NATIONAL AUTOMATIC SPRINKLER INDUSTRY

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November 2016

To All Participants in the NASI Welfare Fund

From the Board of Trustees

The Board of Trustees of the National Automatic Sprinkler Industry Welfare Fund is pleased to again report that the NASI Welfare Fund is maintaining a strong financial position. Investment returns have been nicely positive so far this year which, along with improving contribution hours and claim expenses consistent with expectations, is expected to leave the Fund with a positive income-over-expense result by year end. In recognition of the overall financial situation, **the Board of Trustees has decided that there will be no changes made to the deductibles, co-insurance levels or out-of-pocket maximums for 2017.**

New Procedures for Pre-Service and Urgent Claims and Appeals

The Board of Trustees recently updated the Plan Document and Summary Plan Description procedures for processing "pre-service" claims and appeals. A pre-service claim generally is any claim that requires approval of the benefit in advance of obtaining medical care. More specifically, in the case of the NASI Welfare Fund, only claims related to specified drugs that require preauthorization are considered pre-service claims. A list of drugs requiring preauthorization is available from the Fund Office upon request. These procedures are briefly summarized below, however, for complete details on these procedures, please refer to the 2017 NASI Welfare Fund Plan Document and SPD, available on the NASI Welfare Fund's website www.nasifund.org.

Pre-Service Claims. Under the new procedures, the prescriber of a drug that requires pre-authorization should submit the prior authorization request (either electronically, by phone, or by fax) to the NASI Welfare Fund's pharmacy benefit manager, Express Scripts. After a request is filed you will generally be notified of the determination within 15 days after Express Scripts receives your coverage request. If the necessary information needed to make a determination is not received from the prescriber within 15 days, a letter will be sent to the patient and the prescriber informing them that certain information must be received within 45 days or the claim will be denied. If the additional information is provided in response to this request, a determination will be made within 15 days of when the information is received.

Urgent Care Claims. An urgent care claim is a pre-service request that arises when a patient or provider determines that the patient cannot wait for a decision on a preauthorization request because the patient's health may be in serious jeopardy, or the patient may experience pain that cannot be adequately controlled while awaiting a preauthorization determination. Under such circumstances, the provider or patient may telephone Express Scripts to request expedited review of a preauthorization request. You will be notified as soon as possible if your urgent care request is incomplete but not later than 24 hours after receiving your request. You will then have 48 hours to provide the specified information. Upon receiving this additional information, you will be notified of the coverage determination as soon as possible, within the earlier of 48 hours after receiving the information or the end of the period within which you must provide the information.

Appeal of Pre-Service and Urgent Care Claim Determinations. Express Scripts provides two levels of review of pre-service and urgent care claims that have been denied. Under Level One, should your initial pre-service claim for a drug that requires pre-authorization be denied, you or your authorized representative may file an appeal with Express Scripts by mail or fax within 180 days from the date you received notice that your request for pre-authorization or expedited review was denied. A decision on your pre-service claim will be made as soon possible, but no later than 15 days after it is received by Express Scripts. If your appeal is granted, you will receive an automated phone call (or letter if the call is unsuccessful) advising you of the decision. You will be notified by mail if your claim is denied.

An urgent appeal may be submitted if, in the opinion of the attending provider, the time period for making a non-urgent care determination could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the drug that is the subject of the appeal. Urgent appeals must be submitted by phone or fax. Appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent. A decision on your pre-service claim will be made as soon possible, but no later than 72 hours after it is received by Express Scripts. If your appeal is granted, you will receive an automated phone call advising you of the decision. You will be notified by an Express Scripts representative by phone if your claim is denied. You will also be advised of the decision by mail. The doctor who prescribed the drug at issue will receive notice of the decision via fax (or by letter if the fax is not successful) from Express Scripts.

Should your Level One appeal be denied, you or your authorized representative may request a second level of review from Express Scripts within 90 days of the date you are notified of the denial of your Level One appeal. In circumstances where the appeal was not considered an urgent claim as a Level One appeal, it may be considered as urgent as a Level Two appeal if, in the opinion of the attending provider, the time period for making a non-urgent care determination could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or subject the patient to severe pain that cannot be adequately managed without the drug at issue on appeal. The timeframe for receiving a notice of a decision of a Level Two appeal from Express Scripts is identical to the timeframe applicable to Level One appeals discussed above.

Finally, should your Level Two appeal be denied, you may, as summarized briefly below, pursue you appeal with an independent review organization and the Board of Trustees.

External Review Appeal Process

The right to request an independent external review may be available for certain denials (also referred to as adverse benefit determinations). Generally, the internal appeal rights discussed above must be exhausted prior to requesting an external review of a denial. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of your claim. Requests for external review must be received by MCMC (the entity that conducts the external review these claims filed with Express Scripts) within four months of the date you receive the final denial of your appeal under the internal procedures discussed above.

