AUTOMOBILE MECHANICS' LOCAL 701 WELFARE FUND

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IMPORTANT BENEFIT PLAN CHANGES

The Trustees of the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund have made certain changes to the **Premier Plus** plan as documented in the applicable combination Summary Plan Description and Plan Document ("SPD/Plan") that was previously provided to you. Each change is summarized below and is effective as of the date noted below.

1. Effective February 1, 2017, the Plan's pharmacy benefits manager will be Express Scripts, not OptumRx. This will result in some changes as of that date, as explained in more detail below. Effective May 1, 2017, the Plan will be switching to a new drug formulary, resulting in further changes, as also discussed below.

2. Effective February 1, 2017, corresponding with the Plan's change to Express Scripts as its new pharmacy benefits manager, there will be changes to the Plan's internal appeals process for prescription drug claims, as discussed below.

3. Effective February 1, 2017, the Plan will cover certain immunizations when administered by a properly licensed pharmacist within Express Scripts' network, as discussed in more detail below.

4. Effective February 1, 2017, the Trustees contracted with One Call Care Management to provide Plan participants the option of using a network of preferred providers of imaging procedures (CT/PET scans and MRIs) in order to have such procedures covered at no cost to you.

SUMMARY OF MATERIAL MODIFICATIONS

This document, referred to as a "summary of material modifications," is intended to supplement the SPD/Plan. You should retain this summary of material modifications with your copy of the SPD/Plan. If you have any questions, you may contact the Fund Office (708) 482-0110 ~ Toll Free (800) 704-6270.

1. Change to Express Scripts to the Plan's pharmacy benefits manager

Effective February 1, 2017, the Plan will be switching to Express Scripts ("ESI") as its pharmacy benefits manager. OptumRx will no longer be managing the Plan's prescription drug program as of February 1, 2017. Accordingly, this will result in certain changes to your prescription drug benefits under the Plan. As explained below, some changes will take effect as of February 1, 2017, while other changes will take effect as of May 1, 2017.

- **What changed as of February 1, 2017?**

  - Walgreens became a preferred retail pharmacy: You will still be able to obtain two fills of maintenance medications from any network retail pharmacy at the co-pays shown in the Schedule of Benefits. What has changed is that you can now continue to fill maintenance drugs at Walgreens retail pharmacies after two fills. After two fills, you can obtain maintenance medications through either mail order or at Walgreens retail pharmacies at the mail order co-pays shown below in the Schedule of Benefits. If you choose to continue obtaining your maintenance medications from network retail pharmacies other than Walgreens, you will be charged 100% of the drug cost, minus applicable network discounts. This rule will apply to fills obtained on or after February 1, 2017 (i.e., you will be able to obtain two fills at any network retail pharmacy after February 1, 2017 before having to pay 100% of the discounted drug cost).

  - No more minimum co-pays: Your co-pays may be less than the amounts shown in the Schedule of Benefits below if the actual cost of the drug is less than the co-pay. For example, if a 30-day supply of your generic medication costs $4, your co-pay will be $4, not $6.

- **What will change effective May 1, 2017?**

  - New formulary: The Plan will adopt ESI's standard formulary. Under this formulary, your specific medication could be excluded, and you may have to switch to a generic or another brand alternative unless the alternative medication does not sufficiently treat your condition. If the alternative medication does not sufficiently treat your condition, you may access ESI's appeal process to request that your current medication continue to be covered as is. You will receive information in the mail from ESI with instructions on how you can find out whether your specific medication is covered, and if not, what alternatives are available.

  - Different Three-Tier Drug Classification: Drugs will be classified under ESI's three-tier system (generic, preferred brand, and non-preferred brand). The classification of your drug under ESI's three-tier system may be different from its classification under OptumRx's three-tier system (generic, single-source, and multi-source), which could affect what your co-pay will be. You will receive information in the mail from ESI with instructions on how you can find out how your drug is classified under Express-Script's three-tier system.

- Changed Schedule of Benefits: As a result of the changes described above, the Plan's Prescription Drug Benefits Schedule of Benefits as of May 1, 2017 is reproduced below (changes are underlined or ~~struck out~~):

Prescription Drug Benefits (Active Employees and their Dependents)			
Participating Retail Pharmacy Program	**For up to a 30-day supply, you pay the lesser of actual drug cost or:**		**For each 30-day supply fill at Retail after two, you pay:**
• Generic Medication	$6 copayment		100% of network discounted drug cost (Walgreens Retail Pharmacies are same as mail order – see below)
• ~~Single Source~~ Preferred Brand Drug	$25 copayment		100% of network discounted drug cost (Walgreens Retail Pharmacies are same as mail order – see below)
• ~~Multi Source~~ Non-Preferred Brand Drug	$40 copayment		100% of network discounted drug cost (Walgreens Retail Pharmacies are same as mail order – see below)
Mail Order Service or Walgreens Retail Pharmacies (preferred after two fills)	**For 1-30 day supply, you pay the lesser of actual drug cost or:**	**For 31-60 day supply, you pay the lesser of actual drug cost or:**	**For 61-90 day supply, you pay the lesser of actual drug cost or:**
• Generic Medication	$6	$12	$15
• ~~Single Source~~ Preferred Brand Drug	$25	$50	$65
• ~~Multi Source~~ Non-Preferred Brand Drug	$40	$80	$100

2. Changes to the Plan's internal claims and appeals process for prescription drug claims

Effective February 1, 2017, and corresponding to the Fund's change to ESI as its new pharmacy benefits manager, there will be changes to the Plan's internal claims and appeals process. You will receive more information in the mail with details regarding the Plan's new claims and appeals procedure with respect to prescription drug claims.

