ARTICLE II – CLAIM AND APPEAL PROCEDURES

2.1 Application and Forms for Defined Contribution Plan.

In order to receive benefits under this Plan, an Employee is required to complete and file with the Board an application and all other forms approved by the Board, and to furnish all information required by the Board within the time periods established in the rules and procedures promulgated by the Board. The Employee is also required to keep the Board advised of his current mailing address. The Board may rely upon the information provided without further verification of same.

2.2 Timing and Notification of Benefit Determination

(a) Retirement Benefits

Claims for benefits under the Plan may be filed in writing with the Trustees. Written notice of the disposition of a claim shall be furnished to the claimant within 90 days after the application is filed.

This period may be extended by the Fund for up to 90 days, if special circumstances require an extension of the time for processing the claim. In such case, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90 day period. In no event shall such extension exceed 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(b) Disability Benefits

A claim for disability benefits includes an initial claim for disability benefit or any rescission of coverage of a disability benefit.

In the case of a claim for disability benefits, the Fund Office shall notify the claimant, in accordance with this Section of the Fund's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Fund Office.

This period may be extended by the Fund for up to 30 days, provided that the Fund Office both determines that such an extension is necessary due to matters beyond the control of the Fund and notifies the claimant, 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 render a decision. If, prior to the end of the first 30-day extension period, the Fund Office determines that, due to matters beyond the control of the Fund, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up

to an additional 30 days, provided that the Fund Office notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this provision, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

2.3 Manner and Content of Notification of Benefit Determination

The Fund Office shall provide a claimant with written or electronic notification of any adverse benefit determination (i.e. denial of claim).

Before the Plan can issue a notice of benefit determination based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of benefit determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Plan can issue a notice of benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of benefit determination is required to be provided, to give the claimant a reasonable opportunity to respond prior to that date.

The notification shall set forth, in a manner calculated to be understood by the claimant –

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Fund's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review; and

(e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other

similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request, or if applicable, a statement that such rule, guideline, protocol or other criterion does not exist.

With respect to an adverse benefit determination regarding disability benefits, the determination must also include the following:

(1) An explanation of the basis for disagreeing with any of the following:

(i) The health care professionals that treated the Claimant;
(ii) The advice of the health professional obtained by the Plan; or
(iii) A disability determination from the Social Security Administration.

(2) A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.

(3) If the denial was based on medical necessity or experimental treatment, the denial must include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claim or statement or a statement that such explanation will be provided free of charge upon request.

(4) The denial must be in a culturally and linguistically appropriate manner.

2.4 Appeal of Adverse Benefit Determination

(a) Appeals must be forwarded to and received by the Fund Office within 60 days (180 days for appeals involving disability benefits) following receipt of a notification of an adverse benefit determination (i.e. denial of claim). As part of any such appeal, a claimant may submit written comments, documents, records, and other information relating to the claim for benefits.

(b) A claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(c) Upon appeal, the Trustees will review all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(d) If the appeal is a denial of disability benefits:

(1) A review on appeal will not afford deference to the initial denial and an individual who made the initial denial, or a subordinate of such individual will not decide an appeal.

(2) In deciding an appeal of a benefit based on medical judgment, the fiduciary deciding the appeal shall consult with a health care professional who has appropriate training in the field of medicine involved (and who was not involved in reviewing the initial claim); and

(3) The Plan must provide for the identification of any medical or vocational experts whose advice was obtained by the plan in connection with the initial denial, regardless of whether the advice was relied upon.

2.5 Trustees Decision on Appeal

(a) Timing of Decision

The Trustees shall make a benefit determination on appeal no later than the date of the board meeting that immediately follows the Fund Office's receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the benefit determination may be made no later than the date of the second board meeting following the Fund Office's receipt of the request for review.

If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third board meeting following the Fund Office's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Fund Office shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Fund Office shall notify the claimant of its decision on appeal but not later than five days after the benefit determination is made.

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Fund can a notice of decision on appeal with respect to disability benefits based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as

possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date

(b) Manner and Content of Notification of Trustees Notice of Decision on Appeal

The Fund Office shall provide a claimant with written or electronic notification of any adverse benefit determination on review. The notification shall set forth, in a manner calculated to be understood by the claimant –

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(4) A statement of the claimant's right to bring a civil action under section 502(a) of ERISA;

(5) A statement describing any contractual limitation period that applies to the Claimant's right to bring an action under ERISA §502(a) and the calendar date on which such contractual limitations expires;

(6) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request, or, if applicable, a statement that such rules or guidelines do not exist;

(7) If the adverse benefit determination is 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 the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(8) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

In addition to the above, a notice of decision on appeal pertaining to a claim for disability benefits will include the following:

(1) An explanation of the basis for disagreeing with any of the following:

(i) The health care professionals that treated the Claimant;

(ii) The advice of the health professional obtained by the Plan; or

(iii) A disability determination from the Social Security Administration.

(2) The benefit denial must be in a culturally and linguistically appropriate manner.

2.6 Discretion of Trustees

The Trustees have full discretionary authority to determine eligibility for benefits, interpret Plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

2.7 Timely Submission of Appeals

All appeals must be timely submitted. A Participant or dependent who does not timely submit an appeal waives his/her right to have the benefit denial further reviewed by the Fund or in a court of law.

2.8 Limitations of Actions

No action may be brought to recover benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal.

2.9 Failure to Follow Claims Procedures

If the Plan fails to follow claims procedures with respect to any claim for benefits, the Claimant is deemed to have exhausted administrative remedies and is entitled to pursue all remedies under ERISA §502(a) on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits.

In addition to the above, if the plan fails to strictly adhere to all procedures with respect to a claim for disability benefits and the claimant chooses to pursue remedies under section ERISA §502(a), the claim is deemed denied on review without the exercise of discretion by the Trustees.

Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant**.**

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

If a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception to the deemed exhaustion rule, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the court rejects the claim for immediate review (not to exceed ten days), the Plan shall provide the Claimant with the notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

2.10 Avoiding Conflicts of Interest

The Plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons 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 expert) must not be made based upon the likelihood that the individual will support the denial of benefits.