BENEFIT • PENSION • ANNUITY
IW TRUST FUNDS
Building Futures Together

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IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST

Benefit Trust Summary of Material Modifications

Date of Notification: August 2020

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

Please note the following Plan changes from 2019 and thus far in 2020:

Effective 1/1/2020
Active and Non-Medicare Retiree Plans:

The Plan elected to forego Grandfathered status. The respective **Schedule of Benefits** were modified with respect to the medical deductibles, out-of-pocket maximums, and preventative care, as well as the prescription deductibles, co-payments and out-of-pocket maximums as shown below, to the Active and Non-Medicare Retiree Health Plans.

Active Participants and Dependents
Schedule of Benefits

Medical Benefits	Network Coverage	Non-Network Coverage
Calendar Year Deductible	$500 per person; $1,000 per family	$1,000 per person; $2,000 per family
Calendar Year Out-Of-Pocket Maximum	$4,000 per person; $8,000 per family	$8,000 per person; $16,000 per family
Preventive Care / Immunizations	You pay $0 Copayment	You pay 30% Coinsurance
Prescription Drug Benefits	**Network Pharmacy**	**Non-Network Pharmacy**
Deductible (combined network and non-network Pharmacy)	$65	
Retail Pharmacy Maximum Supply: 30 days Copayment: Generic Brand Formulary Brand Non-Formulary Specialty	 Per prescription: You pay $10 You pay $40 You pay $60 You pay $60	 You pay 50%; minimum $55 You pay 50%; minimum $55 You pay 50%; minimum $55 You pay 50%; minimum $55
Mail-Order Maximum Supply: 90 days Copayment: Generic Brand Formulary Brand Non-Formulary Specialty	 Per prescription: You pay $20 You pay $60 You pay $90 You pay $90	Not covered

Calendar Year Out-Of-Pocket Maximum	$4,150 per person; $8,300 per family	Unlimited

Plan A Non-Medicare Eligible Retirees and Dependents Schedule of Benefits

Medical Benefits	Network Coverage	Non-Network Coverage
Calendar Year Deductible	$400 per person; $1,000 per family	$700 per person; $1,800 per family
Calendar Year Out-Of-Pocket Maximum	$3,250 per person; $6,500 per family	$6,000 per person; $12,000 per family
Preventive Care / Immunizations	You pay $0 Copayment	You pay 40% Coinsurance
Prescription Drug Benefits	**Network Pharmacy**	**Non-Network Pharmacy**
Deductible (combined network and non-network Pharmacy)	$50	
Retail Pharmacy Maximum Supply: 30 days Copayment: Generic Brand Formulary Brand Non-Formulary Specialty	 Per prescription: You pay $10 You pay $25 You pay $40 You pay $40	 You pay 50%; minimum $40 You pay 50%; minimum $40 You pay 50%; minimum $40 You pay 50%; minimum $40
Mail-Order Maximum Supply: 90 days Copayment: Generic Brand Formulary Brand Non-Formulary Specialty	 Per prescription: You pay $20 You pay $50 You pay $80 You pay $80	Not covered
Calendar Year Out-Of-Pocket Maximum	$4,900 per person; $9,800 per family	Unlimited

Plan B Non-Medicare Eligible Retirees and Dependents Schedule of Benefits

Medical Benefits	Network Coverage	Non-Network Coverage
Calendar Year Deductible	$1,000 per person; $2,000 per family	$2,000 per person; $4,000 per family
Calendar Year Out-Of-Pocket Maximum	$5,250 per person; $10,500 per family	$10,500 per person; $21,000 per family
Preventive Care / Immunizations	You pay $0 Copayment	You pay 50% Coinsurance
Prescription Drug Benefits	**Network Pharmacy**	**Non-Network Pharmacy**

Deductible (combined network and non-network Pharmacy)	$200	
Retail Pharmacy Maximum Supply: 30 days Copayment: Generic Brand Formulary Brand Non-Formulary Specialty	 Per prescription: You pay $10 You pay $30 50%; min $50/$100 max 50%; min $50/$100 max	 You pay 50%; minimum $50 You pay 50%; minimum $50 You pay 50%; minimum $50 You pay 50%; minimum $50
Mail-Order Maximum Supply: 90 days Copayment: Generic Brand Formulary Brand Non-Formulary Specialty	 Per prescription: You pay $20 You pay $70 You pay $125 You pay $125	Not covered
Calendar Year Out-Of-Pocket Maximum	$2,900 per person; $5,800 per family	Unlimited

Effective 1/1/2020

Active and Non-Medicare Retiree Plans:

The following external claims review process was added to the Plan.

