North Central States Regional Council of
Carpenters' Benefit Funds
Pension • Health • Supplemental Pension • Training • LMC Trust

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To All Participants:

The Trustees of the North Central States Regional Council of Carpenters' Pension Fund ("Plan") regularly review the Plan and make changes when necessary.

Please take time to read this Notice carefully and thoroughly because it contains important information regarding changes to the Summary Plan Description (SPD).

Disability Retirement Claims and Appeals Procedures

Effective for claims filed on or after April 1, 2018, the Department of Labor has issued new regulations for administering claims and appeals for disability retirement claims (the "Final Regulations"). The changes require that the Plan provide you with additional information in the written denial of a disability retirement claim.

The section titled ***Appeal of Denial of Benefits***, beginning on page 33 of the SPD, has been revised, as follows, for the Final Regulations and to clarify how the Plan's claims and appeals procedures differ for different types of claims.

Appeal of Denial of Benefits

How Will I Know if My Application for Benefits is Denied?

The Administrative Manager or the Eligibility Committee of the Trustees will give you (or your legal representatives, as may be appropriate) written or electronic notice if your application for benefits is denied, in whole or in part, with respect to your eligibility for, or amount of, your benefits, including a reduction, termination, or suspension of benefits.

For claims other than disability claims, your claim will be reviewed and a decision made within 90 days. In some cases the decision may be delayed for an additional 90 days due to matters beyond

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the control of the Plan or in order to provide additional time to you to provide necessary information. If additional time is needed to render a decision on your claim, the Plan will notify you in writing, prior to the expiration of the initial 90-day period, of the reasons for the delay and the date by which the Plan expects to render a decision on your claim. For claims other than disability claims, such notice will include the following:

1. Why your claim was denied;

2. The specific provisions of the Plan governing the decision; if an internal rule, guideline, protocol, standard or other similar criteria was relied upon in making the adverse determination, the Plan will provide a copy of either the specific rule, guideline, protocol, standard or other similar criteria; or a statement that such a rule, guideline, protocol, standard or other criteria relied upon will be provided to free of charge to you upon request;

3. What additional material or information is needed, if any, and why such material or information is needed; and

4. What steps you may take to have your claim reviewed and the applicable time limits to request review of your claim.

For disability claims, written notice will be given within a reasonable period of time, but not to exceed 45 days. This period may be extended by the Plan for up to 30 days, provided that the Administrative Manager or the Eligibility Committee of the Trustees determine that such an extension is necessary due to matters beyond the control of the Plan and notify you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Administrative Manager or the Eligibility Committee of the Trustees determine that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Administrative Manager or the Eligibility Committee of the Trustees notify you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension under this subsection pertaining to disability claims, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues, and you will be afforded 45 days within which to provide the

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specified information. For disability claims, such notice will include the following:

1. Why your claim was denied, including a discussion of the decision and an explanation of the basis for disagreeing with or not following;

   a. The views presented by you to the Plan of any health care professionals who treated you or vocational professionals who evaluated you;

   b. The views of any medical or vocational experts whose advice was obtained by the Plan in connection with your claim; and

   c. A disability determination made by the Social Security Administration presented by you to the Plan.

2. The specific provisions of the Plan governing the decision; if the denial was based on an internal rule, guideline, protocol, standard or other similar criteria, the Plan will provide you with a copy of such specific rule, guideline, protocol, standard or other similar criteria; or a statement that no such internal rule, guideline, protocol, standard, or other similar criteria exists;

3. What additional material or information is needed, if any, and why such material or information is needed;

4. A statement that you are entitled to receive, free of charge upon request, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits; and

5. What steps you may take to have your claim reviewed and the applicable time limits to request review of your claim.

How Do I Make My Appeal?

If, after reading the written explanation of why your claim was denied, you feel that the action taken on your claim may be incorrect, you **immediately** should ask the Fund Office to review your claim with you. At that time, the Fund Office will let you know if there is any additional information which might enable your claim to be reconsidered.

If your claim for benefits is denied in whole or in part you are otherwise dissatisfied with a determination of the Administrative

Manager or the Eligibility Committee of the Trustees with respect to your eligibility for, or amount of, your benefits, you have the right to appeal. The procedures for appeal follow. These procedures have been established in accordance with Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA) and ERISA regulations under Section 2560.503-1.

Here's What to Do:

1. Notify the Fund Office in writing that you wish to have your claim reviewed by the Eligibility Committee or Executive Committee. If you wish, you may request a hearing before the Committee.

2. Your written request for a review (or a hearing, if applicable) must be submitted within 60 days after you received the denial notice. For disability claims see the following paragraph 4.

3. Include in your written request all facts, issues, and comments regarding your claim as well as the reason(s) you feel the original decision was incorrect. Submit any additional or supplemental material or information which may have been requested in the denial notice or which you may consider desirable.

   In your written request, you may request an inspection, or copies, free of charge, of designated, pertinent documents or files to complete the information you need for review of your claim.

4. A written request for a review of a disability claim must be submitted within 180 days of the denial notice required to be given, wherein your claim for disability benefits is denied in whole or in part, or if you are otherwise dissatisfied with a determination of the Administrative Manager or Eligibility Committee of the Trustees with respect to your eligibility for, or amount of, your benefits, or if you have not received such notice of denial of claim within 45 days, or within expiration of the 45-day period as extended as explained previously after receipt of your claim. In deciding an appeal of a disability claim that is based in whole or in part on medical judgment, the Eligibility Committee or Executive Committee of the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and will identity the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your

disability claim, without regard to whether the advice was relied upon in making the determination. The health care professional engaged for the purposes of a consultation will not be the same individual consulted with on the initial determination, nor the subordinate of such individual. In deciding an appeal of a disability claim, the Trustees will not afford deference to the initial adverse decision.

