Summary of Material Modifications
to the
RETIREMENT PLAN FOR EMPLOYEES AND REPRESENTATIVES OF WOODMENLIFE
Summary Plan Description

This document is a "Summary of Material Modifications" to your Summary Plan Description for the Retirement Plan for Employees and Representatives of WoodmenLife (the "Plan"), and reflects changes pursuant to U.S. Department of Labor rules applicable to certain disability-related claims filed after April 1, 2018. Please keep this Summary of Material Modifications ("SMM") with your copy of the Summary Plan Description for future reference.

If you have any questions regarding this SMM, please contact the Benefits Department in any of the following ways:

Phone: 1-800-328-2968 ext. 57047
Email: benefits_mailbox@woodmen.org

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Effective April 2, 2018, the Section titled "**CLAIMS BY PARTICIPANTS AND SPOUSES**" is revised as follows:

1. The first paragraph of the Section is revised to read as follows: "Any claim for benefits must be made in writing, and it should be made to the Administrator on the forms supplied by the Employer."

2. The last sentence to the second bullet in the second paragraph is revised as follows: "Any written notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. If you are asked to provide additional information so that the claim can be processed, you will have forty-five (45) days to provide the additional information."

3. The following is added after the written notice requirements in the third paragraph: "In addition, if the denial relates to an initial disability claim, the notice will be written in a culturally and linguistically appropriate manner and will also include the following:

1. A discussion of the Plan Administrator's decision, including an explanation of why the Plan Administrator disagreed with (1) the views of a health care professional who evaluated you, (2) the views of medical experts whose advice was obtained in connection with the denial (even if the Plan Administrator did not rely on the advice), and (3) a disability determination made by the Social Security Administration;
2. If the denial is based on a medical necessity, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical

circumstances, or a statement that such explanation will be provided to you free of charge upon request;

3. Either the specific internal guidelines or similar criteria relied upon in making the denial, or a statement that such guidelines or criteria do not exist; and
4. A statement that you are entitled to receive upon request and free of charge access to and copies of all documents and information relevant to your claim."

4. The following changes were made under "The Claims Review Procedure."

a. The first bullet point under paragraph #2 is revised to read as follows: "with the Administrator no later than sixty (60) days after you have received written notification of the denial of your claim for benefits; or"

b. Paragraph #3 is deleted and the subsequent paragraphs are renumbered accordingly.

c. A new paragraph #4 is added and reads as follows: "You have the right to submit written comments, documents, records and other information relating to your claim without regard to whether such information was submitted or considered in the initial benefit determination. The Administrator will re-examine your claim, along with all comments, documents, records and other information that you submit relating to the claim, regardless of whether or not it was submitted or considered in the initial determination. In deciding an appeal that is based in whole or in part on a medical judgment, the decision maker shall consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and who was not consulted in connection with the initial adverse determination and is not the subordinate of someone who was. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. As soon as possible and sufficiently in advance of the date on which you receive notice of a denial of an appeal of a claim for disability benefits, you will be given, free of charge, any new or additional evidence or rationale considered by any person deciding your appeal."

d. The paragraph that states "If your claim is denied on review, you will be provided a written notice of denial within a reasonable period of time in accordance with the following" is renumbered as paragraph #5 and subsequent paragraphs are renumbered accordingly.

e. The second sentence of subparagraph (a) to paragraph #5 is revised to read as follows: "This 60-day period may be extended up to an additional sixty (60) days if special circumstances require an extension of time for processing the claim."

f. The last three sentences of paragraph #6 (as renumbered) are deleted and replaced with the following: "If a claim for disability benefits is denied on review, then the written notice of denial will be written in a culturally and linguistically appropriate manner and will also include:

1. A description of any contractual limitations on your ability to bring a civil action under Section 502(a) of ERISA following denial on review, including the calendar date on which the contractual limitations period expires;
2. A discussion of the Plan Administrator's decision, including an explanation of why the Plan Administrator disagreed with (1) the views of a health care professional(s) who evaluated you, (2) the views of medical experts whose advice was obtained in connection with the denial (even if the Plan Administrator did not rely on the advice), and (3) a disability determination made by the Social Security Administration;
3. If the denial is based on a medical necessity, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request; and
4. Either the specific internal guidelines or similar criteria relied upon in making the denial, or a statement that such guidelines or criteria do not exist."

g. A new paragraph #7 is added and reads as follows: "After exhausting the claims procedure, nothing shall prevent you from pursuing any other legal remedy. However, no legal action may be taken against the Administrator (or Disability Claims Administrator) after the earlier of three (3) years after the Administrator notifies you of the denial of your claim or the expiration of the relevant statute of limitations in the state having jurisdiction of the claim." Subsequent paragraphs are renumbered accordingly.

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