CENTRAL ILLINOIS CARPENTERS RETIREMENT SAVINGS FUND

200 South Madigan Drive • Lincoln • Illinois 62656
Phone 217-732-1919 • Office Hours: 8 am – 4:30 pm Mon-Fri

IMPORTANT ANNOUNCEMENT
SUMMARY OF MATERIAL MODIFICATIONS

To: All Participants, Beneficiaries and Alternate Payees

The Trustees of the **Central Illinois Carpenters Retirement Savings Fund** ("Fund") wish to notify you of the following changes to the provisions of the Fund's Retirement Savings Plan.

Disability Benefit Claims and Appeals Procedures

The Fund was amended to comply with the new disability claims and appeals regulations effective for Disability Benefit Claims filed on or after April 1, 2018. A copy of the new and updated claims procedures are attached hereto. These rules require additional disclosures and information in the event a claim for disability benefits is denied. Should you submit a claim for Disability Benefits after April 1, 2018, your claim will be subject to the updated claims procedures.

If you have any questions regarding this Notice, please contact the Fund Office toll-free at 866-732-1919..

Sincerely,

Board of Trustees

This Notice constitutes a Summary of Material Modifications for the Central Illinois Carpenters Retirement Savings Fund and is intended to highlight changes to the Central Illinois Carpenters Retirement Savings Fund's Plan Documents. Full details are contained in the Plan Documents (which include the Summary Plan Description and Plan Document, and applicable amendments). If there is a discrepancy between the wording here and wording in the Plan Documents, the wording in the Plan Documents will govern.

Please keep this Notice with your Summary Plan Description. As a reminder, all benefits are subject to amendment and/or termination as the governing Board of Trustees may determine to be in the best interests of the Fund's participants and beneficiaries. Please contact the Fund Office if you have any questions.

Section 5.1(b) Claims Procedures for Disability Claims

(1) Any claim for which a Participant's eligibility is based on his Total and Permanent Disability must be in writing on a form provided by the Trustees. Unless an extension as described herein below applies, the Trustees must advise the Participant of its initial decision within forty-five (45) days of actual receipt of the written claim.

(2) The Trustees may extend the date for rendering an initial decision by two separate periods of thirty (30) days, provided any extension is due to circumstances beyond the control of the Fund. Such circumstances will include a delay in obtaining medical information from a physician or other health care provider. The Fund will notify the Participant in writing before the end of the forty-five (45) day period if the first extension is utilized and prior to seventy-five (75) days if the second extension is utilized.

A Participant may however withdraw his application any time before the Trustees reach a determination with respect to his claim.

(3) Any request to the Participant for additional information must be made within the initial forty-five (45) day period. The Participant then has forty-five (45) days to obtain the additional information. If the Participant does not provide the requested information, then the claim must be approved or denied within thirty (30) days of the Participant's deadline.

(4) In the event that a Participant's claim for a total and permanent disability is denied, then the Trustees shall provide the Participant with a notice of adverse determination. The notice of adverse determination shall include the following:

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

(B) Reference to the specific Plan provision on which the determination is based;

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

(D) A description of Plan's review procedures and applicable time limits applicable to such procedures, including a statement of the right to bring a civil action under ERISA Section 502(a) of the Act following an adverse benefit determination on review;

(E) A discussion the adverse benefit determination, 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;

ii. The views 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; and

iii. A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

(F) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either 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 of charge upon request; and

(G) The specific internal rules, guidelines, protocols, standards or other similar criteria 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

(H) 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, as that term is defined at 29 CFR 2560.503-1(m)(8), to the claimant's claim for benefits.

(I) The notification shall be provided in a culturally and linguistically appropriate manner. The Plan is considered to provide relevant notices in a "culturally and linguistically appropriate manner" if the Plan meets the following requirements:

i. The Plan must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;

ii. The Plan must provide, upon request, a notice in any applicable non-English language; and

iii. The Plan must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

(5) A Participant may authorize a representative to act on the Participant's behalf during the claims process. An authorization to use a representative must be provided to the Trustees on a written form provided by the Fund Office, if applicable, or in a manner satisfactory to the Trustees.

