, if you decide not to enroll in the SilverScript Prescription Drug Plan, and instead enroll in a different Medicare prescription drug plan, you and your eligible Spouse and Dependents will lose your Welfare Fund coverage (Medicare Wrap-Around Plan hospital and medical coverage, Prescription Drug Plan, Vision and Life Insurance Benefits).

MES SPD Pg. 20 / Add Section

Termination of Retiree Benefits

Your benefits terminate upon your death or if you stop receiving pension benefits or return to work in the Plumbing and Pipe Fitting Industry. If you return to work, you must re-establish eligibility as an Active Employee by satisfying the Initial Eligibility requirements described on page 2 of the SPD.

If you decide not to enroll in the SilverScript Prescription Drug Plan, and instead enroll in a different Medicare prescription drug plan, you and your eligible Spouse and Dependents will lose your Welfare Fund coverage (Medicare Wrap-Around Plan hospital and medical coverage, Prescription Drug Plan, Vision and Life Insurance Benefits).

MES SPD Pg. 26 / Add SilverScript

Other Preferred Provider Networks

SilverScript *Medicare Prescription Drug Plan*

The names, addresses and phone numbers of all the Preferred Provider Networks with which the Plan has arrangements are listed on page 134.

MES SPD Pg. 72 / Replace Section

Medicare Wrap-Around Plan Schedule

NOTE: ALL PLAN PAYMENTS ARE BASED UPON MEDICARE-APPROVED AMOUNTS AND ARE MADE IN ACCORDANCE WITH THE TERMS AND LIMITATIONS OF THE PLAN. PAYMENTS BY MEDICARE ARE MADE AFTER SATISFACTION OF THE $166.00 ANNUAL DEDUCTIBLE WHERE APPLICABLE. **(Note: Medicare Coverage is based on the Medicare Premium, and Deductibles for 2016 which are subject to change annually based on Medicare regulations)**

Service or Supply	Medicare Coverage	Plan Pays	Retiree Pays
Physician Visits (Primary or Specialist)	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Chiropractic Care	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Allergy Testing and Treatment	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
X-Ray and Lab	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Second Surgical Opinion	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Surgical Benefits	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Surgical Assistant	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Chemotherapy	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Routine Physical Exam	Not covered if routine	Not covered if routine	You pay 100% for routine physical exam
Immunization Benefit	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Emergency Room (initial visit for emergency care)	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Hospital Care	Hospital Day 1-60: all but $1,288 Day 61-90: all but $322/day Day 91-150: all but $644/day 150 day limit Surgical: 80% of approved amount	Hospital Day 1-60: $1,288 Day 61-90: $322/day Day 91-150: $644/day 150 day limit Surgical: 20% of approved amount	Hospital Day 1-60: $0 Day 61-90: $0 Day 91-150: $0 Over 150 days: You pay 100% beyond 150 days Surgical: $0 (1)* (2)** See notes 1 & 2 below
Outpatient Surgery, Therapy (in-hospital)	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below

Service or Supply	Medicare Coverage	Plan Pays	Retiree Pays
Anesthesia	80% of approved amount	20% of approved amount	$0 [(1)*] [(2)**] See notes 1 & 2 below
Organ Transplant	80% of approved amount	20% of approved amount	$0 [(1)*] [(2)**] See notes 1 & 2 below
Durable Medical Equipment & Supplies	80% of approved amount	20% of approved amount	$0 [(1)*] [(2)**] See notes 1 & 2 below
Prosthetic Appliances	80% of approved amount	20% of approved amount	$0 [(1)*] [(2)**] See notes 1 & 2 below
Skilled Nursing Facility[(3)***] See note 3 below	Day 1-20: 100% of approved amount Day 21-100:all but $161/day 100 day limit/benefit period	Day 1-20: $0 (Medicare) Day 21-100: $161/day Over 100 days: $0	Day 1-20: $0 Day 21-100: $0 Over 100 days: You pay 100%
Home Health Care	100% limit of 21 consecutive days	Day 1-21: $0 (Medicare) Over 21 days – not covered	Day 1-21: $0 Over 21 days – You pay 100%
Inpatient Physical Therapy	80% of approved amount	20% of approved amount	$0 [(1)*] [(2)**] See notes 1 & 2 below
Outpatient Physical Therapy	80% of approved amount	20% of approved amount	$0 [(1)*] [(2)**] See notes 1 & 2 below
Other Outpatient Therapies	80% of approved amount	20% of approved amount	$0 [(1)*] [(2)**] See notes 1 & 2 below
Cardiac Rehabilitation	80% of approved amount	20% of approved amount	$0 [(1)*] [(2)**] See notes 1 & 2 below
Inpatient Mental Health	Hospital Day 1-60: all but $1,288 Day 61-90: all but $322/day Day 91-150: all but $644/day 190 day lifetime limit	Hospital Day 1-60: $1,288 Day 61-90: $322/day Day 91-150: $644/day 190 day lifetime limit	Hospital Day 1-60: $0 Day 61-90: $0 Day 91-190: $0 Over 190 days: You pay 100%
Outpatient Mental Health	80% of approved amount	20% of approved amount	$0 [(1)*] [(2)**] See notes 1 & 2 below

