

# **SOUTHERN CALIFORNIA PIPE TRADES VACATION AND HOLIDAY FUND SUPPLEMENT**

To: All Participants  
From: Board of Trustees  
Date: July 2002  
Re: New Procedures for Processing Claims and Appeals  
(Effective January 1, 2002)

**PLEASE INSERT THIS PURPLE COLORED NOTICE BEHIND  
TAB 3 OF YOUR SUMMARY PLAN DESCRIPTION BOOKLET.**

*The following replaces the Appeals Procedure Section on  
page 10 of the Summary Plan Description.*

## **PROCEDURES FOR PROCESSING CLAIMS AND APPEALS**

The Fund will treat any written request for a plan benefit made by you (or your authorized representative) in accordance with the procedures described in this Summary Plan Description as a "claim for benefits." You have the right to appeal any Fund decision regarding the amount or timing of a benefit withdrawal using the procedures for a denied benefit claim outlined in this Summary Plan Description.

Except for benefits from the Fund that are paid automatically, in order to make a claim for benefits, you must obtain an approved claim form from the Fund Office. The claim form must be completed, signed, and submitted to the Fund Office. A claim will be treated as submitted on the date it is received by the Fund Office. If your claim is incomplete, you will be notified as soon as possible with a written request for additional information.

Every effort will be made to process your claim for benefits within 90 days after its receipt by the Fund Office. This 90-day period will begin upon receipt of the signed claim form by the Fund Office without regard to whether all of the information necessary to decide the application has been submitted.

If a decision on your claim cannot be made within 90 days of its receipt, a letter will be sent to you, prior to the expiration of the 90 days, explaining the special circumstances requiring another 90 days to take action. If final action cannot be taken at the end of the second 90-day period, you will be sent a written explanation in advance of the expiration

of the second 90-day period. At this time, you will be awarded any partial benefits that can be determined with the available information. If partial benefits cannot be awarded because of a lack of necessary information, the Fund Office will conditionally deny your claim. The Fund Office will continue to seek the necessary information to make a final determination.

If your claim for benefits is denied, in whole or in part, the Fund Office will provide you with a written notice that states the specific reason or reasons for the denial, refers to the specific Plan provisions on which the denial is based, describes any additional material or information that might help your claims, explains why that information is necessary, and describes the Fund's review procedures and applicable time limits, including a right to bring a civil action under Section 502(a) of ERISA.

If your claim is denied, in whole or in part, you may request that the Appeals Committee of the Board of Trustees review your benefit denial. All appeals must be in writing and must be received by the Fund Office within 180 days after you receive the written notice of the denial from the Fund Office. Failure to file a timely written appeal shall constitute a complete waiver of your right to appeal, and the decision of the Fund Office will be final and binding.

In presenting your appeal, you have the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits. You are also 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. Personal appearances on appeals are at the discretion of the Appeals Committee.

Your written appeal should state the specific reasons why you believe the denial of your claim was in error. You should also submit any documents or records that support your claim. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefits you are claiming. The Appeals Committee can best consider your position if it clearly understands your claims, reasons, or objections.

The review of the Appeals Committee will take into account all comments, documents, records, and other information that you submit, without regard to whether such information was submitted or considered by the Fund Office in its determination.

Once the Appeals Committee has reviewed your appeal, you will be mailed a written decision no later than 60 days after receipt of the appeal. If special circumstances require an extension of time for processing your appeal, a decision will be mailed no later than 120 days after receipt of the appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Appeals Committee is expected to reach a decision.

If your appeal is denied, in whole or in part, the written decision will include: the specific reason or reasons for the denial; the specific Plan provisions on which the denial is based;

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; and a statement of your right to bring a civil action 502(a) of ERISA.

The decision of the Appeals Committee on review is final and binding on all parties, including anyone claiming a benefit on your behalf. The Appeals Committee has full discretion and authority to determine all matters relating to appeals including, but not limited to, the standard of proof required for any claim and the application and interpretation of the Plan. The Fund Office maintains records of determinations on appeal and Plan interpretations so that those determinations and interpretations may be referred to in future cases with similar circumstances.

If the Appeals Committee denies your appeal, and you decide to seek judicial review, the Appeals Committee's decision will be subject to limited judicial review to determine only whether the decision was arbitrary and capricious. No lawsuit may be brought without first exhausting the above claims and appeals procedure. Nor may any evidence be used in court unless it was first submitted to the Appeals Committee prior to the decision on appeal. No legal action may be commenced or maintained against the Trust, the Plan, or the Trustees more than two years after the claim has been denied.