SHEET METAL | AIR | RAIL | TRANSPORTATION

LOCAL 36 BENEFIT FUNDS
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October 3, 2017

Summary of Material Modification
Permanent Disability Benefits Claims and Appeals

To comply with the Department of Labor's Final Regulations regarding claims and appeals of disability benefits, the Trustees of the International Association of Sheet Metal, Air, Rail and Transportation Workers ("SMART") Local Union No. 36 Pension Plan have adopted the enclosed revised procedures for claims and appeals for Disability Benefits filed on or after January 1, 2018.

There have been some changes in the Trustees of the International Association of Sheet Metal, Air, Rail and Transportation Workers ("SMART") Local Union No. 36 Pension Fund. The Trustees are:

Mr. David C. Zimmermann
Mr. Ray Reasons
Mr. Dennis Westray
Mr. George L. Welsch
Mr. William Meeh
Mr. Michael Corrigan

You should keep this notice with your SPD and other important plan documents. If you have any questions about these changes or any benefits please call the Benefits Office at 314-652-8175 and toll free 800-741-9411.

Sincerely yours,

Trustees of the International Association of Sheet Metal, Air, Rail and Transportation Workers ("SMART") Local Union No. 36 Pension Plan

10.5 Disability Claims and Appeals.

(a) Claims Processing.

Claims for Disability Benefits will be ruled on within 45 days after receipt of a completed application. In some cases, additional time may be needed, up to another 30 days. The Plan may extend the time to resolve the claim for only two (2) additional 30 day periods.

If the Plan needs to extend the time period to resolve the claim, the Participant (or his authorized representative) will receive a notice of the extension explaining the standards for entitlement to the benefit, why an extension is needed (what issues are unresolved), and what additional information is needed. The Participant will have at least 45 days to supply the requested information. The period of time to make a determination (the original time and the up to two additional 30 day periods), however, may be tolled if the Plan requests additional information. In addition to asking for additional information, the Plan may have the Participant examined in connection with the claim of disability.

The denial of a claim or part of a claim will be provided to the Participant in writing, in a culturally and linguistically appropriate manner (as described in 29 C.F.R. § 2560.503-1(o)) that is calculated to be understood by the Participant, and will include:

(1) The specific reason or reasons for the denial;

(2) A reference to pertinent Plan provisions on which the denial is based;

(3) An explanation of the basis for disagreeing with or not following:

  (i) The views presented by the Participant or health care professionals treating the Participant and vocational professionals who evaluated the Participant;

  (ii) The views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Participant's claim, without regard to whether the advice was relied upon in making the adverse determination; or

  (iii) A disability determination made by the Social Security Administration regarding the Participant;

(4) The specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

(5) A description of any additional information necessary for the Participant to perfect the claim; and

(6) An explanation of the steps to be taken if the Participant wishes to appeal the denial.

(b) Appeal Procedure.

The Participant (or his authorized representative) may appeal any denial of a request for Total Disability benefits by filing a written request for review. The written appeal must be filed with the Fund Office within 180 days from the date of receipt of written denial of an application for Total Disability benefits. Use of this Permanent Disability Claims and Appeals Procedure is mandatory.

The Participant may submit in writing issues, comments and evidence for consideration by the reviewing party. The Participant may request copies of all documents, records, and other information relied on by the Fund in making the adverse determination including any internal rule, guideline, protocol or other criteria. There is no charge to the Participant for these copies. The Participant may also supply additional medical or other information in support of his claim.

The appeal will be reviewed by the Trustees, (or an authorized committee or agent of the Trustees), who are fiduciaries of the Plan and not the persons who made the original determination on the claim or subordinates of those persons. If the Trustees have designated a party or parties to decide the appeal the Board of Trustees may review (and may change) the decision. If the adverse determination on the claim was based in whole or in part on a medical judgment then the Trustees shall consult with an appropriately trained health care professional with experience in the relevant field of medicine who was not consulted in making the initial determination on the claim. Any decisions regarding the hiring, compensation, termination, promotion, or other similar matters with respect to any individual involved in any decision made pursuant to this Permanent Disability Claims and Appeals Procedure may not be made based upon the likelihood that the individual will support the denial of benefits.

If, in considering an appeal, the Trustees (or any party designated by the Trustees to decide the appeal) become aware of any new or additional evidence that was considered, relied upon, or generated by the Plan in making the adverse determination or any new or additional rationale for making the adverse determination, copies of such new or additional evidence or rationale will be provided to the Participant, as soon as possible. The Participant will then have 45 days after receiving such new or additional evidence or rationale to submit a written response to the Trustees (or any party designated by the Trustees to decide the appeal).

A decision deciding the appeal will be provided to the Participant in writing, in a culturally and linguistically appropriate manner (as described in 29 C.F.R. § 2560.503-1(o)) that is calculated to be understood by the Participant, within 45 calendar days after receipt of the written statement constituting the appeal. If special circumstances require an extension of time for processing the appeal then the Plan will notify the Participant of the

reason for the extension within the initial 45 day period. This extension can be for no more than 45 days. The period of time to make a determination (the original time and any extension), however, may be tolled if the Plan requests additional information.
The written decision on the appeal will be mailed to the Participant. If the decision is adverse to the Participant, it will include:

(1) The specific reason or reasons for the adverse determination;

(2) A reference to the specific Plan provisions on which the adverse determination is based;

(3) An explanation of the basis for disagreeing with or not following:

(i) The views presented by the Participant of health care professionals treating the Participant and vocational professionals who evaluated the Participant;

(ii) The views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Participant 's claim, without regard to whether the advice was relied upon in making the adverse determination; or

(iii) A disability determination made by the Social Security Administration regarding the Participant;

(4) The specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

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

(6) A statement of the Participant=s right to bring a court action under Section 502(a) of ERISA.