Standard External Review: MCMC will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO), and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review, and if the IRO has determined that the claim involves medical judgment, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Voluntary Trustee Review of Pre-Service and Urgent Care Claims

Finally, the Trustees of the NASI Welfare Fund have made available a voluntary appeal to the Trustees of Pre-Service and Urgent Care Claims. The voluntary appeal will take place ONLY at the Trustees' regularly scheduled meetings. The voluntary appeal to the Trustees may be requested only after Level One and Level Two appeals have been completed.

Blue Distinction Centers
Now Includes Maternity Care

The Blue Cross Blue Shield ("BCBS") Association has identified certain hospitals across the nation that have demonstrated expertise in delivering specialty care. Some of these facilities are close to where you live. The BCBS evaluation process involves reviewing the expertise of the medical team, the number of times the facility has performed the procedure and the facility's track record for procedure results. Facilities identified as "Blue Distinction Centers" have a proven track-record for delivering better results such as fewer complications and fewer readmissions than facilities not recognized as Blue Distinction Centers.

Blue Distinction Centers delivering the following types of specialty care have been identified:

- Bariatric Surgery
- Cardiac Care
- Knee and Hip Replacement
- **Maternity Care**
- Spine Surgery
- Transplants

If you or someone in your family is contemplating a procedure (e.g. surgery, delivery) in one of the above medical categories, the Board of Trustees encourages you to consider doing so at a facility that specializes in that care. Finding the right facility can have a direct impact on the care you receive and your procedure results, including better medical outcomes, fewer complications, fewer readmissions for the same condition, lower hospital-acquired infection rates and lower mortality rates. Better care is better for you and will likely result in lower medical costs to you and the Fund.

Some of the facilities identified as Blue Distinction Centers also have lower costs associated with their high-quality care. Facilities that are considerably more efficient at providing expert specialty care have been further classified as **"Blue Distinction Centers +".** A better medical outcome might be enough incentive for you to choose to use a Blue Distinction Center but, in addition to expert medical care, those who receive one of the above categories of specialized care at a Blue Distinction Center + facility will also receive a $500 incentive benefit payment.

By receiving specialized care in one of the above categories at a Blue Distinction Center + facility, you will be refunded $500 of your out-of-pocket expenses that you recently incurred. Even if you previously met your out-of-pocket maximum such that the Fund is covering 100% of the covered expenses for the Blue Distinction Center + facility, you will still receive a refund in the amount of $500 of previously incurred deductible and/or your co-insurance portion of expenses. Individuals receiving this incentive benefit will still be entitled to 100% coverage as if they had incurred the full out-of-pocket maximum expense amount. This incentive is available to active and retired participants, dependents and beneficiaries, except for retired participants and beneficiaries who are Medicare-eligible.

In addition to the six categories of specialty care listed above, the Blue Cross Blue Shield Association has also identified Blue Distinction Centers for Complex and Rare Cancers. Since none of the Blue Distinction Centers for Complex and Rare Cancers are particularly more financially efficient than the others, none have yet been designated as a Blue Distinction Center + facility. Therefore, the $500 incentive is not available for this category of care.

Blue Distinction Center Finder

Use the link on the NASI Welfare Fund's website, www.nasifund.org entitled "Blue Distinction Center Finder". You can search for the particular specialty you need (e.g. cardiac care), and you can limit your search to the state or states you are willing to go to in order to receive the best care available. You will probably find that a specific facility may be a Blue Distinction Center for one or more specialties, but it is not so designated for other specialties. This search tool will also identify whether the facility is a Blue Distinction Center or a Blue Distinction Center + facility.

With the NASI Welfare Fund, you have excellent health care benefits. Consider using those benefits to receive excellent health care.

Federally Required Services

Pregnancy-Related Expenses for Non-Spouse Dependents
In compliance with recently published federal regulations, the NASI Welfare Plan exclusion from coverage for expenses associated with the pregnancy of a non-spouse dependent is removed effective January 1, 2017. All other plan limitations regarding such services, such as medical necessity, continue to apply to such cases.

Transgender Services
Also in compliance with recently published federal regulations, the NASI Welfare Plan exclusion from coverage for expenses associated with transgender services and surgery is removed effective January 1, 2017. All other plan limitations regarding such services, such as medical necessity, continue to apply to such cases.

Level 2 and Level 3 Benefits

The great majority of those eligible for benefits from the NASI Welfare Plan enjoy Level 1 benefits which include non-medical benefits like dental, vision, disability and life insurance. The NASI Welfare Plan also provides two other levels of medical benefits which have different deductible, co-insurance and out-of-pocket maximum expense levels. Groups who have bargained for Level 2 or Level 3 medical benefits can also choose to bargain for some or all of the "additional" benefits; dental, vision, disability and life insurance.

