Iron Workers District Council of Western New York and Vicinity

Welfare, Pension and Annuity Funds

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IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY

WELFARE FUND

SUMMARY OF MATERIAL MODIFICATION/REDUCTION
AND
NOTICE TO PARTICIPANTS

(Plan No: 501; EIN 16-0776208)

January 31, 2017

Dear Participant,

The following is a summary of important changes made to your Plan/Summary Plan Description. Please take a moment to carefully read the information below, then keep this communication with your Welfare Fund booklet for future reference.

Previously Announced Plan Changes Effective January 1, 2017

As was previously announced in a Summary of Material Modification communication dated October 3, 2016, the Fund has made several changes to the Plan effective January 1, 2017. Briefly, these change include:

- Change in network and claims administration to Excellus Blue Cross Blue Shield;
- Cost-sharing changes for the medical and hospital plan administered by Excellus; and
- Cost-sharing changes for the prescription drug plan administered by Express Scripts.

This communication reiterates the previously announced Plan design changes taking effect on January 1, 2017. It also provides additional information about changes to other areas of the Plan including precertification/prior authorization rules, claims and appeals filing information and updated contact information for all of the organizations that help administer your Welfare Fund in case you have any questions about your benefits.

Excellus Blue Cross Blue Shield Medical and Hospital Plan Design Effective January 1, 2017

In the October communication, your new medical plan cost-sharing provisions were provided in a brief summary. During the transition process that occurred over the last several months, the Fund has prepared a more expansive medical benefits summary which goes into more detail about your share of the cost of several highly utilized medical and hospital services. This summary is enclosed.

In addition to the summary of benefits referenced above, a revised Uniform Summary of Benefits and Coverage ("SBC") is also enclosed. This SBC has been updated to reflect your new Excellus medical and hospital benefits and is required to be provided to all participants each year by federal law.

Express Scripts Prescription Drug Plan Design Effective January 1, 2017

The chart below reiterates your new prescription drug plan design that was announced in the October communication.

	Retail (Greater of a 30-day supply or 100 units)	**Mail (90-day supply)**
	NON-SPECIALTY PRESCRIPTION DRUGS	
Generic	$10 Copay	$20 Copay
Brand *Preferred*	20% Coinsurance ($20 Min/$40 Max)	20% Coinsurance ($50 Min/$100 Max)
Brand *Non-preferred*	20% Coinsurance ($40 Min/$80 Max)	20% Coinsurance ($100 Min/$200 Max)
	SPECIALTY PRESCRIPTION DRUGS	
Generic	Not covered	20% Coinsurance ($300 Max per prescription)
Brand *Preferred*	Not covered	20% Coinsurance ($300 Max per prescription)
Brand *Non-preferred*	Not covered	20% Coinsurance ($400 Max per prescription)
	Prescription Drug Out-of-Pocket Maximum	
Per Individual	$4,150	
Per Family	$8,300	

In addition to the new cost-sharing structure of the prescription drug plan, the following changes were also announced in the October communication and are already in effect:

- Adoption of the Express Scripts National Preferred Formulary: Non-Formulary, Preferred and Non-Preferred Brand Name Drugs

  National Preferred Formulary

  The Plan only covers prescription generic and brand name drugs on the Express Scripts National Preferred Formulary. The National Preferred Formulary is a list of commonly prescribed medications that can safely and effectively treat most medical conditions while helping to keep costs down for both you and the Plan. **Because non-formulary drugs are not covered by the Plan, if you fill a prescription for a non-formulary drug, you will have to pay the entire cost for the prescription.** If you were affected by this change, you should already have received a letter from Express Scripts advising you of the change as well as potential therapeutically equivalent alternatives for you and your physician to consider.

Generic, Preferred and Non-Preferred Brand Name Drugs

Generic drugs are typically the lowest cost option available under the Plan. When you purchase generic drugs, you will pay a fixed copayment amount for each prescription. Brand name drugs cost more than generic drugs, and as you can see in the chart above, your share of the cost of a brand name drug beginning January 1, 2017 depends on its placement on the National Preferred Formulary (preferred or non-preferred brand name drugs).

