AMENDMENT NO. 7
TO THE
EIGHTH DISTRICT ELECTRICAL PENSION FUND

WHEREAS, the Plan Document of the Eighth District Electrical Pension Fund, revised and restated April 1, 2014, provides that the Plan may be amended by the Board of Trustees from time to time; and

WHEREAS, it is the desire of the Trustees to amend the Plan Document;

NOW, THEREFORE, BE IT RESOLVED, that the Plan shall be amended as follows:

1. Effective for claims filed after April 1, 2018, Article 9 shall be amended by deleting Section 9.05, and inserting in its place the following Section 9.05:

9.05 Appeals Procedure and Determination of Disputes.

a. No Employee, Participant, Pensioner, Beneficiary or other person shall have any right or claim to benefits under the Plan other than as specified in the Plan. Any dispute as to eligibility, type, amount or duration of benefits shall be resolved by the Board under and pursuant to the Trust Agreement and Plan and its decision shall be final and binding on all parties. No action may be brought for benefits under the Plan or any amendment or modification thereof, or to enforce any right thereunder, until after the claim therefor has been submitted to and determined by the Board, and thereafter the only action which may be brought is to enforce the decision of the Board or to clarify the rights of the parties under such decision. No such action may be brought at all unless brought within two (2) years after the date of such decision.


   (i) Initial Claims for Benefits

   If a claim for benefits under the Plan is wholly or partially denied by the administrative office, written notice of the denial shall be furnished to the affected Employee or Participant (claimant) within ninety (90) days after receipt by the administrative office of the notice of claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the administrative office expects to render final decision.

   If notice of denial of a claim is not furnished to claimant in accordance with the preceding paragraph, the claim shall be deemed denied and the claimant shall be permitted to proceed to the review stage described in subsection (b)(ii).

The written notice of denial shall set forth in a manner calculated to be understood by the claimant:

1. the specific reason or reasons for the denial;
2. specific references to pertinent provisions of the Plan on which the denial is based;
3. 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; and

4. a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring civil action under ERISA Section 502(a) following an adverse benefit determination on review.

(ii) Appeal of Denial of Claim for Non-Disability Benefits.

The claimant or his duly authorized representative may appeal a claim to the Board and obtain a full and fair review of the claim and its denial.

Written request for review shall be filed with the administrative office within ninety (90) days after receipt by the claimant of written notification of denial of the claim. The request for review shall state in clear and concise terms the reason or reasons for disputing the denial and shall be accompanied by any pertinent documentary material not already furnished to the administrative office. The request for review may contain a description of the issues and comments relating thereto. The claimant or his authorized representative shall be provided, upon request and free of charge, and shall have access to review relevant documents relating to the claim and denial. Upon good cause shown, the Board may permit the request for review to be amended or supplemented prior to review. The request for review may include a written request for hearing. If a hearing is requested, the Board may, at its discretion, hold a hearing and shall receive and hear any evidence or argument that cannot be presented satisfactorily by correspondence. The administrative office shall advise the claimant in writing of the date, time and place of the hearing at least twenty (20) days prior thereto.

The failure to file a written request for review within the ninety (90) day period (shall constitute a waiver of the claimant's right to a review of the denied claim. Such failure shall not, however, preclude the claimant from establishing his entitlement to benefits at a later date based on additional information and evidence which was not available to claimant at the time of decision on review. The failure of a claimant to timely request a hearing, or the failure of a claimant to appear at a hearing scheduled upon his request, shall constitute a waiver of the claimant's right to a hearing.

Upon receipt of a request for review the Board shall proceed to review the administrative file, including the request for review and its contents. Review of an adverse determination shall take into account 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. Review of an adverse benefit determination for disability benefits shall not afford deference to the initial benefit determination.

The Board shall make a decision on review at regularly scheduled meetings held at least quarterly, and a decision on review shall be made no later than the date of the meeting of the Board that immediately follows the administrative office's receipt of the request for review, unless the request for review is filed within thirty (30) days preceding the date of such meeting. In such case, a decision may be made no later than the date of the second meeting following the receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for review, a decision shall be rendered not later than the third meeting of the Board following the administrative office's receipt of the request for review.
If an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension. The Plan shall notify the claimant of the decision of the Board as soon as possible after the meeting, but not later than five (5) days after the decision is made.

The written notice of denial shall set forth in a manner calculated to be understood by the claimant:

1. the specific reason or reasons for the adverse determination;
2. reference to specific Plan provisions on which the determination is based;
3. 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 benefits; and
4. a statement of the claimant's right to bring civil action under ERISA section 502(a).

The decision on review shall be furnished to the claimant within the appropriate time described in this subsection 9.05(b)(ii). If the decision on review is not furnished within such time, the claim shall be deemed denied on review.

c. Claims and Appeals Procedures for Disability Claims

(i) Initial Claim for Disability Benefits.

If the application for benefits is a claim for disability benefits, the Plan shall notify the claimant of a denial in writing within a reasonable period of time, but not later than forty-five (45) days after the receipt by the Plan of the application or claim for benefits.

This period may be extended for up to thirty (30) days, provided the Plan determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial forty-five (45) day period, of the circumstances requiring the extension and date by which a final decision is expected to be rendered. The period for making the determination may be extended by another thirty (30) day period if the Plan determines that the extension is necessary and notifies the claimant, prior to the end of the first thirty (30) day extension period of the circumstances requiring an extension and the date by which a final decision is expected to be rendered. Any notice of extension under this paragraph shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and additional information needed to resolve those issues. The claimant shall be afforded at least forty-five (45) days to provide such additional information.

