



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

To: **All Active Participants of the Southwest Carpenters Health and Welfare Trust**

Important Participant Benefit Program Notice

APRIL 2018

PARTICIPANT NOTICE

This notice highlights changes to the Southwest Carpenters Health and Welfare Trust (the Plan). This information is **very important** for you and your covered dependents, so please take the time to read it carefully.

Aviso a los participantes que hablan español: Si tiene alguna pregunta referente a este aviso o requiere alguna otra información referente a su cobertura de salud, por favor de comunicarse con la oficina administrativa al (213) 386-8590 o (800) 293-1370, donde habrá varios representantes bilingües que le ayudarán.

The Plan offers Long Term Monthly Disability (LTD) benefits if you become totally disabled and meet certain other conditions. This notice describes the new review procedures for LTD claims filed on and after April 1, 2018. You can find more information about LTD benefits in Chapter 5 of the Summary Plan Description (SPD) for Active Carpenters, updated April 1, 2016. This notice modifies the claims review procedures for LTD benefits described in the SPD (Chapter 9, starting on page 104).

NEW – HOW TO FILE A CLAIM FOR LTD BENEFITS (EFFECTIVE APRIL 1, 2018)

If you become totally disabled, contact the Administrative Office to obtain a Long Term Disability (LTD) claim form and further instruction. Return your completed claim form to the Administrative Office. New LTD claims must include proof of your total disability as outlined under “Initial Proof of Total Disability” section below.



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Initial Proof of Total Disability

The Plan accepts either of the following as proof of your total disability when you first apply for LTD benefits:

- A Disability Award from the Social Security Administration (SSA). Applying for a Social Security Disability Award is free. See the SSA application site at <https://www.ssa.gov/planners/disability/>.
- A written opinion by an Independent Review Organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC). Contact the Administrative Office about the steps you need to take to have your medical records reviewed by an IRO to confirm that the IRO concurs with your physician (MD, DO, or DPM) that you are totally disabled. You pay \$200 for the IRO review, and the Fund pays the balance of the IRO's cost.

Neither the Plan nor the Administrative Office make a determination of disability. Instead, the determination is made by Social Security or a URAC-accredited IRO.

The Administrative Office verifies that you're eligible to apply for LTD benefits and that you've submitted initial proof of your disability that is acceptable in accordance with the Plan's rules.

Definition of Total Disability

You qualify for the Plan's LTD benefits if you meet the definition of totally disabled:

- You are not able to engage in any substantial gainful activity because of a medically determinable physical or mental impairment that is expected to either result in your death or continue for at least 12 months, and
- Such bodily injury or disease is not due to:
 - Your commission of or attempt to commit a felony,
 - Your engagement in any felonious activity or occupation,
 - The self-infliction of any injury, or
 - Habitual drunkenness or the use of narcotics (unless administered pursuant to the orders of a licensed physician).

The Board may waive the application of the above provisions if good cause is established that is satisfactory to the Board.

Continuing Proof of Total Disability

If you are receiving LTD benefits from the Plan, you must provide the Plan with proof of your continuing total disability on an annual basis. Each year, the Administrative Office will send you a letter requesting:

- Proof of your continuing Social Security Disability Income benefits, or
- A completed Physician Attestation of Continuing Disability form (if no Social Security Award), certifying that you remain totally disabled (as defined by the Plan).



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As long as you provide proof of your continuing disability in a timely manner, your LTD benefits continue. If you do not provide timely proof of your disability, your LTD benefits end (benefits can be reinstated once the Plan receives proof of your continuing total disability). If your LTD benefits end, you receive an initial denial (an adverse benefit determination) letter as discussed below.

Notice of Approval or Denial of Claim

Following are the notices you may receive when you submit an LTD claim:

- Based on the Administrative Office's receipt of your Social Security Award or IRO confirmation of total disability, as well as your eligibility for LTD benefits under the Plan, the Administrative Office will notify you in writing whether your request for LTD benefits is approved or denied (an adverse benefit determination). You will receive the notice within 45 days of the date the Administrative Office receives the Social Security Award or IRO confirmation.
- You will be notified if you do not follow the Plan's procedures (for example, you do not submit the initial proof of disability). You then have 45 days in which to obtain the additional information. The 45-day period can be extended for up to 30 calendar days, provided the Administrative Office determines that an extension is necessary due to matters beyond its control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period. The notification will indicate that additional time is needed to process the claim, the special circumstances for the extension, and the date by which the Administrative Office expects to provide its determination.
- If, prior to the end of the first 30-day extension, the Administrative Office determines that due to matters beyond its control it cannot provide a notification within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days. You will be notified prior to the first 30-day extension period of the circumstances that require the second extension, as well as the date by which the Administrative Office expects to provide a notification. The notice of extension will explain the:
 - Standards on which entitlement to a benefit is based,
 - Unresolved issues that are preventing a decision, and
 - Additional information that is 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 time period is extended because you fail to submit information, the time period will be measured from the date on which the notice of extension is sent until the date on which you respond, or until the day on which 60 days have elapsed since the date the notice was sent (whichever is earlier).



