[ON PLAN LETTERHEAD]

SECOND SUMMARY DESCRIPTION OF MATERIAL MODIFICATION OF THE SHEET METAL WORKERS' UNION LOCAL 33 CLEVELAND DISTRICT HEALTH BENEFITS PLAN AS AMENDED AND RESTATED NOVEMBER 2015

I. INTRODUCTION

This document is designed to describe modifications to the Sheet Metal Workers' Local 33 Cleveland District Health Benefits Plan (hereinafter "Plan"). This document should be read in conjunction with the Summary Plan Description/Plan Document (hereinafter "SPD") which was provided to you previously and dated November 2015. These modifications reflect changes to the disability claims procedures regulations issued by the Department of Labor. These changes are intended to comply with the new requirements of the Department of Labor effective for all claims received on or after April 1, 2018. These modifications also reflect changes to the coverage of statins and aspirin to provide for one hundred percent coverage for certain participants meeting age requirements effective on or after May 1, 2018.

Information contained in this Summary Description of Material Modification (hereinafter "Summary Description") supersedes what is contained in the SPD. However, this Summary Description changes only the provisions to which it specifically refers and any other provisions in the SPD remain the same.

II. CHANGES TO DISABILITY CLAIM PROCEDURES

On December 19, 2016, the Department of Labor's Employee Benefit Security Administration issued updated regulations governing benefit plans that offer disability benefits. These regulations were subsequently determined to become effective for disability claims submitted on or after April 1, 2018. Pursuant to those regulations, the Sheet Metal Workers' Local No. 33 Cleveland District Pension Plan must now amend its claim procedures as they relate to disability benefit claims so that the procedures are compliant with the newly effective regulations. The regulations created additional protections for participants who make claims for disability. For example, the regulations now require that the independence and impartiality of the persons involved in making claims decisions be ensured by prohibiting decisions relating to that person's employment to be based on a likelihood that the individual will support a denial of benefits. Moreover, the regulations further require administrators to explain the basis for disagreeing with treating physicians, treating vocational professionals, the Social Security Administration, or any other medical or vocational expert retained by the Plan to assist in reviewing the claim. The regulations also require Plans to provide any additional evidence compiled in the claim file or any new rationales for denying a claim free of charge to the claimants prior to the final decision to deny an appeal, and to give such claimants a chance to respond prior to the date of the final decision.

Accordingly, effective April 1, 2018, Sections C, D, E, F and G of Article XIII of the SPD are deleted and amended to read as follows:

C. IF A CLAIM IS DENIED

If a claim is denied (in whole or in part), the Plan will provide you with certain information about your claim and notify you of the denial of your claim within certain timeframes. In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office. If a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered. This formal procedure applies to any adverse benefit determination, including a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time). Additionally, all notices provided to participants will be provided in a culturally and linguistically appropriate manner. The Plan will provide oral language services such as a telephone customer assistance hotline that include answering questions in any "applicable non-English language" and providing assistance with filing claims and appeals in "any applicable non-English language." In addition, the Plan will provide, upon request, a notice in any "applicable non-English language" and will include in the English version of all notices a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan. "Applicable non-English languages" include, with respect to an address in any United States county to which a notice is sent, a non-English language in which ten percent or more of the population residing in the county is literate only in that language.

All claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based on the likelihood that the individual will support a denial of benefits.

1. *Information Requirements*. When the Plan notifies you of its initial denial on your claim, it will provide:

    a. The specific reason or reasons for the decision, and (for medical claims) the denial code and its corresponding meaning will be included in the initial decision;

    b. Reference to the Plan provisions or rules and regulations on which the decision was based;

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

    d. A copy of the Plan's internal 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

    e. For medical claims, information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable) as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes; and

    f. For medical claims, a description of the plan's standard, if any, that was used in denying the claim; and

    g. For medical claims, a description of available internal appeals and external review processes including information regarding how to initiate an appeal.

h. For medical claims, information regarding the availability of and contact information for the Consumer Affairs Division of the Ohio Department of Insurance to assist individuals with the internal claims and appeals and external review process.

i. For medical and disability claims, the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the decision or, alternatively a statement that such rules, guidelines, protocols, standards or similar criteria of the plan do not exist; and

j. For medical and disability claims, 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.

k. For health claims, if your appeal is due to the denial of an urgent care claim, the notice will also include a description of the expedited review process.

