**CHICAGO REGIONAL COUNCIL OF CARPENTERS**
**SUPPLEMENTAL RETIREMENT PLAN**

# BENEFIT CLAIMS PROCEDURES

The Board of Trustees ("Trustees") of the Chicago Regional Council of Carpenters Supplemental Retirement Plan (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 October 1, 2010 and amended as of February 19, 2014, April 1, 2018 and July 27, 2020, constitute the Plan's written benefit 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, as defined in the Plan document, is responsible for the administration of these Procedures. However, the Trustees pursuant to sections 8.1(b) and (c) of the Plan document may allocate responsibility for administering some of these administrative duties for specific types of claims to a third party. References to "Administrator" herein shall therefore include the Administrator and any third party that has been allocated responsibility under these Procedures. All benefit claims, appeals and related inquiries should be addressed to Administrator at the address identified and communicated by the Trustees.

**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 (other than a claim for a disability benefit).

1. Notification of Adverse Benefit Determination. The Administrator may make an adverse benefit determination of a claim for benefits. The Administrator will provide written notification to the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Administrator. The notice of adverse benefit determination will:

   (a) State the specific reason or reasons for the adverse determination;

(b) Refer to specific Plan provisions on which the determination is based;

(c) Describe any additional material or information necessary for the claimant to perfect the claim and explain why such material or information is necessary; and

(d) Describe the Plan's review procedures and the time limits applicable to such procedures. The notice will include a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

An adverse benefit determination includes any of the following (in whole or in part): a denial, reduction, or termination of, or a failure to provide or make payment for, a benefit, including such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan.

2. Extension of Time for Processing a Claim. If the Administrator determines that an extension of time for processing the claim is required, the Administrator will provide written notice of the extension to the claimant before the end of the initial 90-day claim determination period. The notice must explain the special circumstances requiring a delay in the decision and set a date, no later than 180 days after the initial receipt of the claim, by which the claimant can expect to receive a decision.

3. Appeal of Adverse Benefit Determinations. A claimant who receives an adverse benefit determination will be entitled to a full and fair review of the determination. Within 60 days following the receipt of an adverse benefit determination, a claimant must file a written appeal of the adverse determination with the Trustees. The claimant may submit written comments, documents, records, and other information relating to the claim for benefits with the appeal. The claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

A document, record or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information:

(a) Was relied upon in making the benefit determination;

(b) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or

(c) Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.

4. Review of Denied Claim. The Trustees' review of the claim will take into consideration 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. The Trustees' determination on review is binding on all parties.

5. Notification of Benefit Determination on Review. The Administrator will provide the claimant with written notification of the Plan's benefit determination on review. The Administrator will provide the notice within five days after a decision is made.

The notification of determination on review will:

(a) State the specific reasons or reasons for the adverse determination;

(b) Refer to the specific Plan provisions on which the benefit determination is based;

(c) State 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; and

(d) State the claimant's right to bring an action under section 502(a) of ERISA and applicable deadlines.

Legal action against the Plan may not be commenced more than 12 months after the Administrator notifies the claimant of the Plan's benefit determination on review.

6. Review by Trustees or Committee. The Trustees or a committee designated by the Trustees shall meet quarterly to render a determination on appeals received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting shall be decided at the next quarterly meeting. The Trustees or committee designated by the Trustees will make a decision on review no later than the date of the meeting of the Trustees or committee designated by the Trustees which immediately follows the Administrator's receipt of a request for review, unless the request for review is filed less than 30 days before the date of such meeting. If the request for review is filed less than 30 days before a scheduled meeting, a decision may be made no later than the date of the second meeting following the Administrator's receipt of the request for review. If special circumstances require a further extension of time for processing, a decision shall be rendered not later than the third meeting of the Trustees or committee designated by the Trustees following the Administrator's receipt of the request for review.

If such an extension of time for review is required because of special circumstances, the Administrator will provide the claimant with written notice of the extension before the extension begins. The notice must describe the special circumstances and the date as of which the benefit determination will be made. The Administrator will notify the claimant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made. The notice must comply with the requirements of paragraph 5 above.

7. Calculation of Time Periods. The period of time for making a benefit determination begins when a claim is filed in accordance with the reasonable filing procedures established by the Plan. The period of time begins without regard to whether all of the information necessary to decide the claim accompanies the filing. Days are measured in calendar days. In the case of a benefit determination on review, if the 60-day period for review is extended due to the claimant's failure to submit information necessary to decide the claim, the total

120-day period for processing the claim is suspended from the date on which notice is sent to the claimant to the date on which a response from the claimant is received by the Administrator.

