

**Plasterers Local 31 Insurance Fund**

**&**

**Plasterers Local 31 Pension Plan**

**PITTSBURGH, PENNSYLVANIA**

**SUMMARY PLAN DESCRIPTION**

**and**

**PLAN BOOKLET**

September 2005

# Plasterers Local 31 Insurance Fund

## Summary Plan Description

Federal ID # 25-1189104

### THE BOARD OF TRUSTEES

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O.P. & C.M.I.A Combined Funds, Inc.  
1900 Andrew Street  
Munhall, PA 15120

#### **INSURANCE CARRIERS:**

Highmark Blue Cross Blue Shield  
Fifth Avenue Place  
120 Fifth Avenue  
Pittsburgh, PA 15222-3099

### **NOTICE**

This Booklet sets forth the Death, Disability, Hospitalization, Medical-Surgical, Major Medical, Vision, Dental, Prescription Drug, and Maintenance Prescription Drug Option Provisions of the Plan, as well as the Eligibility Requirements for Participants and Retirees of the Plasterers Local 31 Insurance Fund.

The Trustees reserve the right to change or amend this "Plan" at any time, including but not restricted to the amount and extent of all benefits; the eligibility requirements; and the contributions and related regulations, in accordance with the provisions of the Trust Agreement.

**PLASTERERS LOCAL NO. 31  
INSURANCE FUND**

**O.P. & C.M.I.A Combined Funds, Inc.  
1900 Andrew Street  
Munhall, PA 15120  
Telephone: (412)-464-2851  
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Dear Participants,

We are pleased to provide you with this new and revised booklet which contains the new Rules of Eligibility and the Plan of Benefits in effect on May 1, 2005. The Plan provides Death, Accidental Death and Dismemberment, and Weekly Disability Benefits paid directly by the Fund. The Preferred Blue PPO Program provides Hospitalization, basic Surgical, Medical, and Prescription Drug Benefits which are underwritten by Highmark Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield. National Vision Administrators provide the vision benefits and Delta Dental of Pennsylvania provides the dental benefits.

The more important benefits provisions relating to Benefits provided directly by the Fund, Eligibility, General Claim and Appeal Procedures are described in this booklet. The benefits provided by the Preferred Blue PPO Program are described in a separate booklet distributed by Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield. We strongly recommend that you familiarize yourself with both the contents of this booklet and that of the Preferred Blue PPO Program so that you may be fully aware of all the benefits which you and the members of your family may be entitled to in time of need. Should you have any questions or require additional information, please contact the Fund Administrator.

*Respectfully yours,*

**BOARD OF TRUSTEES**

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**SECTION 1.0  
GENERAL INFORMATION**

- 1.1 Enrollment Card:** Every Participant must submit a completed enrollment card before any claims can be paid. Enrollment cards may be obtained by calling or writing the Fund Office.
- 1.2 Identification Card:** Each Employee who has returned a completed enrollment card and who meets the Eligibility Requirements will be issued an Identification Card indicating that he is eligible for benefits under the Plasterers Local 31 Insurance Fund.
- 1.3 Participating Employees:** All employees working under the jurisdiction of the Union for an employer who has executed a Collective Bargaining Agreement requiring Welfare Payments to this Fund; the employees of the Union for whom the required Welfare Payments are made.
- 1.4 Participating Employer:** Participating Employer means an Employer who is party to a Collective Bargaining Agreement with the Union, such Agreement requiring the Employer to make Welfare Payments to the Plasterers Local 31 Insurance Fund.
- 1.5 Unions Or Participating Unions:** Participating Union means the Operative Plasterers and Cement Masons Union, Local 31.
- 1.6 Employees:** Employees are defined as persons working under the jurisdiction of the "Union," persons employed by the Union on a full-time basis and any full-time employee, Official or Supervisory Employee of a Participating Employer (providing the Participating Employer has executed an "Assent to Participate") and who has agreed to make the required contributions on their behalf.
- 1.7 Dependent:** "Dependents" are defined as your lawful spouse and each unmarried child who has not attained his 19th birthday, or up to age 23 while he is attending on a full-time basis, a college, university, trade or training school beyond the high school level.
- (a) "Child" includes stepchild, adopted child, or foster child, provided the child is dependent on the employee for support and maintenance. Dependents who work sufficient hours to be eligible under the Plan shall be insured as employees only.
- 1.8 Physically Handicapped Or Mentally Retarded Children:** If an employee's unmarried dependent child is incapable of self-sustaining employment because of mental retardation or a physical handicap and is dependent upon the employee for support and maintenance, his benefits will be continued, provided his incapability commenced prior to attaining age 19. Proof of your dependent child's incapability must be submitted to the Trustees within 31 days after the date he attains 19 years of age. Proof of the continued existence of such incapability must be furnished to the Trustees from time to time as they may request.

- 1.9 Effective Date Of Coverage:** An Employee's coverage and that of his dependents will be made effective on the date he becomes eligible. However, if at that time, he is absent or unavailable for work because of illness or injury, his coverage will not be made effective until the date he returns to work or is available to return to work. A dependent who is disabled on the date he would otherwise become covered will not be covered until he has been finally discharged from the hospital. However, if a newborn dependent child incurs charges for services over and above the usual cost of nursery charges for routine well baby care because of sickness, injury, congenital defects or premature birth, insurance begins from birth.
- 1.10 Maintenance Of Coverage:** Maintenance of coverage refers to an eligible participant's continuance in the Plan. Such participants must have met the initial eligibility requirements, and be eligible in the current quarter in order to be able to make a SELF-PAYMENT to maintain continuity of coverage in the next Insurance Period.
- 1.11 Change In Family Status:** If a change occurs in your family status by reason of marriage, birth of a child, death, divorce or legal separation you must immediately notify the Fund Office. Failure to notify the Fund Office immediately may result in loss of coverage and future benefits.
- 1.12 Plan Description:** The plan as described in this booklet is subject to the terms and conditions of the contracts issued by Blue Cross and Blue Shield and any amendments adopted and approved by the Board of Trustees.
- 1.13 Trustees' Right To Amend The Plan:** The Trustees reserve the right to alter the Plan of Benefits or the Rules and Regulations of this Plan at any time, in accordance with the terms of the Agreement and Declaration of Trust.

**SECTION 2.0**  
**GENERAL CLAIM PROCEDURES**

- 2.1 Filing Claims:** All claims must be filed within 90 days after the claim has arisen. Claim forms may be obtained from the Fund Office.
- 2.2 Claim Forms:** The Trustees, upon receipt of a notice of claim, will furnish to the claimant, such forms as are usually furnished by it for filing Proof of Loss. The Trustees shall have been deemed to have supplied such forms upon mailing such forms to the last known mailing address of the eligible participant as recorded in the Fund Office records.
- 2.3 Proof Of Loss:** Written Proof of Loss must be furnished to the Trustees within 90 days from the date of loss. Proof of Loss shall consist of the Completed Claim Form, together with all itemized bills or other documents called for under the Plan, signed and certified to by the claimant or in the case of death, his or her beneficiary.

Failure to furnish notice or proof within the time provided in this plan shall not invalidate nor reduce any claims if it shall be shown that such notice or proof was furnished as soon as was reasonably possible.

- 2.4 Payment Of Claims:** Disability Benefits under this plan will be paid directly to the eligible participant. In no event may the participant assign Death, Accidental Death Benefits or Weekly Disability Benefits under this plan.

In the event that benefits are payable to an eligible participant who is deceased, then the benefits will be paid to the named beneficiary, if living. If the beneficiary shall have pre-deceased the eligible participant, then the benefits shall be payable to the first surviving class of the following classes of successive beneficiaries:

- (a) widow or widower
- (b) surviving children
- (c) surviving parents
- (d) surviving brothers and sisters
- (e) executors or administrators

- 2.5 Errors In Benefit Payments:** The Trustees specifically retain the right to recover all monies paid in error to, or in behalf of any person, from such person. Upon the discovery of a payment "made in error," the Trustee shall notify the recipient or beneficiary of such payment, indicating the circumstances and amount of such payment, together with a request for re-payment. Upon failure to repay the amount due within a reasonable time after such notification, the Trustees may take such legal action as they deem necessary, or in the case of a participant of the Fund, the amount of the payments made in error may be deducted from any future benefit payments which such participant or his dependents or beneficiary may become entitled to under this plan.
- 2.6 Fraud:** Any person attempting to submit false, misleading or incomplete information, or who in any way attempts to defraud the Fund, may be prosecuted in such manner as the Trustees deem advisable.

