AMENDMENT NO. 17
TO THE EIGHTH DISTRICT ELECTRICAL BENEFIT FUND
SUMMARY PLAN DESCRIPTION /PLAN RULES AND REGULATIONS
For Active Employees, Early (non-Medicare-eligible) Retirees and Medicare-eligible Retirees
Effective January 1, 2014

Effective as listed below, the Summary Plan Description/Plan Rules and Regulations is amended as follows:

Effective April 1, 2018, Article XIV, Section 7(b) is deleted in its entirety and replaced as follows:

b. **Adverse Benefit Determination**: For the purpose of the initial and appeal claims processes, an adverse benefit determination is defined as a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit including any such denial, reduction, termination or failure to provide or make a payment that is based on:

- a determination of an individual's eligibility to participate in this Plan; or
- a determination that a benefit is not a covered benefit; or
- a reduction in a benefit resulting from the application of any utilization review (medical review) decision, source of injury exclusion, network exclusion or other limitation on otherwise covered benefits, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or
- any rescission of coverage, including a rescission of disability coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

Effective April 1, 2018, Article XIV, Section 10 is deleted in its entirety and replaced as follows:

Section 10: HOW TO FILE A CLAIM FOR WEEKLY DISABILITY BENEFITS (DISABILITY CLAIM PROCESS)

A claim for disability benefits is a request for weekly disability plan benefits made by you (an individual covered under the Weekly Disability Benefits) or your authorized representative (as defined in this Article) in accordance with the Plan's disability claims procedures, described below in this Article. See also the "Key Definitions" subheading of this Article for a definition of a "claim" and the information on what is and is not considered a claim.

Eligible employees who become totally disabled from an occupational or non-occupational illness or injury should apply (file a claim) for disability benefits within 30 calendar days after the date on which the illness or injury began, according to the following steps:

1. Obtain a disability claim form from the Administrative Office. Complete the patient portion of the form. Then give the form to your physician to complete the health care provider section of the form. Return the completed disability claim form to the Administrative Office at their address listed on the Quick Reference chart in the front of this document. **Disability claims will be determined no later than 45 calendar days after receipt of the claim for disability benefits by the Appropriate Claims Administrator.** (See below for information on extension of this time period.)

2. You will be notified if you did not follow the disability claim process or if you need to submit additional medical information or records to prove a disability claim and provided 45 calendar days in which to obtain this additional information.

   - Proof of disability must be provided to the Plan no later than 90 calendar days after the end of the period for which disability benefits are payable. If you do not provide proof of disability within the time specified, you can still claim full benefits if you can show that proof was furnished as soon as reasonably possible.
   - The Plan reserves the rights to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefit is pending or payable.

3. The Board of Trustees or its designee determines if employees are eligible to receive disability benefits under this Plan. The Plan will review your disability claim and notify you or your authorized representative in writing (or electronically, as applicable) no later than 45 calendar days from the date the Appropriate Claims Administrator receives the claim.

   - This 45-day period may be extended for up to 30 calendar days provided the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period, that additional time is needed to process the claim, the special circumstances for this extension and the date by which it expects to render its determination.
   - If, prior to the end of this first 30 day extension, the Appropriate Claims Administrator determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.
   - A Notice of Extension will 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 the Appropriate Claims Administrator needs additional information from you to make its decision, you will have at least 45 calendar days to submit the additional information. If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.

4. Disability benefits begin when the claim for disability benefits has been determined to meet the definition of total disability under this Plan and it is determined that Plan disability exclusions do not apply to the claim.

5. If the claim for disability benefits is approved, benefit payments will begin.

6. If the claim for disability benefits is denied in whole or in part, a notice of this initial denial (adverse benefit determination), will be provided to the employee in writing and in a culturally and linguistically appropriate manner (or electronically, as applicable). This notice of initial denial will:

   - include the specific reason(s) for the denial;
   - a copy of the specific Plan provision(s) on which the determination is based;

- describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- provide an explanation of the Plan's appeal procedure along with time limits;
- contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, the denial will include a copy of the specific internal rule, guideline, protocol or criteria that was relied upon or alternatively, a statement that such rule, guideline, protocol ,standard or other similar criteria of the Plan do not exist; and
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment tor the denial will be provided free of charge to you, upon request.
- discuss the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by the participant to the Plan of health care professionals treating the participant 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 participant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - A disability determination regarding the participant presented by the participant to the Plan made by the Social Security Administration
- A statement that the participant 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 participant's claim for benefits.

7. If you disagree with the denial of a disability claim, you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section 11: APPEAL OF A DENIAL OF A DISABILITY CLAIM

Appeals must be in writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document. You will be provided with:

- the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- free of charge, 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) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you 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 you a reasonable opportunity to respond prior to that date.

- the opportunity to submit written comments, documents, records and other information relating to the claim for bene fits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. The Plan then will make a determination as follows:
   - no later than the date of the Board of Trustees meeting that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 calendar days preceding the date of such meeting. In such case, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of the request for review.
   - If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be made no later than the third meeting of the Board following the Plan's receipt of the request for review.
   - If such an extension is necessary the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
   - The Plan will notify you of the benefit determination on the appeal no later than five (5) calendar days after the benefit determination is made.
2. The Plan may obtain a 45-day extension if you are notified of the need and reason for an extension before expiration of the initial 45-day period. (If a period of time is extended due to failure to submit information, the time period is lolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
3. You will receive a notice of the appeal determination in a culturally and linguistically appropriate manner. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;

- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- a statement that you have the right to bring civil action under ERISA section 502(a) following the appeal. This statement will also describe any applicable contractual limitations period that applies to the participant's right to bring such action, including the calendar date on which the contractual limitations period expires for the claim;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a copy of such rule, guideline, protocol or criteria that was relied upon; or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; ;
- A discussion of the decision, including an explaining of the basis for disagreeing with or not following:
  - The views presented by the participant to the Plan of health care professionals treating the participant 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 participant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - A disability determination regarding the participant presented by the participant to the Plan made by the Social Security Administration
- A statement that the participant 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 participant's claim for benefits.
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free or charge to you, upon request

4. Unless it is found to be a "de minimis violation", if the Plan fails to strictly adhere to all the requirements found in Sections 10 and 11 of this Article XIV, 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 Section 10 and 11 of this Article XIV, 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 11(4), 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.

5. This concludes the disability appeal process under this Plan.

CONFIRMATION

The undersigned Chair and Secretary of the Board of Trustees of the Eighth District Electrical Benefit Fund do hereby certify that the foregoing Amendment #17 to the 2014 Plan was duly adopted and executed at a meeting of the Board of Trustees called and held on March 29, 2018.

By: _____
Chair

By: _____
Secretary