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Adjudication of Claims

The Plan takes steps to ensure that claims and appeals are adjudicated in a manner that is designed to ensure the independence and impartiality of those involved in making the decision. Accordingly, hiring decisions and decisions related to compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or a medical or vocational expert) will not be made based on the likelihood that the individual will support the denial of benefits. Under the terms of the Plan, the Plan does not make a determination of disability. However, if the Plan were to make a determination of disability, medical and vocational experts would be selected based on their professional qualifications.

The Plan provides 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. Such evidence is 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.

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 is 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.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that you do not have a reasonable opportunity to respond, the period for providing a final determination is delayed until you have such an opportunity.

If you provide initial proof of disability that meets the Plan's definition of total disability, your claim is approved, and you are eligible to receive LTD benefits. If your claim for LTD benefits is approved, you are notified in writing (or electronically, as applicable) and hours will be credited.

Notice of Adverse Benefit Determinations

If your claim for LTD benefits is denied in whole or in part, you will receive a notice of this initial denial (an adverse benefit determination) in writing (or electronically, as applicable). This notice of initial denial:

- Gives the specific reason(s) for the denial (including information as to why you are not eligible for LTD benefits);
- Indicates that the Plan does not determine disability and instead accepts a disability determination from SSA or a URAC-accredited IRO;
- References the specific Plan provision(s) on which the determination is based;
- Contains a statement that you are entitled to receive upon request, free access to and copies of all documents, records, and other information relevant to your claim;
- Describes any additional information needed to perfect your claim, and an explanation as to why such additional information is necessary;
- Provides an explanation of the Plan's appeals procedures, along with time limits;



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- Contains a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal;
- Describes 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);
- Includes any internal rule, guideline, protocol, standard, or similar criterion on which the denial was based and a statement that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you upon request; and
- If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.

If you do not understand English and have questions, contact the Administrative Office at (800) 293-1370 or (213) 386-8590 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, kwijigo holne' (213) 386-8590 or (800) 293-1370.

If you disagree with a denial of your claim, 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.

NEW – APPEAL OF A DENIAL OF A CLAIM FOR LTD BENEFITS (EFFECTIVE APRIL 1, 2018)

You must submit your appeal in writing to the Board of Trustees in care of the Administrative Office (contact information for the Administrative Office is included on this letterhead). You must be provided with:

- Reasonable access to and copies of all relevant documents, records, and other information relevant to your claim for benefits.
- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- A full and fair review that takes into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination.



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- 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 (automatically and free of charge). Such evidence is 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) so that you have reasonable opportunity to respond.

Additionally, before the Plan issues an adverse benefit determination on review based on new or additional rationale, you are provided (automatically and free of charge) with the rationale. The rationale is 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) so that you have reasonable time to respond.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that you do not have a reasonable opportunity to respond, the period for providing a final determination is delayed so that you have such opportunity.

- 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.
- Under the terms of the Plan, the Plan does not make a determination of disability. However, if it were to make a determination of disability 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:
 - Consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and who 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
 - Identify the 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.

Determination on Appeal

The Board of Trustees makes a determination on the appeal no later than the date of the Board of Trustees' meeting that immediately follows the Plan's receipt of a request for review (provided you file the request for appeal review within 30 calendar days preceding the date of such meeting). If you file the appeal more than 30 days before the next meeting, a benefit determination is made no later than the date of the second meeting following the Plan's receipt of the request for review.

If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination is made no later than the third meeting of the Board following the Plan's receipt of the request for review. If an extension is necessary, the Plan provides you a notice of extension that describes the special circumstances and the date the benefit determination will be made.



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The Plan notifies you of the benefit determination on the appeal no later than five calendar days after the benefit determination is made. The Plan may obtain a 45-day extension if you are notified of the need and reason for the extension before the initial 45-day period expires. (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 date on which you respond, or 60 days have elapsed from the date the notice was sent to you, whichever is earlier).

Notice of Appeal Determination

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

- The specific reason(s) for the adverse appeal review decision (including information as to why you are not eligible for LTD benefits),
- The fact that the Plan does not determine disability and instead accepts a disability determination from SSA or a URAC-accredited IRO,
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim,
- A statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal,
- 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),
- A statement of the voluntary Plan appeal procedures, if any,
- Any internal rule, guideline, protocol, standard, or similar criterion on which the denial was based and a statement that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you upon request,
- If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
- A 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)."

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 the Administrative Office at (800) 293-1370 or (213) 386-8590 to find out if assistance is available.

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This is the appeals process under this Plan related to claims for disability benefits. This Plan does not offer any additional voluntary appeals processes. If the Plan fails to strictly adhere to its internal claims and appeals requirements, you are deemed to have exhausted the Plan's internal claims and appeals process and can proceed with legal action.

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If you have any questions about this notice, visit the Trust's website at www.carpenterssw.org. Or, contact the Administrative Office at (800) 293-1370 or (213) 386-8590.

Sincerely,

THE BOARD OF TRUSTEES

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