In general, preferred brand name drugs are drugs that have been shown to be as effective at treating certain conditions as non-preferred drugs, but which cost less. If you are using a non-preferred brand name drug, you should speak to your pharmacist or physician about changing your prescription to a less costly therapeutic equivalent preferred drug. **You will pay less for preferred brand drugs than non-preferred brand drugs because the coinsurance minimums and maximums are lower for preferred brand drugs.**

Additional Information on Formulary and Preferred Brand Name Drugs

Express Scripts will periodically reach out directly to you if you continue to use a non-formulary drug. The Fund Office is also working with Express Scripts to identify those that continue to use non-preferred brand name drugs. Any outreach by the Fund Office or Express Scripts is intended to help you save by providing an alternative prescription drug for less cost to you. As always, please be sure to speak with your physician and pharmacist to ensure the safest and most cost-effective therapy for you.

Please note that a drug's placement on National Preferred Formulary is subject to change. To find out whether a medication is on the formulary, or whether it is a preferred on non-preferred drug, call Express Scripts at the number listed in the Quick Reference Chart of your SPD or visit Express Scripts online at www.express-scripts.com.

- Change to exclusive distribution of specialty medications through Accredo Pharmacy, a specialty mail-order pharmacy division of Express Scripts.

  Also in the chart on Page 2, your share of the cost of a drug depends on whether the drug is a specialty drug. In general, specialty drugs are used to treat a broad array of complex diseases that may require special handling, administration by infusion or injection, or specialized support. In addition, if you are prescribed a specialty drug, it can only be filled through the Accredo specialty pharmacy. If you try to fill your specialty prescription at a retail pharmacy, you will be directed to contact Accredo. In many cases, Accredo will automatically reach out to you to assist you with filling your prescription so that it is covered by the Plan. If you need to contact Accredo, please call (877)-222-7336 or visit www.accredo.com.

New Plan Changes Effective January 1, 2017

Hearing Aid Benefit

Effective January 1, 2017, Excellus will administer the hearing aid benefit through the medical program. The hearing aid benefit remains the same, but the frequency has been clarified to reflect such that the hearing aid benefit is available once every three calendar years.

Transplant Coverage

Effective January 1, 2017, the Fund has removed all per transplant maximum benefits.

Preauthorization Requirements

Beginning January 1, 2017, you will no longer have to precertify certain benefits through American Health Holding as Excellus will now administer the medical management program. The new preauthorization program is similar to the precertification program in that it ensures that treatments you receive are medically appropriate and necessary, which helps you and the Fund save money by avoiding unnecessary health care. As you will see below, preauthorization is completely automatic when you use an in-network provider, so you no longer need to call to get a service precertified when you see an in-network provider. The Excellus preauthorization medical management program is summarized below.

Certain covered services and supplies require preauthorization from the Plan before you receive them. Under the terms of the Plan, your physician or provider is responsible for obtaining preauthorization for in-network services and supplies subject to the preauthorization requirement. For out-of-network services, you are responsible for obtaining preauthorization.

To request preauthorization, you or your provider should call Excellus at (800)-499-1275. After receiving a request for preauthorization, Excellus will review the reasons for the proposed treatment and determine if benefits are available under the Plan and, where applicable, whether medical necessity exists.

The following services or supplies require preauthorization:

- Inpatient Admissions (except routine maternity) to any facility including hospital, elective and direct admission, acute rehabilitation, skilled nursing, mental health, chemical dependency
- Durable Medical Equipment
- Home Care and Infusion Services
- Radiation Therapy
- Inpatient and certain outpatient Mental Health and Substance Use Services including but not limited to intensive outpatient, residential treatment, partial hospitalization, group therapy, psychological testing
- Surgical Procedures
- Orthopedic / Orthotic Devices
- Prosthetics
- Advanced imaging (CT, CTA, MRA, MRI, PET Scans Nuclear Cardiology)
- Occupational, Physical, Vision and Speech Therapy
- Transplants
- Experimental and Investigational Procedures and Services

To learn more about the preauthorization requirement or to obtain a complete list of services subject to the preauthorization requirement, visit Excellus at www.excellusbcbs.com or call (800)-499-1275.

Claims and Appeals Procedures

The following changes apply to the Claims and Appeals procedures:

The following definition of an adverse benefit determination replaces the current definition and for the purpose of the internal claims and appeal process:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for, a benefit (collectively, "denial"), including any denial based on (1) a determination of an individual's eligibility to participate in the Plan, (2) an application of utilization review, or (3) a determination that the item is Experimental, Investigational, or not Medically Necessary or appropriate;

- A rescission of coverage, whether or not there is an adverse effect on any particular benefit.

