

**SEVENTH AMENDMENT
TO THE
BUILDING TRADES PENSION FUND
OF WESTERN PENNSYLVANIA
(As Amended and Restated January 1, 2014)**

WHEREAS, the Board of Trustees has the right to amend the Building Trades Pension Fund of Western Pennsylvania, as amended and restated January 1, 2014 (the "Plan"); and

WHEREAS, the U.S. Department of Labor has issued final regulations revising the claims procedures for disability benefits effective April 1, 2018.

NOW, THEREFORE, the Board of Trustees hereby amends Section 9.04 of the Plan, effective April 1, 2018, to read as follows:

9.04 Claims, Appeals and Review Procedure

- (a) Claims for benefits under the Plan shall be filed in accordance with the procedures established for this purpose and on forms made available upon request.
- (b) A claim for benefits shall be decided by the Administrative Manager within a reasonable period of time following the Plan's receipt of the claim, but not later than 90 days after receipt. The Administrative Manager shall notify the Board of Trustees of the decision.
- (c) If special circumstances require, the initial 90-day period to consider a claim may be extended for up to an additional 90 days. Written (or electronic) notice of an extension shall be provided to the claimant before the end of the applicable prior period. Such notice shall indicate the circumstances requiring the extension and the date by which the Plan expects to decide the claim.
- (d) If a claim for benefits is wholly or partially denied:
 - (1) Written (or electronic) notice of the denial shall be provided to the claimant by the date established by subsections (b) and (c) of this Section to decide the claim.
 - (2) The denial notice shall set forth (i) the specific reasons for the denial, (ii) specific references to the pertinent provisions of the Plan, (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation why it is necessary, (iv) an explanation of the procedures for review of the denied claim, including the applicable time limits, and (v) a statement of the claimant's right to bring a civil action under ERISA following an adverse determination upon review.
- (e) A claimant may appeal a denial of benefits to the Board of Trustees for review. Such appeal shall be made in writing no later than 60 days of the date of the denial. An appeal shall set forth all of the reasons the claim should not have been denied and identify and include all of the issues related to the claim for

benefits. A claimant shall be entitled to review all documents, records and other information relevant to the claim and to receive copies free of charge and to submit written documents, records and other information related to the claim and have the same taken into account whether or not previously submitted or considered.

- (f) If an appeal is timely filed, the Board of Trustees shall conduct a full and fair review of the claim and provide written (or electronic) notice of its decision on review to the claimant.
- (g) For so long as the Board of Trustees holds regularly scheduled meetings at least quarterly, the decision on review shall be made no later than the date of the first meeting of the Board of Trustees that follows the receipt of the application for review from the claimant. However, if received within 30 days preceding the date of the first meeting, the decision shall be made no later than the date of the second meeting of the Board of Trustees that follows the receipt of the application for review. If special circumstances require a further extension of time for processing, the decision on review shall be made no later than the third meeting of the Board of Trustees that follows the Plan's receipt of the request for review. A written (or electronic) notice of such extension that describes the special circumstances and the date by which the Board of Trustees expects to decide the request for review shall be provided to the claimant before the commencement of any such extension. Written (or electronic) notice of the Board of Trustees' decision on review shall be provided to the claimant within five days of the meeting at which the decision is made.
- (h) If the Board of Trustees does not hold regularly scheduled meetings at least quarterly, the decision on review shall be made and written (or electronic) notice of the Board of Trustees decision provided to the claimant within a reasonable period of time following the receipt of the application for review from the claimant, but not later than 60 days after receipt. If special circumstances require, said initial 60-day period may be extended by an additional 60 days. A written (or electronic) notice of such extension that describes the special circumstances and the date by which the Board of Trustees expects to decide the request for review shall be provided to the claimant before the commencement of any such extension.
- (i) If the Board of Trustees' decision on the review of an appeal is adverse, the notice of the decision shall set forth (i) the specific reasons for the decision, (ii) specific references to the pertinent provisions of the Plan, (iii) a statement that the claimant is entitled to review all documents, records and other information relevant to the claim and to receive copies free of charge, and (iv) a statement of the claimant's right to bring a civil action under ERISA.
- (j) At the claimant's expense, a duly authorized representative of a claimant may act on behalf of the claimant in filing a claim for benefits or requesting a review of any denial thereof. The Board of Trustees may establish reasonable procedures for determining whether an individual has been duly authorized to act on behalf of a claimant.

