TILE INDUSTRY TRUST FUNDS
LOCAL # 18

NOTICE OF MATERIAL MODIFICATIONS

To the

TILE INDUSTRY HEALTH & WELFARE FUND

(As amended and restated effective January 1, 2012)

TO: Participants of the Tile Industry Health and Welfare Trust Fund

FROM: Board of Trustees

DATE: May 2016

RE: Changes to Plan/Loss of Grandfathered Status under the Patient Protection and Affordable Care Act (PPACA), Benefit Improvements to Prescription Drugs Provided Through the Trust Fund, and Eligibility for Participation as a Non-Bargaining Participant

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This document is a Summary of Material Modifications ("Summary") intended to notify you of important changes made to the Tile Industry Health & Welfare Fund ("the Fund") since the Summary Plan Description ("SPD") was last distributed to you.

You should take the time to read this Summary carefully and keep it with the copy of the SPD that was previously provided to you. If you either need another copy of the SPD or if you have any questions regarding these changes to the Plan, please contact the Trust Fund Office by telephone during normal business hours at (877) 908-9996, by mail at Tile Industry Health & Welfare Fund, P. O. Box 2559, West Covina, CA 91793 or by e-mail at staff@tilelocal18benefits.org.

The Board of Trustees has made the following changes to the Plan:

1. Effective April 1, 2016, the Board of Trustees has elected to lose its Grandfathered Status under the Patient Protection and Affordable Care Act which will apply to prescription drugs provided through the Plan. The medical plans provided through the Trust already provide non-grandfathered benefits, which generally means all preventive medical care and well-baby visits are provided to you free with no co-payment. The effect of this action by the Board of Trustees is to provide its participants and eligible dependents with the following benefit improvements. The following preventive prescription drugs will now be available to participants and eligible dependents free with no co-payment:

Aspirin: All strengths and dosage forms of generic aspirin covered with prescription of men and women ages 45-79.

Oral Fluoride: As prescribed through age 5.

Generic OTC Folic Acid Supplements: Generic strengths covered with prescription for women beginning at age 55.

Iron Supplement Drops: As prescribed by child's physician up to age 1.

Vitamin D: As prescribed by physician for patients over age 65.

Immunizations: Routine childhood and adult immunizations, Herpes Zoster (Shingles) for males and females age 60 and over and influenza.

Breast Cancer Chemo Preventative: The full cost of coverage will be provided in the case of preventative use.

Tobacco Cessation Medications: Both RX and OTC tobacco cessations products covered up to two 90 day treatments per year with additional treatments available as prescribed by the physician and under special circumstances.

In addition, the following woman's prescription drugs for contraceptive coverage will be available through the plan at no co-payment:

Oral Contraceptive (i.e. combination, progestin only, extended cycle, Plan B, Ella).

Rx- Non-Oral Contraceptive (i.e., patch, ring, injection, implant, IUD, Cervical Cap, diaphragm)

OTC - Non-oral Contraceptive (i.e., female condom, sponge, spermicide)

In addition, the following procedures are provided at no cost to the Participant:

Colorectal Cancer Screening Tests: The full cost of coverage will be provided in the case of preventative use.

2. Effective April 1, 2016, in an effort to address the high expense of new prescription drugs that are prescribed to cure Hepatitis C, the Board of Trustees has implemented a "High Impact Advocacy Program" through its pharmacy benefits manager, Sav-Rx, for certain expensive prescription drugs prescribed to treat Hepatitis C, whereby a participant needing this type of prescription drug will pay 25% of the cost of the prescription drug, subject to reimbursement of the 25% co-payment less $5.00. The net out-of-pocket cost to the participant who is prescribed prescription drugs to treat Hepatitis C will be $5.00 under this "High Impact Advocacy Program."

3. Coverage for employees who participate in the Health and Welfare Fund in a non-bargaining unit position is provided monthly (as opposed to quarterly for those employees who

gain eligibility as a result of working under a collective bargaining agreement) based on the payment of a flat monthly premium for such coverage, subject to adjustment on an annual basis by the Board of Trustees.

