The following Claim Procedures replace those in the Summary Plan Description, effective for claims filed on or after April 1, 2018:

XIV. Claim Procedures

What Is a Claim?

These procedures only apply to a “claim for benefits.” A claim for benefits under the Plan arises only if you have filed a written request for a benefit determination with the Plan Administrator. To make a claim for benefits, you must submit the Plan’s benefit claim application form, including information required by the form and all requested attachments, to the Administrative Office. Contact the Administrative Office for a copy of the form.

What is Not a Claim?

Certain casual inquiries or questions regarding the eligibility conditions for, or the availability of, benefits, or the circumstances under which benefits might be paid under the terms of the Plan, made without filing a claim on the Plan’s application form are not subject to the time limits that apply to claims, described below, and carry no right to appeal.

Where to File a Claim?

Claims must be received by the Plan Administrator, located at:

Board of Trustees  
c/o Administrative Office Idaho Plumbers and Pipefitters Pension Plan  
1220 SW Morrison Street, Suite 300  
Portland, Oregon 97205  
(208) 288-1610  
Toll-free: (800) 808-1687

Claim and Appeal Procedures

The following sets forth the Plan’s timelines for deciding your claim, and your appeal rights if your claim for benefits is denied. Please note that there are special rules that apply to a claim that requires a determination of disability (“disability claim”), which for purposes of these procedures means any claim that requires the Plan Administrator to make a determination regarding whether you are disabled (within the meaning of the particular Plan provision at issue). A disability claim can include a rescission of a determination you are disabled. A disability claim does not include a claim in which disability is based solely on an external standard, such as entitlement to Social Security Disability Benefits.
All references to Plan Administrator in these claim procedures include any designee allocated claim administration responsibilities by the Plan Administrator, or such other person or entity specified in applicable Plan documents.

Your authorized representative may file a claim or appeal a denied claim on your behalf. For purposes of these procedures, your “authorized representative” is any individual you authorize in writing to act on your behalf, or any individual authorized by court order to submit claims on your behalf.

**General Provisions Applicable to Disability Claims**

If you live in a county where 10 percent or more of the population is literate only in the same non-English language, as determined by applicable federal guidance:

- Oral language services such as a telephone hotline in the applicable non-English language will be available to answer questions and assist in filing claims and appeals;

- Upon request, the Plan will provide a claim or appeal denial notice in the applicable non-English language; and

- The Plan will include in the English version of all claim and appeal denial notices a statement in the applicable non-English language clearly indicating how to access the language services.

The Plan ensures that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the person involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be based upon the likelihood that the person will support a denial of benefits.

If the Plan fails to adhere to all the requirements of the claims review process, you may be deemed to have exhausted the internal claims and appeal process. A deemed exhaustion, however, does not occur if violations of the claims review process are *de minimis* violations that do not cause, and are not likely to cause prejudice or harm to you so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between you and the Plan. You may request a written explanation of the violation from the Plan, which must be provided within 10 days, including the bases for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. In case there is a deemed exhaustion, you may also be entitled to remedies under Section 502 of ERISA by filing a case in court. Unless otherwise specified herein, you are required to exhaust the internal claim and appeal process before filing a lawsuit.

**Pension or Disability Claim Determinations**
Timing of written notice of benefit determination – Benefit Claims Other Than Disability Claims

If your claim is other than a disability claim, a written denial notice will generally be provided to you within 90 days after the date your claim is received by the Plan Administrator. However, if special circumstances require an extension of time for processing the claim beyond the initial 90-day period, written notice of the extension will be furnished to you before the end of the initial 90-day period. An extension of time will not exceed a period of 90 days from the end of the initial 90-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

Timing of written notice of benefit determination - Disability Claims

If your claim is a disability claim, a written denial notice will be provided to you within a reasonable period of time, but not later than 45 days after receipt of your claim by the Plan Administrator. If matters beyond the control of the Plan Administrator require an extension of the time for processing your disability claim, the initial period may be extended for up to 30 days. Written notice of an extension will be sent before the end of the initial 45-day period. In addition, another 30-day extension of time for processing your claim due to matters beyond the control of the Plan Administrator may be taken. Written notice of such second extension will be sent before the end of the first 30-day extension period. The extensions shall not exceed a period of 60 days from the end of the initial 45-day period.

An extension notice will explain the reasons for the extension, the expected date of a decision, the standards for a benefit entitlement, any unresolved issues that prevent a decision on your claim, and any additional information needed to resolve those issues. If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days).

Contents of Written Notice of Benefit Denial

If your claim for a benefit is denied, you will be notified in writing by the Plan Administrator. The written notice will include the following:

- the specific reason or reasons for the denial;
- references to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary in order for you to perfect the claim, and an explanation of why such material or information is needed;
- an explanation of the Plan’s review procedure for denied claims, including the applicable time limits for submitting your claim for review; and
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- a statement of your right to bring a civil action under Section 502(a) of ERISA if your claim is denied on appeal; and

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all Relevant Documents (defined below).

In addition, if your claim is a disability claim, the written notification will also include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views you presented to the Plan of health care professionals that treated you and vocational professionals that evaluated you, (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the decision, without regard to whether the advice was relied upon in making the decision, and (3) any disability determination made by the Social Security Administration about you, which you presented to the Plan;

- a copy of any internal rule, guideline, protocol, standard, or other similar criterion of the Plan that was relied upon in deciding your claim for benefits, or a statement that such does not exist; and

- if the decision was based on a medical necessity or experimental treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request.