**2.7 Filing Claims Under The Preferred Blue PPO Program:** Please consult the documentation provided by the PPO Blue Program for information regarding filing for claims. For the most part, the PPO Blue Program does not require you to file for claims. Your Primary Care Physician and your referral providers will file your claims directly with Highmark Blue Cross and Blue Shield.

**SECTION 3.0  
ELIGIBILITY RULES**

- 3.1 Employees:** Employees are defined as persons working under the jurisdiction of the “Union”, persons employed by the Union on a full-time basis and any full-time employee, Official or Supervisory Employee of a Participating Employer (providing the Participating employer has executed an “Assent to Participate”) and who has agreed to make the required contributions on their behalf.
- 3.2 Early Retirees:** Defined as eligible employees between **the ages of 55 but not yet 60** who have elected an early retirement benefit under the Plasterers Local 31 Pension Fund. Such persons shall be eligible to maintain their coverage hereunder by making the required COBRA payment for a maximum period of thirty-six months, commencing with the first month following their retirement date. Further, such participants shall be permitted to make COBRA payments for their dependents for a maximum period of thirty-six months, commencing with the first month following their retirement date.
- 3.3 Retirees:** Defined as eligible employees between **ages of 60 - 65** who have elected to retired under the Plasterers Local 31 Pension Fund. Such persons shall be eligible to maintain their coverage hereunder by making the required COBRA payment for a maximum period of thirty-six months, commencing with the first month following their retirement date. Further, such participants shall be permitted to make COBRA payments for their dependents for a maximum period of thirty-six months, commencing with the first month following their retirement date.
- 3.4 Qualifying Work Periods:** Defined as the period in which a employee must work in order to qualify for benefits in the corresponding benefit period.
- 3.5 Benefit Period:** Defined as the period in which the employee is covered by the benefit.

<b>Qualifying Work Period</b>	<b>Benefit Period</b>
June 1 – Aug. 31	Dec. 1 – Feb. 29
Sept. 1 – Nov. 30	Mar. 1 – May 31
Dec. 1 – Feb. 29	June 1 – Aug. 31
Mar. 1 – May 31	Sept. 1 – Nov. 30

- 3.6 Lag Period:** Defined as the three-month period immediately following the Qualifying Work Period and preceding the Benefit Period.
- 3.7 350 Hour Initial Eligibility Rule:** An Employee covered under the Collective Bargaining Agreement of the Union and working for a Participating Employer shall be eligible on the first day of the Benefit Period corresponding to the Work Period in which he has worked three-hundred and fifty (350) hours for a Participating Employer(s). In the event a new participant fails to work 350 hours in such work period, he may be permitted to make a self-payment for the difference between the actual hours worked and 350 hours, providing he has worked at least 100 hours for a contributing employer(s) in the Qualifying Work Period preceding the Benefit Period. New employees who have worked less than one hundred (100) hours for a contributing employer(s) will not be permitted to make a self-payment toward initial eligibility.
- 3.8 Basic 300 Hour Rule:** After meeting the initial eligibility rule, an Employee covered under the Collective Bargaining Agreement of the Union and working for a Participating Employer shall be eligible on the first day of the Benefit Period following the Qualifying Work Period in which he has worked three hundred (300) hours for a Participating Employer(s).
- 3.9 1000 Hour Special Exemption:** After meeting initial eligibility, any employee covered under the Collective Bargaining Agreement of the Union and working for Participating Employers, who fails to work three hundred (300) hours in a Qualifying Work Period, but who has worked one thousand (1000) hours in the preceding four (4) consecutive Qualifying Work Periods shall remain eligible during that Benefit Period. Hours for which Voluntary Contributions have been made shall not be considered as hours worked for the purposes of determining eligibility under this provision.

Shown below is a schedule of the four (4) consecutive Qualifying Work Periods for the 1000 hour Rollback Rule and the Benefit Periods to which they apply for eligibility purposes:

<b>QUALIFYING WORK PERIOD</b>	<b>INSURANCE PERIOD</b>
<b>Dec 2003 - Nov 2004</b>	<b>Mar 2005 - May 2005</b>
<b>Jan 2004 - Feb 2005</b>	<b>June 2005 - Aug 2005</b>
<b>June 2004 - May 2005</b>	<b>Sept 2005 - Nov 2005</b>
<b>Sept 2004 - Aug 2005</b>	<b>Dec 2005- Feb 2006</b>

**3.10 Self Payment Provision - Active Employees who Fail to Work the Required Number of Hours:** Active eligible employees working at the trade for a participating employer, who worked less than three hundred (300) hours in the Work Period, shall be permitted to make a self-payment for the lesser of:

- (a) The difference between the hours worked and the minimum of three hundred (300) hours required to maintain normal eligibility in the Plan provided the employee has worked at least 1 hour in the corresponding work period. or,
- (b) Provided you have at least 700 hours reported in your Special Exemption Work Period, you may pay the difference between the hours reported in the Special Exemption Work Period and the 1,000 hours required by the Special Exemption Period.

**3.11 Termination and Payment Requirements:**

Coverage shall terminate for an eligible participant and his/her dependents on the first day of a Covered Benefit Quarter when requirements as described above have not been met. In order to re-gain coverage under the Plan, a participant must then re-qualify as outlined above in the 350 Hour Initial Eligibility Rule.

**3.12 COBRA Regulations For Eligible Participants And Dependents:** An Eligible Participant or Eligible Dependent (as defined herein) whose group coverage is scheduled to be terminated will be permitted to make individual COBRA payments to maintain his or her Benefits. All such COBRA payments shall be subject to the regulations outlined in this Section 4.0.

**SECTION 4.0**  
**CONSOLIDATED OMNIBUS BUDGET**  
**RECONCILIATION ACT OF 1986 (COBRA)**

**Consolidated Omnibus Budget Reconciliation Act of 1986:** Requires that the Trustees offer those eligible employees and dependents whose Health Benefits are scheduled to be terminated, the opportunity of continuing their Group Health Benefits through a series of monthly direct payments for a limited period of time. The following paragraphs are intended to explain and summarize your rights and those of your dependents under this law.

## **COBRA RIGHTS**

- 4.1 Definitions:** An "Eligible Employee" is any Employee who has met the Eligibility Requirements of the Plan, but whose coverage is scheduled to be terminated due to failure to meet the Eligibility Requirements of the Plan.
- An "Eligible Dependent" is defined as:
1. the SPOUSE of an Active Employee, or upon the death of an Eligible Employee, the surviving spouse of such deceased Eligible Employee, and
  2. any Dependent CHILD of such Eligible Employee or deceased Eligible Employee. Dependent CHILD is each unmarried child who has not attained age 19, or an unmarried dependent child under age 23 who is attending a college, university, trade or training school (beyond the high school level) as a full time student. Such child must be dependent upon the employee for support and maintenance.
- 4.2 Employees:** If you are an active employee whose benefits are scheduled to be terminated due to having failed to work the required number of hours, you have the right to continue your Group Health Benefits through a series of monthly direct payments for a period of up to eighteen months, starting with the date your regular eligibility under the Plan was scheduled to be terminated due to failure to work the required number of hours.
- 4.3 Disabled Participants:** Active employees who become totally disabled prior to age 65 and while eligible hereunder shall be permitted to make Cobra Payments when their normal eligibility terminates. Under Cobra the participant shall be permitted to maintain their Group Health Benefits for themselves and their dependents until such time as they become eligible for Medicare, but not beyond thirty-six months, except that should they become, eligible for Medicare prior to the expiration of such thirty-six month period, they may continue the group health coverage for their dependents on a COBRA payment basis until the expiration of such thirty-six month period
- 4.4 Spouse:** Your spouse (husband or wife) also has the right to continue his or her Group Health Benefits on a direct payment basis under any of the following circumstances:
- (a) upon your death (providing you were eligible at the time of death).
  - (b) upon your termination from the Plan due to failure to work the required number of hours.
  - (c) upon divorce or legal separation from you.
  - (d) when you become eligible for Medicare and your regular Group Health Benefits are terminated.