**Disability Claims Procedures.** The following benefit claims procedures apply to the review of a claim for a disability benefit.

1. Description of a Disability Claim. A claim for disability benefits is subject to these separate benefit claims procedures if the Administrator must make a determination of disability to approve or deny the claim. These claims procedures for a disability claim will not apply if the payment of a disability benefit under the Plan is conditioned solely on a finding of disability by a third party other than the Administrator. For example, if the Plan provides a disability benefit to a Participant based solely on a finding of disability by the Social Security Administration, a claim for benefits would not be subject to these separate disability claims procedures.

2. Notification of Adverse Benefit Determination. The Administrator may make an adverse benefit determination of a claim for benefits. The Administrator must provide written or electronic notification to the claimant of the Administrator's adverse benefit determination within a reasonable time period, but no later than 45 days after the Administrator receives the claim.

   The notice of adverse benefit determination will:

   (a) State the specific reason or reasons for the adverse determination, including a discussion of the decision and the basis for disagreement with or not following:

      (i) The views of a health care or vocational professional who treated or evaluated the claimant;

      (ii) The views of a medical or vocational expert whose advice was solicited by the Plan in connection with the claim; or

      (iii) A disability determination regarding the claimant made by the Social Security Administration;

   (b) Refer to specific Plan provisions on which the determination is based;

   (c) Describe any additional material or information necessary for the claimant to perfect the claim and explain why such material or information is necessary;

   (d) Describe the Plan's review procedures and the time limits applicable to such procedures;

   (e) Include a copy of any internal rule, guideline, protocol or similar criteria that was relied on, or a statement that no such rule, guideline, protocol or similar criteria was considered in the adverse determination;

(f) If determination was based on medical necessity, experimental treatment, or similar exclusion or limit, state the claimant is entitled to receive, free of charge upon request, an explanation of the scientific or clinical judgment for the determination that applies Plan terms to the claimant's medical circumstances;

(g) State 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; and

(h) State the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

An adverse benefit determination includes any of the following (in whole or in part): a denial, reduction, or termination of, or a failure to provide or make payment for, a benefit, including such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan.

For a disability claim, an adverse benefit determination shall also include a rescission of coverage. A "rescission" means any cancellation or discontinuance of Plan coverage for disability benefits that has a retroactive effect.

3. Extension of Time for Processing a Claim. If the Administrator determines that an extension of time for processing the claim is required, written notice of the extension will be furnished to the claimant before the end of the initial 45-day claim determination period. The notice must explain the special circumstances requiring the delay and set a date no later than 75 days after the initial receipt of the claim by which the claimant can expect to receive a decision. If the Administrator determines that a decision cannot be rendered within the extended period due to matters beyond the control of the Administrator, the period for making the determination may be extended for up to an additional 30 days, and the Administrator will provide written notice of the extension to the claimant before the end of the 30-day claim determination extension period. The extension may not exceed 105 days after the initial receipt of the claim.

The notice of extension must 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. If additional information is requested, the claimant will have a minimum of 45 days from the date the claimant received the notice to submit information. A decision will be made within 30 days of the claimant's response, or the deadline date. The Administrator relies on a general presumption that a notice sent by first class mail will be received within 5 business days of mailing, and a notice sent electronically is received upon satisfaction of the electronic delivery requirements set forth by the Department of Labor.

Alternatively, the notice of extension may include a notice of adverse benefit determination stating that the Administrator will deny the claim if the claimant fails to provide any information in response to the Administrator's request within a minimum of 45 days. In such case, the claimant may appeal the claim in accordance with these Procedures. The

notice must further advise that the period for appealing the denied claim begins to run at the end of the deadline period set by the Plan. The notice must comply with the content requirements for the notification of adverse benefit determination as described in paragraph 2 above.

4. Appeal of Adverse Benefit Determination. A claimant who receives an adverse benefit determination of a disability claim is entitled to a full and fair review of the determination. A written appeal of the adverse determination must be filed with the Administrator within 180 days following receipt of a notification of an adverse benefit determination. The claimant may submit with the appeal written comments, documents, records, and other information relating to the claim for benefits. The claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

   A document, record or other information will be considered "relevant" to a claimant's claim if such document, record, or other information:

   (a) Was relied upon in making the benefit determination;

   (b) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

   (c) Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or

   (d) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

5. Review of Denied Claim. The Trustees' review of the claim shall take into consideration 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. The Trustees' determination on review is binding on all parties. In the course of the Trustees' review, the Administrator shall provide the claimant, free of charge, with (i) any new or additional evidence considered, relied upon, or generated by the Plan or the Trustees, or (ii) any new or additional rationale relied upon in connection with the claim. Such new or additional evidence or rationale shall be provided as soon as possible and sufficiently in advance of the Trustees' final decision in order to give the claimant a reasonable opportunity to respond.

