NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

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TO: ACTIVE AND RETIRED PARTICIPANTS

RE: SUMMARY OF MATERIAL MODIFICATIONS TO THE NORTHERN CALIFORNIA PIPE TRADES SUPPLEMENTAL 401(k) RETIREMENT PLAN ("PLAN")

The Board of Trustees of your Plan is pleased to provide you with the following summary of a recent change to the Plan. The Plan's Disability Claims and Appeals Procedure has been updated to comply with recent Department of Labor regulations.

DISABILITY CLAIMS AND APPEALS PROCEDURE - Plan Amendment
Subsection 10.4 of Section 10 – Effective January 1, 2018

C. Disability Claims and Appeals

Disability claims and/or determination appeals must be reviewed within 45 days of the Plans receipt unless special circumstances exist. The Plan may require an extension of time not exceeding 30 days due to matters beyond the Plan's control.

The notice of extension will include, in addition to the reasons for the denial, the Plan's standards for determining benefit entitlement; the unresolved issues that prevent a decision on the claim and a request for any additional information needed to resolve those issues. The Claimant would have at least 45 days to provide any specified information. The Board of Trustees' deadline to render its decision starts from the date the Board sends the claim extension notification to the Claimant until the date the Board receives a response from the Claimant.

A retroactive rescission (meaning cancellation or discontinuance) of your disability benefit coverage will be considered an adverse benefit determination that would trigger the Plan's claims and appeals procedures. However, if the retroactive rescission was due to a failure to timely pay required premiums or contributions toward the cost of coverage that would not be considered an adverse benefit determination.

Effective January 1 2018, any **Notice of an Adverse Benefit Determination** will include:

(1) The reason(s) for the denial;
(2) The specific internal rule, guideline, protocol, standard, or other similar criterion, if any, relied upon in making the determination or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;
(3) An explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation or a statement that such explanation will be provided free of charge upon request;

(4) Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);
(5) Statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records, and other information to your claim for benefits;
(6) Statement of your right to present evidence and testimony in support of your claim during the appeal/review process;
(7) Statement that on appeal, you will have the right to respond to the denial if the Plan receives new or additional evidence and you will also be provided, free of charge, with a copy of any new or additional evidence considered, as soon as it becomes available to the Plan and sufficiently in advance of the date on which the appeal determination notice is required to be provided to you under the Plan's rules. (This will usually be before the next regularly scheduled meeting of the Board of Trustees unless special circumstances requires a further extension of time); and
(8) If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

If the application for benefits of a claim is denied, the Claimant or the Claimant's duly authorized representative may petition the Board of Trustees for review of the decision. The Claimant or the Claimant's duly authorized representative shall file the petition for review with the Trust Fund Office within 180 days of receipt of the notification of adverse benefit determination. The Claimant shall have access to relevant documents, records and other pertinent information, including any statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination. The Board of Trustees will not afford any deference to the initial benefit determination. If the adverse benefit determination is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Such consultant shall not be any individual consulted in connection with the initial determination, nor the subordinate of any such person.

The Board of Trustees shall notify the Claimant of their decision in writing. Effective January 1, 2018, any **Notice of Adverse Benefit Determination** shall include:

(1) The reason(s) for the denial:
(2) The specific internal rule, guideline, protocol, standard, or other similar criterion, if any, relied upon in making the determination or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;
(3) An explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation or a statement that such explanation will be provided free of charge upon request;
(4) Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts

whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);

(5) Any Plan imposed timeline for filing a lawsuit pursuant to your right under ERISA section 502(a) and the expiration date for bringing suit; and

(6) If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

If the Plan has failed to comply with the Claims and Appeals Procedure requirements for disability claims, you will not be prohibited from filing suit or seeking court review of a claim denial based on a failure to exhaust the administrative remedies under the Plan unless the violation was the result of a minor error or considered "de minimis." This would mean: (a) non-prejudicial, (b) attributable to good cause or matters beyond the Plan's control, (c) in the context of an ongoing good-faith exchange of information, and (d) not reflective of a pattern or practice of non-compliance by the Plan.

IN ACCORDANCE WITH THE REQUIREMENTS OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, AS AMENDED ("ERISA"), THIS DOCUMENT SERVES AS A SUMMARY OF MATERIAL MODIFICATIONS ("SMM") TO THE PLAN AND SUPPLEMENTS THE RESTATED SUMMARY PLAN DESCRIPTION THAT HAS BEEN SEPARATELY PROVIDED TO YOU. YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR COPY OF THE RESTATED SUMMARY PLAN DESCRIPTION.

If you have any questions, please call the Trust Fund Office at 925/356-8921 ext. 246 or toll free at 800/780-8984, ext. 246.

Respectfully submitted,

Fund Manager
On Behalf of the Board of Trustees