- (k) The following provisions apply to a claim related to a Disability Benefit filed before April 1, 2018 and shall modify any contrary provisions in subsections (a) through (j) of this Section and be in addition thereto:
- (1) The claim for the Disability Benefit shall be decided by the Chairman and Secretary of the Board of Trustees, and if they do not agree on the Disability Benefit claim, the claim shall be deemed denied and appropriate notice of the denied claim given to the Participant.
 - (2) A claim for the Disability Benefit shall be decided not later than 45 days after receipt of the claim.
 - (3) The initial 45-day period to consider the Disability Benefit claim may be initially extended for up to an additional 30 days and then for up to an additional 30 days after the initial extension if, in each case, the extension is necessary due to matters outside the control of the Plan. In addition to the circumstances requiring the extension and the date by which the Plan expects to decide the claim, the notice of such extension shall also explain (i) the standards on which entitlement to the benefit is based, (ii) the unresolved issues that prevent a decision on the claim, and (iii) any additional information needed to resolve said issues.
 - (4) If the reason for extending a period to decide the Disability Benefit claim is due to the claimant's failure to submit information necessary to decide the claim, the claimant shall be so notified and shall be provided with at least a 45-day period to provide the material or information. In such case, the period to decide said claim shall be tolled until the date the claimant responds to the request for additional information.
 - (5) The denial notice for the Disability Benefit claim shall include (i) any internal rule, guideline, protocol or other similar criterion relied on for the denial, or a statement that it was relied on and a copy will be provided free of charge upon the claimant's request and (ii) if the denial was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the plan terms to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon the claimant's request.
 - (6) A claimant may appeal a denial of a claim for the Disability Benefit to the Board of Trustees no later than 180 days of the date of the denial.
 - (7) For a review of the Disability Benefit claim on appeal:
 - (A) The review shall be made by the Board of Trustees other than the Chairman and Secretary of the Board of Trustees, and it shall not afford any deference to the initial benefit determination.
 - (B) If the initial benefit determination was based on a medical judgment, the determination shall be made after consultation with a health care professional who has appropriate training and

experience in the relevant field of medicine. Said health care professional shall not be an individual who was consulted with respect to the initial benefit determination or a subordinate of that individual.

- (C) It shall provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied on in making the determination.
- (8) When the Board of Trustees does not hold regularly scheduled meetings at least quarterly, the decision on review of a Disability Benefit claim on appeal shall be made and written (or electronic) notice of decision provided to the claimant not later than 45 days after receipt. If special circumstances require, said initial 45-day period may be extended by an additional 45 days.
- (9) The notice of an adverse decision on review of a Disability Benefit claim on appeal shall include (i) any internal rule, guideline, protocol or other similar criterion relied on for the decision, or a statement that it was relied on and a copy will be provided free of charge upon the claimant's request and (ii) if the decision was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision, applying the plan terms to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon the claimant's request.
- (I) The following provisions apply to a claim related to a Disability Benefit filed on or after April 1, 2018 and shall modify any contrary provisions in subsections (a) through (j) of this Section and be in addition thereto:
 - (1) The claim for the Disability Benefit shall be decided by the Chairman and Secretary of the Board of Trustees, and if they do not agree on the Disability Benefit claim, the claim shall be deemed denied and appropriate notice of the denied claim given to the Participant.
 - (2) A claim for the Disability Benefit shall be decided not later than 45 days after receipt of the claim.
 - (3) The initial 45-day period to consider the Disability Benefit claim may be initially extended for up to an additional 30 days and then for up to an additional 30 days after the initial extension if, in each case, the extension is necessary due to matters outside the control of the Plan. In addition to the circumstances requiring the extension and the date by which the Plan expects to decide the claim, the notice of such extension shall also explain (i) the standards on which entitlement to the benefit is based, (ii) the unresolved issues that prevent a decision on the claim, and (iii) any additional information needed to resolve said issues.
 - (4) If the reason for extending a period to decide the Disability Benefit claim is due to the claimant's failure to submit information necessary to decide

the claim, the claimant shall be so notified and shall be provided with at least a 45-day period to provide the material or information. In such case, the period to decide said claim shall be tolled until the date the claimant responds to the request for additional information.

- (5) The denial notice for the Disability Benefit claim shall include:
 - (A) A discussion of the decision to deny the claim, including an explanation of the basis for disagreeing with or not following (i) any views presented by the claimant of a health care professional treating the claimant or a vocational professional who evaluated the claimant, (ii) the views of medical or vocational experts whose advice was obtained by the Plan in connection with a denial of the claim, without regard to whether the advice was relied upon, and (iii) any determination of disability by the Social Security Administration presented by the claimant (in any case where said disability determination does not establish the Participant's Disability).
 - (B) If the denial was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the plan terms to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon the claimant's request.
 - (C) Either the internal rules, guidelines, protocols, standards, or other similar criterion relied on for the denial, or alternatively, a statement that internal rules, guidelines, protocols, standards, or other similar criterion do not exist.
 - (D) A statement that the claimant is entitled to review all documents, records and other information relevant to the claim and to receive copies free of charge.
- (6) A claimant may appeal a denial of a claim for the Disability Benefit to the Board of Trustees no later than 180 days of the date of the denial.
- (7) For a review of the Disability Benefit claim on appeal:
 - (A) The review shall be made by the Board of Trustees other than the Chairman and Secretary of the Board of Trustees, and it shall not afford any deference to the initial benefit determination.
 - (B) If the initial benefit determination was based on a medical judgment, the determination shall be made after consultation with a health care professional who has appropriate training and experience in the relevant field of medicine. Said health care professional shall not be an individual who was consulted with respect to the initial benefit determination or a subordinate of that individual. No decision related to the retention of said health care

