SMART GROUP VSTD PLAN

CLAIMS PROCEDURES

WHEREAS, the Trustees of the SMART Group VSTD (the "Plan") are appointed to administer the Plan; and

WHEREAS, the Trustees are desirous of establishing a procedure governing the processing, review and appeal of claims for benefits under the Plan;

NOW, THEREFORE, the following procedures are hereby adopted by the Trustees, to be effective for all claims for benefits first filed with the Plan on or after April 1, 2018:

1. Payment of Claims by Plan:

All claims received by the Plan will be processed for payment as soon as possible. However, no claim will be paid until all information necessary to process the claim has been received.

Once the information required to make a determination as to whether a claim is payable has been received, a decision will be made promptly and the Eligible Member will be notified regarding any benefit payments.

The Plan will send written notice of a claim decision to the claimant within 45 days after it receives proof of loss. If there are special circumstances that require additional time, the Plan will send the claimant a written notice within this time frame that an additional 30 days is needed. If more time is still needed to make a claim determination, the Plan will send the claimant written notice during the initial 30 day extension stating the special circumstances that require an additional 30 days. If the Plan requests additional information, the claimant will have 45 days to respond to the request, and the Plan will send written notice of its claim decision within 30 days after it receives the response.

2. Notice of Adverse Benefit Determination:

Upon determination that a claim submitted by or on behalf of an Eligible Member is not covered under the Plan, the Eligible Member will be notified in writing within the time frame outlined above regarding the adverse benefit determination. This notice will set forth, in a manner calculated to be understood by the claimant, all of the following information:

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

(b) Reference to the specific Plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, after the claimant exhausts the Plan's appeal procedures, including a description of any contractual limitation period that applies to the claimant's right to bring an action ; and

(e) If the claim is denied because the claimant has failed to establish proof of disability:

(1) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

A. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant (if any);

B. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

C. A disability determination presented by the claimant to the Plan made by the Social Security Administration;

(2) A copy of 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; and

(3) A statement that the clamant 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.

The notification will be provided in a culturally and linguistically appropriate manner in accordance with Department of Labor Regulations Section 2560.503-1(o).

3. Claimant's Right to Review of an Adverse Benefit Determination:

A claimant whose claim for benefits has been denied under the terms of the Plan and to whom a notice of adverse benefit determination has been issued in accordance with paragraph 2. above will have the right to appeal the adverse benefit determination and will be entitled to a full and fair review of the decision by the Board of Trustees, or by a committee appointed by them. The procedures by which the claimant may appeal the adverse benefit determination and receive a full and fair review of the claim are as described below.

(a) Review Procedure

The procedures hereunder will:

(1) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination in which to appeal the determination;

(2) Provide for an independent review by the Board of Trustees, or their committee. The review will not be conducted by the individual who made the adverse benefit determination that is the subject of the appeal, nor by the subordinate of such individual;

(3) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees or their committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(4) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(5) Provide that the health care professional engaged for purposes of this appeal 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;

(6) In the event a claim is denied due to failure to establish proof of disability, the Trustees, or a committee appointed by them, will:

A. Prior to issuing an adverse benefit determination on review, provide to the claimant, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. The 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 the claimant reasonable opportunity to respond prior to that date, and

B. Prior to issuing an adverse benefit determination on review based on a new or additional rationale, provide the claimant, free of charge, 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 the claimant reasonable opportunity to respond prior to that date.

(b) Notice of Trustees' Decision

A decision on the claimant's appeal will be made by the Trustees or their committee and communicated in writing to the claimant within five days of the decision. The appeal will be reviewed at the meeting of the Trustees or the committee that immediately follows the Plan's receipt of a request for a review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, 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, but in no instance more than 120 days following receipt of the appeal.

(c) Access to Plan Documents

At any time during the course of these appeal proceedings a claimant will be granted access to, and copies of, documents, records and other information relied upon by the Trustees or the committee in making their decision, as requested by the claimant.

(d) Notification of Decision on Appeal

Each claimant whose adverse benefit determination has been appealed to the Trustees will receive notification in writing, within the time period outlined above, of the Trustees' or the committee's decision. Such notification will set forth, in a manner calculated to be understood by the claimant:

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

(2) Reference to the specific Plan provisions on which the benefit determination is based;

(3) A statement that the claimant 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 claimant's claim for benefits;

(4) A statement describing any additional voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures, should the Board of Trustees adopt such procedures, and a statement of the claimant's right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended; and

(5) The following information where applicable —

A. If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that such rule, guideline, practice or procedure was relied upon in making the adverse determination and that a copy of the rule, guideline, practice or procedure will be provided free of charge to the claimant upon request;

B. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge to the claimant upon request; and

C. A statement that the claimant and the Plan may have other voluntary alternative dispute resolution options, although the Plan is not required to offer such options, and that the claimant may contact the local U.S. Department of Labor office or his state insurance regulatory agency to determine what options might be available to the Plan.

(6) If the claim was denied because the claimant failed to establish satisfactory proof of disability:

A. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant (if any);

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the

adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) A disability determination presented by the claimant to the Plan made by the Social Security Administration;

B. A copy of 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; and

C. The statement required under (4) above will also describe any contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the limitations period expires for the claim.

The notification will be provided in a culturally and linguistically appropriate manner in accordance with Department of Labor Regulations Section 2560.503 1(o).

4. Rights Granted Hereunder Are Limited to One Appeal:

In appealing an adverse benefit determination under these procedures, the claimant may choose to make a written appeal, in which event the Plan's administrative manager will present all documents in the claimant's behalf, or the claimant may choose to personally appear before the Trustees for the purpose of presenting an appeal, or designate a representative to appear in his behalf. Claimant appeals rights are limited to one written or personal appeal per denied claim.

5. Compliance with Appeal Procedures:

The claimant may at this own expense have legal representation at any stage of these appeal procedures. The Trustees will interpret Plan provisions in a consistent and equitable manner. The claimant will be required to exhaust these appeals procedures before proceeding to litigation.

6. Limitation of Actions:

No legal action can be taken until 60 days after written proof of loss has been given as outlined herein. No legal action can be taken more than 3 years after written proof of loss was required as outlined herein. Legal action with respect to a claim that has been denied, in whole or in part, is contingent upon first having obtained the Plan's reconsideration of that claim in accordance with the Plan’s procedures as explained herein.