If the application for benefits is a claim for disability benefits, the written notice of denial shall be furnished to the applicant, in a culturally and linguistically appropriate manner. Such notice shall include:

1. the specific reason or reasons for the denial;
2. specific references to pertinent provisions of the Plan on which the denial is based;
3. 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;
4. a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   a. the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; or
   b. 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.

5. a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring civil action under ERISA Section 502(a) following an adverse benefit determination on review;

6. 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;

7. 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; and

8. 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 benefits.

(ii) Appeal of Denial of Claim for Disability

The claimant or his duly authorized representative may appeal a claim of a denial of a disability benefit to the Board and obtain a full and fair review of the claim and its denial.

The claimant shall be afforded one hundred eighty (180) days after written notification of denial is provided to file a written request for review. The request for review shall state in clear and concise terms the reason or reasons for disputing the denial and shall be accompanied by any pertinent documentary material not already furnished to the administrative office. The request for review may contain a description of the issues and comments relating thereto. The claimant or his authorized representative shall be provided, upon request and free of charge, and shall have access to review relevant documents relating to the claim and denial. Upon good cause shown, the Board may permit the request for review to be amended or supplemented prior to review. The request for review may include a written request for hearing. If a hearing is requested, the Board may, at its discretion, hold a hearing and shall receive and hear any evidence or argument that cannot be presented satisfactorily by correspondence. The administrative office shall advise the claimant in writing of the date, time and place of the hearing at least twenty (20) days prior thereto.

The failure to file a written request for review within the one hundred eighty (180) day period shall constitute a waiver of the claimant's right to a review of the denied claim. Such failure shall not, however, preclude the claimant from establishing his entitlement to benefits at a later date based on additional information and evidence which was not available to claimant at the time of decision on review. The failure of a claimant to timely request a
hearing, or the failure of a claimant to appear at a hearing scheduled upon his request, shall constitute a waiver of the claimant's right to a hearing.

Before the Plan issues an adverse benefit determination on review of a disability benefit claim, the Plan 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 disability claim. Such evidence will 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) to give the claimant a reasonable opportunity to respond prior to that date.

Additionally, before the Plan can issue an adverse benefit determination on review of a disability benefit claim based on a new or additional rationale, the claimant will be provided, free of charge, with the rationale. The rationale will 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) to give the claimant a reasonable opportunity to respond prior to that date.

Upon receipt of a request for review the Board shall proceed to review the administrative file, including the request for review and its contents. Review of an adverse determination shall take into account 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. Review of an adverse benefit determination for disability benefits shall not afford deference to the initial benefit determination.

All notices to claimant shall be deemed to have been received by claimant three (3) days after such notice shall have been mailed by first class mail, postage prepaid, addressed to claimant at his last known address appearing in the records of the administrative office.

The Board shall make a decision on review at regularly scheduled meetings held at least quarterly, and a decision on review shall be made no later than the date of the meeting of the Board that immediately follows the administrative office's receipt of the request for review, unless the request for review is filed within thirty (30) days preceding the date of such meeting. In such case, a decision may be made no later than the date of the second meeting following the receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for review, a decision shall be rendered not later than the third meeting of the Board following the administrative office's receipt of the request for review.

If an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension. The Plan shall notify the claimant of the decision of the Board as soon as possible after the meeting, but not later than five (5) days after the decision is made.

The written notice of denial of a disability benefit shall be furnished to the applicant, in a culturally and linguistically appropriate manner. Such notice shall include:

1. the specific reason or reasons for the adverse determination;
2. reference to specific Plan provisions on which the determination is based;
3. a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

   a. the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; or

   b. 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.

4. 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 benefits;

5. a statement of the claimant’s right to bring civil action under ERISA section 502(a) including a description of the two (2) year limitations period that applies to the claimant’s right to bring such an action and the calendar date on which the two (2) year limitations period expires for the claim;

6. 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

7. if the adverse benefit determination on review 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.

(iii) Deemed Exhaustion of Claims and Appeals Rules for Disability Benefits.

Unless it is found to be a “de minimis violation”, if the Plan fails to strictly adhere to all the requirements found in Subsection 9.05(c), then the participant is deemed to have exhausted the administrative remedies under the Plan. “De Minimis” violations are defined as violations that “do not cause, and are not likely to cause, prejudice or harm to the participant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the participant.”

If the participant believes that the Plan failed to strictly adhere to all of the requirements found in this Subsection 9.05(c), the participant may request a written explanation of the violation from the Plan. The Plan will provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted.

If a participant files a lawsuit regarding the participant’s claim or appeal for disability benefits and the court rejects the participant’s request for immediate review on the basis because the court determined that Plan met the requirements of this Subsection 9.05(c)(iii), the claim shall be considered as refiled on appeal upon the Plan’s receipt of the decision by the court. With a reasonable time after the receipt of the decision, the Plan shall provide the participant with notice of the resubmission.
d. The decision on review shall be final and binding upon all parties including the claimant and any person claiming by or under the claimant. The provisions of this section 9.05 shall apply to and include any and every claim to benefits under the Plan and all rights asserted or capable of being asserted thereunder or against the Plan, regardless of the grounds or basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

All other terms and conditions of the Plan shall remain in full force and effect.

Executed this 28 day of March, 2018

[Signature]
Chair

[Signature]
Secretary