MID-AMERICA CARPENTERS REGIONAL COUNCIL
MILLMEN PENSION FUND

BENEFIT CLAIMS PROCEDURES

The Board of Trustees ("Trustees") of the Mid-America Carpenters Regional Council Millmen Pension Fund (the "Plan") has established the following Benefit Claims Procedures ("Procedures") governing the filing of benefit claims, notification of benefit determinations and appeal of adverse benefit determinations. These procedures, effective as of July 1, 2014, and amended as of April 1, 2018, constitute the Plan's written claims procedures and are incorporated in the Plan by reference.

These Procedures are intended to comply with section 503 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), Department of Labor ("DOL") regulations thereunder and DOL interpretations of such regulations. These Procedures may not be construed in any manner which would unduly inhibit or hamper the initiation or processing of any claim for benefits. All benefit determinations made pursuant to these Procedures will be made in accordance with the documents governing the Plan and, where appropriate, will be applied consistently with respect to similarly situated claimants.

Administration of Claims Procedures. The Administrator is responsible for the administration of these Procedures. All benefit claims, appeals and related inquiries should be addressed to:

Administrator
Mid-America Carpenters Regional Council Millmen Pension Fund
12 East Erie Street
Chicago, IL 60611

Format of Written Notices. A written notice required to be provided to a Participant or Beneficiary in accordance with these Procedures may be delivered by first class mail or electronically in accordance with Department of Labor regulations.

Application for Benefits. A person entitled to benefits from the Plan must complete an application for benefits as directed by the Administrator. The Administrator's approval or denial of the claim will be processed in accordance with the Plan document and these Procedures.

Claims Procedures (Other than Disability Claims). The following benefit claims procedures will apply to the review of a claim.

a. Claims for benefits under the Plan may be filed with the Plan on forms supplied by the Plan. Written notice of the disposition of a claim shall be furnished to the claimant within ninety (90) days after the application is filed appeal (unless there has been an extension of ninety (90) days due to special circumstances, provided the delay and the special circumstances occasioning it are communicated to the claimant within the ninety (90) day period). In the event the claim is denied, for claims filed before January 1, 2002, the reasons for the denial shall be specifically set forth in the notice in language calculated to be understood by the claimant, pertinent provisions of the Plan shall be cited, and, where appropriate, an explanation as to how the claimant can perfect the claim will be provided. In addition, the claimant shall be furnished with an explanation of the Plan's claims review procedure.

b. Effective for claims filed on or after January 1, 2002, a notice of adverse determination shall include the following: (1) specific reason(s) for the adverse determinations; (2) reference to the specific Plan on which the determination is based; (3) 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; (4) detailed description of the Plan's appeal procedures described in this Article VI; (5) statement of the claimant's right to bring a civil action under ERISA Section 502(a); and (6) if an adverse determination

is based upon an internal rule, guideline, protocol or other similar criteria, a statement that claimant may obtain a free copy of an explanation of the scientific or clinical judgment for the determination upon request.

Appeals (Other than Disability Claims).

a. Any Employee, former Employee, or Beneficiary of either, who has been denied a benefit by a decision of the Plan pursuant to Section 6.1 shall be entitled to request the Plan to give further consideration to his claim by filing with the Plan (on a form which may be obtained from the Plan) an appeal. Such request, together with a written statement of the reasons why the claimant believes his claim should be allowed, shall be filed with the Plan no later than sixty (60) days after receipt of the written notification provided for in Section 6.1. The appeal shall be decided by the Trustees, whose decision shall be communicated to the claimant within five (5) days thereof.

b. The Trustees meet four times per year. If the appeal is filed more than thirty (30) days prior to a regular meeting of the Trustees, the appeal will be decided at that meeting unless special circumstances require an extension of time for processing, in which case a decision will be made on the appeal at the next following meeting of the Trustees. If the appeal is filed within the thirty (30) day period immediately preceding the regular quarterly meeting of the Trustees, the appeal will not be decided at that meeting but will be decided at the next following meeting unless special circumstances require an extension of time for processing the appeal. In that case, a decision will be made on the appeal at the third quarterly meeting following the date the appeal was filed.

c. At the meeting at which the appeal is considered (or prior thereto upon five (5) business days written notice to the Plan), the claimant or his representative shall have an opportunity to review all documents in the possession of the Plan which are pertinent to the claim at issue and its disallowance and the claimant may be represented by an attorney or any other representative of his choosing and the claimant shall have an opportunity to submit written and oral evidence and arguments in support of his claim.

d. A final decision on the appeal shall be written in a manner calculated to be understood by the claimant and shall include specific reasons for the decision and specific references to the pertinent Plan provisions on which the decision is based.

e. The Trustees' written decision on a claimant's appeal shall: (1) contain the reason or reasons for the decision; (2) refer to specific Plan provisions on which the decision is based; (3) notify the claimant of his right to access and copy (free of charge) all documents, records and other information relevant to the claim; (4) notify the claimant of the right to bring a civil action under ERISA within twelve (12) months from the date of the adverse determination on appeal; and (5) notify the claimant of any additional voluntary appeal procedures offered by the Plan, if any.

Disability Claims

a. **Effective Date:** Notwithstanding anything contained hereinto the contrary, this Section 6.3 is effective only for claims for a Disability Pension pursuant to Section 3.8 and only for those claims for a Disability Pension filed on or after April 1, 2018.

b. **Initial Claims:** Any claim for a Disability Pension must be in writing on a form provided by the Trustees. Unless an extension applies, the Trustees must advise the claimant of its initial decision within forty-five (45) days of actual receipt of the written claim.

