AMENDMENT NO. 10
TO THE
RESTATED PLAN DOCUMENT
OF THE
EIGHTH DISTRICT ELECTRICAL PENSION FUND ANNUITY PLAN

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

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:

Effective for claims filed after April 1, 2018, Article 11 shall be amended by deleting Section 11.02 and inserting the in its place:

11.02 Claims Appeal.

No participant, beneficiary or other person shall have any right or claim to benefits under the Plan, or any right or claim to payments from the Fund, other than as specified herein. Any dispute as to eligibility, type, amount or duration of benefits or any right or claim to payments from the Fund shall be resolved by the Board pursuant to the terms of the Plan, and its decision of the dispute, right or claim shall be binding upon all parties thereto. All claims for benefits and appeals of whole or partial denials of benefits shall be determined in accordance with the Plan’s reasonable claims and appeals procedures established by the Board in accordance with Section 2560.503-1 of the Department of Labor Regulations and all other applicable law.

a. Claims and Appeals Procedures for Non-Disability Claims
   i. Initial Claim for Benefits for Non-Disability Claims.

Any person whose application for benefits under the Plan has been denied in whole or in part, or whose claim to benefits or against the Fund is otherwise denied, shall be notified in writing of such denial within 90 days) after receipt of such application or claim. An extension of time not exceeding 90 days) may be required by special circumstances. If so, notice of such extension, indicating what special circumstances exist therefore and the date by which a final decision is expected to be rendered, shall be furnished the claimant prior to the expiration of the initial 90-day period. If notice of denial of a claim is not furnished in accordance with this paragraph, the claims shall be deemed denied and the claimant shall be permitted to proceed to the review stage described below.

The 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 reference to pertinent Plan provisions 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.

Any claimant may petition the Board for a review of the denial. A petition for review shall be in writing, shall state in clear and concise terms the reason or reasons for disputing the denial, shall be accompanied by any pertinent documentary material not already furnished to the Fund, and shall be filed by the claimant or his duly authorized representative with the Administrator of the Fund within 60 days after the claimant received notice of the denial. The claimant or his duly authorized representative shall be provided, upon request and free of charge, copies of and shall have access to and be permitted to review relevant documents and submit issues and comments in writing.

c. Upon good cause shown, the Board shall permit the request for review to be amended or supplemented and shall grant a hearing on the request for review before the Board to receive and hear any evidence or argument. The claimant may be represented at such hearing by an attorney or any other representative of his choosing. The failure to file a petition for review within such 60-day period, shall constitute a waiver of the claimant's right to review of the denial, provided that the Board may relieve a claimant of any such waiver for good cause if application for such relief is made within 120 days after the date shown on the notice of denial. Such failure shall not, however, preclude the applicant or claimant from establishing his entitlement at a later date based on additional information and evidence which was not available to him at the time of the decision. Review of an adverse benefit 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.

The Board shall make a decision on any request for 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 Administrator'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 will be made at 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.

The Plan shall notify the claimant of the decision of the Trustees as soon as possible after the meeting, but not later than five (5) days after the decision is made. Notification of the decision upon review shall be in writing and shall include, written 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).

b. 

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;
   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. 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 Benefits

Any such person may petition the Board for a review of the denial of a disability claim. A petition for review shall be in writing, shall state in clear and concise terms the reason or reasons for disputing the denial, shall be accompanied by any pertinent documentary material not already furnished to the Fund, and shall be filed by the claimant or his duly authorized representative with the Administrator of the Fund within 180 days after the claimant received notice of the denial. The claimant or his duly authorized representative shall be provided, upon request and free of charge, copies of and shall have access to and be permitted to review relevant documents and submit issues and comments in writing.

Upon good cause shown, the Board shall permit the request for review to be amended or supplemented and shall grant a hearing on the request for review before the Board to receive and hear any evidence or argument. The claimant may be represented at such hearing by an attorney or any other representative of his choosing. The failure to file a petition for review within such 180-day period, shall constitute a waiver of the claimant’s right to review of the denial, provided that the Board may relieve a claimant of any such waiver for good cause if application for such relief is made within 180 days after the date shown on the notice of denial. Such failure shall not, however, preclude the applicant or claimant from establishing his entitlement at a later date based on additional information and evidence which was not available to him at the time of the decision. Review of an adverse benefit 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.

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.

The Board shall make a decision on any request for 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 Administrator'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 will be made at 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.

The Plan shall notify the claimant of the decision of the Trustees as soon as possible after the meeting, but not later than five (5) days after the decision is made.

In the case of a claim for disability benefits on appeal, a written notice of the decision upon review 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);
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 that apply to disability claims found in this Section 11.02(b), 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 Section 11.02(b), 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 Section 11.02(b)(iii), the claim shall be considered as refilled 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.

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