Amendment 2018-2 to
Iron Workers Welfare Plan of Western Pennsylvania

WHEREAS, the Board of Trustees of the Iron Workers Welfare Plan of Western Pennsylvania ("Plan Sponsor") sponsors the Iron Workers Welfare Plan of Western Pennsylvania (the "Plan");

WHEREAS, the Plan provides for weekly accident and sickness benefits for eligible members; and

WHEREAS, the Department of Labor has changed the requirements for denials for disability benefits; and

WHEREAS, the Board of Trustees wishes to amend the plan to comply with the new disability claims rules;

NOW THEREFORE, the Plan provisions regarding Claims and Appeals Procedures for Weekly Accident and Sickness Benefits are amended, effective as of April 1, 2018, to read as follows:

For Weekly Accident and Sickness Benefits

You should file your claim for Weekly Accident and Sickness benefits within 90 days from the date of the accident or the date of onset of the sickness. In no event will claims be honored that are filed later than one year after the date of the accident or the date of onset of the sickness.

The Trustees, acting by majority decision or through the Chair and Co-Chair, will make a decision on the claim and notify you of the decision within 45 days. If the Trustees require an extension of time due to matters beyond their control, the Trustees may extend the 45-day period for an additional 30 days. You will be notified of the reason for the extension and when the decision will be made. This notification will occur before the expiration of the 45-day period. The period for making a decision may be delayed an additional 30 days, provided the plan administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Trustees expect to render a decision.

If your claim for Weekly Accident and Sickness Benefit is denied, your denial notice must provide you with the following information:

1. The specific reason or reasons for the denial of benefits or other adverse benefit determination;
2. A specific reference to the pertinent provisions of the Welfare Plan upon

which the decision is based;

3. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;

4. A copy of the Welfare Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim;

5. A copy of any internal rule, guideline, protocol or similar criteria that was relied on;

6. A copy of the scientific or clinical judgment, or statement that it is available to you at no cost upon request, for Welfare Plan claims that are denied due to:

    a. Medical necessity;

    b. Experimental treatment; or

    c. Similar exclusion or limit.

7. 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 your claim for benefits; and

8. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

    a. The views you presented to the Welfare Plan of health care professionals treating you and vocational professionals who evaluated you;

    b. The views of medical or vocational experts whose advice was obtained on behalf of the Welfare Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

    c. A disability determination made by the Social Security Administration regarding you presented by you to the Welfare Plan.

<u>Your Right to Request a Review of a Denied Weekly Accident and Sickness Claim</u>

You have the right to a full and fair review if your claim for benefits is denied by the Trustees. You must file your appeal in writing. You must make your request to the Plan Office within 180 days after you receive notice of denial. Your application for appeal must be in writing and it must include the specific reasons you feel the denial was improper. You may submit any document you feel appropriate, as well as submitting your written issues and comments.

Review Process for Weekly Accident and Sickness Claims

The review process works as follows:

You have the right to review documents relevant to your claim and receive copies free of charge. A document, record or other information is relevant if:

1. It was relied upon by the Trustees in making the decision;
2. It was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon);
3. It demonstrates compliance with the Welfare Plan's administrative processes for ensuring consistent decision-making; or
4. It constitutes a statement of Welfare Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Trustees on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Before the Welfare Plan can issue an adverse benefit determination on appeal, the Welfare Plan must provide you, automatically and free of charge:

1. Any new or additional evidence considered, relied upon, or generated by the Welfare Plan in connection with your claim; and
2. Any new or additional rationale that is the basis for an adverse benefit determination.

The evidence and rationale must 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, so as to give you a reasonable opportunity to respond prior to that date.

Timing of Notice of Decision on Appeal of Weekly Accident and Sickness Claims

Ordinarily, decisions on appeals involving Weekly Accident and Sickness Benefit Claims 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 no later than 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.

IN WITNESS WHEREOF, pursuant to the proper approval and delegation by the Trustees, the following Employer and Union Trustees have affixed their signatures effective as of the 27th day of April, 2018.

David D. Daquelente
Employer Trustee

Greg Bernarding
Union Trustee