Carpenters Southwest Administrative Corporation
533 South Fremont Avenue • Los Angeles, California 90071-1706 • Tel: 213-386-8590 • Toll Free: 800-293-1370
www.carpenterssw.org

IMPORTANT ANNOUNCEMENT

June 2017

To: All Active Carpenters of the Southwest Carpenters Health and Welfare Plan for Active Employees

PARTICIPANT NOTICE

This Participant notice will advise you of certain material modifications that will be made to the Plan. **This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully.

The Board of Trustees is pleased to announce the credit for disability hours that was suspended on January 1, 2015 will be reinstated for disabilities that occur on and after July 1, 2017.

This credit pertains to Health and Welfare hours only and has no effect on your pension credits.

As explained more fully below, the Board of Trustees has restored prior rules that allowed participants to receive credit for disability hours following an injury or illness that prevents them from performing their regular and customary duties of their occupation.

CREDIT FOR DISABILITY HOURS
EFFECTIVE FOR DISABILITIES THAT OCCUR ON AND AFTER JULY 1, 2017

If an Active Carpenter becomes Disabled in a Work Quarter he will be credited with disability hours **at the rate of eight (8) hours for each day he is Disabled** (excluding Saturdays, Sundays and holidays). The total of disability hours credited and hours worked in a Work Quarter may not exceed the minimum hours worked to maintain eligibility.

The maximum number of disability hours that can be credited during a work quarter is 360, less the number of hours actually worked during that quarter.

Disability hours credit can be given for a maximum of two consecutive work quarters.

For this purpose, an Active Carpenter is deemed to have a "**Disability**" when he/she is **unable to perform the regular and customary duties of his/her occupation because of an illness or injury**.

Disability hours will be credited once all the following requirements are met:

a. the **Disabled status must be certified in writing by a Physician who is a medical doctor**;

b. **Time Limits:** the written certification of disability must be submitted to the Administrative Office by the earlier of:

   1) 90 days following the date the Active Carpenter became Disabled,

   2) 60 days following the first date the Active Carpenter loses eligibility under the Plan (after the date on which the Active Carpenter becomes Disabled).

c. the Active Carpenter must have been credited with Hours Worked for reasons other than having been Disabled or a qualified family or medical leave within the 90-day period ending on the date he became Disabled;

d. the Active Carpenter must have been an Eligible Individual on a non-self-pay basis during both of the two consecutive Eligibility Quarters that ended immediately prior to the commencement of the Eligibility Quarter in which he became Disabled; and

e. the Active Carpenter must not be receiving a Pension Benefit from the Southwest Carpenters Pension Trust.

The Active Carpenter is to submit a **request for crediting of disability hours** along with the **Physician's written certification of the disability** to the Administrative Office within the time limits specified above. The Administrative Office will make a determination on the request and notify the Active Carpenter in writing whether the request for crediting of disability hours is approved or denied (a denial is called an Adverse Benefit Determination). The Active Carpenter can appeal an Adverse Benefit Determination by following the Plan's claim appeal process, outlined below.

HOW TO FILE AN APPEAL OF A CLAIM FOR CREDITING OF DISABILITY HOURS

1. The Administrative Office will make a determination on the request for crediting of disability hours and notify the Active Carpenter in writing whether the request is approved or denied (an Adverse Benefit Determination). Eligible employees who have a disability must apply (file a claim) for crediting of disability hours within the required timeframe described in the Plan. **Failure to file your claim within the required timeframe will invalidate your claim.**

   Send a request for crediting of disability hours along with the certification of the disability to:

   Southwest Carpenters Health and Welfare Trust
   Attn: Credit of Disability Hours
   533 S. Fremont Ave.
   Los Angeles, CA 90071

2. The request for crediting of disability hours will be determined no later than **45 calendar days** after receipt of both the request and Physician certification by the Administrative Office.

3. You will be notified **if you did not follow the Plan's procedures** (such as not submitting the Physician certification to prove a disability) and provided **45 calendar days** in which to obtain this additional information.

   This 45-day period may be extended for up to 30 calendar days provided the Administrative Office determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period, that additional time

is needed to process the claim, the special circumstances for this extension and the date by which it expects to render its determination.

(a) If, prior to the end of this first 30-day extension, the Administrative Office determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.

(b) A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. **If the Administrative Office needs additional information from you to make its decision**, you will have at least 45 calendar days to submit the additional information. (If a period of time is extended due to failure to submit information, the time period is measured from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed from the date that the Notice was sent to you.)

