

**CEMENT MASONS PENSION TRUST FUND FOR NORTHERN CALIFORNIA
220 CAMPUS LANE
FAIRFIELD, CALIFORNIA 94534-1499
TELEPHONE (707) 864-3300 OR TOLL-FREE (888) 245-5005**

**IMPORTANT NOTICE REGARDING
NEW CLAIMS AND APPEALS PROCEDURES**

TO: ALL PLAN PARTICIPANTS

Effective January 1, 2002, the Department of Labor established new claims and appeals procedures that apply to the Cement Masons Pension Plan. These new claims and procedures are described below:

Filing A Claim

Your application for benefits must be made in writing on a form provided by the Board of Trustees and must be filed with the Fund Office before you are entitled to receive any benefits.

Your claim will be considered filed when the Fund Office receives your application, regardless of whether all the information necessary to make a benefit determination accompanies your application. If all necessary information does not accompany your application, the Fund 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 your claim; and
3. The additional information needed to resolve those issues.

Once your claim has been filed, the Fund Office will make the initial determination of benefits within the time periods described below.

***Determining Initial Claim – Part 1 of 2
For All Pensions, Including Disability Based on Social Security Administration
(See Part 2 of 2 for Disability Pensions Based on Medical Evidence)***

The initial determination of benefits will be made within a reasonable period of time, but not longer than 90 calendar days after the Fund Office receives your application for benefits and all required information.

If the Fund Office determines that special circumstances require an extension of time for processing your claim, the Fund 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 to make a determination. The extension cannot be more than 90 calendar days from the end of the initial 90-day period.

Determining Initial Claim Part 2 of 2
For Disability Benefits Based on Medical Evidence
(Under Section 3.08 of the Plan)

In the absence of a Social Security Disability Benefit, the Pension Plan provides a Disability Pension based on medical evidence (see Section 3.08 of the Plan). The Board of Trustees makes a determination of disability based on medical evidence as proof of the disability.

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

The initial 45-day period may be extended for up to 30 calendar days, for a total of 75 calendar days, if an extension of time is necessary due to matters beyond the control of the Plan. The Fund 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 you can expect a determination.

If a second extension of time is needed to make a determination due to circumstances beyond the control of the Plan, you will be notified of an 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, the Fund Office will notify you, in writing, of the circumstances requiring a second extension and the new date by which you can expect a determination.

If your 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. (See *Right to Appeal* on the following page.)

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 to complete your claim and an explanation of why that material or information is necessary;
4. A description of the Plan's review procedures and the time limits that apply to those procedures, including a statement of your rights to bring civil action under §502(a) of ERISA following an adverse determination on review; and
5. Any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim for disability benefits under Section 3.08 of the Plan. The Fund Office will provide you with a statement, indicating the rule, guideline, protocol or other similar criterion that was relied upon in making the determination and will provide you with a copy of that document, free of charge, if you request it.

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 may be entitled, you have the right to petition the Board of Trustees to reconsider 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 Fund Office within 60 days after you receive the notice of denial. In the case of a claim for disability benefits based on medical evidence under Section 3.08 or of the Plan, your petition for reconsideration must be filed with the Fund Office within 180 days after you receive the 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 Section 3.08 of the Plan, any statement of policy or guidance with respect to the Plan concerning the denial of disability benefits, without regard to whether this advice or statement was relied upon in making the benefit determination.

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 that meeting, the appeal may be reviewed at the second quarterly meeting following receipt of your appeal. If special circumstances require an extension of time, the Board of Trustees will make its decision at the third scheduled quarterly meeting following the receipt of your appeal. The Fund 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 the event that the required information is not received with your appeal, the time period for reviewing your appeal will be suspended during the time you are obtaining the required information.

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. This health care professional will not be the same individual who was consulted in connection with the initial adverse benefit determination, nor will a 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 appeal, the written denial will include the reason(s) for the determination, including references to 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 (that is, you have failed to file a written request within the required time limit), or the decision of the Board or the Board's designated Appeals 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.

You may, however, re-establish your entitlement to benefits at a later date based on any additional information and evidence not previously available to you at the time of the decision of the Board of Trustees.

**APRIL 2003
INSERT #4 TO 9/1/01 BOOKLET**

- PLEASE PLACE THIS INSERT IN YOUR PENSION PLAN BOOKLET -