Appeal Procedures

Procedure for appeal of denied claim – Benefits Other Than Disability Claims

If you wish to appeal an initial denial of a claim for benefits other than disability benefits, you or your authorized representative must file a written appeal with the Plan Administrator within 60 days after receipt of written notice of the denial.

You or your authorized representative may submit written comments, documents, records, and other information relating to the claim. You may also, free of charge and upon request, have reasonable access to and copies of Relevant Documents. The review will consider all comments, documents, and other information submitted by you or your authorized representative relating to the claim, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with Plan documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants.

The Board of Trustees, as the Plan Administrator and claims fiduciary, reviews appeals of denied claims and makes final determinations. The Board of Trustees has full discretionary authority, including power to administer, construe and interpret the terms and provisions of the Plan, SPD and Trust Agreement, and other Plan documents, and to determine eligibility for benefits under
the Plan, and any decision of the Board of Trustees on such matters is final and binding and shall be subject to the fullest deference provided by law.

**Procedure for appeal of denied claim – Disability Claims**

The appeal procedures set out above for benefits other than disability claims apply to disability claims except that you have 180 days instead of 60 days in which to appeal a denial of a claim with the Plan Administrator. In addition, the following apply to disability claims:

- the appeal decision will not defer to the initial decision denying your claim and will be made by the Plan Administrator who is not a person who made the initial decision, nor a subordinate of such person;

- if the initial denial decision was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- any health care professional engaged for such consultation will not be a person consulted in the initial decision, nor a subordinate of any such person;

- any medical or vocational expert whose advice was obtained in connection with the decision to deny your claim will be identified upon request, whether or not the advice was relied upon; and

- you will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan or at the direction of the Plan in connection with the disability claim, and any new or additional rationale on which the appeal decision is based. Such information will be provided as soon as possible and sufficiently in advance of the date the appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date.

**Timing of written notice of appeal decision**

If the Board of Trustees holds regularly scheduled meetings at least quarterly, the decision on your appeal generally will be made at the next regularly scheduled meeting after the appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled meeting after your appeal is received. Written notice of any extension of time will be sent before it commences explaining the reason for the extension and the expected date of the appeal determination. Notice of the appeal decision will be provided not later than five days after the decision is made.

If the Board of Trustees does not hold regularly scheduled meetings at least quarterly, a decision on your appeal will be made no later than 60 days (45 days, if you are appealing a denied disability claim) after your appeal is received, unless there are special circumstances that require an
extension of time for processing your appeal, in which case a decision will be made not later than 120 days (90 days, if you are appealing a denied disability claim) after your appeal is received. Written notice of any extension of time will be sent before the end of the initial 60-day period explaining the reason for the extension and the expected date of an appeal decision.

If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

**Hearing on Appeal**

Within a reasonable time after receipt of your appeal, you will be notified of the date, time, and place of the appeal hearing by regular mail addressed to your address as shown on your appeal. You may request to be present at the hearing before the Board of Trustees. You may be represented by an attorney or by any other representative of your choosing. The proceedings at the hearing may be recorded by a method determined by the Board of Trustees. In conducting the hearing, the Board of Trustees will not be bound by the usual common law or statutory rules of evidence. Copies of all documents and records introduced at the hearing and all other Relevant Documents will be attached to the record of the hearing and will be part of the record.

**Contents of written notice of appeal decision**

If your claim is denied on appeal, the decision on review will be in writing and will include the following information:

- the specific reason or reasons for the decision;
- reference to the specific Plan provisions on which the decision is based;
- a statement of your right to receive, upon request free of charge, reasonable access to and copies of all Relevant Documents; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA, including a statement of the Plan’s limitations period that applies and the calendar date on which the limitations period expires for the claim.

In addition to the above information, in the case of a disability claim, the written decision on review will also include:

- a copy of any internal rule, guideline, standard, protocol or other similar criterion that was relied upon in deciding your claim for benefits on review, or a statement that such does not exist;
- if the decision on review 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
determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request; and

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views you presented to the Plan of health care professionals that treated you and vocational professionals that evaluated you, (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the decision, without regard to whether the advice was relied upon in making the decision, and (3) any disability determination made by the Social Security Administration about yourself, which you presented to the Plan.

**Relevant Documents**

“Relevant Document” means any document, record or other information that:

- was relied upon in making a decision to deny benefits;
- was submitted, considered, or generated in the course of making the decision to deny benefits, whether or not it was relied upon in making the decision to deny benefits;
- demonstrates compliance with any administrative processes and safeguards designed to confirm that the benefit determination was in accord with the Plan and that Plan provisions, where appropriate, have been applied consistently regarding similarly situated individuals; or
- if your claim is a disability claim, constitutes a statement of policy or guidance with respect to the Plan concerning a denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the decision to deny benefits.

**Limitations on when a lawsuit may be filed**

You may not file a lawsuit to obtain benefits until you have exhausted all of the claim and appeal procedures and a final decision has been made on your appeal, or until the appropriate time frame described above has elapsed without a final decision being rendered on your claim or appeal for benefits. In order to file a lawsuit against the Plan, the Trust Fund, the Plan Administrator, or any of the Trustees, you must file suit within two years after your appeal is denied or, if earlier, within two years after the date your cause of action first accrued.

These procedures are intended to comply with ERISA § 503 and Regulations developed by the United States Department of Labor at 29 CFR § 2560.503-1 effective for benefit claims filed with the Administrative Office on and after April 1, 2018.