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Annuity Trust Summary of Material Modification

Date of Notification: August, 2019

To: All Annuity Plan Participants.

Effective 2/7/2018
The Claims Appeal Procedure was amended to add the following new subsection:

Restriction on Venue: An Employee, Participant, Pensioner, Beneficiary, Dependent, Surviving Spouse, or any other individual or entity asserting any right under this Plan, or hereby bound directly or indirectly or with rights or obligations hereunder, shall only bring an action in connection with the Plan exclusively in the United States District Court for the Southern District of Ohio at Dayton, Ohio.

This Plan shall be construed under and in accordance with the law and the laws of the United States of America. In the event there is a matter involving state law which is not preempted by federal law, Ohio law shall be the controlling state law.

Effective 4/1/2018
The Claims Review Procedures were amended as follows:

(a) Initial Benefit Claim. Any claim by an Employee, Participant, Pensioner, Beneficiary, Contingent Annuitant, or the authorized representative of any of the foregoing (all of whom are hereafter collectively referred to in this Section 7.01 as "Claimant") for a Plan benefit shall be in writing and delivered to the Trustees.

If the Trustees denies the claim in whole or in part, it shall furnish written notice of such decision to Claimant not later than 90 days from the time the claim is received; provided, however, if special circumstances warrant, the Plan Administrator may extend the time for processing the claim by so notifying Claimant in writing within said 90 days, specifying the special circumstances requiring the extension of time and the date by which a final decision is expected. In no event may be the extension period exceed 90 days from the end of the initial 90-day period.

Notwithstanding the immediately preceding paragraph, in the case of a claim for benefits due to being totally and permanently disabled (as defined under Section 5.02(c)), the claim shall be reviewed by a committee designated by the Trustees. If the claim for benefits is denied by this committee it shall furnish written notice of its adverse determination within 45 days from the date the claim is received. This period may be extended by the committee for up to 30 days, provided the committee both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the committee expects to render a decision. If, prior to the end of the first 30-day extension period, the committee determines that due to matters beyond its control a decision cannot be rendered within the extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the committee notifies the Claimant prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the committee expects to render a decision.

Any denial by the Trustees or the committee designated by the Trustees in the case of a disability determination shall set forth, in a manner calculated to be understood by the claimant:

(i) The specific reason or reasons for the adverse benefit determination;

(ii) Reference to the specific Plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such material or information is necessary; and

(iv) A description of the Plan's review procedures and time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA after he has exhausted the Plan's review procedure

Disability Claims. Claim denial notices will contain the following additional information:

(i) An explanation as to why the Plan disagreed with the views of (i) health care or vocational professionals who evaluated the Claimant or advised the Plan, or (ii) a disability determination of the Social Security Administration.

(ii) If a denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

(iii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist or were not used.

(iv) 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 information relevant to the claim.

(v) If the denial is a final internal denial, a statement of the Claimant's right to bring an action under Section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

(vi) Denial notices will be provided in a culturally and linguistically appropriate manner.

Disability Claims. Other considerations:

(i) A retroactive cancellation of disability coverage will be treated as a claim denial unless it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(ii) Disability claims and appeals will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

If no notice of denial is furnished to Claimant within the time periods set forth above, as may be extended as provided above, the claim shall be deemed denied and the Claimant may proceed to the review procedure.

(b) Full and Fair Review. The Claimant shall have the right to seek a full and fair review of any denied claim before the Trustees. In order to afford a full and fair review, the Trustees shall provide the Claimant with the following:

(i) A period of 60 days after receipt of the notice of denial of the claim to make a written request to the Board of Trustees formally appealing the claim, or if no written denial of the claim was provided, a period of 60 days after the deemed denial of the claim. Notwithstanding the previous sentence, when the Claimant is seeking a benefit under the Plan based upon being totally and permanently disabled, the period for filing an appeal shall be a period of 180 days after receipt of the notice of denial of the claim or a deemed denial of the claim;

(ii) An opportunity on appeal to submit written comments, documents, records and other information relating to the claim;

(iii) A statement that the Claimant is entitled, upon request and free of charge, access to, and copies of, all documents, records and other information relevant to the claim for benefits;