In addition, in the event the determination disagrees with the views of (1) a health care professional treating you; (2) vocational professionals who have evaluated you; (3) a medical or vocational expert whose advice was obtained on behalf of the Plan in connection with your claim; or (4) a disability determination regarding you made by the Social Security Administration; then the decision to deny shall set forth an explanation of the basis for disagreeing with those views or opinions. If the decision to deny was based on a medical necessity, experimental treatment or similar exclusion or limit, the decision will set forth either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.

The decision shall be final and binding upon you unless that decision is appealed as hereinafter set forth below.

D. APPEALING A DENIED CLAIM

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you appeal through the external claims review process and before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Board of Trustees at the Fund Office as soon as possible. For urgent care claims, your appeal may be made orally. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within:

1. 180 days from the date of a decision for **medical care** or **Short-Term Disability Benefit** claims; or

2. 60 days from the date of a decision for **Life, AD&D, or Dependent Life Insurance Benefit** claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative. A health care provider that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

1. Submit additional materials, including comments, statements or documents; and

2. Request to review all relevant information (free of charge).

In addition, if your claim is for **medical care** or **Short-Term Disability Benefits** and is denied based on:

1. An internal rule, guideline, protocol or other similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.

2. A medical necessity, experimental treatment or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.

The review of a Short-Term Disability benefit appeal will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is subject of the appeal nor a subordinate of such individual. If the appeal of a Short-Term Disability decision is based in whole or in part on medical judgment, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual. The reviewer will also identify medical or vocational experts whose advice was obtained on behalf of the plan in connection with the initial adverse benefit determination, without regard to whether the advice was relied upon by the initial determination.

Prior to making a decision to deny a Short-Term Disability appeal, you will be provided, free of charge, with any additional evidence considered, relied upon, or generated by the Plan, or other person making the benefit determination in connection with the claim. 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 provided so as to give you a reasonable opportunity to respond prior to that date. If the determination is based on new or additional rationale, the plan administrator shall provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review of a Short-Term Disability claim is provided so as to give you a reasonable opportunity to respond prior to that date.

E. CONTINUED COVERAGE PENDING THE OUTCOME OF AN INTERNAL APPEAL FOR MEDICAL CLAIMS

If your claim is a medical claim, you will receive continued coverage under the Plan pending the outcome of your internal appeal. This means that the Plan will not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review.

F. APPEAL DECISIONS

If you file your appeal on time and follow any applicable required procedures, a new, full and independent review of your claim will be made, and the decision will not be deferred to the initial benefit decision. An appropriate fiduciary of the Plan will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will provide you with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. This evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination will be provided to you in order to give you an opportunity to respond prior to that date.

The Plan will notify you, in writing, of the decision on any appeal within five calendar days. However, oral notice of a determination on your urgent care claims may be provided to you sooner.

1. *Appeal Time Frames*. The Plan's determination of its decision will be made within certain timeframes. The deadlines differ for the different types of claims as shown in the following information:

    a. **Health Care Claims**.

        1) Urgent Care Claims – A determination will be made within 72 hours from receipt of your appeal.

        2) Pre-Service Claims – A determination will be made within 30 calendar days from receipt of your appeal.

        3) Post-Service Claims – A determination will be made within 60 calendar days from receipt of your appeal. However, the determination may be made at the Plan's next meeting if the appeal is received within 30 days of that meeting.

        4) Concurrent Care Claims – A determination will be made before termination of your benefit.

    b. **Short-Term Disability Benefits**. A determination will be made within 45 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 45 days), a decision will be made within 90 days after the date the Plan receives your request for review. However, the Plan may:

        1) Make its decision at the next quarterly meeting of the Board of Trustees; or

        2) If your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting.

        3) If special circumstances require an extension of time for processing, then the Board of Trustees may consider the appeal no later than the third meeting following the receipt of the notice of appeal. If such extension is required, you will be provided with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made prior to commencement of the extension.

