AGC-International Union of Operating Engineers Local 701 Trust Funds

15 - 82nd Drive, Suite 110 • Gladstone, Oregon 97027
Phone (866) 697-5750 or (503) 657-9740 • Fax (503) 657-9737 • Website www.agc-iuoe701trusts.com

Administered by
Welfare & Pension Administration Service, Inc.

April 20, 2018

TO: All Plan Participants of the Defined Benefit Plan of AGC-International Union of Operating Engineers Local 701 Pension Trust Fund

RE: Summary of Material Modifications

Dear Participant or Beneficiary,

Since issuance of the January 1, 2015, Summary Plan Description booklet and the July 28, 2016, and July 21, 2017, summaries of material modifications (collectively, the "SPD"), the Plan was amended to reflect certain legal changes that affect the information in the SPD, effective April 1, 2018. The changes are summarized below, with references to the corresponding SPD sections and page numbers. **Please keep this summary of material modifications to the SPD with your booklet.**

Denial of a Claim - Contents of Notice - Disability Claims (SPD pages 57 and 58). The section is replaced by the following:

Disability Claims: The notice of an adverse disability benefit determination, including a rescission, will also include the following information:

- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria that were relied on in deciding the claim, or a statement that such criteria do not exist.
- If the denial was based on a medical necessity, experimental treatment, or similar exclusion or limit, the notice will either explain the scientific or clinical judgment for the decision, or it will state that you may obtain such an explanation free of charge upon request.
- A discussion of the decision, including an explanation of the basis for disagreeing with, or not following:
  - The views presented by you, to the Plan, of health care professionals treating you or vocational professionals who evaluated you;
  - The views of medical or vocational experts whose advice was obtained by the Plan in connection with the claim, without regard to whether the advice was relied upon in making the decision;
  - A disability determination made by the Social Security Administration and presented by you to the Plan; and
- A statement that you are entitled to receive, upon request and free of charge, a copy of all documents relevant to the claim.

<u>Review of a Denied Claim (SPD pages 58 through 61)</u>. The section is replaced in its entirety by the following:

Time Period to Request Review

General Claims: If your claim is denied in whole or in part, you have the right to request the Board of Trustees to review the claim. Except as provided below for disability claims, your request must be in writing and must be made by personal delivery or mailing to the Board of Trustees within 60 days after being advised of the Board of Trustees' decision. *If your written request for review is not made within the applicable time period, you waive any right to review under these procedures and any right to sue in state or federal court.*

Disability Claims: Your request for review of a denied disability claim must be made within 180 days after you are advised of the denial. *If you fail to request review within the 180 days, you waive any right to review under these procedures and any right to sue in state or federal court.*

Review Procedure

General Claims: The Board of Trustees will then conduct a review. As a part of that review process, you may present your position. In doing so, you may review all pertinent documents, if any, supporting the claim, and you may submit issues and comments in writing. The information you submit will be taken into account in the review process even if it was not considered in deciding the initial claim. You will also be provided, on request and free of charge, reasonable access to, and copies of, all information relevant to your claim. The Board of Trustees may, but is not required to, hold a hearing if it believes it is necessary.

Disability Claims: The following additional rules apply with respect to a disability claim:

- The review will not give any deference to the initial claim decision. It will be conducted by a Plan fiduciary who did not decide the initial claim and who is not a subordinate of the person who decided the initial claim.
- If the initial claim denial was based in whole or in part on a medical judgment, the Plan fiduciary will consult a health care professional with appropriate training and experience. The health care professional must be someone who was not consulted in connection with the initial claim decision, and who is not a subordinate of any health care professional who was consulted on the initial claim.
- You will be notified of any medical or vocational experts who were consulted in connection with the initial claim decision.
- Before the Trustees notify you of their decision, they will provide you, free of charge, with any new or additional evidence that they considered in connection with your claim. Before a decision is made based on the new or additional evidence, the Trustees will provide you, free of charge, with a description of their rationale as soon as possible and sufficiently in advance of their final decision to allow you a reasonable opportunity to respond.

