BENEFIT • PENSION • ANNUITY
IW TRUST FUNDS
Building Futures Together

1470 Worldwide Place • Vandalia, OH 45377-1156
Phone (937) 454-1744 • Fax (937) 454-5457 • Toll free (800) 331-4277

Benefit Trust Summary of Material Modification

Date of Notification: August, 2019

To all Active and Non-Medicare Plan Participants, the following plan changes have been made to the Benefit Plan.

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 Claim Denials and Appeal Procedures were amended as follows:

If all or a part of the claim is denied after all requested, necessary information from the claimant is received, the claimant will be sent a written notice giving the reason(s) for the denial. The notice will include:

1. Reference to the Plan provisions on which the denial was based;
2. A description of the appeal procedures and the applicable time limits for following the procedures;
3. If applicable, a description of any additional material or information necessary for the claimant to perfect the claim and the reason such information is necessary;
4. For urgent care claims, a description of the Plan's expedited review process will be provided; and
5. A statement concerning the claimant's right to bring a civil action under Section 502(a) of ERISA following an appeal.

Disability Claims. Claim denial notices will contain the following additional information:
1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. Denial notices will be provided in a culturally and linguistically appropriate manner.

Disability Claims. Other considerations:

1. 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.
2. 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.

Claim Appeal Procedure

Appealing a Claim Denial

If a claim for Medical or Prescription Drug benefits is denied in whole or part, the claimant must follow the Complaint and Appeals Procedure provided through the Plan's third-party administrator. **This Claims and Appeals Procedure provides two mandatory levels of appeal.** After these appeals are exhausted, a claimant may file a voluntary appeal to the Board of Trustees under the appeal procedure outlined in this section.

With respect to any appeal concerning a claim under the Medicare Advantage PPO Plan, the claimant shall file such appeal with the third party in accordance with the procedures set forth in the Evidence of Coverage booklet provided to the claimant by the third party.

If a claim for eligibility, Dental, Vision, Hearing Aid, Weekly Disability or HRA benefits is denied in whole or part, the claimant may request a full and fair review (also called an appeal) by filing a written notice of appeal with the Board of Trustees. A claim for Medical, Prescription Drug, Life and Accidental Death and Dismemberment benefits must be appealed to the insurance carrier under its procedures first. The claimant should submit the request for review for the Board of Trustees to:

Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust Office
1470 Worldwide Place
Vandalia, OH 45377
(937) 454-1744 or (800) 331-4277

When filing an appeal to the Plan:

▪ The appeal must be received by the Benefit Trust Office or the insurance carrier not more than 180 days (60 days for Life or AD&D claims) after the claimant receives the written notice of denial of the claim. The claimant must identify himself or herself as a Plan Participant.

▪ The claimant may orally request that the Plan review its denial of an urgent care claim by calling the Benefit Trust Office at (937) 454-1744 or (800) 331-4277 or the claimant may also submit the request in writing at the address listed above. The Benefit Trust Office may notify the claimant of its decision by telephone or facsimile.

▪ If the claimant disagrees with a claim denied by the Benefit Trust Office, the claimant may request a review by the Board of Trustees. The Trustees decision will be made within the time remaining for a decision on the appeal after the denial of the appeal.

▪ Another person may represent the claimant in connection with an appeal. If another person claims to be representing the claimant in the claimant's appeal, the Trustees have the right to require that the claimant give the Benefit Trust Office a signed statement, advising the Trustees that the claimant has authorized that person to act on the claimant's behalf regarding the claimant's appeal. Any representation by another person will be at the claimant's own expense.

▪ The claimant (and the claimant's authorized representative, if any) may request to appear in person before the Trustees. If the Trustees grant the claimant's request, the claimant's and his or her representative's appearance must be at the claimant's expense.

▪ The claimant or his or her authorized representative may review pertinent documents and may submit comments and relevant information in writing.

▪ Upon written request, the Benefit Trust Office will provide reasonable access to, and copies of, all documents, records or other information relevant to the claim.

▪ If an appeal involves a medical judgment, such as whether treatment is Medically Necessary, the Trustees will consult with a medical professional who is qualified to offer an opinion on the issue. If a medical professional was consulted in connection with the original claim denial, the Trustees will not consult with the same medical professional (or a subordinate of that person) for purposes of the appeal.

▪ If the opinion of a medical or vocational expert was obtained in connection with the claim, the claimant may request, in writing, the name of that expert.

▪ The Benefit Trust Office will not charge the claimant for copies of documents requested in connection with an appeal.

▪ In deciding the claimant's appeal, the Trustees will consider all comments and documents submitted, regardless of whether that information was available at the time of the original claim denial. The review will not defer to the initial denial, and will take into account all comments, documents, records, and other information submitted by the claimant, without regard to whether such information was previously submitted or relied upon in the initial determination.

The decision on the appeal of a claim made by the Trustees or by a committee delegated by the Trustees is final and binding.

Notification Following Review

If the appeal is for an urgent care claim, the claimant will be notified of the decision about the appeal as soon as possible, taking into account the circumstances, but no later than 72 hours after receipt of the request for review. Oral notification of a decision on an urgent care claim appeal will be followed up with a written or electronic notification within three days of the oral notification. In the case of pre-service claims, the claimant will be notified no later than 30 days after receipt of the request for review.

A review and determination for post-service claim to the Board of Trustees will be made no later than the date of the meeting of the Trustees that immediately follows the Plan's receipt of a request for review. However, if the request is filed within 30 days preceding the date of such meeting, a determination may be made by no later than the date of the second meeting.

If special circumstances (such as the need to hold a hearing) require a further extension of time, a determination will be made no later than the third meeting of the Trustees. Before the start of the extension, the claimant will be notified in writing of the extension, and that notice will include a description of the special circumstances and the date as of which the determination will be made.

If the Plan fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, the claimant may go to court to enforce his or her rights. A claimant may not file suit against the Plan until the claimant has exhausted all of the procedures described in this section.

The claimant will be informed of the Trustees' decision, normally within five calendar days of the determination. The decision will be in writing unless the appeal was for an urgent care claim. When the claimant receives the written decision, it will contain:

1. The reasons for the decision and specific references to the particular Plan provisions upon which the decision was based;
2. A statement explaining 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; and
3. A statement of the claimant's right to bring an action under Section 502(a) of ERISA.

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

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. Denial notices will be provided in a culturally and linguistically appropriate manner.

Disability Claims on Appeal.

1. 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.

2. 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.

Effective 5/14/2019
The Medical and Prescription Drug Benefits sections are amended as follows:

Gene Therapies and gene therapy drugs are excluded from Medical and Prescription Drug coverage for the active and Non-Medicare Retiree Plans.

Board of Trustees

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

Iron Workers Local Union No.	Union Trustees	Employer Trustees
22	Ralph Copley	Mike Kerr
44	David Baker	Mark Douglas
70	Tommy Carrier	Mark Bishop
147	Ron Starkey	Robert Fruchey
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

506