**NEAT & WILSON, INC. HEALTH & WELFARE PLAN**
**SUMMARY OF MATERIAL MODIFICATIONS**
**FOR DISABILITY CLAIMS AND APPEALS PROCEDURES**

The purpose of this Summary of Material Modifications (SMM) is to inform you of changes that have been made to the Neat & Wilson, Inc. Health & Welfare Plan (Plan). This change has affected the information previously provided to you in the Plan's Summary Plan Description (SPD). Please keep this SMM with your SPD.

A. Modifications of Disability Claims and Appeals Procedures--Generally

Recently, new regulations were adopted by the United States Department of Labor concerning claims and appeals procedures for employee benefit plans providing disability benefits. This SMM describes those changes. In reviewing this SMM, remember that this Plan is what is known as a "wrap plan" which wraps various welfare benefits offered by your employer. The wrap plan essentially "sits on top" of all of the other benefit plan disclosures and documents you have been provided. The wrap plan document uses the term "Subsidiary Contracts" for those other benefit plan disclosures. It is important to understand that, if any Subsidiary Contract contains its own legally compliant claims and appeals procedures, that document will control over the disability claims and appeals procedures described below. For example, if an insured long term disability benefit is one of the benefits contained in this Plan, then the claims and appeals procedures provided by the disability insurer in the Subsidiary Contract will control over what is in this SMM.

For any additional information regarding disability claims and appeals procedure, please contact the applicable disability insurer or Plan Administrator.

B. Effective Date

The amendments to the Plan are only for claims filed on or after April 1, 2018 and only for disability claims and appeals. The provisions below are in addition to disability claims and appeals procedures already in the Plan document and SPD. For example, the timing for responding to disability claims and appeals as contained in the SPD and Plan document have not changed.

C. Form and Content of a Notice Denying A Disability Claim or Adverse Decision on Appeal

1. The denial of any claim for disability benefits or any adverse decision on appeal (an appeal is also known as a decision on review) will contain the following:
   - Specific reason(s) for the benefit denial or adverse decision on appeal;
   - Reference to specific plan provision(s) on which the denial or adverse decision on appeal is based;

- Discussion of the decision denying the claim or appeal, including reasons for disagreeing with views of:
    - Treating professionals,
    - Medical or vocational experts consulted without regard to whether the advice was relied upon in making the benefit determination,
    - A disability determination made by the Social Security Administration and presented to the Plan;
- The specific internal rules, guidelines, protocols, or similar criteria relied on in denying the claim or appeal, or, alternatively a statement that such internal guidelines or criteria do not exist;
- If the denial of the claim or appeal was based on medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free upon request;
- A statement regarding right to obtain, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for disability benefits; and
- A statement of claimant's right to bring suit under ERISA §502(a) following a benefit denial and subsequent adverse decision of an appeal.

2. An initial denial of a disability claim will also contain:
    - A description of any additional information needed to perfect the claim, and explanation of why such information is needed; and
    - A description of the Plan's review procedures and time limits that apply to them.

3. Any adverse decision on appeal will also contain:
    - A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures; and
    - Any applicable contractual limitations period that applies to the Claimant's right to bring suit under ERISA §502(a) including the calendar date on which the contractual limitations period expires for the claim.

4. Any denial of a disability benefit claim or decision on appeal will be written in a linguistically and culturally appropriate manner.

D. Additional Procedures For Disability Claims on Appeal

1. Any review on appeal cannot afford deference to the initial benefit denial. The review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of that individual.
2. The Plan will provide for full and fair review, including providing the Claimant with access to, upon request and free of charge, copies of information and documents relevant to the claim and opportunity to submit comment. All disability benefit determinations must be made in a manner that ensures independence and impartiality of the decision-makers involved in the process.

3. Any review on appeal will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
4. For determinations regarding whether a treatment is experimental or not medically necessary, the named fiduciary must consult with an independent medical expert (i.e., a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and was neither consulted in connection with the initial denial nor a subordinate of that individual).
5. If the advice of medical or vocational experts was obtained by the Plan in connection with the initial denial, the review procedures will identify those experts without regard to whether their advice was relied on.
6. Before the Plan issues any adverse decision on appeal, a Claimant will automatically be provided with any new evidence or rationale considered, relied on, or generated by the Plan or decision maker in connection with the claim or appeal. That new evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse decision on appeal is required to be provided in order to give the Claimant a reasonable opportunity to respond prior to that date.

E. Rescissions of Coverage

A rescission of coverage will also be considered a denial of a claim for benefits under the Plan. A rescission of coverage means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

F. SMM is also an Amendment to the Plan Document

This SMM is also considered an amendment to Section 5.01 of the Plan document and the procedures for disability claims and appeals contained in that Section 5.01 are modified in accordance with this SMM.

**NEAT & WILSON, INC.**
**ADOPTING RESOLUTION**

The undersigned authorized representative of Neat & Wilson, Inc. (the Employer) hereby certifies that the following resolutions were duly adopted by the Employer:

RESOLVED, that the attached Summary of Material Modification (SMM) to the Neat & Wilson, Inc. Health & Welfare Plan (Plan) is effective as of April 1, 2018.

FURTHER RESOLVED, that the SMM also constitutes an amendment to the Plan and that the signature on this Adopting Resolution shall constitute execution of that amendment.

Date: 7/19/18

Signed: Rhonda Thomas

RhondaThomas Director of Admin.
[print name/title]