AMENDMENT 10
TO THE
IRON WORKERS ST. LOUIS DISTRICT COUNCIL WELFARE PLAN

In accordance with the authority granted to the undersigned Trustees in the Iron Workers St. Louis District Council Welfare Summary Plan Description, as amended and restated in 2014, said Summary Plan Description is hereby amended as follows:

1. **Effective for claims filed after April 1, 2018, Section 16.03 – If a Claim is Denied – is amended to comply with the disability claim procedures under 29 C.F.R. § 2560.503-1 as follows:**

Section 16.03 If a Claim is Denied

If your medical claim is denied (in whole or in part), the Plan will:

1. Notify you of its denial of your claim within the timeframes described above, and

2. Provide you with a notice about that denial that includes the following information:

   a. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meeting;

   b. The specific reason or reasons for the decision;

   c. Reference to the Plan provisions on which the decision was based;

   d. A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;

   e. A copy of the Plan's appeal 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; and

   f. Your right to file an external appeal.

3. The notice will be provided in a culturally and linguistically appropriate manner when the claimant's address is in a county where 10 percent or more of the population is literate only in the same non-English language.

In addition, for **health care** and **Weekly Income Benefit** claims, the notice will include:

1. A copy of any internal rule, guideline, protocol or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request; and

2. A copy of the scientific or clinical judgment, or a statement that a copy is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

For **Weekly Income Benefit** claims, the following additional information must also be provided in the notice:

1. An explanation of the decision, including the basis for disagreeing with or not following:

    a. The views presented by you of the health care and vocational professionals who treated or evaluated you;

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

    c. A disability determination by the Social Security Administration.

2. The specific internal rules, guidelines, protocols, standards or similar criteria the Plan relied on in deciding your claim or alternatively, a statement that such internal rules, guidelines, protocols, standards or other similar criteria do not exist.

3. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.

2. Effective for claims filed after April 1, 2018, Section 16.04(2) – Internal Appeal – is amended to comply with the disability claim procedures under 29 C.F.R. § 2560.503-1 as follows:

2. Internal Appeal

If you file your appeal on time and follow all required procedures, then your claim will be reviewed by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor the subordinate of that individual. The appeal will be a full and fair review that takes into account all comments, documents, and other information submitted, without regard to whether such information was submitted or considered in the initial benefit determination. This review will be made independent of the original decision.

In deciding an appeal of any initial adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, or other item is Experimental or Investigative, not Medically Necessary, or not appropriate, the appropriate named fiduciary will:

a. Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment;

b. 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 such individual; and

c. The Plan 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.

Before the Plan can issue a final internal adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must 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 to give you a reasonable opportunity to respond prior to that date.

The Plan will notify you, in writing, of the decision on any appeal.

3. **Effective for claims filed after April 1, 2018, Section 16.04(4) – Information Requirements – is amended to comply with the disability claim procedures under 29 C.F.R. § 2560.503-1 as follows:**

4. Information Requirements

The Plan will provide you with a written decision, in a culturally and linguistically appropriate manner, on any appeal of your claim. When the Plan notifies you of its determination on your appeal, it will provide:

a. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meeting;

b. The specific reason or reasons for the adverse appeal review decision, including reference to the Plan provisions on which the decision was based;

c. A statement notifying you that you have the right to request a free copy of all documents, records and relevant information;

d. A statement informing you or your right to an external appeal;

e. A statement that you may bring a civil action suit under ERISA after you have exhausted the Plan's appeal procedures;

f. The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes;

g. A copy of any internal rule, guideline, protocol or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request; and

h. A copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

If the adverse determination on your claim was based in whole or in part on a medical judgment, then the Trustees will consult with an appropriately trained health care professional with experience in the relevant field of medicine who was not consulted in making the initial determination on your claim and who is not a subordinate of the person consulted for the initial determination.

For **Weekly Income Benefit** claims on appeal, the following additional information must also be provided in the notice:

a. An explanation of the decision, including the basis for disagreeing with or not following:

i. The views presented by you of the health care and vocational professionals who treated or evaluated you;

ii. The views of medical or vocational experts obtained by the Plan in connection with your claim, without regard to whether the advice was relied upon in making the adverse benefit determination; and

iii. A disability determination by the Social Security Administration.

b. The specific internal rules, guidelines, protocols, standards or similar criteria the Plan relied on in deciding your claim or alternatively, a statement that such internal rules, guidelines, protocols, standards or other similar criteria do not exist.

c. A description of any contractual limitations period applying to your right to bring a civil action under ERISA following an adverse appeal review decision, including the calendar date on which the Plan's two year limit for filing suit expires.

4. **Effective for claims filed after April 1, 2018, Section 16.04(5) – Adverse Benefit Determination – is added to comply with the disability claim procedures under 29 C.F.R. § 2560.503-1 as follows:**

5. Adverse Benefit Determination

For purposes of Sections 16.03, 16.04 and 16.05, an adverse benefit determination includes:

a. any denial, reduction, termination, or failure to provide or make payment in whole or in part for a benefit;

b. a determination after service occurred, of an individual's eligibility to participate in the Plan;

c. a benefit denial resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not, medically necessary or appropriate;

d. payment in accordance with plan benefits, but less than the total amount of expenses submitted with regard to a claim;

e. any rescission of coverage with respect to a claimant (whether or not in connection with the rescission, there is an adverse effect of any particular benefit at that time). The term rescission means a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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IN WITNESS WHEREOF, this Amendment to the Iron Workers St. Louis District Council Welfare Plan was signed on behalf of the full board of Trustees on the 25th of April 2018.

Chairman

Co-Chairman