NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

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April 2017

TO: ACTIVE AND RETIRED PARTICIPANTS

RE: SUMMARY OF MATERIAL MODIFICATIONS TO THE NORTHERN CALIFORNIA PIPE TRADES PENSION PLAN ("PLAN")

The Board of Trustees of your Plan is pleased to provide you with the following summary of recent changes to the Plan. The Plan's Disability Claims and Appeals Procedure has been updated to comply with recent Department of Labor regulations and the Plan's Pre-Retirement Death Benefit rules have been clarified on Pro-Rata Reciprocity and Contiguous Non-Covered Service for vesting purposes.

VESTING CREDIT – Plan Clarification and Amendment
Article I, Section 22(c) – Effective March 1, 2009
Article I, Section 22(d) – Effective January 1, 2017

Effective as of March 1, 2009, **all Contiguous Service**, which shall consist of all employment for an Employer maintaining the Plan for which the Employer is not required to make a contribution to the Plan immediately preceding or following Covered Employment without a quit, retirement, or discharge between the Covered and Non-Covered Employment, is calculated on the same basis as Vesting Service Credit but only to the extent required by the applicable Department of Labor regulations. However, effective for any Participant retiring on or after January 1, 2008, a Participant who would otherwise qualify for Contiguous Service under the Section were it not for the fact that the Participant worked for different employers (i.e., *not just the same Employer*) maintaining the Plan will have such employment count as Contiguous Service for purposes of earning Vesting Credit. **Contiguous Service will not apply toward Service Retirement Benefit, the Special Disability Benefit, or any Pre-Retirement Death Benefits.** Contiguous Service Vesting Credits will be considered for Disability Retirement Pensions, Early Retirement Pensions, and Normal Retirement Pensions only. For Disability, Retirement Pensions, Early Retirement Pensions, and Normal Retirement Pensions, the Plan will consider Contiguous Service Vesting Credits in an amount equal to or less than Vesting Credits accrued in Covered Employment up to a maximum of 5 Contiguous Service Vesting Credits.

Effective as of January 1, 2017, all years of Vesting Credits for service accrued under a pension plan affiliated with the United Association of Journeyman and Apprentices of the Plumbing and Pipefitting Industry of the U.S. and Canada with which this Plan has a reciprocity agreement recognizing such Vesting Credit for purposes of providing a full or proportionate benefit pursuant to this Plan. Pro-Rata Reciprocal Vesting credits will apply toward Normal Retirement Pensions only. **Pro-Rata Reciprocal Vesting Credits will not apply toward Disability Retirement Pensions, Early Retirement Pensions, Service Retirement Pensions, Special Disability Benefits, or any Pre-Retirement Death Benefits.**

OPTIONAL PRE-RETIREMENT DEATH BENEFITS – Plan Amendment
Article IV, Section 3 – Effective January 1, 2017

For purposes of vesting, a vested Employee is qualified if at the time of the Employee's death, he was credited with no less than 300 hours of Covered Employment in the Northern California Pipe Trades Pension Plan during (1) one of the three (3) Plan Years immediately preceding the date of death. In determining whether an Employee is vested for this benefit option, Pro-Rata Reciprocity and Contiguous Non-Covered Service are excluded. The requirement of 300 hours of Covered Employment shall, however, be waived if the Employee suffered from a permanent and total disability as defined in Article II, Section 3.

DISABILITY CLAIMS AND APPEALS PROCEDURE - Plan Amendment
Article X, Section 4(d) – Effective January 1, 2018

4. APPEALS PROCEDURES.

d. Disability Claims and Appeals. Effective as of January 1, 2002, if a claim pertains to disability benefits, the rules and rights set forth in this subsection shall apply in addition to those set forth above to the extent applicable. Any person whose Application for disability benefit is denied shall be notified of such denial within a reasonable period but not later than 45 days after receipt of such Application or claim. An extension of time not to exceed 30 days may be necessary due to matters beyond the Plan's control in which case a notice will be sent to the Participant prior to the expiration of the 45 day period. If a decision cannot be rendered due to matters beyond the Plan's control prior to the expiration of the 30 day extension, an additional extension of 30 days is permitted in which case a notice shall be furnished to the Participant. The notice of extension will include in addition to the information set forth above in subsection a, the standards on which entitlement to a benefit is based, the unresolved issues that prevented a decision on the claim and any additional information needed to resolve the dispute.

The Participant shall be afforded at least 45 days to provide the requested information, if any. The deadline for the Trustees to render a decision on the disability appeal is tolled from the date on which the notification of the extension is sent to the Participant until the Participant's response is received by the Plan.

Effective January 1, 2018, the **Plan's Notice of Adverse Benefit Determination on a Disability Claim** shall include:

(1) The reason(s) for the denial;
(2) The specific rule, guideline, protocol, 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 clinical or scientific judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusions 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.

A petition for review of a denial of a disability claim shall be filed within 180 days of receipt of the notification of the Plan's adverse determination. The Participant shall have access to relevant documents, records, and other information relied upon by the Plan, In addition, the Participant shall be entitled to 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. If the adverse benefit determination is based in part or in whole on a medical judgment, the Trustees shall consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Such consultant shall be different from any individual consulted in connection with neither the initial determination nor the subordinate of any such person. In addition, effective January 1, 2018, any **Notice of Adverse Benefit Determination on the Appeal** 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) 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) and 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