

**AMENDMENT NO. 2
TO THE
ELECTRICAL WORKERS LOCAL NO. 292 DEFINED CONTRIBUTION AND 401(K)
PLAN
(Amended and Restated as of October 20, 2003)**

WHEREAS, Section 11.1 (AMENDMENT) of the Electrical Workers Local No. 292 Defined Contribution and 401(k) Plan (Amended and Restated as of October 20, 2003) (the "Plan Document") provides that the Trustees may amend the Plan Document;

WHEREAS, the Trustees wish to amend the plan to reflect the requirements of the U.S. Department of Labor Regulations regarding the timing, manner, and content of notifications of benefit determination and regarding what constitute a full and fair review of an adverse benefit determination;

NOW THEREFORE, BE IT RESOLVED, that the Plan Document is hereby amended as follows:

1. ***Section 8.2 (CLAIMS PROCEDURE) of ARTICLE EIGHT (ADMINISTRATION OF THE PLAN) of the Plan Document is hereby deleted in its entirety and replaced by the following:***

8.2. CLAIMS PROCEDURE.

(a) **Claim for Benefits.**

- (1) A claim for benefits may only be made by delivering a written application to the Administrative Manager at the Fund Office. The Board of Trustees reserves the right to require the application to include a claim form that is available from the Fund Office.
- (2) Within 90 days after receiving a complete application for a benefit other than a disability benefit, the Plan will notify the claimant of (1) the claim decision or (2) a 90-day extension of the claim decision required by special circumstances (as well as a description of the special circumstances and the expected decision date). Within any such extension period, the Plan will notify the claimant of the claim decision.
- (3) Within 45 days of receiving a complete application for a disability benefit, the Plan will notify the claimant of (1) the claim decision or (2) a 30-day extension of the claim decision required by matters beyond the Plan's control (as well as a description of the circumstances requiring the

extension and the expected decision date). Within any such extension period, the Plan will notify the claimant of (1) the claim decision or (2) an additional 30-day extension of the claim decision required because the Plan needs additional information from the claimant (as well as a description of the circumstances requiring the extension and the expected decision date). Any such extension will explain the standards required for receiving the benefit, the unresolved issues preventing a claim decision, the additional information needed to resolve those issues, and that the claimant has 45 days to provide any specified information the Plan needs from the claimant.

- (4) If a claim is partly or completely denied, the notice of adverse benefit determination will be written in a manner calculated to be understood by the claimant and will:
- (A) Provide the specific reason the claim was denied;
 - (B) Reference the specific Plan provision(s) on which the determination was based;
 - (C) Describe any additional material or information needed to perfect the claim and will explain why the material or information is necessary;
 - (D) Describe the Plan's review procedures and the time limits for those procedures and indicate that the claimant has the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") if the claim is denied on appeal;
 - (E) If the Plan relied on an internal rule in denying a claim for a disability benefit, either provide a copy of the rule or state that the claimant can obtain a copy of the rule, upon request and free of charge, from the Plan; and
 - (F) If the denial of a claim for disability benefits was based on a medical necessity or experimental treatment or similar exclusion or limit, either provide an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant's medical circumstances) or state that

the claimant can obtain that explanation, upon request and free of charge, from the Plan.

(b) Appeal of Adverse Benefit Determination.

- (1) A claimant will have only 60 days (or, in the case of a claim for disability benefits, 180 days) after receiving notice of an adverse benefit determination to submit a written appeal of the determination to the Administrative Manager at the Fund Office explaining why the determination should be reviewed. In support of the appeal, the claimant (or the claimant's duly authorized representative) may submit written comments, documents, records, and other information relating to the claim for benefits which the claimant believes will support the claim but will not have the right to make a personal appearance before the Trustees or any committee created by the Trustees. Upon request and free of charge, the claimant (or the claimant's duly authorized representative) will receive reasonable access to and copies of all documents, records, and other information relevant to the claim.
- (2) The Trustees reserve the right to refuse to treat an individual as a claimant's duly authorized representative unless the claimant has delivered to the Administrative Manager at the Fund Office a letter explicitly authorizing the individual to serve as the claimant's duly authorized representative.
- (3) The review will be conducted by an Appeals Committee (or, if none has been appointed, by the Board of Trustees acting as an Appeals Committee). The review will take into account all comments, documents, records, and other information the claimant submits relating to the claim regardless of whether they were submitted before the adverse benefit determination.
- (4) If the appeal relates to a claim for disability benefits, the review will not be conducted by anyone that made the adverse benefit determination or who reports to the individual or committee that made the adverse benefit determination, and the review will not afford deference to the adverse benefit determination. If the appeal relates to an adverse benefit determination that was based at least in part on a medical judgment (including a judgment about whether a particular treatment, drug, or other item is experimental, investigational, or not medically appropriate or necessary),

the Appeals Committee will consult with a healthcare professional who is training and experienced in the field of medicine involved in that medical judgment and who was not consulted in connection with the adverse benefit determination and who does not report to anyone who was so consulted. Upon request, the Plan will identify any healthcare professional that the Appeals Committee consulted in relation to the claim

- (5) The Appeals Committee will review the appeal at its next regularly scheduled meeting after the Administrative Manager receives the appeal, unless the Administrative Manager receives the appeal within 30 days of that meeting. In that case, the Appeals Committee will review the appeal at the second regularly scheduled Appeals Committee meeting after the Administrative Manager receives the appeal. If special circumstances require a further extension of time for processing, the Plan will notify the claimant of the extension in writing (describing the special circumstances and the expected decision date) before the extension begins, and the Appeals Committee will review the appeal no later than the third regularly scheduled Appeals Committee meeting after the Administrative Manager receives the appeal.
- (6) Once the Appeals Committee reviews the appeal, the Plan will notify the claimant (or the claimant's duly authorized representative, if any) of the appeal decision within 5 days.
- (7) If the appeal is partly or completely denied, the notification of adverse benefit determination on review will be written in a manner calculated to be understood by the claimant and will:
 - (A) Provide the specific reason or reasons for the denial of the appeal;
 - (B) Reference the specific Plan provisions on which the denial is based;
 - (C) State that the claimant has the right to receive, upon request and free of charge, reasonable access and copies of all documents, records, and other information relevant to the claim;
 - (D) State the claimant has the right to bring a civil action under Section 502(a) of ERISA;

- (E) If the Plan relied on an internal rule in denying an appeal for a disability benefit, either provide a copy of the rule or state that the claimant can obtain a copy of the rule, upon request and free of charge, from the Plan; and
 - (F) If an appeal for disability benefits was denied based on a medical necessity or experimental treatment or similar exclusion or limit, either provide an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant's medical circumstances) or state that the claimant can obtain that explanation, upon request and free of charge, from the Plan.
- (8) The procedures described in this Section will be the sole and exclusive procedures available to a participant, beneficiary, or any other person who is dissatisfied with an eligibility determination or benefit award or who is otherwise adversely affected by any action of the Trustees or of any committee created by the Trustees."

This amendment will be effective December 1, 2004.

IN WITNESS WHEREOF, the undersigned being all the Trustees of the Electrical Workers Local No. 292 Defined Contribution and 401(k) Plan hereby adopt and approve this amendment this 18th day of November 2004.

UNION TRUSTEES

EMPLOYER TRUSTEES