Effective January 1, 2017, the hourly contribution rates associated with these benefits are as follows:

Level 2 Medical Benefits	$7.03
Level 3 Medical Benefits	$6.71
Dental	$0.68
Disability	$0.07
Life	$0.01
Vision	$0.11

Flu shots and other Immunizations

Remember to get your seasonal flu shot from your Blue Cross Blue Shield participating physician or at your local pharmacy that participates with Express Scripts. Most immunizations, including flu shots are covered at 100% by the NASI Welfare Fund when using an In-Network provider.

Personal Health Management

In 2014, the NASI Welfare Fund joined with Carewise Health in an effort to help certain participants with specific chronic conditions to take actions that can help them avoid some of the complications of those conditions. Not everyone with a chronic condition will be contacted by Carewise Health, but if you are contacted, the Trustees ask that you Take the Call from Carewise Health. The fact that Carewise Health is contacting you is an indication that they have seen something in your claims or prescription drug history that identifies you as a person at elevated risk for complications.

Please, Take the Call.

Program incentives and penalties will remain in place in 2017.

Pensioner Medical Coverage

Retirees with medical coverage pay a premium that is deducted from their monthly pension benefit. The amounts retirees pay are designed to cover 50% of the cost of retiree coverage.

Pensioners and beneficiaries who do NOT have Medicare

The monthly self-payment for pensioners or beneficiaries who are not yet eligible for Medicare will increase from $800 per month in 2016 to $823 per month beginning January 1, 2017.

Pensioners and beneficiaries whose local union has a Retired Employee Subsidy Account (RESA) and who are eligible for their local union's RESA will continue to benefit from their Local Union's subsidy of the cost of their coverage. If your Local Union determines that your RESA will not pick up the additional cost by increasing its subsidy to its covered members, you will be advised in a separate announcement.

Pensioners and beneficiaries WITH Medicare

The monthly self-payment for pensioners or beneficiaries who became eligible for Medicare before 2002 will increase in cost from $280 per month in 2016 to $293 per month in 2017. For those pensioners or

beneficiaries who become eligible for Medicare after 2001, the monthly self-payment cost for coverage will increase in cost from $330 per month in 2016 to $343 per month in 2017.

Medicare-eligible Pensioners and beneficiaries whose local union has a Retired Employee Subsidy Account (RESA) and who are eligible for their local union's RESA will continue to benefit from their Local Union's subsidy of the cost of their coverage. If your Local Union determines that your RESA will not pick up the additional cost by increasing its subsidy to its covered members, you will be advised in a separate announcement.

Monthly Cost for Those Participating in NASI Welfare Fund through Participation Agreements

The premium for the NASI Welfare Fund for those participating in the Fund through participation agreements (e.g. owner members) will be $1,467.20 per month.

REMINDERS

Retiree Benefits and Medicare

Medicare is the primary coverage for retirees, dependents of retirees and beneficiaries. The NASI Welfare Plan requires that individuals who are eligible for Medicare Part B benefits sign up for those benefits. Additionally, if an individual is not entitled to cost-free Medicare Part A, that individual must also purchase Part A coverage from Medicare when they become eligible to do so at age 65.

Since ***Medicare does not pay for hospital or medical services outside of the United States***, in order to have adequate coverage when traveling or living outside the United States, you need to purchase travel insurance or other medical insurance. The NASI Welfare Fund will not provide primary medical coverage for Medicare-eligible individuals; instead, the Plan will limit its coverage to the amount the Plan would have paid on your behalf had you received those services in the United States. For example, if you are hospitalized in the United States, Medicare Part A pays all of the cost of the hospitalization but for the deductible ($1,288 in 2016). If you are, instead, hospitalized outside of the United States, the Plan will process your claim assuming your medical expense was $1,288 (i.e., the amount that would not have been covered by Medicare if the expense was incurred in the United States), and you will be responsible for the remainder of the charges unless you have travel insurance or other coverage.

Notification Requirement upon Divorce

Notice of your divorce must be provided to the Fund office within 60 days of your divorce.
If notice of your divorce is not provided to the Fund Office in this time frame and, as a result, benefits are paid to an ineligible dependent, the Fund can recover those benefits by treating such benefits as an advance to you and deducting such amounts from benefits which become due to you until the entire amount of benefits erroneously paid is recovered.

Make Sure Your Beneficiary is Up-to-Date

Be aware that your divorce does not invalidate your beneficiary designation. Forms to designate or change a beneficiary for your NASI Welfare Fund life insurance benefit as well as for your NASI Pension Fund death benefit (for active participants) and for your SIS Pension Fund death benefit are available on the Funds' website, www.nasifund.org, or by calling the Fund office.

Entitlement to Social Security Disability Benefits

If you become entitled to Social Security Disability Benefits, you have to provide the Fund Office with a copy of your award within nine months of your receipt in order to fully benefit from Plan provisions that can restore or continue eligibility for benefits.

Annual Reminder (as required by federal law) regarding Women's Health and Cancer Rights Act of 1998

The NASI Welfare Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

Call the Fund Office at 1-800-638-2603 for more information.

Summary of Benefits and Coverage

The pages that follow this announcement are designed to meet requirements of the PPACA.