CARPENTERS PENSION FUND OF ILLINOIS

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NOTICE OF CHANGE TO DISABILITY CLAIMS & APPEALS PROCEDURES

February 2018

Due to legislative changes, the procedures for claims and appeals related to disability pension claims filed on or after April 1, 2018 will be slightly different than for claims filed prior to April 1, 2018. Your current Summary Plan Description (SPD) describes the claims and appeals procedures for disability pension applications made prior to April 1, 2018. This Notice provides the claims and appeals procedures for disability applications filed on or after April 1, 2018.

Filing a Disability Pension Application

You must complete the application form and submit it to the Administrative Manager. The Administrative Manager will approve or disapprove the application, and inform you of the initial decision with 45 days of the date your written application is received.

This timeframe may be extended for up to two periods of 30 days each if extra time is needed due to circumstances beyond the control of the Plan (for example, there is a delay in receiving medical information from the physician or other provider). If this is the case, the Administrative Manager will notify you in writing before the end of the first 45 days (if the first 30-day extension is needed), and prior to the end of 75 days (if a second 30-day extension is needed).

If additional information is needed from you, the Administrative Manager will request it from you in writing within the initial 45-day period. You then have 45 days to obtain the requested information. If you do not provide the requested information, the application for a disability pension will be denied within 30 days of your deadline.

If Your Application is Denied

If your application is denied, in whole or in part, you will receive a written notice of the denial from the Administrative Manager that will include the following information:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provision on which the determination is based.
- A description of any additional information that might complete your claim and why this information is necessary.
- A description of the Plan's review procedures and applicable time limits, including the right to bring a civil action under ERISA Section 502(a) of the Act following an adverse benefit determination on review.

- A discussion of the adverse benefit determination, including an explanation of the basis for disagreeing with or not following:
    - The view you presented to the Plan of the health care and vocational professionals who treated and evaluated you;
    - The views of medical or vocational experts whose advice was obtained by the Plan in connection with your adverse benefit determination, regardless of whether that advice was relied upon in making the benefit determination; and
    - A disability determination made by the Social Security Administration that you presented to the Plan.
- If the adverse benefit determination is based on a medical necessity or experimental treatment, or a similar exclusion or limit—either an explanation of the scientific or clinical judgement for the determination (applying the Plan's terms to your medical circumstances); or a statement that such an explanation will be provided free of charge upon request.
- The specific internal rules, guidelines, protocols, standards, or other similar criteria that the Plan relied upon in making the adverse determination; or a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.
- 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.

Filing an Appeal

You have up to 180 days after you receive a denial notice to file a written appeal with the Administrative Manager. You may authorize a representative to act on your behalf in this matter. The Administrative Manager will provide you with the necessary form to file your appeal and appoint a representative (if your wish).

If you file a timely written appeal for a Disability Pension, you:

- May submit additional materials, including any written comments, documents, records, statements, or other information relating to your claim.
- May review all relevant information, free of charge, by making a reasonable request to the Trustees. A document, record, or other information is relevant if it:
    - Was relied upon by the Plan in making the decision; or
    - Was submitted, considered, or generated (regardless of whether it was relied upon); or
    - Demonstrates compliance with the claims processing requirements.
- Have the right to be advised of the identity of any medical experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the benefit determination.
- Have the right to legal counsel.
- May, upon reasonable notice to the Administrative Manager, attend (and/or have your legal counsel or authorized representative attend) the Appeal Review Committee meeting at the time your appeal is reviewed.

The Appeal Process

Upon receipt, the Administrative Manager will forward your written appeal, together will all files, papers, documents, materials, and relevant information to the Appeal Review Committee. The Appeal Review Committee will consider all information submitted or considered in the initial determination, as well as all subsequent information and comments you submit on your appeal.

If the initial determination was based on medical necessity or appropriateness, the Appeal Review Committee will consult with a medical professional who is not the same person consulted with during the initial review of your claim, or his/her subordinate.

