California Field Ironworkers Pension Trust
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PENSION CLAIMS APPEAL PROCEDURES

Effective January 1, 2002, the Plan has new claims and appeals procedures, which are described below.

I. Filing A Claim

Your application for benefits must be made in writing on a form established by the Board of Trustees and must be filed with the Trust Office prior to the payment of any benefits.

Your application will not be considered complete until the Trust Office receives all the information required by that application.

Your claim will be considered filed when your application is received by the Trust Office, without regard to whether all information necessary to make a benefit determination accompanies your application. If all necessary information does not accompany your application, the Trust Office will notify you, in writing, of:

1. The standards on which entitlement to benefits is based;

2. The unresolved issues that prevent a decision on the claim; and

3. The additional information needed to resolve those issues.

Determining Initial Claim

Benefits Other Than Disability Benefits Under Either Article III, Section 6(b) or Article VI, Section 4(c) of the Plan[1]:

The initial determination of benefits will be made within a reasonable period of time but not later than 90 calendar days after the Trust Office receives your application for benefits and all required information. (If all the required information is not received with your application, the 90-day period for making the initial determination will be suspended during the time you are obtaining the additional information.)

If the Trust Office determines that special circumstances require an extension of time for processing the claim, the Trust Office will notify you, in writing, prior to the expiration of the 90 days of the circumstances requiring the extension of time and the date by which the Plan expects

[1] The Disability Pension (Article III, Section 6(b)) is based not only on findings of disability made by the Social Security Administration, but is also based on a determination of disability made by the Board of Trustees.

Article VI, Section 4(c) of the Plan provides for the granting of disability credits for a period of absence from Covered Employment due to a disability. Such disability is determined by the Board of Trustees.

to make a determination. The extension cannot be more than 90 calendar days from the end of the initial 90-day period.

Disability Benefits Under Either Article III, Section 6(b) or Article VI, Section 4(c) of the Plan:

The initial determination of benefits will be made within a reasonable period of time but not later than 45 calendar days after the Trust Office receives your application for benefits and all required information. (If all the required information is not received with your application, the 45-day period for making the initial determination will be suspended during the time you are obtaining the additional information.)

The initial 45-day period may be extended for up to 30 calendar days, to a total of 75 calendar days, if an extension of time is necessary due to matters beyond the Plan's control. The Trust Office will notify you, in writing, prior to the expiration of the initial 45-day period of the circumstances requiring the extension of time and the date by which the Plan expects to make a determination.

If the Plan needs a second extension of time to make a determination due to circumstances beyond its control, you will be notified of an additional extension of up to 30 calendar days, or a maximum of 105 calendar days after the initial receipt of your application. Before the end of the first 30-day extension period, the Trust Office will notify you, in writing, of the circumstances requiring the extension and will give you the new date by which a determination will be made.

If an application for benefits is not acted on within these time periods, you may proceed to the appeal procedures as if the claim had been denied.

II. Notice of Claim Denial

If the Plan denies your application for benefits, in whole or in part, you will be notified in writing of the determination and be given the opportunity for a full and fair review of the benefit decision. The written notice of denial will include:

1. The specific reason(s) for the denial;

2. The specific reference to pertinent Plan provision(s) on which the denial is based;

3. A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your rights to bring civil action under §502(a) of ERISA following an adverse benefit determination on review; and

5. For a claim for disability benefits under either Article III, Section 6(b) or Article VI, Section 4(c) of the Plan: If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy of that document will be provided to you free of charge upon request.

Right to Appeal

If you apply for benefits and your claim is denied, or if you believe that you did not receive the full amount of benefits to which you are entitled, you have the right to petition the Board of Trustees for reconsideration of its decision. Your petition for reconsideration:

1. Must be in writing; and

2. Must state in clear and concise terms the reason(s) for your disagreement with the decision of the Board of Trustees; and

3. May include documents, records, and other information related to the claim for benefits; and

4. Must be filed by you or your authorized representative with the Trust Office within 60 days after you received notice of denial. In the case of a claim for disability benefits under either Article III, Section 6(b) or Article VI, Section 4(c) of the Plan, your petition for reconsideration must be file with the Trust Office within 180 days after you received notice of denial. Failure to file an appeal within these time limits will constitute a waiver of your rights to a review of the denial of your claim. A late application may be considered if the Board of Trustees finds that the delay in filing was for reasonable causes.

Upon request, you will be provided, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits; including, in the case of a claim for disability benefits under either Article III, Section 6(b) or Article VI, Section 4(c) of the Plan, any statement of policy or guidance with respect to the Plan concerning the denial of such disability benefits, without regard to whether such advise or statement was relied upon in making the benefit determination.

III. Review of Appeal

A properly filed appeal will be reviewed by the Board of Trustees (or by a committee authorized to act on behalf of the Board of Trustees) at its next regularly scheduled quarterly meeting. However, if the appeal is received within 30 days prior to such meeting, the appeal may be reviewed at the second quarterly meeting following the receipt of your appeal. If special circumstances require an extension of time, the Board of Trustee will render a decision at the third scheduled quarterly meeting following the receipt of your appeal. The Trust Office will notify you, in writing, before the beginning of the extension of the special circumstances and the date that the Board of Trustees will make its decision.

The Board of Trustees will review all submitted comments, documents, records and other information related to your claim, regardless of whether the information was submitted or considered in the initial benefit determination. The Board of Trustees will not give deference to the initial adverse benefit determination.

In deciding an appeal that is based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual who was consulted in connection with the initial adverse benefit determination, nor the subordinate of that individual.

You will receive written notification of the benefit determination on an appeal no later than 5 calendar days after the benefit determination is made.

In the case of an adverse benefit determination on the appeal, the written denial will include the reason(s) for the determination including references to the specific Plan provisions on which the determination is based. The written denial will also include a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. The written notification of an adverse benefit determination in regard to disability benefits will also include the specific rule, guideline, protocol or other similar criterion relied upon in making the adverse determination.

The denial of a claim to which the right to review has been waived, or a decision of the Board of Trustees or its designated committee with respect to a petition for review, is final and binding upon all parties, subject only to any civil action you may bring under ERISA. Following issuance of the written decision of the Board of Trustees on an appeal, there is no further right of appeal to the Board of Trustees or right to arbitration.