Service or Supply	Medicare Coverage	Plan Pays	Retiree Pays
Inpatient Substance Abuse	Hospital Day 1-60: all but $1,288 Day 61-90: all but $322/day Day 91-150: all but $644/day 190 day lifetime limit	Hospital Day 1-60: $1,288 Day 61-90: $322/day Day 91-150: $644/day 190 day lifetime limit	Hospital Day 1-60: $0 Day 61-90: $0 Day 91-190: $0 Over 190 days: You pay 100%
Outpatient Substance Abuse (Physician Charges)	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Lifetime Limit	None except as result of individual benefit max	N/A	N/A

*(1) In 2016, you must pay an annual $166 deductible for Part B services and supplies before Medicare begins to pay its share. These deductibles are not paid by the Plan and are subject to change annually based on Medicare regulations.
**(2) Actual amounts you must pay may be higher if Physicians, health care providers or suppliers don't accept assignment.
***(3) Medicare will cover skilled care only if you have Medicare Part A (Hospital Insurance) AND you have days left in your benefit period available to use AND you have a qualified hospital stay, which is an inpatient hospital stay of three (3) consecutive days or more, not including the day you leave the hospital. You must enter the skilled nursing facility within 30 days of leaving the hospital. In the event you are discharged from an inpatient hospital and admitted to a skilled nursing facility one day prior to becoming eligible for Medicare, the Plan will pay up to a maximum charge of $41,000.

MES SPD Pg. 74 / Replace Section

Additional Retiree Benefits

***Vision Care Benefit** (Offered through PPO: Vision Screening, Inc.)*	Up to $100 payable once every 24 months No deductible
Hearing Aids	Limit $500 every 3 years
Life Insurance	$10,000 Retired Employee
Prescription Drug Benefits	See below

For Prescriptions Filled at a Participating Pharmacy in the SilverScript National Retail Network			
	30-Day Supply (First Fill and After)	**60-Day Supply** (First Fill and After)	**84-90-Day Supply** (First Fill and After)
Generic Medication	$10	$20	$30
Single-Source	$30	$60	$90
Multi-Source	$50	$100	$150

Using the CVS/caremark Mail Service for Maintenance Medications

You will need to complete a mail order form for you and any eligible Dependent(s) who will be utilizing the mail order services. This will set up each member's profile in the mail order system with. Then simply mail the completed form, along with an original prescription written for a 90-day supply and payment. It will take approximately 14 days to receive your mail order prescription. ***It may be necessary to obtain two prescriptions from your Physician, one for a 30-day supply so you can start or continue your medication without interruption and one for the 90-day mail order supply.*** After your prescription has been filled the first time and you have available refills, you can re-order your mail prescription online at www.caremark.com, by calling SilverScript Customer Care or by mailing in your re-order form that you received with your prescription.

You are encouraged to use either CVS/caremark Mail Service Pharmacy or a local CVS Retail pharmacy in order to obtain maintenance drugs at mail order co-pays.

For CVS/caremark Mail Service Pharmacy your prescriber can submit your original prescription electronically or you can submit by mail or online at www.caremark.com and your medications will be sent directly to your home, office or a location of your choice.