EXTERNAL REVIEW PROCESS

- **Claims Adjudicated by the Plan's third-party administrator.**

- **First Level Appeal:**

  With respect to those claims adjudicated by the Plan's third-party administrator, the Claimant is required to appeal any adverse benefit determination directly to the Plan's third-party administrator in accordance with these procedures.

- **Second Level Appeal:**

  Once the Claimant receives the Plan's third-party administrator determination on such appeal, the Claimant has the right to a second-level external review through an Independent Review Organization (IRO), if certain criteria are met. The request for external review must be made within four (4) months from the Claimant's receipt of the adverse benefit determination from the Plan's third-party administrator. The Claimant may be eligible to have a decision reviewed through the external review process if the following criteria are met:

  - The adverse benefit determination involves medical judgement, as determined by the external reviewer, or a rescission of coverage;
  - The mandatory internal appeal process has been exhausted unless under applicable law you are not required to exhaust the internal appeal process (for example, when your claim is entitled to expedited external review and you request an expedited external review to proceed simultaneously with an urgent internal appeal, or if you do not receive a timely internal appeal decision);
  - The Claimant is or was covered under the Plan at the time the service was requested, or, in the case of retrospective review, was covered under the Plan when the service was provided, and;

- The Claimant has provided all of the information and forms necessary to process the external review.

The external review will be conducted by an IRO accredited by a nationally recognized accrediting organization. The Claimant will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review the claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO in not based in any manner on the likelihood that the IRO will support a denial of benefits.

The IRO conducting the review will be provided with a copy of the records that are relevant to your medical condition and the external review. The IRO will review the claim without being bound by any decisions or conclusions reached during the internal claim and appeal process.

- **External Review for Non-Urgent Care Claim Appeals**

If the Claimant's request for external review is complete and the Claimant is eligible for external Review, an IRO will conduct the review. The IRO will notify the Claimant and give the Claimant ten (10) business days to submit information for its consideration. The IRO will issue a written decision within 45 days after it receives the request for external review. This written decision will include the main reasons for the decision, including the rationale for the decision.

- **Expedited External Review for Urgent Care Claim Appeals**

The Claimant may request an external review for urgent care claims at the same time the Claimant requests an expedited internal appeal of an urgent claim.
An expedited review may be requested if the Claimant's condition, without immediate medical attention, could result in serious jeopardy to the Claimant's life or health or the Claimant's ability to regain maximum function; or the Claimant has received a final internal appeal denial concerning admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

If the Claimant's request for external review is complete and the Claimant is eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the main reasons for the decision, including the rationale for the decision.

If the IRO grants the appeal, then the IRO's decision is final and binding. However, if the IRO denies the appeal, a voluntary appeal is available whereby the Claimant may then appeal any such adverse determination to the Fund's Board of Trustees as described below.

Appeals to the Plan's third-party administrator should be addressed as follows:

Anthem Blue Cross Blue Shield
Attn: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Effective 7/12/2019
Active Plan New Employee Eligibility:

The default rule for new employee eligibility for the Active Plan was clarified as follows.
New Employees. New bargaining unit ironworkers to this District Council who have never had hours reported to this Plan including Apprentices, newly organized and, transfers from other district councils, generally are eligible for coverage after 500 hours of work in Covered Employment during a five-consecutive month period, provided some hours are worked in the first month of the five-month period.

Example
Chris is an apprentice who begins work on January 1, 2020 and completes 500 hours of work in Covered Employment prior to June 1, 2020 (worked 500 hours during consecutive 5-month period). He will be eligible for benefit coverage beginning July 1, 2020 (the first day of the second month after satisfying hours' requirement).

Effective 3/18/2020
Families First Coronavirus Response Act of 2020

Effective March 18, 2020, through the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, the section entitled **Schedule of Benefits** shall be amended to waive cost sharing for the following services:

> Diagnostic tests to detect the virus that causes COVID-19 that are approved or authorized by the FDA, including the administration of such tests; and
>
> Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the test described above, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

Effective March 18, 2020, through the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, the section entitled **Schedule of Benefits** shall be amended to waive the Participant co-pay for LiveHealth Online.

Effective March 18, 2020, through the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, the section entitled **Schedule of Benefits** shall be amended to waive the Participant co-pay for telehealth and virtual office visits.

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

Iron Workers Local Union No.	Union Trustees	Employer Trustees
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147	Ron Starkey	Robert Fruchey
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290	Jeffrey S. Bush, Sr.	John Hesford
292	Robert Kara	Ronald Fisher
769	Russell Montgomery	Scott Massie
787	Bradley Winans	Clinton Suggs

Sincerely,

BOARD OF TRUSTEES