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

As has been previously announced, as of January 1, 2017, Excellus BlueCross BlueShield will be the new Claims Administrator for Medical/Hospital benefits and Express Scripts ("ESI") continues to be the pharmacy benefits manager ("PBM") for Prescription Drug benefits. Excellus and ESI will be the Claims Administrator for all Post-Service, Pre-Service, Urgent Care and Concurrent claims as currently defined in the Summary Plan Description. Claims should be submitted to the address on the Quick Reference Chart or you can find the information on your Identification (ID) Cards.

For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

The following describes the new appeals procedures for Medical/Hospital and Prescription Drug benefits.

Appeal Procedures for Medical/Hospital and Prescription Drug Benefits

Internal Appeals

To file an internal appeal for Medical/Hospital and Prescription Drugs, you must submit a written statement to the Plan within **180 days** of the adverse benefit determination:

Appeals for Medical/Hospital Benefits

The Plan maintains a two-level Appeal Process for Medical/Hospital Benefits. First-level appeals for Medical/Hospital Benefits should be submitted to Excellus at the address shown in the Quick Reference Chart at the end of this communication.

Second-Level appeals should be submitted to the Board of Trustees at the address shown in the Quick Reference Chart at the end of this communication.

Appeals for Prescription Drug Benefits

The Plan maintains a one-level Appeals Process for Prescription Drug benefits. Appeals for prescription drug benefits should be submitted to Express Scripts at the address shown in the Quick Reference Chart at the end of this communication.

Appeal requests involving Urgent Care Claims may be made orally by calling Excellus or ESI at the telephone number listed on the Quick Reference Chart or the one found on your ID card.

Request for Either Kind of Internal Appeal

Your request for an internal appeal must include the specific reasons why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide you with:

- The opportunity to submit to the Plan written comments, documents, records, and other information relating to your initial claim for benefits;
- The opportunity, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to your initial claim for benefits;
- A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;
- Any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim, free of charge. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a 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 adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, or Medically Necessary or appropriate, the fiduciary will consult with a health care professional who has appropriate experience in the field of

medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

- ***Pre-Service Claims for Prescription Drug Benefits.*** You will be notified of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days from the date your written request for an appeal is received by ESI. No extension of the Plan's internal appeal review timeframe is permitted.

- ***Pre-Service Claims for Medical/Hospital Benefits.*** Under the Plan's two-level appeals process, Excellus will notify you of its first-level determination no later than 15 days after receipt of the appeal. If the first-level review results in an adverse benefit determination, you may request a second level of review by the Board of Trustees. You will have 90 days from the date you received the first-level determination to request a second-level appeal review by sending a written request to the Board of Trustees. You will be notified of the second-level appeal determination no later than 15 days after the Plan receives your request for a second-level appeal review. No extension of the Plan's internal appeal review timeframes is permitted.

- ***Urgent Care Claims for Medical/Hospital and Prescription Drug Benefits.*** You will be notified of the determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but no later than 72 hours after the appropriate Claim Administrator's receipt of your (oral or written) request for appeal. A claim involving urgent care is any claim with respect to which the application of the time periods for making non-urgent care could seriously jeopardize your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The plan will defer to determination of your attending provider regarding whether the claim involves urgent care.

- C***oncurrent Claims for Medical/Hospital and Prescription Drug Benefits.*** You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the appropriate Claims Administrator. You will be notified of the determination of your internal appeal as soon as possible before the benefit is reduced or treatment is terminated.

- ***Post-Service Claims for Prescription Drugs.*** You will be notified of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 60 days from the date your written request for an appeal is received by ESI. No extension of the Plan's internal appeal review timeframe is permitted.

- ***Post-Service Claims for Medical/Hospital Benefit Claims.*** Under the Plan's two-level appeals process, Excellus will notify you of its first-level determination no later than 30 days after receipt of the appeal. If the first-level review results in an adverse benefit determination, you may request a second level of review by the Board of Trustees. You

will have 90 days from the date you received the first-level determination to request a second-level appeal review by sending a written request to the Board of Trustees. You will be notified of the second-level appeal determination no later than 30 days after the Plan receives your request for a second-level appeal review. No extension of the Plan's internal appeal review timeframes is permitted.