Time Period for Decision on Review

The Board of Trustees holds regularly scheduled meetings at least quarterly (every three months). If you request review of your claim more than 30 days prior to the date of the Trustees' next regularly scheduled meeting, the Trustees will make a decision on your claim at that next regularly scheduled meeting. If you submit your request for review 30 or fewer days before the date of the Trustees' next regularly scheduled meeting, the Trustees' decision will be made by the date of the second regularly scheduled Trustees' meeting following the filing of your request. If special circumstances, such as the need to hold a hearing, require a further extension of time for reviewing your claim, the Trustees will make their decision by the date of the third regularly scheduled meeting after you file the request for review. If an extension of time is needed, you will be notified in writing, prior to the start of the extension, of the reason the extension is needed and the date by which the Trustees expect to make their decision. The Trustees will notify you of their decision as soon as possible, but no later than five days after they reach a decision.

In the event the Trustees do not hold regularly scheduled meetings at least quarterly, the time periods described below will apply to the review of your claim.

General Claims: Except as provided below for disability claims, the Board of Trustees will issue a written or electronic decision within 60 days after the date on which you request review. If special circumstances require an extension of time for processing (such as the need to hold a hearing), a decision will be made and furnished to you not later than 120 days after review is requested. If an extension is required, you will be notified within 60 days after you request review. The notice will describe the special circumstances and the date by which a decision is expected.

Disability Claims: The Board of Trustees will issue a written or electronic decision within 45 days after the date on which review is requested. If special circumstances require an extension of time for processing, a decision will be made and furnished to you not later than 90 days after review is requested. If an extension is required, you will be notified within 45 days after review is requested. The notice will indicate the special circumstances and the date by which a decision is expected.

Contents of Review Decision

General Claims: The decision on review will include the reasons for the decision and pertinent Plan provisions on which it is based. The decision will also inform you of your right to request information relevant to the claim and to bring a civil action under ERISA. A copy of the decision will be furnished to you.

Disability Claims: The decision on review of a disability claim will also include the additional information described in "Contents of Notice, Disability Claims," beginning on page 57. The statement of your right to bring an action under ERISA Section 502(a) will also describe the limitations period that applies to your right to bring such action (see "Effect of Review and Subsequent Review" on page 61), including the calendar date on which the limitations period expires for your claim.

Additional Rules Applicable to Claims for Disability Benefits

Avoiding Conflict of Interest: All disability claims will be reviewed in a manner designed to ensure the independence and impartiality of those involved in making the decision, including those retained as medical or vocational experts. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of the claim.

Notices: Notices will be provided in a manner that is culturally and linguistically appropriate. If 10% or more of the population in the county in which you reside is literate only in the same non-English language (the "applicable non-English language") as determined in guidance published by the U.S. Department of Labor, then the Plan will:

- Provide oral language services in the applicable non-English language and provide assistance with filing claims and requests for review in the applicable non-English language;

- Provide, upon request, a notice in the applicable non-English language; and

- Include in the English versions of all notices, a statement, prominently displayed, in the applicable non-English language, indicating how to access the language services provided by the Plan.

Assertion of Deemed Exhaustion of Claims Procedure: If you request a written explanation of a failure by the Plan to follow its claim procedure with respect to a claim for disability benefits, the Plan shall provide you with such explanation within 10 days. The explanation shall include a specific description of the reasons, if any, that the violation should not cause the claims procedure to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Plan met the standards under 29 CFR § 2560.503-1(l)(2)(ii), the claim shall be treated as re-filed upon the Plan's receipt of the court's decision. The Plan shall provide you with notice of the resubmission within a reasonable time after receipt of the court's decision.

Effect of Review and Subsequent Review

The Trustees' decision on review is final and binding upon you, the Board of Trustees, and all other persons involved.

If your claim has been denied, you cannot undertake any legal action with respect to the claim until you have exhausted all the procedures described above. <u>If you fail to follow those procedures, you waive any right to further review, judicial or otherwise. In no event will you be able to file a lawsuit more than two years from the date the Plan's internal review has concluded</u>.

Any further review, judicial or otherwise, will be based on the record before the Board of Trustees and will be limited to whether the Board of Trustees acted arbitrarily or capriciously in the exercise of its discretion.

If you have any questions regarding these changes, contact the Gladstone Administration Office at the address or telephone numbers listed above.

Sincerely,

BOARD OF TRUSTEES
DEFINED BENEFIT PENSION PLAN OF AGC-IUOE LOCAL 701 PENSION TRUST FUND

NL:hkg opeiu#8
S:\Mailings\Individual Trust Fund Mailings (SMM, Benefit Changes, etc.)\F07-00\F07-04 - Mailing - 2018 - 04.20 - SMM.docx