Up to 30-day supply through CVS/caremark Mail Order Pharmacy	$10 co-pay for up to 30-day generic $30 co-pay for up to 30-day single-source $50 co-pay for up to 30-day multi-source
Up to 60-day supply through CVS/caremark Mail Order Pharmacy	$17 co-pay for up to 60-day generic $50 co-pay for up to 60-day single-source $87.50 co-pay for up to 60-day multi-source
Up to 90-day supply through CVS/caremark Mail Order Pharmacy	$ 25 co-pay for up to 90-day generic $75 co-pay for up to 90-day single-source $125 co-pay for up to 90-day multi-source

Mail Order Co-pays for Maintenance Medications at CVS Retail

You and your eligible Dependent(s) can fill select maintenance medications for up to a 90 day supply at a CVS Retail Pharmacy and pay the applicable mail order co-pay, which saves you money.

Here's how the co-payments for maintenance medications work:

For Prescriptions Filled at a CVS Retail Pharmacy			
	30-Day Supply (First Fill and After)	**60-Day Supply** (First Fill and After)	**90-Day Supply** (First Fill and After)
Generic Medication	$10	$20	$25
Single-Source	$30	$60	$75
Multi-Source	$50	$100	$125

For a list of covered maintenance medications or for more information, call SilverScript Customer Care at 1-855-282-9586, available 24 hours a day, 7 days a week. TTY users should call 711.

MES SPD Pg. 102 / New Section

Right to Review Denied Claims/Appeals Procedure

Requests for review of denied Prescription Drug Claims should be sent to the following address:

SilverScript Insurance Company
Prescription Drug Plans
Coverage Decisions and Appeals Department
P.O. Box 52000, MC 109
Phoenix, AZ 85072-2000

Fax Number: 1-855-633-7673

Physicians may submit urgent appeal requests by calling the physician-only toll-free number at (855) 344-0930.

MES SPD Pg. 102 / New Section

SilverScript Appeals Process

A coverage decision is a decision SilverScript makes about your benefits and coverage or about the amount SilverScript will pay for your prescription drugs. In some cases, SilverScript may decide a prescription drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Filing an appeal - If SilverScript makes a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking SilverScript to review and change a coverage decision that has been made.

- **LEVEL 1 APPEALS**

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, SilverScript will review the coverage decision.

To start your Level 1 Appeal, you and/or your attending physician may submit an appeal by contacting SilverScript Insurance Company.

The appeal should include the following information:

- Name of the person the appeal is being filed for;
- SilverScript Identification Number;
- Date of birth;
- Written statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Written comments, documents, records or other information relating to the Claim

The appeal and supporting documentation may be mailed or faxed to SilverScript:

SilverScript Insurance Company
Prescription Drug Plans
Coverage Decisions and Appeals Department
P.O. Box 52000, MC 109
Phoenix, AZ 85075-2000

Fax Number: 1-855-633-7673

You must make your Level 1 appeal request within 60 calendar days from the date on the written notice SilverScript sends informing you of its coverage decision.

- **LEVEL 1 “FAST APPEAL”**

If you wish to appeal a decision SilverScript has made about a drug you have not yet received, you and your physician or other prescriber can request a “Fast Appeal”. SilverScript will give you an answer within 72 hours after receipt of the Level 1 “Fast Appeal”.

To request a Level 1 “Fast Appeal”, you may make it in writing and mail or fax it to SilverScript:

SilverScript Insurance Company
Prescription Drug Plans
Coverage Decisions and Appeals Department
P.O. Box 52000, MC 109
Phoenix, AZ 85075-2000

Fax Number: 1-855-633-7673

- **LEVEL 1 “STANDARD APPEAL”**

If you wish to appeal a decision SilverScript has made about a drug you have not yet received, you and your physician or other prescriber can request a “Standard Appeal”. SilverScript will give you an answer within 7 calendar days after receipt of the Level 1 “Standard Appeal”.