- 4.5 Divorced or Legally Separated Spouse:** The spouse of an eligible Active Participant following a divorce or legal separation may continue his or her Group Health Coverage on a COBRA payment basis. The spouse of such Active Participant must apply within a sixty-day period immediately following the effective date of such divorce or separation. COBRA payments will be permitted for up to thirty-six months but not after such period, nor for any period following the date such spouse becomes either eligible for Medicare or another Group Health Insurance Plan
- 4.6 Dependent Children:** Your dependent children (as defined in the Plan) may also continue their Group Health Benefits on a direct payment basis under any of the following circumstances:
- (a) upon your death (providing you and such dependent child were covered at the time of your death).
  - (b) upon termination of your employment (providing your child was covered at the time of such termination).
  - (c) upon your divorce or separation.
  - (d) upon the date your eligibility (and that of your dependent child) ceases due to becoming eligible for Medicare.
  - (e) the date your dependent child ceases to be a dependent (due to age, marriage, change in student status, etc. [see 1.7]).
- 4.7 Coverage for Child or Children:** Eligible dependent children who are scheduled to be terminated as a result of attaining age 19, or if a full student, age 23 (as provided under the Plan), may maintain their Group Health Benefits by making Cobra payment. Such Cobra payments may be continued for a period of up to thirty-six months, but not after the date such child ceases to be a dependent of the active participant, or after such child qualifies under another Group Health Insurance Plan.
- 4.8 Widows and Dependent Children of Deceased Employee:** Upon the death of an eligible employee, the surviving widow and child or children will be continued for the duration of the Insurance Period in which he died, and thereafter, such dependents may continue their Group Health Benefits through Cobra Payments. Widows of a deceased Active Employee will be given an option to continue their Group Health Benefits through COBRA payments for a period of up to thirty-six months following the death of their spouse. They may elect to continue Group Health Benefits for themselves only (Single Coverage) or for themselves and their dependent children (Widow and Child Coverage). The Election Form, together with the initial self-payment will be due thirty days from the date the self-payment notice is given
- 4.9 Notification and Payment Requirement:** When an Active Participant's eligibility for benefits is scheduled to be terminated due to having worked an insufficient number of hours, such participant will be notified of his right to make a self-payment. A participant who wishes to continue his/her coverage through self-payment must then complete and return the payment coupon from his/her Work History Report, together with the initial payment. Such payment and election forms are due within fifteen days from the date of notice. All monthly payments ***must*** be made by the first day of the month in which such payment is due.

**4.10** **Limitations:** The privilege of continuing an individual participant's or dependent's Group Health Benefits through COBRA payments shall cease upon the first of any of the following events:

- (a) when the participant or dependent fails to make the required COBRA payment on a timely basis.
- (b) the date such participant becomes covered under another group health plan.
- (c) the date such participant becomes eligible for Medicare.
- (d) in the case of a divorced spouse, the date such person remarries or becomes covered under another group plan

**SECTION 5.0**  
**DEATH BENEFITS FOR ACTIVE PARTICIPATING EMPLOYEES AND RETIREES**

In the event of your death from any cause, on the job or off, while you are eligible, the proceeds will be paid to the named beneficiary.

**ACTIVE PARTICIPATING EMPLOYEE DEATH BENEFIT:**

Any Active Participating Employee who is Eligible to receive Benefits under this Plan at the time of his/her death shall receive a sum of \$10,000.00

**RETIREE DEATH BENEFIT:**

Any eligible Employee age 55 and over who retires and who meets the requirements shown below, shall be eligible for the retiree death benefit of \$5,000.00, providing;

- He/She is eligible for and receiving benefits under this plan immediately prior to retirement, and
- He/She has completed an application for Retiree Death Benefits, which is approved by the Board of Trustees.

**Beneficiary:**

You may name anyone you wish as your beneficiary and you may change your beneficiary at any time by filling out the proper form.

**Extended Death Benefit:**

If prior to age 60, you become totally and permanently disabled, your benefit will continue without cost for a period of twelve months. Prior proof of total and permanent disability must be presented within the twelve month period and yearly thereafter to continue the benefit in force.

**Assignment Of Death Benefit:**

No assignment by an eligible participant of the Death benefits under this Plan shall be valid.

<p><b>SECTION 6.0</b>  <b>ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT</b></p>
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In the event you sustain any of the following losses solely through accidental bodily injuries, the indicated benefit shown in the Schedule of Benefits will be paid in addition to any other benefits payable under the Plan.

**Accidental Death & Dismemberment Benefits**

Any Active Participating Employee who is Eligible for Benefits under this Plan at the time of his/her Accidental Dismemberment shall receive Benefits in accordance with the schedule shown below. The Full amount of benefits that can be paid to any single Active Participating Employee under the “Accidental Death & Dismemberment Benefit” is \$6,000.00

Loss of Life .....	Full Amount
Loss of two limbs, sight of both eyes, or loss of one limb and sight of one eye.....	Full Amount
Loss of one limb or sight of one eye .....	One-half of the Amount

Loss must occur within 90 days from the day of the accident, except for loss of life which has no time limitations.

Loss of limb means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means the total and irrevocable loss of sight.

If more than one of the losses set forth above is suffered as the result of any one accident, not more than the full amount of the Accidental Dismemberment Benefit, will be payable. No payment will be made for death or any loss resulting from or caused directly, wholly or partly, by bodily or mental infirmity, ptomaines, bacterial infections (except infections caused by pyogenic organisms which shall occur with and through an accidental cut or wound), or disease or illness of any kind, or intentional self-destruction, or intentional self-inflicted injury, while sane or insane, or participation in the committing of a felony, or war or an act of war, or service in any military, naval or air force of any country while such country is engaged in war or police duty as a member of any military, naval or air organization.

**ASSIGNMENT OF BENEFIT:**

No assignment of the Accidental Death and Dismemberment Benefit by an eligible participant or beneficiary shall be valid.

**SECTION 7.0**  
**WEEKLY DISABILITY BENEFITS**

The Weekly Disability Benefit will be payable to you if, while eligible for benefits, you become disabled and unable to work because of a non-occupational accident or sickness. Injuries or sickness sustained on the job or which are compensable under workmen's compensation are not covered.

Benefits will normally begin as of the eighth day of disability and will be limited to a maximum of 13 weeks for any one period of disability. However, if you are confined to a hospital, benefits will commence as of the first day of hospitalization.

Weekly Disability Benefits \$ 600.00

Successive periods of disability separated by less than 150 credited hours of employment shall be considered as one continuous period of disability unless they arise from different and entirely unrelated causes.

You do not have to be confined to your home to collect benefits, but you must be under the care of a physician.

**CLAIM PAYMENTS**

To qualify for Weekly Disability Benefits, disabled employees must submit a completed claim form. The participant's attending physician must certify on this form that the participant was totally disabled and show the dates of all examinations and treatments. A physician's certification of disability will not be accepted as proof of disability unless received by the Fund (or postmarked if mailed to the Fund) within two (2) weeks of the examination on which it is based.

The Trustees reserve the right to have any claimant for Weekly Disability Benefits referred to a physician of their choice for examination or re-examination. Failure without good excuse to report to the Fund's physician within 48 hours after notice to do so may result in suspension of disability payments.

Disability payments will normally be paid for the period certified on the claim form up until the time of the last examination by the doctor. In order to receive additional payments for continuing periods of disability, the employee must submit Continuance of Disability Claim Forms.

**SECTION 8.0**  
**PPO Blue (Preferred Provider Organization)**

In order to provide you with a brief description of your medical and hospital benefits, a schedule of benefits provided by the PPO Blue Program is shown below. It is not intended to be a complete description of the benefits available to eligible participants. A detailed description of your PPO Blue Program will be provided by Highmark Blue Cross Blue Shield and will govern any discrepancies between the information provided below and that provided by Highmark Blue Cross Blue Shield.

Several definitions that may aid you in understanding the PPO Blue Program are shown below.

**Coinsurance**

- a. For Hospital or Facility Other Providers, the percentage of the Provider's Reasonable Charge for Covered Services which must be paid by the participant and which will be deducted from the Provider's Reasonable Charge.
- b. For Professional Providers or Professional Other Providers, the percentage of the Provider's Reasonable Charge for Covered Services which must be paid by the Subscriber and which will be subtracted from the Provider's Reasonable Charge.

