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

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♦♦SUMMARY OF MATERIAL MODIFICATIONS♦♦

March 2022

To All Participants

The Board of Trustees ("Trustees") of the North Central States Regional Council of Carpenters' Pension Fund ("Plan") is required to provide each participant with a notification of important changes made to the Plan. This notification, which is called a Summary of Material Modifications ("SMM"), is intended to update the July 1, 2019 Summary Plan Description ("SPD"). Please read this SMM closely because it contains important information regarding changes to the Plan's rules governing your right to appeal.

The Plan currently has two mandatory levels of appeal. The Trustees have amended the Plan's appeal procedures to eliminate the second level of appeal and to decide appeals at next regular quarterly meeting following receipt of the written appeal as more fully described below. The attached pages, which replace pages 40 through 45 of your SPD, reflects the Trustees action to:

1. Eliminate the second level of appeal to the Executive Committee of the Board of Trustees.

2. Require the Eligibility Committee of the Board of Trustees to make a decision concerning your written appeal at the first quarterly meeting following receipt of your appeal unless the Plan receives your appeal within 30 days of the quarterly meeting.

3. Require that if your written appeal is received by the Plan within 30 days of the first quarterly meeting following receipt, the Eligibility Committee of the Board of Trustees must make its decision concerning your written appeal no later than the second quarterly meeting following receipt of your appeal.

4. Require that if special circumstances require a further extension of time for review of your written appeal beyond the second quarterly meeting, such as the need to hold a hearing, the Eligibility Committee may reach its decision no later than the third meeting of the Eligibility Committee meeting following receipt of your appeal.

5. Require that once a decision is made, you be notified in writing with 5 days.

The amendment applies to claims that are first filed with the Plan on or after April 1, 2022.

Place this SMM with your SPD and retain it for future reference as it replaces pages 40 through 45 of the SPD. If you do not have a copy of the SPD, please contact the Plan's Administrative Manager (the "Fund Office") using the address and telephone number at the top of this notice.

Please contact the Fund Office should you have any questions or concerns.

Sincerely,

THE FUND OFFICE

This notice, which serves as an SMM, contains only highlights of certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan provisions, the Plan document language will govern. The Trustees reserve the right to amend, modify, or discontinue all or part of the Plan at any time.

If your claim for benefits is denied in whole or in part or 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 revised under ERISA regulations that took effect for disability claims submitted after April 1, 2018.

Here's What to Do:

1. Notify the Fund Office in writing that you wish to have your claim reviewed by the Eligibility 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 the 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, relevant 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 after you receive the notice denying your claim, in whole or in part, or if you are otherwise dissatisfied with a determination made by the Administrative Manager or Eligibility Committee of the Trustees with respect to eligibility for, or amount of, your benefits, or if you have not received such notice denying your claim within 45 days after your claim was received by the Plan, or within the 30-day extension period (explained earlier). In deciding an appeal of a disability claim that is

based in whole or in part on medical judgment, the Eligibility 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 identify 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.

The Plan will provide to you, free of charge, any new or additional evidence or rationale considered, relied on, or generated in connection with an appeal. Such information will be provided as soon as possible and sufficiently in advance of the date on which notice of the Plan's final benefit determination must be provided, in order to allow you a reasonable opportunity to respond prior to that date.

5. In the event you request an appeal 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 and/or your authorized representative do not wish to make a personal appearance before the Eligibility Committee, the Administrative Manager will present your written statement and other relevant 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.

For claims other than disability claims, such written decision will include the following information stated in an easily understandable manner:

a. The specific reason or reasons for the adverse determination;

b. References to the specific Plan provisions on which the benefit determination is based;

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

d. A statement of your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the Plan's benefit appeals procedure. For disability claims, a statement of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

For disability claims, such written decision will include the following information stated in an easily understandable manner:

a. The specific reason or reasons for the adverse determination, including a discussion of the decision and an explanation of the basis for disagreeing with or not following:

   i. the views presented by you of health care professionals treating you and vocational professionals who evaluated you;

   ii. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with you, without regard to whether the advice was relied upon; and

   iii. a disability determination regarding you made by the Social Security Administration.

b. References to the specific Plan provisions on which the benefit determination is based;

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

d. For disability claims, either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination, or alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; and

e. A statement of your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the Plan's benefit appeals procedure. For disability claims, a statement of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

For disability claims, notices for claimants who reside in a county that has been identified by the Census Bureau as having 10% or more of its population literate only in the same non-English language, will be provided in a culturally and linguistically appropriate manner.

8. The Eligibility Committee shall act by the vote of a majority of its members present and shall make its decision at the Eligibility Committee that immediately follows the Office of the Administrative Manager of the Fund's receipt of your request for review, unless the request for review is received by the Office of the Administrative Manager within 30 days preceding the date of such meeting. In such case, a decision will be made no later than the date of the second Eligibility Committee meeting following receipt of your request for review. If special circumstances such as the need to hold a hearing require a further extension of time for processing, a decision will be rendered not later than the third meeting of the Eligibility Committee following the Office of the Administrative Manager's receipt of your request for review. If such an extension of time for review is required because of

special circumstances, the Plan shall notify you in writing of the extension, describing the special circumstances and the date as of which the decision will be made, prior to the commencement of the extension.

Such review will take into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination.

The Eligibility Committee will notify you of its decision in writing within 5 days after the decision is made.

9. 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. 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.

10. You may, at your own expense, have legal representation at any stage 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.

For disability claims, you will be deemed to have exhausted the internal claims review and appeal process with respect to a claim if the Plan fails to strictly adhere to every aspect of the ERISA regulations, except if the violation was: de minimus; non-prejudicial or non-harmful; for good cause or because of matters beyond the Plan's control; in the context of an ongoing, good-faith

exchange of information; and not a pattern or practice of non-compliance.

For disability claims, in the event that you request a written explanation of the violation, the Plan will provide an explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If the court rejects your request for immediate review, the claim will be considered refiled on appeal upon the Plan's receipt of the decision of the court rejecting your request for immediate review. The Plan will provide you with notice of the resubmission within a reasonable time after receipt of the decision of the court.