professional shall be based on the likelihood that the health care professional will support a denial of the Disability Benefit claim.

- (C) It shall provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied on in making the determination.
 - (D) If any new or additional evidence is considered, relied upon, or generated by the Plan upon review (or by any other person acting at the direction of the Plan), such evidence shall be provided to the claimant free of charge as soon as possible and sufficiently in advance of the date on which the decision on review is required to be made to give the claimant a reasonable opportunity to respond prior to that date. No adverse decision on appeal shall be issued before such evidence is provided to the claimant.
 - (E) If a new or additional rationale is considered by the Plan upon review, such rationale shall be provided to the claimant free of charge as soon as possible and sufficiently in advance of the date on which the decision on review is required to be made to give the claimant a reasonable opportunity to respond prior to that date. No adverse decision on appeal shall be issued before such rationale is provided to the claimant.
- (8) When the Board of Trustees does not hold regularly scheduled meetings at least quarterly, the decision on review of a Disability Benefit claim on appeal shall be made and written (or electronic) notice of decision provided to the claimant not later than 45 days after receipt. If special circumstances require, said initial 45-day period may be extended by an additional 45 days.
- (9) The notice of an adverse decision on review of a Disability Benefit claim on appeal shall include:
- (A) A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) any views presented by the claimant of a health care professional treating the claimant or a vocational professional who evaluated the claimant, (ii) the views of medical or vocational experts whose advice was obtained by the Plan in connection with the decision, without regard to whether the advice was relied upon, and (iii) any determination of disability by the Social Security Administration presented by the claimant (in any case where said disability determination does not establish the Participant's Disability).
 - (B) If the decision was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the plan terms to the claimant's medical circumstances, or a statement that

such explanation will be provided free of charge upon the claimant's request.

- (C) Either the internal rules, guidelines, protocols, standards, or other similar criterion relied on for the decision, or alternatively, a statement that internal rules, guidelines, protocols, standards, or other similar criterion do not exist.
 - (D) A description of the applicable limitations period under subsection (n) of this Section including the date on which the period expires for the claim.
- (10) The denial notice for a Disability Benefit claim and the notice of an adverse decision on appeal shall be provided in a culturally and linguistically appropriate manner to the extent and in the manner required by Department of Labor Regulations under ERISA § 503.
- (11) If there is a violation of the claims procedures required by Department of Labor Regulations under ERISA § 503 that the claimant believes should result in a deemed exhaustion of administrative remedies with respect to a Disability Benefit claim, the claimant may request a written explanation of the violation from the Plan, and the Plan shall provide an explanation within 10 days, including a specific description of any basis for asserting that the violation should not cause the administrative remedies to be deemed exhausted. If such claimant brings a legal action under ERISA on the basis that a violation of the claims procedures resulted in a deemed exhaustion of administrative remedies, and if the court rejects the action, in the manner required by the Department of Labor Regulations, the claim shall be considered as re-filed on appeal upon the receipt by the Plan of the decision of the court, and the Plan shall provide the claimant with notice of the resubmission.
- (m) A benefit denial includes a reduction or termination of a benefit and a failure to provide a benefit based on a determination of ineligibility to participate in the Plan, and with respect to a disability benefit, includes a rescission (a retroactive cancellation or discontinuance) of disability coverage.
- (n) Effective January 1, 2015, no legal action can be taken against the Plan or the Board of Trustees more than one year after a claim for benefits has been made. For this purpose, a claim for benefits is deemed to have been made on: (i) the date an application for benefits is denied on review by the Board of Trustees, if the claim is to recover benefits not paid by the Plan; (ii) the date benefits are suspended, if the claim is to recover benefits suspended under the Plan; or, (iii) the date of the benefit statement that was provided for the applicable period of Service, if the claim is in regard to the Board of Trustees' (or designee's) computation of service and benefits under the Plan.

IN WITNESS WHEREOF, this Amendment has been duly executed on this 9th day of January, 2018.

Union Trustee

Employer Trustee

By: Norman Ringer

By: Paul [Signature]