**Copayment**

- a. The fixed, up-front dollar amount you pay for certain covered expenses. Copayment amounts do not apply toward your deductible or coinsurance, and they do not accumulate toward the out-of-pocket maximum.
- b. For Hospital or Facility Other Providers, a specified dollar amount of the Provider's Reasonable Charge which must be paid by the participant and which will be deducted from the Provider's Reasonable Charge before determination of the benefits payable under the Preferred Blue PPO Contract.
- c. For Professional Providers or Professional Other Providers, a specified dollar amount of the Provider's Reasonable Charge which must be paid by the participant and which will be subtracted from the Provider's Reasonable Charge before determination of the benefits payable under this Contract.

**Covered Care**

You can receive care from the *health care provider of your choice*. The PPO program does not require that you select a primary care physician to receive covered care. Instead, the program gives you access to a vast network of physicians, hospitals, and other providers throughout the country. Simply call 1-800-810-BLUE (2583) for information on the nearest PPO providers

Benefits are paid at the higher level of reimbursement. You are responsible to pay the co-payment amounts.

**Covered Service**

A service or supply specified by the Preferred Blue PPO Contract for which benefits will be provided when rendered by a Provider or Supplier.

## **Deductible**

Initial amount a participant must pay each year for covered services before the plan begins to provide benefits.

## **Network (In- or Out-of-Network) Provider or Supplier**

Participating providers have entered into an agreement with Highmark pertaining to payment of benefits for covered services. If you receive services from a health care provider within the PPO Network you will receive a higher level of benefits for covered care from network providers.

Out-of-Network Providers or Suppliers have not entered into an agreement with Highmark. These non-participating providers may not accept the Highmark allowed charges plus any deductible, coinsurance amounts, or copayments as payment-in-full. You will be responsible for payment of any remaining charges. Please consult the material provided by the Preferred Blue PPO Program for complete details regarding In- and Out-of-Network Providers.

## **Self-Referred Care**

You can receive covered care from any health care provider, including specialists, at any time, and there is no need for a referral. You do not have to choose a PCP.

## **Authorization**

The official agreement between the provider and Healthcare Management Services (HMS) that care meets the definition of “medically necessary and appropriate.” *Please note that care authorization does not necessarily indicate benefits coverage.*

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Benefit Period</b>	Calendar Year	Calendar Year
<b>Deductible</b> Individual Family	\$100 \$200	\$250.00 \$500.00
<b>Coinsurance</b>	100%	80% after deductible
<b>Out-of-Pocket Limit</b>	Not Applicable	\$1,000 individual; \$2,000 per family
<b>Lifetime Maximum</b>	\$2,000,000	\$300,000
<b>Precertification Requirements for Inpatient Admission</b>	Performed by Member	
<b>Physician Office Visits</b>	100% after \$15 copayment; deductible does not apply	80% after deductible
<b>Hospital Services</b> (Inpatient and Outpatient)	100% after deductible	80% after deductible
<b>Preventive Care</b>		
<b>Adult</b>		
Routine physical exams	100% after \$15 copayment; deductible does not apply	Not covered
Routine GYN exams including PAP tests	100% after \$15 copayment deductible does not apply	80%; deductible and maximums do not apply
Mammograms as required	100%; deductible does not apply	80% after deductible
Adult Immunizations	100% after deductible	80% after deductible
Allergy Extract/Injections	100% after deductible	80% after deductible
<b>Pediatric Care</b>		
Routine physical exams	100% after \$15 copayment; deductible does not apply	Not covered
Pediatric immunizations	100%; deductible and maximum do not apply	80%; deductible and maximums do not apply

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Diagnostic Services</b> (Lab, X-ray and other tests)	100% after deductible	80% after deductible
<b>Therapy Services</b>		
Physical Therapy	100% after \$15 copayment; deductible does not apply	80% after deductible
Speech Therapy	100% after \$15 copayment; deductible does not apply	80% after deductible
Occupational Therapy	100% after \$15 copayment; deductible does not apply	80% after deductible
Cardiac Rehabilitation	100% after deductible	80% after deductible
Chemotherapy	100% after deductible	80% after deductible
Dialysis Treatment	100% after deductible	80% after deductible
Infusion Therapy	100% after deductible	80% after deductible
Radiation Therapy	100% after deductible	80% after deductible
<b>Maternity Services</b>	100% after deductible	80% after deductible
<b>Medical Services</b> (except office visits)	100% after deductible	80% after deductible
<b>Spinal Manipulations</b>	100% after \$15 copayment; deductible does not apply	80% after deductible
	Combined Limit: 20 visits per benefit period	
<b>Surgical Services</b>	100% after deductible	80% after deductible
<b>Emergency Room Services</b>	100% after \$50 copayment (waived if admitted); deductible does not apply	
<b>Ambulance Service</b>	100% after deductible	100% after deductible
<b>Private Duty Nursing</b>	100% after deductible	Same As Network Services

<b>Benefits</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Hospice Care</b>	100% after deductible	80% after deductible
<b>Transplant Services</b>	100% after deductible	80% after deductible
<b>Skilled Nursing Facility Services</b>	100% after deductible	80% after deductible
<b>Home Health Care</b>	100% after deductible	80% after deductible
<b>Durable Medical Equipment</b>	100% after deductible	80% after deductible
<b>Mental Health Services</b>  Inpatient Benefits	100%	80% after deductible
	Combined limit: 30 visits per benefit period	
Outpatient Benefits	100% after \$15 copayment; deductible does not apply	80% after deductible
	Combined limit: 30 visits per benefit period	
<b>Substance Abuse Services</b>  Inpatient Benefits Detoxification	100% after deductible	80% after deductible
	7 days per admission 4 admissions per lifetime	
Residential and Rehabilitation Therapy Services	100% after deductible	80% after deductible
	30 days per benefit period 90 days per lifetime	
Outpatient	100% after \$15 copayment; deductible does not apply	80% after deductible
	60 visits per benefit period 120 visits per lifetime	

<b>Prescription Drug Program</b>	
<b>Benefits</b>	<b>Benefits available through the Premier Pharmacy Network only.</b>
	<b>Mandatory Generic<sup>1</sup></b>
<b>Retail Pharmacy</b>	Up to 34 day supply
Copayment	\$10 generic \$15 brand/formulary <sup>2</sup> \$30 brand/non-formulary <sup>2</sup>
<b>Maintenance Prescription Drugs through Mail Order</b>	Up to 90 day supply
Copayment	\$20 generic \$30 brand/formulary <sup>2</sup> \$60 brand/non-formulary <sup>2</sup>

<sup>1</sup> The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand name drug. The member payment is the price difference between the brand and generic in addition to the copayment or coinsurance amounts, which may apply.

<sup>2</sup> The Highmark formulary is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above.

**SECTION 9.0**  
**VISION PROGRAM**  
**(Administered by National Vision Administrators – NVA)**

Your Vision Benefits are being provided to you by National Vision Administrators (NVA). NVA maintains an extensive network of participating doctors of Optometry and Ophthalmology nationwide to provide professional vision care for persons covered under the Plan. If you have any questions regarding your benefit, you can call NVA at 1-800-672-7723.

**Benefits**

A participant (and/or dependent) is entitled to **one vision examination and one pair of glasses (lenses and frames) or cosmetic contact lenses once every two calendar years**. Each eligible (both member and dependent) is covered up to a **total reimbursement of \$150.00**. Children under the age of 19 or dependent students under the age of 23 are entitled to the vision benefit once every calendar year.

A member (or dependent) has the option to go to either a NVA network provider or a doctor of their own choosing. However, if consulting a doctor outside the NVA network, the member will not be able to enjoy the discounts in place with NVA.

**VISION EXAMINATION** - A complete analysis of the eyes and related structures to determine the presence of a vision problem. In-network doctors can charge up to \$38.00 for the vision examination.

**LENSES** – The NVA network Doctor will order the proper lenses if needed. The program provides the finest quality lenses fabricated to exacting standards. The doctor also verifies the accuracy of the finished lenses. The costs of the lenses vary according to the type of lens. Network doctors will charge the wholesale cost of the lenses plus 25%. Please consult your provider for price.