(6) The Trustees may delegate the obligation to review and decide claims to Fund Office or any Committee of the Board of Trustees.

(7) The claims procedures set forth in this section of the Plan Document apply to disability claims filed on and after April 1, 2018. Disability claims filed before April 1, 2018, shall be subject to the claims procedures in effect when the disability claim was filed.

Section 6.2 Review of Disability Claims

(a) A Participant may file a written appeal of a denied disability claim with the Trustees within one hundred eighty (180) days after receiving notice that his claim has been denied.

(b) If the Participant files a timely written appeal, he may:

(1) Submit additional materials, including any comments, statements or documents;

(2) Review all relevant information (free of charge) upon reasonable request to the Trustees. A document, record or other information is relevant if;

(i) It was relied upon by the Fund in making the decision;

(ii). It was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon); or

(iii). It demonstrates compliance with the claims processing requirements;

(3) Be advised of the identity of any medical experts upon request;

(4) Request in the appeal petition to appear before the Trustees for a hearing on the merits of the appeal petition. In the event such a request is made, the hearing shall be held at the next regular meeting of the full Board of Trustees or at such other time as may be agreed upon by the Participant and said Trustees. In the absence of such a request, the Trustees will review the entire application and supporting evidence and approve or deny the application at its next regular meeting.

(c) The Trustees' review shall consider all comments, documents, records and other information submitted or considered in the initial determination. The review will consider all comments and records submitted by the Participant. If the determination is based on a medical opinion, the Trustees must consult a medical professional who is not the same individual who consulted on the initial review of the claim or a subordinate of that individual.

(d) Within forty-five (45) days after receipt of the written appeal, the Trustees shall render a determination on the appeal of the claim in a written statement. If special circumstances require a delay in the decision, the Trustees shall notify the Participant of the reasons for the delay within the forty-five (45)-day period. A delayed decision shall be issued no later than ninety (90) days after the date the Trustees receive a request for review.

(e) Alternatively, the Trustees may also render the decision at the next quarterly meeting. If a request for appeal is received within thirty (30) days prior to a quarterly meeting, then the decision may be rendered at the subsequent quarterly meeting or if there are special circumstances by the third meeting following receipt of the appeal. The Fund shall notify the Participant of its decision within five (5) days of the date the decision is made.

(f) The Trustees' written decision on a Participant's appeal shall:

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

(2) Reference to the specific Plan provisions on which the adverse disability 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 disability benefits;

(4) 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;

ii. The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse disability benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

iii. A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

(5) If the adverse disability benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either 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 of change upon request; and

(6) Either 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.

(7) A statement of the claimant's right to bring an action under Section 502(a) of ERISA; and a statement of the claimant's right to bring an action under section 502(a) of the Act; which statement shall also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the **calendar date** on which the contractual limitations period expires for the claim.

In the case of an adverse disability benefit determination on review, the notification shall be provided in a culturally and linguistically appropriate manner as described below.

The Plan is considered to provide relevant notices in a "culturally and linguistically appropriate manner" if the Plan meets the following requirements:

a. The Plan must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;

b. The Plan must provide, upon request, a notice in any applicable non-English language; and

c. The Plan must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

Before the Plan can issue an adverse benefit determination on review on a disability benefit claim, the Plan Administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, or other person making the benefit determination (or at the direction of the plan or such other person) in connection with the claim. Such evidence must 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 under the Plan to give the claimant a reasonable opportunity to respond prior to that date.

In addition, before the Plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the Plan Administrator shall provide the claimant, free of charge, with the rationale. The rationale must 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 under the Plan to give the claimant a reasonable opportunity to respond prior to that date.

(8) The claims review procedures set forth in this section of the Plan Document apply to disability claims filed on and after April 1, 2018. Disability claims filed before April 1, 2018, shall be subject to the claims review procedures in effect when the disability claim was filed.