If you or your representative do not appear on the hearing date, or fail to request a continuance prior to the hearing, the Appeal Review Committee will proceed to review the decision based on all documents, information, and materials forwarded and received. The Appeal Review Committee must receive a request for a continuance of the hearing date prior to the hearing date, and will only grant a continuance under special circumstances. If a continuance is granted, a new hearing date will be scheduled immediately so that the Committee can make a decision no later than 90 days from the date the written request for appeal was received.

The Appeal Review Committee will make a determination on the appeal within 45 days after the date the written appeal was received. If special circumstances require a delay in the decision, the Committee will notify you of the reason for the delay within the initial 45-day period. A delayed decision will be made no later than 90 days after receipt of the appeal. The Committee will notify you of its decision within five days of the date of their decision. Alternatively, the Board of Trustees may also render a decision at their next quarterly meeting. If the request for appeal is received within 30 days of a quarterly meeting, the decision may be made at the subsequent quarterly meeting. You will be notified of the decision within five days of the date the decision is approved by the Board of Trustees.

The Appeal Review Committee has the right to legal counsel, the services of auditors, and of other professionals retained by the Board of Trustees to assist in making decisions on review or reconsideration. Any hearing before the Appeal Review Committee to which you or your representative is invited is conducted informally and will not be recorded electronically or in writing.

If Your Appeal is Denied

If your appeal is denied, in whole or in part, you will receive the Appeal Review Committee's written decision that will include:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provision on which the determination is based.
- A description of the Plan's review procedures and applicable time limits, including the right to bring civil action under ERISA Section 502(a) of the Act following an adverse benefit determination on review.
- A discussion of the adverse benefit determination, including an explanation of the basis for disagreeing with or not following:
    - The view you presented to the Plan of the health care and vocational professionals who treated and evaluated you;

    - The views of medical or vocational experts whose advice was obtained by the Plan in connection with your adverse benefit determination, regardless of whether that advice was relied upon in making the benefit determination; and
    - A disability determination made by the Social Security Administration that you presented to the Plan.
- If the adverse benefit determination is based on a medical necessity or experimental treatment, or a similar exclusion or limit—either an explanation of the scientific or clinical judgement for the determination (applying the Plan's terms to your medical circumstances); or a statement that such an explanation will be provided free of charge upon request.
- The specific internal rules, guidelines, protocols, standards, or other similar criteria that the Plan relied upon in making the adverse determination; or a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.
- 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.

Before the Plan can issue a denial on an appeal, the Administrative Manager must provide you—free of charge—with any new or additional rationale and evidence considered, relied upon, or generated by the Plan or by any other person making the benefit determination. This information will be provided as soon as possible and sufficiently in advance of the date on which the notice of your appeal denial is required to be provided to you. This is to give you a reasonable opportunity to respond to this evidence prior to the notification date.

The decision of the Appeal Review Committee will be subject to a re-hearing, if you or your authorized representative request one in writing within 30 days of the decision. After the 30 days, and upon approval of the Board of Trustees, the decision is final.

If the Appeal Review Committee, upon its preliminary examination and review, determines that the original claim denial should be reversed, the Committee will notify you of the appeal approval within five days of the date of the decision and the hearing is cancelled.

If you fail to request a review of the Administrative Manager's initial or the Appeal Review Committee's appeal decisions within the time frames described in this Notice, your failure to request such review is considered consent by you to the determination(s).

Language Requirements

The Plan must provide notices and requests in a culturally and linguistically appropriate manner, which means the Plan must provide the following:

An applicable non-English language in any county is any language where at least 10% of the population that resides in that county is literate only in that non-English language.

- Oral language services (such as a telephone customer assistance hotline) that includes answering questions and assistance in filing claims and appeals in any applicable non-English language;
- Notice in any applicable non-English language, upon request; and
- An English version of all notices, and a statement prominently displayed in any applicable non-English language that clearly indicates how to access the language services provided by the Plan.

Final Comments

Save this letter with your SPD and other Pension Fund information for future reference.

If you have any questions about the disability claims and appeals procedures, or any questions about the Plan, please call the Fund Office at 630-232-7166 or 800-448-5825.

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