4) After consideration of the appeal as above, the Board of Trustees shall advise you of its decision in writing within five (5) days after the benefit determination is made.

c. **Life, AD&D and Dependent Life Insurance Benefits**. A determination will be made within 60 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 60 days), a decision will be made within 120 days after the date the Plan receives your request for review. However, the plan may:

1) Make its decision at the next quarterly meeting of the Board of Trustees; or

2) If your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting.

2. *Medical Judgments*. If your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional whom:

a. Has appropriate training and experience in the field of medicine involved in the medical judgment; and

b. Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

You have the right to be advised of the identity of any medical experts consulted in making a determination of your appeal.

3. *Information Requirements*. When the Plan notifies you of its determination on your appeal, it will provide:

a. The specific reason or reasons for the decision, including reference to the Plan provision on which the decision was based; and

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

c. Information relating to any additional voluntary appeal procedures offered by the Plan;

d. A statement that you may bring a civil action suit under Section 502(a) of ERISA;

e. The applicable contractual limitations period that applies to your right to bring such an action under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim;

f. For medical claims, information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable) as well as the diagnosis code, the treatment code, and the corresponding meanings of those codes;

g. For medical claims, inclusion of the denial code and its corresponding meaning in the description of the reason or reasons for the adverse benefit determination;

h. For medical claims, a description of the plan's standard, if any, that was used in denying the claim and a discussion of the decision;

i. For medical claims, a description of available external review processes including information regarding how to initiate an appeal;

j. For medical claims, information regarding the availability of and contact information for the Consumer Affairs Division of the Ohio Department of Insurance to assist individuals with the internal claims and appeals and external review process;

k. For medical and Short-Term Disability claims, either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination, or, alternatively a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;

l. For medical and Short-Term Disability claims, 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; and

m. For Short-Term Disability claims, a discussion of the decision including an explanation for disagreeing with or not following any of the following:

1) the views of health care professionals treating the claimant; or

2) the views of vocational professionals who evaluated the claimant; or

3) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the appeal, without regard to whether the advice was relied upon in making the benefit determination; or

4) a disability determination made by the Social Security Administration.

The Trustees shall have full authority to interpret the provisions of this Plan and it is within the sole and absolute discretion of the Trustees to determine if you are entitled to receive a benefit and the amount of the benefit. The decision shall be final and binding upon you.

G. EXTERNAL REVIEW PROCESS FOR MEDICAL CLAIMS

After exhausting the internal review process described above, you may appeal an adverse benefit determination through an external review process if the claim is for medical or prescription benefits. If the Plan fails to adhere to the information requirements set forth in Section C or Section F of Article XIII of the Plan, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external review. (You may also pursue any remedies under section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.) However, minor violations that do not cause, and are not likely to cause, prejudice or harm to you will not trigger a deemed exhaustion of the internal review process if the Plan demonstrates the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing good faith exchange of information between you and the Plan.

For more information regarding the external review process, contact the Plan Administrator at (216) 267-3344.

III. CHANGES TO COVERAGE FOR STATINS AND ASPIRIN

The preventive services required to be implemented by the Plan under the Affordable Care Act have been updated. The updates have required the coverage of aspirin and statins at no cost sharing for adults that are within certain ages and have certain risk factors. The board of trustees have determined to just cover the cost of aspirin and statin medication at no cost sharing to the participant as long as the participant meets the age requirements and are prescribed by a physician without necessitating that the participant prove they have certain risk factors.

Accordingly, effective May 1, 2018, the following language is added after the table in subparagraph iii. of paragraph b of subsection 6 of Section D of Article VI of the SPD:

> Coverage for statins for participants age forty to seventy-five and coverage for aspirin for participants age fifty to fifty-nine is provided one hundred percent and without cost sharing for the participant.

IV. CONCLUSION

This Summary Description should be read in conjunction with the SPD. If you have any questions regarding these changes, please contact the Fund office.

The Board of Trustees
of the
Sheet Metal Workers' Local 33 Cleveland District Health Benefits Plan