AMENDMENT NO. 1 TO THE PLAN DOCUMENT FOR THE CARPENTERS' LOCAL 496 PENSION PLAN

WHEREAS, the Board of Trustees of the Carpenters' Local 496 Pension Plan (the "Plan") may, pursuant to Article XIV, Section 14.01, amend the Plan Document; and

NOW, THEREFORE, BE IT RESOLVED THAT the Plan Document of the Carpenters' Local 496 Pension Plan is hereby amended as follows:

Section 11.16(a) is amended by adding the following, effective July 1, 2007.

When expressed as an annual pension, a benefit shall not exceed $160,000 (the "Dollar Limitation").

For all purposes of this Plan, the maximum Dollar Limitation of $160,000 shall be automatically increased as permitted by the Treasury Department regulations to reflect cost-of-living adjustments. As a result of such adjustment, a benefit which had been limited by the provisions of this section in a previous Plan Year may be increased with respect to future payments to the lesser of the adjusted Dollar Limitation amount or the amount of benefit which would have been payable under this Plan without regard to the provisions of this section.

Pursuant to Regulation 1.415(a)(1)(e), for purposes of applying the limitations of Section 415 with respect to a Participant in a plan maintained by more than one employer, benefits or contributions attributable to the Participant from all of the employers maintaining the plan must be taken into account.

* * *

IN WITNESS WHEREOF, the Board hereby executes this amendment to the Plan by affixing their signatures as of this 4th day of August, 2015.

UNION TRUSTEES

[redacted]

EMPLOYER TRUSTEES

[redacted]

Executed version on file with the Fund Office.

AMENDMENT No. 2 TO THE CARPENTERS LOCAL 496 PENSION FUND PLAN DOCUMENT

WHEREAS, the right to further amend the Plan Document has been reserved by the Board of Trustees under Article XIII, Section 13.01 of the Plan Document thereof, which right the Board of Trustees now desires to exercise.

WHEREAS, we the undersigned, being all of the Trustees and all of the persons entitled to notice of, to attend and to vote at meetings do hereby authorize, consent and agree that the following action may be taken and adopted for the benefit of the Participants covered under the Plan.

WHEREAS, this amendment is adopted to comply with the United States Department of Labor's newly promulgated disability claims regulations. Accordingly, this amendment is effective on the date specified in the regulation (*i.e., January 1, 2018*). If the effective date of the disability claims regulations is delayed or postponed, then the effective dates specified below shall automatically be extended to the new effective date established by regulation. In the event that the United States Department of Labor withdraws or revises the disability claims regulations, then this amendment shall be deemed automatically rescinded by the Trustees.

NOW, THEREFORE, the Trustees amend the Plan as follows subject to the conditions specified above:

1. Section 12.03 of Article XII is hereby amended to read as follows:

Section 12.03 Claims and Appeals Procedure

Claims for Benefits other than a Claim for Benefit due to a Total and Permanent Disability:

Any Participant or Beneficiary who believes he is entitled to a benefit for which provision is made in the Plan, shall file a written claim with the Trustees, and shall furnish such evidence of entitlement to benefits as the Trustees may reasonably require. If a claim for benefit is denied by the Trustees, in whole or in part, the Trustees (or the Administrator hired by the Trustees) shall provide adequate notice in writing to the Participant or Beneficiary whose claim for benefit has been denied within the 90-day period following receipt of the claim by the Trustees. If, under special circumstances, the Trustees require an extension of time for processing the claim, written notice of the extension may be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The notice of the extension shall state both the reason for the extension and the date by which a decision is expected. If written notice of the denial is not furnished in accordance with the above, the claim shall be deemed denied and the claimant may proceed with an appeal of the denial, as provided below. The written notice, if any, regarding the benefit denied shall set

forth (a) the specific reason or reasons for the denial; (b) specific reference to pertinent Plan provisions on which the denial is based; (c) a 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; (d) a statement that any appeal of the denial must be made in writing to the Trustees, within 60 days after receipt of the notice, and include a full description of the pertinent issues and the basis of the appeal; and (e) a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA for any issues denied on appeal. If the Participant or Beneficiary fails to appeal such action to the Trustees in writing within the prescribed period of time, the Trustees' determination shall be final, binding and conclusive.

If the claimant submits a notice of an appeal of the denial of a claim for benefits to the Trustees, the claimant or his authorized representative must also submit, in writing, all issues, comments, additional information and material relating to the claim. The review by the Trustees shall take into account all information submitted by the claimant, without regard to whether such information was submitted or considered in the initial benefit determination. On review, the claimant is entitled to access to and free copies of all documents relevant to his claim whether or not those documents were relied upon by the Trustees in denying the claim. The Trustees or persons designated by the Trustees may hold a hearing or otherwise ascertain such facts as it deems necessary and shall render a decision that shall be binding upon both parties. Such decision will be made within 60 days after the receipt of the notice of appeal, unless special circumstances require a reasonable extension of such 60-day period, but in any event, not later than 120 days after such receipt. If an extension is needed, the Trustees will notify the claimant of the need for the extension before the expiration of the initial 60-day period, stating the reason for the extension and the date by which a decision is expected. Once the Trustees have reached a decision on review, the Trustees will notify the claimant of its decision in writing. The notice of the decision upon review will include specific reasons for the decision, as well as specific references to the Plan provisions on which the decision on the review was based. The notice also will include 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, as well as a statement as to the claimant's right to bring an action under Section 502(a) of ERISA for any issues denied on appeal. If written notice of the denial on appeal of a claim for benefits is not received within the 60 or 120-day period, as applicable, then the claim shall be treated as a denied claim on appeal.