Notice of Adverse Benefit Determination Upon Review

Any notice of denial of your appeal will include the following:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount);
- The specific reasons for the adverse benefit determination upon appeal, including (i) the denial code (if any) and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- Reference the specific Plan provisions on which the denial is based;
- A statement describing the availability, upon request, of the diagnosis code (if applicable) and the treatment code (if applicable) and their corresponding meanings;
- A statement that you are 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;
- A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review;
- If the denial was based on an internal rule, guideline, protocol, or similar criterion, a statement that such rule, guideline, protocol, or criteria will be provided free of charge, upon request;
- If the denial was based on a medical judgement (Medical Necessity, Experimental, or Investigational), a statement that the Plan will provide an explanation, free of charge, upon request, of the scientific or clinical judgement for the denial, applying the Plan's terms to your medical circumstances;
- If applicable, a statement describing voluntary appeal procedures for prescription drug claims; and
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

Voluntary Appeal for ESI Prescription Drug Claims

The Plan offers an additional voluntary appeal level for Prescription Drug claims administered by Express Scripts after the standard appeals process is completed. Therefore, if you are dissatisfied

with the outcome of your standard appeal, you may file a voluntary second-level appeal with the Board of Trustees within 90 calendar days from the date on the notice of the letter denying your first appeal.

You should also submit written comments, documents, medical records, and other information relating to the claim for benefits. In administering the voluntary appeal, the Plan will obtain a written report summarizing the facts underlying the claim and prior denials from ESI.

Decisions on voluntary appeals will be made at the next regularly-scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly-scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly-scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

This second level of appeal is completely voluntary; it is not required by the Plan and is only available if you (or your representative) request it. Regarding voluntary appeals:

- The Plan will not assert a failure to exhaust administrative remedies because you or your authorized representative elect not to pursue a claim through the voluntary level of appeal;
- Where you or your authorized representative choose to pursue a claim in court after completing the voluntary appeal, the Plan agrees that any statute of limitations (or other defense based on timeliness) applicable to your claim in court will be tolled (suspended) during the period of the voluntary appeals process;
- The voluntary level of appeal is available only after you (or your representative) have pursued the appropriate mandatory appeals process required by the Plan;
- Upon your request, the Plan will provide you (or your representative) with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including a statement that the specific information regarding the process for selecting a decision-maker and any circumstances may affect the impartiality of the decision-maker.

The Plan will not impose fees or costs on you (or your representative) if you or your authorized representative chooses to invoke the optional appeals process. Note that this voluntary level of appeal has no effect on the claimant's right to any other benefits under the Plan.

External Review of Medical/Hospital and Prescription Drug Claims

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Claims Eligible For The External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; or its determination whether the Plan is complying with the nonquantitative treatment limitations of Code section 9812. The IRO will determine whether a denial involves a medical judgment.
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible For The External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.
- A determination that you or your dependent are not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning you did not request review within the four-month deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).
- Claims that relate to benefits other than health care benefits (such as disability benefits, death benefits, and dental/vision benefits that are considered excepted benefits).
- Claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first.
- In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation

exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

External Review Of A Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must made in writing within four months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, do the following:

- Submit Prescription Drug claims appeals to Express Scripts at the address found in the Quick Reference Chart.
- Submit Medical/Hospital claims appeals to Excellus at the address found in the Quick Reference Chart.

Preliminary Review Of A Standard (Non-Urgent Care) Claim By The Plan

Within five business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.
- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to a failure to meet the requirements for eligibility under the terms of the Plan, a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.
- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).
- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review.
- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).)
- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four-month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

Review of A Standard (Not Urgent Care) Claim By The IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, no IRO is eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within 10 business days. The IRO is not required to, but may, accept and consider additional information you submit after the 10 business day deadline.
- Within five business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If the Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one business day. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reasons for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meaning, and the reason for the previous denial.
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.
- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
- A discussion of the principal reasons for the decision, including the rationale for the decision and any evidence-based standards relied upon.

- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.
- A statement that judicial review may be available to you.
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Expedited External Review Of An Urgent Care Claim

You may request an expedited external review in the following situations if:

- The adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

To begin a request for expedited external review, do the following:

- Submit Prescription Drug claims appeals to Express Scripts at the address found in the Quick Reference Chart.
- Submit Medical/Hospital claims appeals to Excellus at the address found in the Quick Reference Chart.

Preliminary Review Of An Urgent Care Claim By The Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for external review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review Of An Urgent Care Claim By The IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, no IRO is eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim de novo, meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than 72 hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within 48 hours after it is made.

