AUTOMATIC SPRINKLER
LOCAL 281, U.A.
WELFARE FUND

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SUMMARY OF MATERIAL MODIFICATIONS #1

Important Notice Regarding the Claims and Appeals Procedures Effective April 1, 2018

March 2018

Dear Participant:

This notice, referred to as a Summary of Material Modifications (SMM), describes important changes related to the Automatic Sprinkler Local 281, U.A. Welfare Fund. You should read this notice carefully and keep it with your Summary Plan Description and Plan Document (SPD).

UPDATED CLAIMS AND APPEALS PROCEDURES FOR COMPLIANCE WITH FEDERAL DISABILTY RULES

Recent amendments to Department of Labor regulations establish special procedural requirements for claims and appeals that involve disability determinations. For your SPD, these amendments may impact how the Fund reviews claims or appeals involving Weekly Accident and Sickness Benefits, eligibility determinations for disabled Employees, and eligibility determinations for disabled adult Eligible Dependent children.

The claims and appeals procedures set forth in this SMM apply in addition to the claims and procedures in Chapter 15 of your SPD. To see exactly how your SPD has been modified, please refer to the enclosed amendment.

Initial Notification of Disability Decision

Timing of Notification for a Disability Claim. The Fund will decide Disability / Weekly Accident and Sickness claims within a reasonable time but not later than 45 days from the date of the receipt of the claim. The initial 45-day period may be extended for up to two additional 30-day periods for circumstances beyond the control of the Fund if the Fund notifies you of the extensions prior to the expiration of the initial 45-day and first 30-day extension period, respectively. Any notice of extension will indicate the circumstances requiring an extension, the date by which a decision is expected to be reached, the standards upon which entitlement to a benefit is based, the unresolved issues that require the extension, and the additional information needed to resolve those issues.

Content of Notifications for a Disability Claim. The Fund will provide you with written notice of its determination in a culturally and linguistically appropriate manner. The notice will include the information specified in SPD Section 15.05 (“Content of Initial Denial Notices”), along with a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views you presented to the Fund of health care professionals treating you and vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse benefit determination; and (3) if applicable, a disability determination that you presented to the Fund made by the Social Security Administration.

If the adverse benefit determination is based on medical necessity or an experimental treatment or similar exclusion or limit, the notification will include either an explanation of the scientific or clinical

judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The notification will also include: (1) either the specific 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, and (2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Special Appeal Procedures for Disability Determinations | New Evidence or Additional Rationale

In the case of an appeal involving a disability determination, the Fund will, before issuing an adverse benefit determination on appeal, provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund or other person making the benefit determination (or at the direction of the Fund or such other person) in connection with your claim. You will be provided with such evidence as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided (see "Notification of Disability Decision on Appeal" below) to give you a reasonable opportunity to respond prior to that date.

In addition, before the Fund can issue an adverse benefit determination on appeal based on a new or additional rationale, the Fund will provide you, free of charge, with the rationale. You will be provided with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on appeal is required to be provided (see "Notification of Disability Decision on Appeal" below) to give you a reasonable opportunity to respond prior to that date.

Notification of Disability Decision on Appeal

Timing of Notification for a Disability Appeal. The Trustees or a designated Committee of the Trustees will review your appeal within 45 days following receipt of your appeal. If special circumstances require a further extension of time for review by the Trustees, a benefit determination will be made not later than 90 days following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision. Once a decision on review of the claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Content of Notifications for a Disability Appeal. The Fund will provide you with written notice of its determination in a culturally and linguistically appropriate manner. The notice will include the information specified in SPD Section 12.08 ("Content of Notice of Decision on Appeal"), as well as a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views you presented to the Fund of health care professionals treating you and vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse benefit determination; and (3) if applicable, a disability determination that you presented to the Fund made by the Social Security Administration.

If the adverse benefit determination is based on a medical necessity or an experimental treatment or similar exclusion or limit, the Fund will provide you with either an explanation of the scientific or clinical

judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of change upon request.