To request a Level 1 “Standard Appeal”, you may make it in writing and mail or fax it to SilverScript:

SilverScript Insurance Company
Prescription Drug Plans
Coverage Decisions and Appeals Department
P.O. Box 52000, MC 109
Phoenix, AZ 85075-2000

Fax Number: 1-855-633-7673

- **LEVEL 2 APPEALS**

If SilverScript denies your Level 1 “Fast” or “Standard” Appeal, you may file a Level 2 Appeal. A Level 2 Appeal is reviewed by an Independent Review Organization (“IRO”), which is an independent organization that is retained by Medicare. The IRO is not affiliated in any way with SilverScript and it is not an agency of the government.

To file a Level 2 Appeal, you or your representative, physician, or other prescriber must contact the IRO asking for a review of your case. You will receive instructions as to who may make a Level 2 Appeal, what the deadlines for filing a Level 2 Appeal are, and how to contact the IRO.

If you make an appeal to the IRO, SilverScript will send the information regarding your appeal to the IRO. This information is called your “case file”.

- **LEVEL 2 “FAST APPEAL” & “STANDARD APPEAL”**

When filing a Level 2 Appeal with the IRO, you may request a “Fast Appeal” or a “Standard Appeal”.

Level 2 Fast Appeal - If the IRO approves a “Fast Appeal”, it must give you an answer to your Level 2 Appeal within 72 hours after it receives your appeal request. If the “IRO” approves part or all of what you appealed, SilverScript will provide the drug coverage that was approved by the “IRO” within 24 hours after receipt of the decision.

Level 2 Standard Appeal - If the IRO approves a “Standard Appeal”. It must give you an answer within 7 calendar days after it receives your appeal request. If the “IRO” approves all or part of what you appealed, SilverScript will provide the drug coverage that was approved by the “IRO” within 72 hours after the receipt of the decision.

If you have already purchased the drug that was initially denied and IRO approves a refund request, SilverScript will send payment to you within 30 calendar days after receipt of the decision.

- **LEVEL 3 APPEALS**

If the IRO denies your Level 2 Appeal, you have the right to a Level 3 Appeal.

A Level 3 Appeal can only be made if the dollar value of the prescription drug coverage you are requesting meets a minimum amount. If the dollar value of the prescription drug coverage you are requesting is too low, you **cannot** make a Level 3 Appeal, and the decision of the Level 2 Appeal **is final.**

Making a Level 3 Appeal - If the dollar value of the prescription drug coverage meets the requirement for a Level 3 Appeal, you will receive instructions on how to file a Level 3 Appeal when you receive a determination of your Level 2 Appeal from the IRO.

A Level 3 Appeal is reviewed by an Administrative Law Judge who is an employee of the Federal Government.

If the Administrative Law Judge approves your Level 3 Appeal, SilverScript must authorize or provide the drug coverage that was approved within 72 hours or make payment no later than 30 days after the receipt of the decision.

- **LEVEL 4 APPEALS**

If your Level 3 Appeal is denied, you will receive instructions on how to file a Level 4 Appeal when you receive a determination of your Level 3 Appeal from the Administrative Law Judge.

A Level 4 Appeal is reviewed by an Appeals Council which is an entity used by the Federal Government for such appeals.

If the Appeals Council approves your Level 4 Appeal, SilverScript must authorize or provide the drug coverage that was approved within 72 hours or make payment no later than 30 days after the receipt of the decision.

- **LEVEL 5 APPEALS**

If your Level 4 Appeal is denied, you will receive instructions on how to file a Level 5 Appeal when you receive a determination of you Level 4 Appeal from the Appeals Council.

A Level 5 Appeal is reviewed by a Federal District Court.

MES SPD Pg. 134

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

The Plan has arrangements with various Preferred Provider Organizations and claims payers to provide the benefits of the Plan. The following is a list of those providers:

CVS/caremark Mail Service Pharmacy
Call SilverScript Customer Care at 1-855-282-9586

SilverScript Prescription Drug Cards
Call SilverScript Customer Care at 1-855-282-9586

MES SPD Pg. 43 / Add to Section

Preventive Services

The U.S. Preventive Services Task Force has issued its reports whereby the following four new services will be considered preventive services and will be paid at 100% when provided that will be effective January 1, 2016 that are not on the above list:

(1) Hepatitis B screening for all persons at high risk for infection.

(2) Preeclampsia prevention: aspirin for pregnant women after 12 weeks.

(3) Intensive behavioral counseling interventions to obese adults who have risk factors for cardiovascular disease.