**FRAMES** – A participant may select any frame. All frames provided by network providers will cost the wholesale price plus 20%. Please consult with your provider about the cost of the frame prior to purchase.

**CONTACT LENSE** – When contact lenses are selected in lieu of glasses, the network provider will charge the wholesale cost plus 25%.

**OVERAGES** – Any charges exceeding the \$150.00 maximum reimbursement will be the responsibility of the patient based on the plan allowance and wholesale pricing plus the appropriate percentages.

**Filing Claims** – In-network claims will be handled by the participating provider. You only have to present your NVA card. For out-of-network services, you will have to pay the claim and submit a claim form to NVA for reimbursement. Claim forms can be obtained by calling NVA at 1-800-672-7723.

**SECTION 10.0**  
**DENTAL PROGRAM**  
**(Administered by Delta Dental of Pennsylvania)**

**10.1 Benefit:** If an Eligible Active Participant or dependent receives one or more of the covered dental services outlined below from a participating dentist, the following co-payments shall apply, subject to a maximum annual allowance of \$1,000.00 per eligible person.

**10.2 Covered Dental Services:**

	<u>% Paid by Delta<sup>1</sup></u>	<u>% Paid by Patient<sup>1</sup></u>
DIAGNOSTIC (exam & x-rays) .....	80%	20%
PREVENTIVE (flouride treatments to age 19, teeth Cleaning – children, adults & sealants to age 14) .....	80%	20%
BASIC RESTORATIVE (fillings) .....	80%	20%
UNCOMPLICATED EXTRACTIONS (routine removal of teeth) .....	80%	20%
ENDODONTICS (root canal therapy) .....	80%	20%
PERIODONTICS (treatment of gum disorders) .....	80%	20%
MAJOR RESTORATIVE (crowns).....	80%	20%
PROSTHODONTICS (dentures) .....	80% <sup>2</sup>	20%
ORTHODONTICS (straightening teeth) .....	50% <sup>3</sup>	50%

1. Payment percentages refer to (1) participating dentist's charges or (2) non-participating dentist's charges that are within "usual customary and reasonable" (UCR) maximum levels as calculated by Delta.
2. Benefit available once every five years.
3. \$1,500 **lifetime** maximum per patient up to age 19.

**10.3 PREDETERMINATION:** If the amount of care to be rendered to any one patient will exceed \$300, the dentist must submit the claim form to Delta Dental for predetermination before completing the treatment. Delta's dental consultants will examine the treatment plan and x-rays, which should accompany the form, and future benefits will be detailed. This is generally a very simple procedure that takes only a few days, but it is very important because it assures you and the dentist that you are eligible for dental benefits, and it tells both you and the dentist if the proposed services are covered by the contract.

**10.4 DENTISTS:** A number of licensed dentists in Pennsylvania have entered into agreements with Delta to abide by Delta's policies regarding services, your portion of the charged fees and other matters pertinent to Delta's obligations to its subscribers. These dentists, known as participating dentists, will send claim forms to Delta and will be paid directly by Delta. You pay only for services not covered or co-payment amounts as stated in the notification of payment form, which Delta will send you with each claim. Other dentists not participating in Delta also regularly perform services for Delta subscribers; in such cases, payment is made directly to you. Payout by Delta is the same in either case. While Delta can guarantee your personal co-payment with participating dentists, you have complete freedom of choice in selection of your dentist. A list of participating dentists in your area may be obtained by contacting Delta Dental at 1-800-932-0783

**10.5 LIMITATIONS AND EXCLUSIONS:** The following limitations and exclusions apply to your dental plan. No benefits will be paid for dentistry that is performed for appearance only, preventative plaque control programs, periodontal splinting, and services rendered or devices started prior to the effective date of coverage.

**10.6 CLAIM FORMS:** Claim forms may be obtained from the Fund Office or by contacting Delta Dental.

Fill in Sections 1 through 15. Sections 1 through 8 are self-explanatory; Section 9 may be skipped. Section 10 should be "1020". Sections 11 through 15 are to be completed since they are used to assist Delta in determining whether you are entitled to dual coverage and/or coordination of benefits with another carrier. The form should be given to the dentist of your choice at your next appointment.

If you or your dentists have any questions about claim filing procedures or the status of your claim, please feel free to contact Delta's Benefit Service Department at:

**Delta Dental  
One Delta Drive  
Mechanicsburg, Pennsylvania 17055**

**Phone Number: 717-766-8500  
Toll-Free Number: 1-800-932-0783**

**SECTION 11.0**  
**Other ERISA Rights**

**11.1 RULES AND PROCEDURES FOR PROCESSING QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

- All Medical Child Support Orders should be immediately forwarded to the Fund Administrator.
- The Fund Administrator will notify the participant and the alternate recipients of receipt of the medical child support order. The Fund Administrator will also give each participant and alternate recipient a copy of these Procedures for Processing Qualified Medical Child Support Orders. The required notices will be mailed to the addresses specified in the medical child support order. If the medical child support order does not specify addresses, the required notices will be mailed to the last addresses known to the Fund Administrator.
- The Medical Child Support Order must contain all of the following information:
  - The name and last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the medical child support order;
  - A reasonable description of the type of coverage to be provided by the Fund to each alternate recipient, or the manner in which such type of coverage is to be determined;
  - The period to which such medical child support order applies; and
  - The name of the Fund: Plasterers Local No. 31 Insurance Fund

The medical child support order will not be considered a qualified medical child support order if it requires the Fund to provide any type or form of benefit, or any option, not otherwise provided for under the Fund, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act. The Fund will require receipt of a certified copy of a qualified medical child support order before benefits will be paid to or on behalf of an alternate recipients under the order.

- The Fund Administrator will review the Medical Child Support order to determine if such Order is a Qualified Medical Child Support Order. If there is any question in regards to whether such Court Order is a Qualified Medical Child Support Order, the Administrator will/may forward such Order to the Fund's attorney for review and advice.
- Once the Administrator determines that it is a proper Qualified Medical Child Support Order, he will notify the participant, the alternate recipients, the participant's counsel, and the alternate recipient's counsel, if any, of the Fund's determination. The notice given by the Fund Administrator may include information of the amount of benefit each party will receive.

## 11.2 Family and Medical Leave Act

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) your eligibility may be continued provided your employer makes the required contribution on your behalf. Eligibility may be for up to 12 weeks during the 12 month period, for any of the following reasons:

- (a) to care for your child after the birth or placement of a child with you for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement of the child;
- (b) to care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or
- (c) for your own serious health condition.

In the event you or your spouse are both covered as eligible participants, the continued coverage under (a) may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

### **Conditions**

- You are eligible to continue your coverage under FMLA if:
  - you have worked for your employer for at least one year;
  - you have worked at least 1,250 hours over the previous 12 months for such employer;
  - your employer employs at least 50 employees within 75 miles from your worksite; and
  - your employer continues to pay the required contributions on your behalf.
- If, on the day your eligibility is to begin, you are already on an FMLA leave of absence, you will be considered actively at work. Benefits for you and any eligible dependents (if applicable) will be in accordance with the terms of the plan as herein set forth.
- You and your dependents (if applicable) are subject to all conditions and limitations of the plan during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.
- FMLA continuation ends on the earliest of:
  - the day you return to work;
  - the day you notify your employer that you are not returning to work;
  - the day your coverage would otherwise end under the plan; or
  - the day coverage has been continued for 12 weeks.

**11.3 Women's Health and Cancer Rights Act of 1998:** Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymph edemas.

This coverage is subject to any of the Plan's normal annual deductibles and co-insurance provisions.

**11.4 Newborn's and Mother's Health Protection Act (NMHPA):** Group Health Plans and Health Insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours), as applicable.

<p style="text-align: center;"><b>SECTION 12.0</b> <b>Subrogation</b></p>
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Subrogation means that if you incur health care expenses for injuries due to an accident or illness caused by another person or organization, the person or organization causing the accident is responsible for paying these expenses.

For example, if you or one of your dependents receives Blue Cross and Blue Shield benefits for injuries caused by another person or organization, Blue Cross and Blue Shield have the right, through subrogation, to seek repayment from the other person or his/her insurance company for benefits already paid.