(iv) A review that takes into account all comments, documents, records, and other information as submitted by the Claimant, without regard to whether such information was submitted or considered in the initial review; and

(v) In the case of a disability determination, a full and fair review must also provide for the following:

(1) A review that does not afford deference to the initial denial decision rendered by the committee;

(2) A review that shall consist of consultation with a health care professional who has appropriate training and experience in the field of medicine involved with the disability determination;

(3) The identification of the medical and/or vocational experts whose advice was obtained on behalf of the Board of Trustees in connection with the denial decision, without regard to whether the advice was relied upon in making the denial decision; and

(4) A review that does not consult with the same health care professional as consulted by the committee at the initial claims review level, nor the subordinate of any such individual.

(c) Appeal Procedures. The written decision of the Trustees on appeal will normally be made at the next regular meeting of the Trustees held after the date the Claimant's appeal request is received, unless, the request is filed within 30 days preceding the meeting. In that case, the appeal decision may be made at the second meeting following the Trustees' receipt of the Claimant's request. If special circumstances exist that require a further extension (such as the need to hold a hearing), the Trustees can make its decision by the third meeting. The Claimant would receive a notice in that event such an extension is needed. The Claimant will be notified of that Trustees' decision regarding the appeal as soon as possible after the meeting in which the appeal is decided and, in no event, any later than 5 days after such meeting. If the Trustees deny the appeal, the reasons for the denial on review shall be specifically set forth in the written notice provided by the Trustees and shall include the following:

(i) The specific reason or reasons for the denial decision;

(ii) The specific plan provision(s), if any, upon which the denial decision was based;

(iii) A statement informing the Claimant that upon request and free of charge, the Claimant is entitled access to, and copies of, all documents, records and other information relevant to the claim for benefits; and

(iv) A statement describing the Claimant's right to bring a legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Disability Claims. Notices on appeal will contain the following additional information:

(i) An explanation as to why the Plan disagreed with the views of (i) health care or vocational professionals who evaluated the Claimant or advised the Plan, or (ii) a disability determination of the Social Security Administration.

(ii) If a denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

(iii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or

other similar criteria of the Plan do not exist or were not used.

(iv) 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 information relevant to the claim.

(v) If the denial is a final internal denial, a statement of the Claimant's right to bring an action under Section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

(vi) Denial notices will be provided in a culturally and linguistically appropriate manner.

Disability Claims on Appeal.

(i) Before the Plan will deny an appeal, the Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination in connection with the claim. The Claimant will then be given a reasonable opportunity to respond prior to the decision on appeal.

(ii) Before the Plan will deny an appeal based on a new or additional rationale, the Plan will provide the Claimant, free of charge, with the rationale. The Claimant will then be given a reasonable opportunity to respond prior to the decision on appeal.

(d) Section 503 of ERISA. The claims review provisions of the Plan are intended to comply with the applicable requirements of Section 503 of ERISA and U.S. Department of Labor Regulation Section 2560.503-1, and shall be construed in a manner consistent therewith. The Claimant may not pursue any legal remedies with respect to denial of the benefit claim, including filing suit under Section 502(a) of ERISA, unless and until the claim review procedures set forth under this Section 7.01 of Plan have been exhausted.

(e) Decision on Appeal To Be Final. The decision by the Board of Trustees on appeals shall be final, binding and conclusive and will be afforded the maximum deference permitted by law unless found by a court of competent jurisdiction to be arbitrary and capricious. **The mandatory levels of appeal must be exhausted before any legal action is brought. Any legal action must be commenced within one (1) calendar year after these claims' review procedures have been exhausted.**

Board of Trustees

The Board of Trustees is currently comprised of the following individuals:

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44	David Baker	Mark Douglas
70	Tommy Carrier	Mark Bishop
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172	Benton Amburgey, Jr.	Craig Wanner
290	Jeffrey S. Bush, Sr.	John Hesford
292	Robert Kara	Ronald Fisher
769	Russell Montgomery	William Howes
787	Bradley Winans	Clinton Suggs

Sincerely,

BOARD OF TRUSTEES