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

d. **Initial Claim Decision**

1. The Plan shall give the Employee notice of a denial within a reasonable time, but not later than forty-five (45) days after the claim is received. This period may be extended for up to thirty (30) days if circumstances beyond the Plan's control warrant the extension. In such case, the Plan shall notify the Employee of the extension within the initial forty-five (45) day period, giving the circumstances requiring the extension of time and the date that the Plan expects to render a decision.

2. The Plan may extend this period for another thirty (30) days if circumstances beyond the Plan's control continue to warrant the extension. In such case, the Plan shall notify the Employee of the additional extension before the end of the first thirty (30) day extension, giving the circumstances requiring the extension of time and the date that the Plan expects to render a decision.

3. In the case of any extension under this subsection d., the notice of extension shall 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. The claimant shall be afforded at least forty-five (45) within which to provide the specified information.

e. The Notice of Adverse Determination. Shall be provided in a culturally and linguistically appropriate manner and shall include the following:

1. Specific reason(s) for the adverse determinations, including an explanation for disagreeing with or not following, as applicable:

   (a) The views presented by the claimant to the Plan of the health care and vocational professionals who treated or evaluated the claimant;

   (b) The views of medical or vocational experts obtained by the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination; and

   (c) A disability determination regarding the claimant and presented to the Plan made by the Social Security Administration.

2. Reference to the specific Plan provisions on which the determination is based.

3. If an internal rule, document, guideline, protocol, or other criterion was relied on in making the denial, either the rule, document, guideline, protocol, or criterion itself, or a statement that it was relied on and that a copy of it will be provided free of charge to the claimant upon request.

4. If the denial was 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 an explanation will be provided free of charge upon request.

5. Detailed description of the Plan's appeal procedures outlined in this Article VI.

6. Statement of the claimant's right to bring a civil action under ERISA Section 502(a).

7. 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 claim for benefits.

8. Description of additional information or material necessary to complete the claim (if any), along with an explanation of why such information or material is necessary."

f. Review of Denied Claim

1. Claimant's Appeal. A claimant may file a written appeal of a denied claim with the Trustees within one hundred eighty (180) days after receiving notice that his claim has been denied. A claimant may authorize a representative to act on the claimant's behalf for this purpose. An authorization to use a representative must be provided to the Trustees on a written form provided by the Plan.

2. Claimant's Rights on Appeal. If the claimant files a timely written appeal, such claimant may:

   (a) submit additional materials, including any comments, statements, or documents; and

   (b) review all relevant information (free of charge) upon reasonable request to the Trustees. A document, record or other information is relevant if it:

      (1) was relied upon by the Plan in making the decision;

      (2) was submitted, considered, or generated (regardless of whether it was relied upon); or

      (3) demonstrates compliance with the claims processing requirements.

   (c) exercise his right to be advised of identity of any medical experts.

3. Full and Fair Review on Appeal

   (a) The review of the Board of Trustees must consider all comments and records submitted by the claimant. The appeal cannot defer to the initial claim determination.

   (b) If the determination is based on medical necessity or appropriateness, the Board of Trustees (or appeals committee) may 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.

   (c) The Trustees shall provide the claimant, free of charge, with the following items before issuing a denial on appeal: any new or additional evidence considered, relied upon, or generated by the Trustees in connection with the claim; and any new or additional rationale for a denial, provided that such rationale is the basis for the denial on appeal.

      Such additional evidence or rationale will be provided as soon as possible and sufficiently in advance of the deadline for issuing a decision on appeal so that the claimant will have an opportunity to respond. If the additional information is provided to the claimant within thirty (30) days of the next quarterly meeting of the Trustees, then the appeal determination will be postponed until the subsequent quarterly meeting."

4. Time Limits on Appeal

   (a) The Trustees meet four times per year. If the appeal is filed more than thirty (30) days prior to a regular meeting of the Trustees, the appeal will be decided at that meeting unless special circumstances require an extension of time for processing, in which case a decision will be made on the appeal at the next following meeting of the Trustees. If the appeal is filed within the thirty (30) day period immediately preceding the regular quarterly meeting of the Trustees, the appeal will not be decided at that meeting but will be decided at the next following meeting unless special circumstances require an extension of time for processing the appeal. In that case, a decision will be made on the appeal at the third quarterly meeting following the date the appeal was filed.

   (b) At the meeting at which the appeal is considered (or prior thereto upon five (5) business days written notice to the Plan), the claimant or his representative shall have an opportunity to review all documents in the possession of the Plan which are pertinent to the claim at issue and its disallowance and the claimant may be represented by an attorney or any other representative of

his choosing and the claimant shall have an opportunity to submit written and oral evidence and arguments in support of his claim.

(c) The Plan shall notify the claimant on the decision within five (5) days of the date the decision is made.

5. **Content of Decision on Appeal.** The Trustees' written decision on a claimant's appeal shall:

   (a) Be provided in a culturally and linguistically appropriate manner;

   (b) Include the information listed in Section 6.3(e); and

   (c) Include a description of the twelve (12) month contractual limitations period for a claimant to bring a civil action under ERISA, including the calendar date on which the Plan's twelve (12) month limit for filing suit expires."

6. **Binding Nature of Decision.** The determination rendered by the Trustees shall be binding upon all parties.

Exhaustion of Remedies; Limitation of Action. In the event of any dispute over benefits under this Plan, all remedies available to the disputing individual under this Article VI must be exhausted before legal recourse of any type is sought. No legal action at law or in equity, including without limitation a civil action under ERISA Section 502(a), may be filed against the Plan, the Trustees, the Plan Administrator, any Employer, or its delegate(s) relating to any dispute over benefits under this Plan more than one (1) year after a final decision under the claims review process described this Article VI.