Blue Cross and Blue Shield plans will provide eligible benefits when needed, but you may be asked to show documents or take other necessary actions to support Blue Cross and Blue Shield plans in their subrogation efforts.

Subrogation does not apply to an individual insurance policy you may have purchased for yourself or your dependents or where subrogation is specifically prohibited by law.

For more information regarding subrogation, please refer to the information provided by the Preferred Blue PPO Program.

<b>SECTION 13.0</b> <b>Coordination of Benefits</b>
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Most group health care programs, including your managed care program, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one group health program. The object of coordination of benefits is to assure you that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision in your Blue Cross and Blue Shield coverage works:

When your other group coverage does not mention “coordination of benefits,” then that coverage pays first. Benefits paid or payable by the other group coverage will be taken into account in determining if additional benefit payments can be made under your program.

When the person who received care is covered as an employee under one group contract, and as a dependent under another, then the employee coverage pays first.

When a dependent child is covered under two group contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the program which covered the parent longer will be the primary program. If the dependent child’s parents are separated or divorced, the following applies:

1. If the parent with custody of the child has **not** remarried, the coverage of the parent with custody pays first.
2. When a divorced parent with custody has remarried, the coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
3. Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

When none of the above circumstances applies, the coverage you have had for the longest time pays first; *provided that*:

1. The benefits of a program covering the person as an employee other than a laid off or retired employee or as the dependent of such person shall be determined before the benefits of a program covering the person as a laid-off or retired participant or as a dependent of such person; and
2. If the other program does not have a provision regarding laid-off or retired participants, and, as a result, the benefits of each program are determined after the other, then the provisions of (1) above shall not apply.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment.

Coordination of benefits prevents duplication and works to the advantage of all members of the group. For more information regarding Coordination of Benefits, please refer to the material provided by the PPO Blue program.

**SECTION 14.0**  
**DENIAL AND APPEAL CLAIM PROCEDURES:**

The following Denial and Appeal Claim Procedures will be effective January 1, 2003.

A claim is a request for a benefit under this Welfare Plan made in accordance with this claim procedure. A request for a benefit under this Welfare Plan will be considered a claim only if it is submitted to the appropriate Claim Administrator identified below. In addition to the information provided on each benefit, information on submitting a claim is shown in Section 9.

**14.1 Claim Administrators:**

- (a) **Inpatient Hospital:** The Claim Administrator for inpatient hospital administration is Highmark Blue Cross Blue Shield. Claims for inpatient hospital administration must be pre-certified as shown under the Highmark Preferred Blue PPO Plan of Benefits and in the Highmark Preferred Blue Plan of Benefits Summary Plan Description. You or your authorized representative may contact the Fund Office if you require further information.
- (b) **Prescription Drug:** The Claim Administrator for prescription drugs is Highmark Blue Cross Blue Shield. Claims for prescription drugs at participating pharmacies will be processed at the time your prescription is filled. You or your authorized representative may contact the Fund Office to obtain information regarding Highmark Blue Cross Blue Shield.
- (c) **Dental Benefits:** The Claim Administrator for Dental Benefits is Delta Dental of Pennsylvania. You or your authorized representative may contact the Fund Office to obtain information regarding Delta Dental of Pennsylvania.
- (d) **Vision Benefits:** The Claim Administrator for Vision Benefits is National Vision Administrators. You or your authorized representative may contact the Fund Office to obtain information regarding National Vision Administrators.
- (e) **Temporary disability benefits:** The Claim Administrator for temporary disability benefits is the Plasterers Local 31 Insurance Fund. You or your authorized representative may contact the Fund Office if you require further information.
- (f) **Death Benefit and Accidental Death:** The Claim Administrator for life insurance and accidental death and dismemberment benefits is the Plasterers Local 31 Insurance Fund.

**14.2 Initial Claim Determination:**

- (a) **Definitions:**
  - 1) **Urgent claims** are requests for eligibility status or for medical care or treatment of an emergency nature, which could seriously jeopardize the life or health or the claimant or would subject the claimant to severe pain.
  - 2) A **pre-service claim** is a request for eligibility status or for benefits for which a Plan requires pre-approval, such as pre-admission certification for a hospital admission or a predetermination of benefits for major dental care.
  - 3) A **post-service claim** is a request for a benefit following the claimant's receipt of services

- 4) A **disability claim** is a request for a disability benefit as described in .
- 5) A **life insurance claim** is a request for life insurance or accidental death and dismemberment benefits under the Welfare Plan.

(b) **Time Limits for Initial Claim Determinations:**

- (1) **Urgent Care Claim:** A decision and notification to you with respect to an *urgent care claim* will be made within seventy-two (72) hours or sooner if possible (whether adverse or not). If the claim is not complete, the Plan will so notify you of the additional information required within twenty-four hours. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with the Claim Denial procedures (described in section 10.3). The plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of
  - i) The plan's receipt of the specified information
  - ii) The end of the period afforded the claimant to provide the specified additional information
- (2) **Pre-Service Claim:** A decision and notification to you on a *pre-service claim* will be made within fifteen (15) days from receipt of the claim. The Plan may take an additional fifteen (15) days, if it is determined an extension is necessary due to matters beyond the control of the Plan and you are advised of the need for the extension, prior to the expiration of the fifteen (15) day period, and the date by which the Plan expects to render a decision. The Plan will advise of a defective or incomplete filing of a pre-service claim within five (5) days of receipt. If the extension is due to failure to submit necessary information to decide the claim, you shall be afforded at least 45 days from receipt of the notice within which to provide the information.
- (3) **Post-Service Claim:** A decision and notification to you on a *post-service claim* will be made within 30 days from receipt of the claim. This determination period may be extended one time for 15 days for reasons beyond the Plan's control, in which case the Plan will notify you in writing within the first 30-day period of the circumstances requiring an extension and the expected date of a decision. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide you at least 45 days from receipt of the notice to provide the necessary information.
- (4) **Disability Claim:** A decision and notification to you on a *disability claim* will be made within 45 days from receipt of the claim. This determination period may be extended two times for 30 days for reasons beyond the Plan's control, in which case the Plan will notify you in writing within the first 45-day period of the circumstances requiring an extension and the expected date of a decision. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide you at least 45 days from receipt of the notice to provide the necessary information. The deadline for the claim determination will be suspended for 45 days or until the information is received.

- (5) **Life Insurance Claim:** A decision and notification to you on a *Life Insurance* claim will be made within 90 days from receipt of the claim. One 90-day extension is permitted if required by special circumstances, in which case the Plan will notify you in writing within the first 90-day period of the circumstances requiring an extension and the expected date of a decision.

(b) **Concurrent Care Decisions:**

- (1) If the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by the Plan of such course of treatment before the end of the period or number of treatments previously agreed to will be considered a denial. The Plan will notify you of this action in advance of the application of the reduction or termination and advise of the appeal rights to permit a review prior to the date the benefit is reduced or terminated.
- (2) A decision to extend the previously agreed to course of treatment for an *urgent care claim* will be acted upon as soon as possible. The Plan will notify you of the determination within twenty-four (24) hours of receipt, provided the claim is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

**14.3 Claim Denial Procedures:** If your claim is denied or partially denied, you will be notified in writing and provided an opportunity for a review.

- (a) The written notice of denial will provide:
  - 1) The specific reason(s) for the denial;
  - 2) The specific Plan provision on which the determination is based;
  - 3) A description of additional information or information necessary for you to perfect the claim and an explanation of why this additional information is necessary;
  - 4) A statement that the specific rule, guideline, protocol or other criterion relied upon in making the determination, if applicable, will be provided at no cost upon request;
  - 5) A statement advising that an explanation of the scientific or clinical judgment relied upon and the names of the individuals from whom opinion(s) were secured, if a determination is based upon medical necessity or experimental treatment, or similar exclusion or limit, will be provided at no cost; and
  - 6) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement regarding your right to bring a civil action under section 502(a) of ERISA.
  - 7) For urgent care claim denials, a description of the expedited review process applicable to urgent care claims.