The Fund's notice will also include: (1) either the specific 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, and (2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

CONCLUSION

The Trustees will continue to monitor the Fund's resources to ensure that it is able to provide high-quality health coverage to members and their families for many years to come. As always, if you have any questions about this SMM, or the Fund in general, please feel free to contact the Fund Office. In the event of an ambiguity or conflict between this SMM and the Plan Document and Summary Plan Description, as amended, the Plan Document and Summary Plan Description will control.

The Importance of Using In-Network Providers

The Fund has contracted with a Preferred Provider Organization (PPO) to help manage certain health care expenses for you and the Fund. PPO Providers, such as hospitals and physicians within the PPO Network, have agreed to charge discounted rates for services. When you choose to use a PPO Provider, both you and the Fund will save money.

The Plan typically covers 85% of the charges associated with treatment rendered by a PPO Provider. However, the Plan will cover only 60% of the Usual and Customary Charges associated with treatment rendered by a non-PPO Provider, and the Usual and Customary Charge will typically be no greater than what a PPO Provider would have charged for the same treatment.

Additionally, unlike PPO Providers, providers outside the PPO Network have not agreed to charge discounted rates for their services. Therefore, if you use a Non-PPO Provider you may be responsible for significant medical fees pursuant to a practice known as *balance billing*. Under this practice, the Non-PPO Provider charges the patient the difference between the amount billed and the amount paid by the Fund. Consequently, the Fund strongly encourages all participants to remain *in-network* when seeking medical care.

Very truly yours,

Tim Morrin, Administrator
On behalf of the Automatic Sprinkler
Local 281, U.A. Welfare Fund

FIRST AMENDMENT TO THE
SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT OF THE
AUTOMATIC SPRINKLER LOCAL 281, U.A. WELFARE FUND
(As Amended and Restated Effective January 1, 2018)

WHEREAS, the Summary Plan Description and Plan Document ("Plan") of the Automatic Sprinkler Local 281, U.A. Welfare Fund ("Fund") was amended and restated effective January 1, 2018; and

WHEREAS, the Trustees of the Fund, by virtue of Chapter 16, Section 16.01 of the Plan, have the authority to amend the Plan at any time.

NOW, THEREFORE, to comply with federal regulations regarding how employee benefit plans process disability claims and appeals, the Trustees of the Fund hereby amend the Plan as follows:

1. **Subsection (b) of Section 15.05 ("Content of Initial Denial Notices") is amended to read as follows:**

   If your Disability / Weekly Accident and Sickness claim is denied, in whole or in part, the Fund will provide you with a written notice of the denial in a culturally and linguistically appropriate manner. The notice will state:

   (1) The specific reason(s) for the adverse determination and references to any pertinent Plan provisions on which the determination was based;

   (2) 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;

   (3) An explanation of the basis for disagreeing with or not following: (i) the views you presented to the Fund of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse benefit determination; and (iii) if applicable, a disability determination that you presented to the Fund made by the Social Security Administration;

   (4) If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

   (5) A description of any additional materials or information which might help your claim (including an explanation of why that information may be helpful);

   (6) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;

   (7) A description of the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review.

2. **Subsection (d) of Section 15.07 ("Timing of Notification of Decision on Appeal") is amended to add the following final paragraph:**

   In the case of a Disability / Weekly Accident and Sickness claim, the Trustees or a designated Committee of the Trustees will review your appeal within 45 days following receipt of your appeal. If special circumstances require a further extension of time for review by the Trustees, a benefit determination will be made not later than 90 days following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision. Once a decision on review of the claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

3. **Subsection (b) of Section 15.08 ("Content of Notice of Decision on Appeal") is amended to read as follows:**

   If your appeal concerning a Disability / Weekly Accident and Sickness claim is denied, in whole or in part, the Fund will provide you with a written notice of the denial in a culturally and linguistically appropriate manner. The notice will state:

   (1) The specific reason(s) for the adverse determination and references to any pertinent Plan provisions on which the determination was based;

   (2) 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;

   (3) An explanation of the basis for disagreeing with or not following: (i) the views you presented to the Fund of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse benefit determination; and (iii) if applicable, a disability determination that you presented to the Fund made by the Social Security Administration;

   (4) If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

   (5) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;

   (6) A description of the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA.

Adopted: March 14, 2018
Effective: April 1, 2018