



NORTHERN CALIFORNIA PIPE TRADES HEALTH AND WELFARE PLAN & HEALTH REIMBURSEMENT ACCOUNT CLAIMS AND APPEALS PROCEDURES

Your Right to Appeal. You may request that the Board of Trustees review an Adverse Benefit Determination (e.g. denial, reduction, termination of, or failure to provide or make payment either in whole or in part of Health and Welfare Benefits, or a retroactive cancellation/termination of entitlement to disability benefits). This is also known as an appeal. You have the right to petition the Board of Trustees to review your claim if:

- Your claim or any part of your claim was denied.
- You believe you did not receive the full amount of benefits to which you are entitled.
- You feel that the reason(s) for the denial were in error or disagree with the decision made on a claim/request for benefits.

Your Right to Information. You have the right to receive, upon written request, reasonable access to and copies of all relevant documents, records, or other relevant information that was submitted, generated by the Plan, considered or relied upon in making a decision on your claim. This includes your right to receive copies of any internal rules, guidelines, standards, protocols or other similar criteria that we may have relied upon in making the decision. If the decision was based on a medical judgment, you may request that the Plan provide you with an explanation of the medical or scientific basis for the determination. The Plan will not charge you for any information you request that is described in this section.

For appeals of disability-related claims you also have the following additional rights:

- To receive an explanation of any disagreement 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);
- To receive an explanation of any disagreement with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your denial (if applicable);
- To receive an explanation of any disagreement with the view of any disability determination made by the Social Security Administration (if applicable);
- The expiration date for any Plan imposed timeline (currently 1 year) for filing a lawsuit pursuant to your rights under ERISA;
- If applicable, statement that any internal rules, guidelines, standards or protocols or other similar criteria that the Plan may have relied on does not exist;
- The right to present evidence and testimony in support of your claim during the appeal process;
- The right to review and respond to the Plan's receipt of any new or additional evidence and to be provided free of charge with any new or additional evidence considered as soon as it becomes available to the Plan but before a final decision is made (this is usually before the next regularly scheduled meeting unless special circumstances require further extension of time); and
- If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

How to Appeal. You or your authorized representative (someone you name to act for you) must send a written request for review to the Board of Trustees. However, appeals of Urgent Claims may be submitted orally followed by a faxed written request within 24 hours. The individual(s) reviewing your appeal will be independent from the individual(s) who reviewed your initial claim. Your request must be in writing and should include the following:

- Your name and last four digits of your Social Security number.
- A statement that you are filing an appeal.
- Sufficient information to identify the claim decision you are appealing such as the type of benefit denied.

- The reason(s) you believe your claim should not have been denied or a different amount should have been paid.
- A summary of all the facts known to you that relate to your request for review, including the names and addresses of persons who have knowledge of any facts regarding your case.
- Copies of any documents, records or other material that you believe are important for the Trustees to review your claim.
- Mail your appeal to the above address to the attention of:
Board of Trustees, Northern California Pipe Trades Health and Welfare Trust

Time Limits to File Your Appeal. You have 180 days following your receipt of a notification of an Adverse Benefit Determination within which to appeal the determination, with certain exceptions noted below. If you desire additional time to present evidence for your appeal, you may submit a written request for additional time to the Plan prior to the expiration of the 180 day period. The Board of Trustees will grant your request provided the request is received before the Board of Trustees has rendered its decision.

IMPORTANT: The failure to file an appeal within the above time periods constitutes a waiver of your right to review under these procedures or in a court of law. Consequently, the initial decision will be final and binding. Therefore, please send in your appeal on a timely basis. You are encouraged to review of the Summary Plan Description which explains the claims and appeals procedures in more detail. These claims appeal procedures do not apply to claims and appeals relating to benefits provided through a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Pharmaceutical Supplier, or an Outside Entity providing other services for the Plan pursuant to a contract. These entities have their own claims and appeal procedures. Please refer to the applicable Evidence of Coverage booklets or contact them for more information. The Board of Trustees or a committee appointed by the Trustees and authorized to act on appeals will review the appeal. Any comments, documents and other information that you submit relating to the claim will be considered without regard to whether such information was submitted or considered in the initial benefit determination.

The Board's Decision on Your Appeal. The Board of Trustees will make its decision on post-service claims at the next regularly scheduled Board of Trustees meeting following the request for review, unless your appeal is received within thirty (30) days preceding the date of such meeting or special circumstances exist requiring additional time. In such case, a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of the appeal request. If special circumstances require a further extension of time for processing, a benefit determination will be made no later than the third meeting following the receipt of the petition for review and you will be notified of such an extension and the date by which a determination will be made. (For Urgent Care claims, the determination will be made no later than 72 hours of receipt of the appeal by the Trust Fund Office.)

The Board of Trustees or its delegate will attempt to notify you in writing of the Trustees' decision on an appeal within five (5) days after the benefit determination is made.

Time Limits to File Lawsuit. If your appeal is denied, you have the right to bring a civil action under ERISA (Employee Retirement Income Security Act of 1974), Section 502(a). No lawsuit may be filed without first exhausting these appeal procedures except for disability-related claims, if the Plan has failed to comply with the claims and appeals procedure for disability claims, you will not be prohibited from filing suit for failure to exhaust these appeal procedures (except for minor Plan errors or matters beyond the Plan's control). **Under the Plan Document, you have one (1) year from the date of the denial of your appeal to file a lawsuit.**

One Year Limitation to File Suit and Choice of Venue Limit. Upon exhausting the claims and appeals procedures for an eligible claim pursuant to the Plan rules, if a Participant or Beneficiary (or Authorized Representative) is still not satisfied, the next step is to file a lawsuit. No legal action or proceeding may be commenced or maintained against the Plan, a individual Trustee, the Board of Trustees, or any other person or

entity involved or associated with the denial or decision on the appeal more than one (1) year after the Board of Trustees' determination on the appeal (counted from the date of the appeal letter), or if not a formal appeal, one (1) year after the date of the act or omission of which is being challenged. If there is a lawsuit, the Participant or Beneficiary (or Authorized Representative) agrees to submit to the jurisdiction of the United States District Court for the Northern District of California and any such lawsuit has to be filed in the United States District Court, Northern District of California which shall be the exclusive venue of any such action or proceeding. The Participant or Beneficiary (or Authorized Representative) also irrevocably and unconditionally waives any objection that it might now or hereafter have to the venue of the aforementioned court and any claim that any action or proceeding brought in the aforementioned court has been brought in an inconvenient forum.

Class Action Waiver. In addition, any person including Participants and Beneficiaries seeking benefits or otherwise challenging action or inaction of the Plan (such as questioning the Plan's investments), the Board of Trustees, an individual Trustee or any other person or entity involved or associated with any Plan action or omission is not permitted to participate in or bring a class action lawsuit as a member in any class or representative action against the Plan, the Board of Trustees, an individual Trustee or any other person or entity involved or associated with any such Plan action or omission. Only individual lawsuits are permitted, meaning any person including Participants and Beneficiaries may only bring claims in its individual capacity, and not as a plaintiff or class member in any purported class or representative proceeding.

Additional Information. Please refer to your Summary Plan Description (also the Plan Document) for more information about the appeals procedures. If there is any conflict between the above policy and the Plan Document, the Plan Document (and its amendments) controls. If you have any questions about your coverage or benefits, you may call or write to the Trust Fund at the telephone number or address above.