**14.4 Claim Appeal Procedures:**

- (a) **Filing an Appeal:** If your claim has either been denied or partially denied and you are not satisfied with the decision, you may appeal the decision and request a review of the claim. The appeal:
  - 1) Must be in writing and can be made by you or your duly authorized representative;

- 2) Should be mailed or delivered to the Fund address shown in the Summary Plan Description;
- 3) Should state the reasons you believe the initial determination was incorrect;
- 4) Should include any written comments, documents, records and other information relating to the claim for benefits; and
- 5) Must be submitted within one hundred eighty (180) days of the date you receive the notice of denial or partial denial.

You will be provided access to and copies of, at a reasonable charge, all documents, records, and other information relevant to your claim.

(b) **Timeframe for Claim Appeal Determinations:**

- 1) A determination of an **urgent care claim** will be made within seventy-two (72) hours after receipt of your request for review.
- 2) A determination of a **pre-service claim** will be made within thirty (30) days of receipt of your request for review.
- 3) A determination of a **post-service claim** will be made during the course of the regular quarterly Trustees' meeting following receipt of the request for review and you will be notified of the decision within five (5) days of the date of such meeting. (If the request for review is received within thirty (30) days of the next regular quarterly Trustees' meeting, the decision on review will be made not later than the date of the second meeting following the Plan's receipt of the request for review). If special circumstances require an extension of time, a decision will be rendered not later than the next following quarterly Trustees' meeting. You will be advised of the special circumstances and the date the decision is expected to be made.
- 4) A determination of a **disability claim** will be made within 45 days from receipt of your appeal. One 45-day extension is permitted if the Claims Administrator provides you with notice and an explanation of the circumstances resulting in the delay prior to the expiration of the initial 45-day period.
- 5) A determination of a **life insurance claim** will be made within 60 days from receipt of your appeal. One 60-day extension is permitted if the Claims Administrator provides you with notice and an explanation of the circumstances resulting in the delay prior to the expiration of the initial 60-day period.

**14.5 Claim Reviewers:**

- (a) Initial Claim Review will be conducted by the Fund Administrator or staff. If medical judgment is required, a qualified medical reviewer will be consulted.
- (b) A review of the claim upon appeal will be conducted by the Board of Trustees. If medical judgment is required, a qualified medical reviewer will be consulted. The qualified medical reviewer will not be connected in any way with the medical reviewer utilized in 10.5 (a).

**14.6 Adverse Appeal Determinations:** If you receive an adverse appeal determination, you will be notified in writing and advised of the following:

- (a) The specific reason for the adverse determination;
- (b) Reference to the specific plan provisions on which the determination is based;
- (c) That a copy of any internal rule guideline, protocol, or similar criteria which was relied upon is available without cost upon request;
- (d) That a copy of the scientific or clinical judgment relating to a claim denial for medical necessity, experimental treatment or similar exclusion or limit is available without cost upon request;
- (e) The identity of any medical or vocational experts whose advice was obtained on behalf of the Plan;
- (f) That you are entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- (g) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement regarding your right to bring a civil action under section 502(a) of ERISA.

THE DECISION OF THE TRUSTEES ON REVIEW WILL BE MADE IN GOOD FAITH AND WILL BE FINAL AND BINDING ON ALL ISSUES. CLAIMANT OR CLAIMANT'S DULY AUTHORIZED REPRESENTATIVE WILL BE REQUIRED TO EXHAUST THE ENTIRE CLAIM REVIEW PROCEDURE BEFORE INSTITUTING ANY OTHER FORM OF ACTION.

**SECTION 15.0**  
**INFORMATION REQUIRED BY EMPLOYEE**  
**RETIREMENT INCOME SECURITY**  
**ACT OF 1974**

**15.1 PLAN NAME, ADDRESS AND TELEPHONE NUMBER:**

Plasterers Local 31 Insurance Fund  
c/o O.P. & C.M.I.A Combined Funds, Inc.  
1900 Andrew Street  
Munhall, PA 15120  
Phone #: 412-464-2851

**15.2 PLAN FIDUCIARIES:** The Board of Trustees of the Plasterers Local 31 Insurance Fund, functioning in their capacity as Trustees under the terms and conditions of the Agreement and Declaration Trust, are the Plan Fiduciaries. The Board of Trustees consist of the following members:

**FOR THE UNION**

Doug Taylor  
Shawn Potts

**FOR THE EMPLOYER**

David Balmert  
Fred Episcopo

**15.3 ADMINISTRATION OF THE PLAN:** The Board of Trustees is responsible for the overall administration of the Plan. The Board of Trustees (Plan Administrators under ERISA) may be contacted by writing or calling at the address shown above.

**15.4 EMPLOYER IDENTIFICATION NUMBER:** The Employer Identification Number issued by the Internal Revenue Service to the Board of Trustees is #25-1189104.

**15.5 LEGAL NOTICE:** All legal notices should be filed with the Board of Trustees of the Plasterers Local 31 Insurance Fund (*c/o O.P. & C.M.I.A Combined Funds, Inc. 1900 Andrew Street Munhall, PA 15120*).

**15.6 PLAN DOCUMENTS:** This Booklet, the Trust Agreement, and all amendments, resolutions and contracts adopted and entered into by the Board of Trustees constitute the Plan.

**15.7 PLAN SPONSORS:** The Plasterers Local Union No. 31 and the employers participating in the Plan are the Plan Sponsors. A complete list of the participating employers may be obtained by written request to the Plan Administrator.

**15.8 COLLECTIVE BARGAINING AGREEMENTS:** The Local No. 31 of the Operative Plasterers and Cement Masons International Association has executed a Collective Bargaining Agreement requiring Employers to make contributions into the Fund.

Copies of the Collective Bargaining Agreements may be secured from the Union at the address listed below:

Local No. 31 of the Operative Plasterers and  
Cement Masons International Association  
1900 Andrew Street  
Munhall, PA 15120

- 15.9 PLAN YEAR:** The financial records of the Plan are maintained on a fiscal year commencing July 1 and ending on the following June 30. In processing claims under the Plan, certain limitations relating to benefit payments are based upon a calendar year running from January 1 through December 31.
- 15.10 PENSION BENEFIT GUARANTY CORPORATION:** The benefits under the Plan are not insured by the Pension Benefit Guaranty Corporation, since the Corporation does not insure medical-type Plans.
- 15.11 FUNDING MEDIUM:** The benefits provided by the Plan are funded by contribution received from the employers pursuant to a Collective Bargaining Agreement or Agreements, contributions made by the Union, and certain Employee contributions, together with any income or earnings derived from the investment of reasonable reserves. Benefits shall be paid only to the extent such contributions and income suffice for the purposes set forth in the Trust Agreement. Neither the Trustees, any Employer, or the Union shall be liable, in any manner, if the Fund shall be insufficient to provide for the payment of the benefits specified herein.
- 15.12 ELIGIBILITY FOR BENEFITS::** The plan's requirements with respect to eligibility for benefits is shown in Section 3 of this booklet.
- 15.13 PROCEDURE FOR FILING CLAIMS:** Claim filing procedures are described in Section 2 of this booklet.
- 15.14 DENIAL OR LOSS OF BENEFITS:** Circumstances which may result in disqualification or ineligibility appear in the Rules of Eligibility starting in Section 2 of this booklet.
- 15.15 CLAIM APPEALS:** The procedures for appealing a claim which has been denied appear in Section 14 of this booklet.

**SECTION 16**  
**PARTICIPANT'S AND BENEFICIARIES' RIGHTS UNDER ERISA**

As a participant in the Plasterers Local 31 Insurance Fund, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

Examine without charges, at the Plan Administrator's Office, all Plan documents, including insurance contracts, Collective Bargaining Agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request, to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report.

File suite in a federal court, if any materials requested are not received within thirty (30) days of the participant's request, unless the materials were not sent because of matters beyond the control of the Administrator. The court may require the Plan Administrator to pay up to \$ 100.00 for each day's delay until the materials are received.

**ERISA REGULATIONS ALSO PROVIDE  
THE FOLLOWING SAFEGUARDS**

Your Employer may not fire or discriminate against you to prevent you from obtaining a Welfare Benefit or exercising your rights under the Plan.

If you are improperly denied a Welfare Benefit, you have the right to file suit in a federal or state court.

If the Plan Fiduciaries are misusing the Plan's money, you may file suit in a federal court or request assistance from the U.S. Department of Labor.