In the event that a period of time in which the Plan is to respond to a claim or appeal is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making either the initial benefit determination or the determination on review shall be tolled from the date on which notification of the extension (and the need for additional information) is

sent to the claimant until the date on which the claimant responds to the request for additional information.

Claims for Benefits due to a Total and Permanent Disability filed after January 1, 2018.

Any Participant who believes he is entitled to a benefit because he has a Total and Permanent Disability under Section 6.01 of the Plan shall file a written claim with the Trustees, who shall immediately refer the claim to the Administrator. The Participant shall furnish such evidence of entitlement to benefits as the Administrator reasonably may require. The claim should provide an explanation of why the claimant believes he is entitled to a benefit, including proof of his total and permanent disability as of the date of his termination of employment, such as medical records or doctors' certifications, as well as evidence that that total and permanent disability rendered the claimant incapable of continuing employment with the Employer.

If a claim for benefits is denied by the Administrator, in whole or in part, the Administrator shall provide adequate notice in writing to, the claimant within the 45-day period following receipt of the claim by the Trustees. If, under special circumstances, the Administrator requires an extension of time for processing the claim, written notice of the extension may be furnished to the claimant prior to the termination of the initial 45-day period. Such extension shall not exceed a period of 30 days from the end of such initial period unless special circumstances warrant an additional 30-day extension, in which case, written notice of the need for the additional extension will be provided to the claimant before the expiration of the initial 30-day extension. In the case of any required extension, the notice of extension shall notify the claimant of the circumstances requiring the extension and the date as of which the Administrator expects to render a decision. The notice of extension further shall 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 the Administrator requests additional information from the claimant in order to process the claim, the claimant will be afforded 45 days following receipt of the request for information in which to provide such information. The Administrator may require a claimant to submit to examination by experts of the Administrator's choosing in connection with a determination as to disability.

The written notice regarding a denial of disability benefits shall include the following:

- 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 material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;

- 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;
- A discussion of the adverse benefit determination, including an explanation of the basis for disagreeing with or not following:
    - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - 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
    - A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
- 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;
- 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
- 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.

If the Participant fails to appeal such action to the Trustees in writing within the 180-day period, the Administrator's initial determination shall be final, binding and conclusive.

If the Trustees receive from a Participant, within the 180-day period following the notice of the claim denial, a notice of an appeal of the denial, such notice shall be considered by the Trustees. The Trustees or their authorized designee may hold a hearing or otherwise ascertain such facts as they deem necessary. A claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim, and the review by the Trustees shall take into account all information submitted by the claimant, without regard to whether such information was submitted or considered in the initial benefit determination. On review, the

claimant is entitled to access to and free copies of all documents relevant to his claim whether or not those documents were relied upon by the Administrator in denying the claim. The decision of the Trustees will be in writing and a copy thereof shall be sent to each party within 45 days after the receipt by the Trustees of the notice of appeal, unless special circumstances (such as the need to hold a hearing) require a reasonable extension of such 45-day period, but in any event, not later than 90 days after such receipt. If an extension of time is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period, and such notice shall indicate the special circumstances requiring an extension and the date by which the Plan expects to render the determination on review.

The review and decision of the Trustees shall be independent of the Administrator's initial decision with respect to the claim and shall give no deference to that initial decision. If the initial determination was based wholly or partly on medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the relevant area of medicine and who is independent of and not a subordinate of any professional consulted with respect to the initial determination. The Trustees also may, but are not required to, consult with other experts (such as vocational or occupational experts) as it deems appropriate. The identity of any experts whose advice is obtained during this process shall be provided to the claimant upon request even if the advice was not relied upon in making a benefit determination.

If the Trustees render a decision adverse to the claimant, its notice to the claimant regarding that decision shall include the following:

- The specific reason or reasons for the adverse disability benefit determination;
- Reference to the specific Plan provisions on which the adverse disability benefit determination is based;
- 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;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - 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
    - A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

- 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;
- 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; and
- A statement of the claimant's right to bring an action under Section 502(a) of ERISA; 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.

Before the Plan can issue an adverse benefit determination on review on a disability benefit claim, the 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 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.

If written notice of the denial on appeal of a claim for benefits is not received within the 45 or 90-day period, as applicable, then the claim shall be treated as a denied claim on appeal.

In the event that a period of time in which the Plan is to respond to a claim or appeal is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making either the initial benefit determination or the determination on review shall be tolled from the date on which notification of the extension (and the need for additional information) is sent to the claimant until the date on which the claimant responds to the request for additional information.

All notifications under this section shall be provided in a culturally and linguistically appropriate manner as required by U.S. Department of Labor regulations.

Claims for disability benefits filed before January 1, 2018, shall be subject to the disability claims procedures then in effect.

Exclusivity of Procedure and Exhaustion.

The procedure specified in this Section shall be the sole and exclusive procedure available to a Participant or Beneficiary of a Participant who is dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected by any action of the Trustees. A Participant or Beneficiary must follow the procedures described above before taking any legal action with respect to a claim for benefits from the Pension Plan.

IN WITNESS HEREOF, this Amendment has been executed this 2nd day of November, 2017.

Ronald H. Fringer