Iron Workers District Council of Western New York and Vicinity

Supplemental Benefit Fund

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SUMMARY OF MATERIAL MODIFICATIONS
AND
NOTICE TO ACTIVE PARTICIPANTS

IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY
SUPPLEMENTAL BENEFIT PLAN

(Plan No.: 501; I.D. No.: 16-1550492)

Dated: March 20, 2018

Dear Participant:

The following is a summary of changes to your Supplemental Benefit Fund:

1. Effective July 1, 2017, the Subsection entitled **Eligibility** of Section 2, **Rules of Eligibility**, located at SPD page 4 of the Summary Plan Description, was amended by deleting the second and third paragraphs and replacing them with the following, with new language in bold italics:

> However, in order to be eligible for an employer contribution to be made to the Supplemental Benefit Fund on your behalf, you must actually be enrolled in the health benefit provided under the Iron Workers District Council of Western New York and Vicinity Welfare Fund or in another employer-sponsored health plan that has been certified to the Plan Administrator as providing "minimum value," as defined under the Affordable Care Act ***(collectively referred to as "Group Coverage"). Effective July 1, 2017, your eligible dependents must also enroll in Group Coverage to participate in the Individual Account.***
>
> If you leave covered employment for reasons other than retirement under the Iron Workers District Council of Western New York & Vicinity Pension Fund, or ***you lose Group Coverage,*** you ***(and your eligible dependents)*** may continue to receive reimbursements from the Supplemental Benefit Fund as long as the required balance is maintained in your Individual Account. However***,*** utilization of benefits will be applicable to only those contributions made ***prior to your loss of coverage***. ***Effective July 1, 2017, if a dependent, otherwise eligible, loses Group Coverage, contributions earned after the loss of coverage will not be available to that eligible individual until he or she enrolls in Group Coverage again.***

(SEE REVERSE SIDE)

Section 5 **Filing Claims for Benefits** was amended by changing the Subsection titled **The Trustees' Decision is Final and Binding**, located on SPD page 12, to read as follows, with new language in bold italics:

The Trustees' Decision is Final and Binding

The Trustees' final decision with respect to their review of your appeal, ***or, if you are eligible for, and pursue, External Review, the External Reviewer's final decision with respect to its review of your claim***, will be final and binding upon you because the***se decision-makers*** have exclusive authority and discretion to determine questions of eligibility and entitlement under the plan. Any legal action against this plan must be started within 180 days from the date the adverse benefit determination denying your appeal, ***or external reviewer's determination,*** is deposited in the mail to your last known address, and may only be started after all administrative procedures set forth in the Plan have been exhausted by you.

2. Section 5 **Filing Claims for Benefits** is amended by adding the following at the end of that Section:

Additional Internal Appeal Procedures

Additional internal appeal procedures include the following:

An "Adverse Benefit Determination" includes a "rescission of coverage." "Rescission" is defined as a cancellation or discontinuance of coverage that has a retroactive effect.

You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with the denied claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided.

Before a final internal adverse benefit determination is issued based on new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided.

Notice of an adverse benefit determination will be made in a "culturally and linguistically appropriate manner" when required by law.

Notice of an adverse benefit determination will now include:

Information sufficient to identify the claim involved. This information includes the date of service, health care provider, and the claim amount (if applicable);

The denial code, if any, and its corresponding meaning;

A description of the plan's or issuer's standard, if any, that was used in denying the claim. If the notice involves a final internal adverse benefit determination, the description will also include a discussion of the decision;

If applicable, a detailed description of the available external review processes, including information regarding how to initiate external review;

The availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793 to assist enrollees with the internal claim and appeal and external review processes; and

If applicable, a statement describing the participant' s right to request any diagnosis code, treatment code, and the corresponding meanings of those codes in connection with adverse benefit determinations.

External Review

You may have the right to external review of a final internal adverse benefit determination. For purposes of external review eligibility, an adverse benefit determination is a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, it is determined that the treatment is experimental or investigational or does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. A rescission of coverage is an adverse determination.

The external review will be made by an independent review organization with health care professionals that have no conflict of interest with respect to the benefit determination. Except for approved expedited external reviews this external review is only available once you have exhausted the Fund's internal grievance process. Any request for external review must be in writing and submitted to the Fund Office at 3445 Winton Place, Suite 238, Rochester, NY 14623-2950 within four months after receipt of the notice of the final adverse benefit determination. Upon application and approval of the request for external review, the Fund Office will assign an independent review organization. Please do not hesitate to contact the Fund Office with any questions regarding external review.

Please keep this information with your Supplemental Benefit Plan Summary Plan Description for permanent reference. If you have any questions regarding it, please contact the Fund Office at (585) 424-3510.

Sincerely,

BOARD OF TRUSTEES OF THE
IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK
AND VICINITY SUPPLEMENTAL BENEFIT PLAN