4. The Plan will take steps to ensure that claims and appeals for crediting of disability hours are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based upon the likelihood that the individual will support the denial of benefits. Medical and vocational experts will be selected based on their professional qualifications.

5. The Plan will provide you, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim for crediting of disability hours. Such evidence will be provided 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) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided 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) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

6. Crediting of disability hours will be approved if the claim has been determined to meet the definition of Disability under this Plan. **If the claim for crediting of disability hours is approved**, you will be notified in writing (or electronically, as applicable) and hours will be credited.

7. **If the claim for crediting of disability hours is denied** in whole or in part, a notice of this initial denial (an Adverse Benefit Determination) will be provided to the employee in writing (or electronically, as applicable). This notice of initial denial will:

   (a) give the specific reason(s) for the denial of crediting of disability hours (including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the plan);

   (b) reference the specific Plan provision(s) on which the determination is based;

(c) contain a statement that you are entitled to receive upon request, free access to and copies of documents, records and other information relevant to your claim;

(d) describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

(e) provide an explanation of the Plan's appeal procedure along with time limits;

(f) contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal;

(g) describe any applicable contractual limitation periods on benefit disputes (such as the Plan's time limit on when a lawsuit may be filed following an appeal);

(h) if the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request; and

(i) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.

8. If you do not understand English and have questions about crediting of disability hours, filing a claim for crediting of disability hours or about a claim denial, contact Administrative Office at 213-386-8590 or 800-293-1370 to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 213-386-8590 or 800-293-1370.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 213-386-8590 or 800-293-1370.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 213-386-8590 or 800-293-1370.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 213-386-8590 or 800-293-1370.

9. **If you disagree with a denial of crediting of disability hours,** you or your authorized representative may ask for an appeal review as described below. You have **180 calendar days** following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A CLAIM FOR CREDITING DISABILTY HOURS

1. Appeals must be submitted in writing to the Board of Trustees in care of the Administrative Office (whose contact information is listed on letterhead in this document). You will be provided with:

   (a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

   (b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

   (c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

   (d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim for crediting of disability hours. Such evidence will be provided 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) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale

will be provided 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) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

(e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the appropriate named fiduciary will:

1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
2) provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

2. A determination on the appeal will be made by the Board of Trustees as follows:

(a) no later than the date of the Board of Trustees meeting that immediately follows the Plan's receipt of a request for review, when the request for appeal review is filed **within** 30 calendar days preceding the date of such meeting. If the appeal **is filed more than 30 days** before the next meeting, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of the request for review.

(b) If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be made no later than the third meeting of the Board following the Plan's receipt of the request for review.

(c) If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

(d) The Plan will notify you of the benefit determination on the appeal no later than five (5) calendar days after the benefit determination is made.

3. **The Plan may obtain a 45-day extension if** you are notified of the need and reason for an extension before expiration of the initial 45-day period. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed from the date that the Notice was sent to you.)

4. You will receive a notice of the appeal determination. If that determination is adverse, it will include:

(a) the specific reason(s) for the adverse appeal review decision of crediting of disability hours (including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the plan);

(b) reference the specific Plan provision(s) on which the determination is based;

(c) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

(d) a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

(e) describe any applicable contractual limitation periods on benefit disputes (such as the Plan's time limit on when a lawsuit may be filed following an appeal);

(f) a statement of the voluntary Plan appeal procedures, if any;

(g) if the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request; and

(h) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(i) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

5. If you do not understand English and have questions about crediting of disability hours, filing a claim for crediting of disability hours or about a claim denial, contact Administrative Office at 213-386-8590 or 800-293-1370 to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 213-386-8590 or 800-293-1370.
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6. This concludes the appeal process under this Plan related to crediting of disability hours. This Plan does not offer an additional voluntary appeal process.

REMINDER ABOUT PRESCRIPTION DRUG PRIOR AUTHORIZATION

REMINDER: Certain drugs require prior authorization. If you present a prescription to the retail or mail order pharmacy, the pharmacist will determine if the drug needs prior authorization. If so, the pharmacist will initiate the prior authorization process with your health care provider.

If you have questions about which drugs require prior authorization, please contact the Pharmacy Benefit Manager, Express Scripts, by calling toll free (800) 753-2851.

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If you have any questions concerning the information in this announcement, please direct them to the Administrative Office at 213-386-8590 or 800-293-1370, where the staff will be happy to assist you. You may also visit the Trust's website at www.carpenterssw.org.

Sincerely,

THE BOARD OF TRUSTEES

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding this Plan change, please contact the Administrative Office.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.

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