For disability claims submitted on or after April 1, 2018, the Plan will provide you, free of charge, copies of any new or additional evidence or rationale considered, relied upon, or generated in connection with your appeal. You will be provided with this information as soon as possible and sufficiently in advance of the date on which notice of the Plan's final benefit determination must be provided to allow you a reasonable opportunity to respond prior to that date.

5. In the event you request a hearing, you can appear in person or choose a duly authorized representative to appear for you before the Eligibility Committee. No verbatim record of any hearing or appearance will be made but the Administrative Manager will prepare a summary of your presentation and preserve the summary, along with any documents which the Eligibility Committee deems pertinent or which you request to have included in the file.

6. If you do not wish to make a personal appearance before the Eligibility Committee, the Administrative Manager will present your written statement and other pertinent information on your behalf.

7. The Eligibility Committee will act by the vote of a majority of its members present. You will receive the Eligibility Committee's decision in writing. The written notice will contain: the decision; specific reason or reasons for the decision; and the pertinent Plan provisions on which the decision was based.

8. The written decision will be sent to you:
   a. Within 60 days after receipt of your written request for review of the denial of your claim (for disability claims, see the following subsection c.);

   b. Within 120 days after receipt of your written requests for review of the denial of your claim if you requested a hearing (for disability claims, see the following subsection c.); or

c. With respect to the appeal of a disability claim, the Eligibility Committee will issue a written appeal decision of a denied disability claim within a reasonable period of time, but not to exceed 45 days after receipt, by the Office of the Administrative Manager of the Fund, of the written request for review by the Eligibility Committee. This period may be extended by the Eligibility Committee for up to 45 days, provided that the Eligibility Committee determines an extension is necessary and notifies you before the initial 45-day period expires. If an extension is needed, you will receive written notice from the Eligibility Committee of the special circumstances and the date your disability claim appeal will be determined.

When reviewing your disability retirement claim appeal, the Trustees will take into account all comments, documents, records, and other information that you have submitted relating to your claim, without regard to whether such information was submitted or considered in the initial determination on your claim.

9. If you are not satisfied with the Eligibility Committee's decision or determination, you may make a written request for further review by the Executive Committee by following the same procedures outlined previously for the original review.

For all disability claims, in the event you are dissatisfied with the decision or determination of a disability claim upon review of the Eligibility Committee issued according to the previously stated procedures, you may make a written request for further review by the Executive Committee of such decision or determination of the Eligibility Committee. Such request for review by the Executive Committee will be filed by you with the Office of the Administrative Manager within 180 days after receipt by you of the decision or determination of the Eligibility Committee. The Executive Committee will act by the vote of a majority of its members present and will notify you of its decision within a reasonable period of time, but not to exceed 45 days after receipt, by the Office of the Administrative Manager of the Fund, of the written request for review by the Executive Committee. This period may be extended by the Executive Committee for up to 45 days, provided that the Executive Committee determines an extension is necessary and notifies you before the initial 45-day period expires. If an extension is needed, you will receive written notice from the Executive

Committee of the special circumstances and the date you disability claim appeal will be determined.

10. The decision of the Eligibility Committee, or of the Executive Committee, respectively, on review, will be in writing.

a. For claims other than disability claims, the written notice will include the following:

1. Why your claim was denied;

2. References to the specific Plan provisions on which the decision was based;

3. A statement that you are entitled to receive, free of charge upon request, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits; and

4. A statement concerning your right to bring a civil action under ERISA after you have exhausted the Plan's benefit appeals procedure, including the calendar date by which you must bring a legal action against the Plan.

b. For disability claims, the written notice will include the following:

1. Why your claim was denied on appeal, including a discussion of the decision and an explanation of the basis for disagreeing with or not following;

(i) The views presented by you to the Plan of any health care professionals who treated you or vocational professionals who evaluated you;

(ii) The views of any medical or vocational experts whose advice was obtained by the Plan in connection with your claim; and

(iii) A disability determination made by the Social Security Administration presented by you to the Plan.

2. References to the specific Plan provisions on which the decision was based;

3. A statement that you are entitled to receive, free of charge upon request, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits;

4. The specific internal rule, guideline, protocol, standard or other similar criteria of the Plan relied upon in making the decision on your claim on appeal; or a statement that such rule, guideline, protocol, standard or other similar criteria of the Plan do not exist; and

5. A statement concerning your right to bring a legal action under ERISA after you have exhausted the Plan's benefit appeals procedure, including the calendar date by which you must bring a legal action against the Plan.

11. These appeal procedures must be followed and exhausted before you may seek any legal action, including actions or proceedings before administrative agencies with respect to a claim concerning your eligibility for, or amount of, your benefits from and under the Fund or Plan. Effective for claims filed on or after January 1, 2003, no legal action (including actions or proceedings before administrative agencies) with respect to a claim concerning your eligibility for, or amount of, your benefits from and under the Fund or Plan may be commenced later than two years from the date the claim was initially filed on which the legal action is based.

12. You may, at your own expense, have legal representation at any state of these appeal procedures.

In reviewing your claim, every effort will be made by the Trustees to handle interpretations of the Plan and claims disputes in a consistent and equitable manner. In addition, the Trustees will make every effort to ensure that you receive a full and fair review if your claim is denied.

Please keep this Notice with your Summary Plan Description (SPD) for future reference. If you have any questions, feel free to call the Plan Office.

Yours very truly,

THE BOARD OF TRUSTEES