What Happens After the IRO Decision is Made?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.
- If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

Quick Reference Chart

The quick reference chart listed on page 10 of your SPD will be replaced with the chart on the next page. Please use this chart for future reference.

QUICK REFERENCE CHART

Information Needed	Contact the following:
Medical and Hospital benefits, PPO Network, Preauthorization and medical review	Excellus Blue Cross Blue Shield 165 Court Street Rochester, NY 14647 (800) 499-1275 www.excellusbcbs.com
Employee Assistance (EAP) services	Workforce Development Institute 96 South Swan Street Albany, NY 12210 (800) 252-4555 (800) 225-2527 www.theEAP.com
Medical eligibility Dental and Orthodontia claims, eligibility, benefits Vision claims, eligibility, benefits HIPAA Certificate of Creditable Coverage Medicare Part D Notice of Creditable Coverage Wage Replacement Account claims, eligibility, benefits Supplemental Disability claims, eligibility, benefits	Iron Workers District Council of WNY 3445 Winton Place, Suite 238 Rochester, NY 14623-2950 (800) 288-0782 (585) 424-3510 Fax: (585) 424-3722
Prescription Drug Benefits Retail and Mail-Order Pharmacy	Express Scripts P.O. Box 66773 St. Louis, MO 63166-6773 Member Services: (866) 544-2926 Pharmacist Help Desk: (800) 235-4357 www.express-scripts.com Mail-Order Express Scripts, Inc. PO Box 52150 Phoenix, AZ 85072 Accredo Specialty Pharmacy (877) 222-7336 www.accredo.com
Life Insurance	Prudential Life Insurance Company of America 80 Livingston Avenue Roseland, NJ 07068 (866) 439-9026
Wage Replacement Account Life and Accidental Death and Dismemberment Insurance	The Hartford Group Benefits Division, Customer Service P.O. Box 2999 Hartford, CT 06104-2999 (800) 523-2233

You should keep this letter with your Welfare Fund Summary Plan Description booklet. It is important to retain this information until a new Summary Plan Description booklet is issued to you.

As always, if you have any questions regarding these benefit modifications, please contact the Fund Office at (585) 424-3510 or toll-free at (800) 288-0782.

Sincerely,

The Board of Trustees

Iron Workers District Council of Western New York and Vicinity

Welfare, Pension and Annuity Funds

LOCAL UNIONS
9–NIAGARA FALLS
12–ALBANY
33–ROCHESTER
60–SYRACUSE
440–UTICA

Phone: 585-424-3510
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Suzanne Ranelli
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Rochester, NY 14623-2950

IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS
AND
NOTICE TO PARTICIPANTS

(Plan No: 501; I.D. 16-0776208)

December 29, 2017

Dear Participant,

The following is a summary of important changes made to your Plan/Summary Plan Description. Please take a moment to carefully read the information below, then keep this communication with your Welfare Fund booklet for future reference.

New Telemedicine Benefit Beginning January 1, 2018

We are pleased to announce that, effective January 1, 2018, the Fund will offer a telemedicine service through Excellus called MDLive. MDLive is a telephone and online based physician consultation service available 24 hours a day, 365 days a year. It is a convenient and affordable option that allows you to talk to a doctor who can diagnose, recommend treatment and prescribe medication, when appropriate, for many common medical issues.

MDLive does not replace your primary care physician. Rather, it is designed to improve your family's access to quality acute medical care at times when your physician's office is closed, does not have an available appointment time that works with your schedule or when you're traveling. At the same time, telemedicine has been shown to help minimize costs for members and benefit plans by preventing unnecessary and costly non-emergency ER and urgent care visits.

While MDLive physicians are licensed in NYS, they cannot prescribe prescriptions such as controlled substances. However, they are able to provide general prescription services to your local pharmacy for medical conditions such as cold and flu symptoms, bronchitis, allergies, sinus problems, ear infections and respiratory infections, to name a few.

When you use MDLive, you will only have to pay a $10 copayment per consultation and is not subject to your deductible.

Enclosed is information from Excellus on how to register for Telemedicine/MDLive. Please visit ExcellusBCBS.com/Telemedicine to get started.

You should keep this letter with your Welfare Fund Summary Plan Description booklet. It is important to retain this information until a new Summary Plan Description booklet is issued to you.

As always, if you have any questions regarding these benefit modifications, please contact the Fund Office at (800) 288-0782.

Sincerely,

The Board of Trustees