4. External Claims and Appeals of adverse benefit claims pertaining to loss of eligibility and prescription drug claims apply commencing April 1, 2016.

Generally, a Participant or Covered Dependent or an Authorized Representative of a Participant or Covered Dependent may only request an External Review after he/she has exhausted the internal review and appeal processes described above.

Only claims that involve medical judgment (including, but not limited to, issues related to the medical necessity, appropriateness, the location of services, a level of care, the effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational) and rescission of coverage are eligible for External Review. However, claims pertaining to a contractual or legal interpretation of the terms of the Plan without any use of medical judgment are not eligible for External Review.

The Independent Review Organization ("IRO") is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IRO's with which it contacts.

Request for External Review: A Participant or Covered Dependent may request an External Review within four calendar months from the date they received notice of an adverse determination or a final internal review adverse benefit determination. A notice sent via first class mail to the last known address reported to the Trust Office will be considered to have been received on the third business day following the date of said notice on the premise it was mailed on said date.

Preliminary Review: Within 5 business days following receipt of a request for External Review the Plan shall complete a preliminary review of said request to determine:

a. If the claimant was a Covered Person under the Plan at the time a request for medical service(s) was requested or at the time medical service(s) were rendered;

b. If the adverse benefit determination does not relate to failure of the person submitting the request to qualify as a Covered Person under the Plan;

c. If the claimant had exhausted the Plan's Internal Appeals Process as is required by the Plan (except, in limited, exceptional circumstances when under the regulations you are not required to do so); and

d. If the claimant has provided all information and documents required to process an External Review.

Within one business day of completing the Preliminary Review the Plan will notify the claimant in writing as to whether the claimant's request for External Review meets the above requirements. This notification will inform the claimant:

a. Whether the claimant's request is complete and eligible for External Review; or

b. Whether the claimant's request is complete but not eligible for External Review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272));

c. If the claimant's request is not complete, the notice will describe the information or materials needed to complete the request, and allow the claimant to request External Review within the four (4) month filing period, or within a 48 hour period following receipt of notification, whichever is later.

Review of Standard Claims by an Independent Review Organization ("IRO")

If the request is complete and eligible for an External Review, the Plan will assign the request to an IRO. Once the claim is assigned to an IRO, the following procedures will apply:

a. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for External Review, including directions about how the claimant may submit additional information regarding the claim (generally, the claimant will need to submit such information within ten (10) business days;

b. Within five (5) business days after the External Review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its adverse determination;

c. If the claimant submits additional information related to the claim to the IRO, the assigned IRO must, within one (1) business day, forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse determination that is subject of the External Review. Reconsideration by the Plan will not delay the External Review. However, if upon reconsideration, the Plan reverses its adverse determination, the Plan will provide written notice of its decision to the claimant and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its External Review;

d. The IRO will review all the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe

the Plan's requirements for benefits;

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from the claimant's medical records, recommendations or other information from the claimant's treating health care providers, other information from the claimant or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer;

e. The assigned IRO will provide written notice of its final External Review decision to the claimant and the Plan within 45 days after the IRO receives the request for External Review;

f. The assigned IRO's decision notice will contain:

(1) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), and reason for previous denial;

(2) The date that the IRO received the request to conduct the External Review and the date of the IRO decision;

(3) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

(4) A discussion of the principal reason(s) for IRO's decision, including rational for its decision and any evidence based standards that were relied on in making the decision;

(5) A statement that the IRO's determination is binding on the Plan and claimant (unless other remedies may be available to you or the Plan under applicable Federal law.);

(6) A statement that judicial review may be available to the claimant and the Plan; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with External Review processes.

(g) In the event a final decision of the Independent Review Organization may reverse an adverse benefit determination, in whole or in part, said decision shall be binding

on the Plan which shall then process for payment all approved portions of each claim without delay even if the Plan may appeal, or seek judicial review of, the decision.

This document has been uploaded and is available on the participant website at www.tilelocal18benefits.org.

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