Effective February 1, 2017, there are four total levels of review for prescription drug claims (as opposed to three for other types of health care claims), as detailed below:

- First review: Initial coverage review by ESI;
- Second review: Level 1 appeal or Urgent Care appeal by ESI;

- Third review: Level 2 appeal by the Fund's Board of Trustees (same as other types of health care claims);

- Fourth review (optional): External review by Independent Review Organization (same as other types of health care claims and only available in certain circumstances).

a. Initial coverage review (reviewed by ESI): The first request for review (after your claim is denied by a mail or retail pharmacy) is called an initial coverage review. ESI reviews both clinical and administrative coverage review requests (depending on the reason for the denial of your claim):

- Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization based on Medical Necessity.

- Administrative coverage review request: A request for coverage of a medication that is based on a Plan rule (e.g. if you are seeking coverage for weight loss medications, which are excluded under the Plan).

To request an initial clinical coverage review, also called prior authorization, your prescriber must submit the request electronically. Information about electronic options can be found at www.express-scripts.com/PA.

To request an initial administrative coverage review, you must submit the request in writing. A Benefit Coverage Request Form, used to submit the request, is obtained by calling the Customer Service phone number on the back of your prescription card. Complete the form and mail or fax it to:

ESI
Attn: Benefit Coverage Review Department
PO Box 66587
St Louis, MO 63166-6587
Fax: 1-877-328-9660

If your situation meets the definition of Urgent Care (as defined in the SPD), an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone at 1 800-753-2851.

A determination on an Initial Coverage Review request and notification to you (and/or your authorized representative) will be made as shown in the chart below:

Type of Claim	Decision Timeframe Decisions are made as soon as possible from receipt of request, but no later than:	Notification of Decision	
		Approval	Denial
Pre-service*	15 days (retail) 5 days (home delivery)	Patient: Automated call (letter if not successful)	Patient: Letter
Post-Service*	30 days	Prescriber: Electronic or fax (letter if not successful)	Prescriber: Electronic or fax (letter if not successful)
Urgent Care	72 hours**	Patient: Automated call and letter Prescriber: Electronic or fax (letter if not successful)	Patient: live call and letter Prescriber: Electronic or fax (letter if not successful)

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

**Assumes that all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48 hour extension will be granted.

b. <u>Level 1 appeal (reviewed by ESI):</u> If your initial coverage review has been denied (i.e. you receive an adverse benefit determination), you (or your authorized representative) have the right to request an appeal within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department (see below) for clinical or administrative review requests, depending on the type of initial coverage review that was denied:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents.

For clinical review requests, send appeals to:

ESI
Attn: Clinical Appeals Department
PO Box 66588
St Louis, MO 63166-6588
Fax 1-877-852-4070

For administrative review requests, send appeals to:

ESI
Attn: Administrative Appeals Department
PO Box 66587
St Louis, MO 63166-6587
Fax 1-877-328-9660

If your doctor believes your claim fits the definition of an Urgent Care appeal, your appeals must be submitted by phone 1-800-753-2851 or fax 1-877-852-4070. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Depending on the type of appeal, appeal decisions are made by a Pharmacist, Physician, panel of clinicians, trained prior authorization staff member, or an independent third party utilization management company. Appeal decisions and notifications are made as shown in the chart below:

Type of Appeal	**Decision Timeframe** **Decisions are made as soon as possible from receipt of request, but no later than:**	**Notification of Decision**	
		Approval	Denial
Pre-service	15 days	Patient: Automated call (letter if not successful) Prescriber: Electronic or fax (letter if not successful)	Patient: Letter Prescriber: Electronic or fax (letter if not successful)
Post-Service	30 days		
Urgent Care*	72 hours	Patient: Automated call and letter Prescriber: Electronic or fax (letter if not successful)	Patient: live call and letter Prescriber: Electronic or fax (letter if not successful)

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

If your Level 1 appeal is denied, in whole or in part, and you receive an adverse benefit determination, you have 180 days to appeal this decision to the Fund's Board of Trustees.

c. **Level 2 appeal:** This is an appeal to the Fund's Board of Trustees, same as other types of health care claims. Please see the subsection titled **Appealing a Denied Claim** under the **Filing and Appealing Claims** section in your SPD for further details.

d. **External review by an Independent Review Organization (IRO):** This is an optional appeal to an external IRO. Just like other types of health care claims, this level of review is only available if your claim denial involves a Medical Necessity determination, or is a rescission of coverage. Please see the section titled **External Review of Adverse Benefit Determination** subsection under the **Filing and Appealing Claims** section in your SPD for further details.

3. Coverage of immunizations administered by network pharmacists

Effective February 1, 2017, the Plan will cover certain immunizations at no cost to you when they are administered by a pharmacist who is within ESI's pharmacist network and is licensed under applicable law to administer immunizations. The following immunizations are covered: influenza, pneumonia, zoster (shingles), hepatitis, measles, mumps, rubella, human papillomavirus (HPV), diphtheria, meningitis, varicella, Haemophilus Influenzae Type B (Hib), inactivated poliovirus, rotavirus, and tetanus/diphtheria/pertussis.

The Plan will not cover any immunizations administered by pharmacists who are outside of ESI's network, or immunizations that are otherwise excluded under the Plan.

4. No-cost imaging procedures at preferred providers

Effective February 1, 2017, the Plan contracted with One Call Care Management ("One Call"), giving Plan participants access to a preferred network of providers for imaging procedures (CT/PET scans, MRIs). If you use a provider through One Call's network to have an imaging procedure performed, the procedure will be covered at no cost to you (no co-insurance and no deductible).

You must contact One Call, 888-458-8746, to schedule your MRI, CT scan or PET scan in order to have your procedure covered at no cost.