   As other requirements, the review on appeal will not defer to the initial adverse benefit determination. The review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor the subordinate of such individual. If the adverse benefit determination is based in whole or in part on a medical judgment, an appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Upon request, the Administrator will provide

the identification of the 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. The health care professional will not be the same professional who was consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. A health care professional is a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

The Trustees' determination on review is binding on all parties.

6. Notification of Benefit Determination on Review. The Administrator will provide the claimant with written notification of a Plan's benefit determination on review. The notice must be provided within five days after a decision is made.

The notification of determination on review will:

(a) State the specific reasons or reasons for the adverse determination;

(b) Refer to the specific Plan provisions on which the benefit determination is based;

(c) State 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;

(d) Include a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views of a health care professional or vocational professional who treated or evaluated the claimant;

(ii) The views of a medical or vocational expert whose advice was solicited by the Plan in connection with the claim; or

(iii) A disability determination made by the Social Security Administration;

(e) Contain copies of any internal rule, guideline, protocol or similar criteria relied on by the Trustees, or a statement that no such rule, guideline, protocol or similar criteria was considered;

(f) State that the claimant may receive, free of charge upon request, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, if the Plan's decision is based on a medical necessity, experimental treatment, or similar exclusion or limitation; and

(g) State the claimant's right to bring an action under section 502(a) of ERISA following an adverse benefit determination on review and applicable deadlines, including the calendar date by which any legal action must be initiated against the Plan.

Legal action against the Plan may not be commenced more than 12 months after the Administrator notifies the claimant of the determination on review.

7. Review By Trustees or Committee. Trustees or a committee designated by the Trustees shall meet quarterly to render a determination on appeals received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting shall be decided at the next quarterly meeting. The Trustees or committee designated by the Trustees will make a decision on review no later than the date of the meeting of the Trustees or committee designated by the Trustees which immediately follows the Administrator's receipt of a request for review, unless the request for review is filed less than 30 days before the date of such meeting. If the request for review is filed less than 30 days before a scheduled meeting, a decision may be made no later than the date of the second meeting following the Administrator's receipt of the request for review. If special circumstances require a further extension of time for processing, a decision shall be rendered not later than the third meeting of the Trustees or committee designated by the Trustees following the Administrator's receipt of the request for review.

   If such an extension of time for review is required because of special circumstances, the Administrator will provide the claimant with written notice of the extension before the extension begins. The notice must describe the special circumstances and the date as of which the benefit determination will be made. The Administrator will notify the claimant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made. The notice must comply with the requirements of paragraph 6 above.

8. Calculation of Time Periods. The period of time for making a benefit determination begins when a claim is filed in accordance with the reasonable filing procedures established by the Plan, without regard to whether all of the information necessary to decide the claim accompanies the filing. Days are measured in calendar days. If the determination period is extended during the initial benefit determination due to the claimant's failure to submit information necessary to decide the claim, the time period for processing the claim is suspended from the date on which the notice is sent to the claimant to the date the Administrator receives the claimant's response, or 45 days, if later. If instead the determination period was extended during the benefit determination on review due to the claimant's failure to submit information necessary to decide the claim, the time period for processing the claim is suspended from the date on which the notice is sent to the claimant to the date the Administrator receives the claimant's response to the request.

**Deemed Exhaustion of Remedies.** If the Administrator fails to follow these Procedures in accordance with applicable law, a claimant will be deemed to have exhausted the administrative remedies available under the Plan unless the failure is *de minimis*. A failure to follow these Procedures will be considered *de minimis* if it is (1) non-prejudicial to the claimant, (2) attributable to good cause or matters beyond the Plan's control, (3) in the context of an ongoing good-faith exchange of information with the claimant, and (4) not reflective of a pattern of noncompliance. The claimant is entitled to receive, upon request, an explanation of the Plan's basis for asserting that the Administrator's failure was *de minimis*. The Plan shall provide such explanation within 10 days of the claimant's request. The claimant is entitled to pursue any available remedies under

section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of a claim. In the event a claimant appeals an adverse benefit determination and the appeal is denied, any legal action must begin within 12 months of the date the Plan provides an adverse benefit appeal determination.

**Authorized Representative of Claimant.** These Procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. The Trustees may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the claimant. In the absence of contrary direction from the claimant, the Administrator will direct all information and notifications to the representative authorized to act on the claimant's behalf.

**Miscellaneous.** Electronic notification by the Administrator must comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii) and (iv); or 29 CFR 2520.104b-31.