**SHOULD YOU HAVE ANY QUESTIONS ABOUT YOUR RIGHTS UNDER ERISA, YOU SHOULD CONTACT THE PLAN ADMINISTRATOR OR THE NEAREST AREA OFFICE OF THE U.S. DEPARTMENT OF LABOR-MANAGEMENT.**

## **PART II**

### **Plasterers Local 31 Pension Plan**

## PENSION FUND

**O.P. & C.M.I.A Combined Funds, Inc.**

**1900 Andrew Street**

**Munhall, PA 15120**

**Telephone: (412)-464-2851**

**Fax: (412)-461-9923**

Dear Participants and Beneficiaries:

We are pleased to distribute this new Summary Plan Description describing the provisions of the Plasterers Local 31 Pension Plan. (We refer to the Pension Plan as “the Plan” or “the Fund” in this booklet. Both of these mean the same thing.)

The effective date of this booklet is designated as May 1, 2005. It applies to all persons who are Participants in the Plan or who retire on or after that date, to be sure that as required by law, it reflects the terms of the Plan at or shortly before the time this booklet was first distributed. Also, in general, this booklet describes the essential terms of the formal Plan document as amended and restated effective June 1, 1998, plus later amendments. After the June 1, 1998 Amendment/Restatement was adopted, the Internal Revenue Service certified its determination of the Plan’s compliance with the requirements for qualified pension plans.

This booklet summarizes the eligibility rules for participation in the Plan, the benefits provided to those who are eligible and the procedures you must follow when applying for benefits. The Plan generally covers all employees who work within the territorial jurisdiction of the Plasterers Local 31 in employment for which an employer is required to make contributions to the Plan (generally, under the Plasterers Local 31 Collective Bargaining Agreement or another CBA, or in some cases, under another written agreement) and meet the Eligibility Rules as defined by the Trustees.

This booklet has attempted to summarize the major provisions of the plan and is designed to be understandable to you. You should note that the Plan is a defined contribution pension plan in which employer contributions made on your behalf are accounted for in an Individual Account. The contributions are accumulated with other Participants’ contributions and invested by an Investment Manager hired by the Fund Trustees to provide professional investment advice and services.

**The booklet is the summary plan description of the Plan, and does not modify or serve as an interpretation of the formal Plan document. The Plan document contains all of the terms and conditions of the Plan and controls in the event of a conflict between this booklet and the plan document. The Fund’s Board of Trustees, who sponsor and administer the Plan, have the authority to interpret the terms of the Plan and to determine eligibility for benefits under the Plan, and they are the only persons with such authority.**

If you wish to have a complete copy of the official Plan Document, you may request one in writing. It will be provided to you at a cost of \$.25 per page. If you do not want to purchase the document but want to read it, you may do so by going to the Fund Office.

This is your benefit booklet. Make sure you read it from cover to cover and put it in a safe place for future reference. If at any time you have questions about the Plan, call or write the Fund Office for assistance. As changes occur in the Pension Plan, the Fund Office will advise you.

Yours very truly,

BOARD OF TRUSTEES

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- 1.1 WHO WILL BE A PARTICIPANT:** In general, if you are working for an Employer who has a collective bargaining agreement with Plasterers Union Local #31 and that agreement requires contributions to be made to the Pension Plan, you are a participant upon receipt by the Fund of those contributions.
- 1.2 PLAN FISCAL YEAR:** The Plan Fiscal Year is the Calendar Year.
- 1.3 WHO PAYS THE COST OF THE PENSION PLAN:** Except for the Expenses of the Fund described in Section 1.9, the entire cost of the Pension Plan is under the provisions of the Collective Bargaining Agreement.
- 1.4 WHAT IS AN INDIVIDUAL ACCOUNT:** An Individual Account is the account established and maintained for each participant into which is placed employer contributions made on your behalf. In general, it will be:
- (a) The sum of all past and present contributions made on your behalf, PLUS
  - (b) All investment earnings (realized and unrealized) credited to your account, MINUS
  - (c) All investment losses (realized and unrealized) credited to your account MINUS
  - (d) Your share of the expenses of operating the Fund, MINUS
  - (e) All amounts paid out to you, your beneficiary or an alternate payee
- 1.5 CAN I CONTRIBUTE TO MY INDIVIDUAL ACCOUNT:** No, a participant may not make personal contributions to their individual account. The only contributions that can be accepted must be in accordance with the provisions of the Collective Bargaining Agreement.
- 1.6 HOW OFTEN IS THE ACCOUNT VALUED:** All investment accounts are valued every day of the year.
- 1.7 HOW WILL THE PENSION FUND ASSETS BE INVESTED:** The Pension Fund qualifies as a "404(c)" plan, whereby the law relieves the Trustees and other Plan Fiduciaries of the responsibilities for making all investment decisions regarding the Fund assets. A 404(c) plan permits the participants to direct the investment of their individual account according to the rules of Section 404(c) of the Employee Retirement Income Security Act of 1974 ("ERISA") and Title 29 of the Code of Federal Regulations, Section 2550.404c-1. As a result, the Fund's Fiduciaries, including the Trustees, will not be liable for losses that are a direct and necessary result of investment instructions the Trustees received from you.

**Once you have become a participant, you can transfer money from your existing account into one or more of several investment options. You can also designate and change the way new contributions to your account are allocated among the investment options.**

The investment options are selected and reviewed by the Trustees. They have varying levels of risk.

- 1.8 ACCOUNT BALANCE – STATEMENTS:** The Fund employs a Record keeper, Fifth Third Bank, who keeps track of all transactions in your individual account. The Recordkeeper maintains a toll-free telephone number that will permit you to obtain the current value of each of the investments in your individual account.

**Toll Free Number: 1-866-258-4777**

**Web site: [www.Retire.53.com](http://www.Retire.53.com)**

**In addition, the Recordkeeper will send you a quarterly statement showing the contributions, investment earnings withdrawals and expenses applied to your account. If you believe that there are any discrepancies in your statement, you should contact the Recordkeeper or the Fund Office as soon as possible.**

**1.9 EXPENSES:** The Trustees carefully monitor the expenses of the Fund. These expenses include the cost of the Fund Office and Professionals (Lawyers, Accountants, Consultants, Recordkeeping Services, Investment Management, etc.) The expenses are assessed in two ways: First, a per-capita charge is applied directly to your account and shown on your statement. The second part is a percentage of the assets in your account. This part is deducted daily by the firm that manages the investments.

**1.10 CHANGING INVESTMENTS:** If you do not make any changes to your investment allocation, all contributions will be entered into the Default Fund. Details of the Default Fund and the other investment options will be distributed to you upon becoming a participant of the Plasterer's Local 31 Pension Fund.

You may also change investments daily by calling the Retirement Response Line (RRL). The RRL is a system that provides participants with twenty-four (24) hour access to their account information. Upon dialing the number, **(866) 258-4777**, you will be able to interact with the system by pressing the number pad on your touch tone telephone. A pin number will be assigned to you upon becoming eligible for participation in the Fund. The RRL will provide instructions on how to check balances, change election options, and change investment options. Any changes to your investments will result in a written confirmation being mailed to your home address on file with Fifth Third Bank. You may also change your investments over the internet at **www.Retire.53.com**.

**1.11 WHEN ARE BENEFITS PAYABLE FROM THE PENSION FUND:** In general, you will receive the amounts in your Individual Account when:

- (a) You retire- normal retirement age is 60, early retirement age is 55;
- (b) you die prior to retirement;
- (c) you become totally and permanently disabled;
- (d) upon termination, when you have an individual account and employer contributions have not been made on your behalf for at least six (6) consecutive months.

**1.12 IN WHAT FORM WILL PENSION BENEFIT PAYMENTS BE MADE TO ME:** If you were married throughout the one year period ending on your Annuity Starting Date, the normal form of receiving benefit payments under this Plan shall be a Qualified Joint and Survivor Annuity with your spouse. The Qualified Joint and Survivor Annuity is a series of monthly payments, payable as long as you are alive and, if your spouse survives you, 50% of the monthly amount will be payable upon your death, to your spouse for life. You may also elect not to receive a Qualified Joint and Survivor Annuity, in which event, your election must be consented to by your spouse in writing which must be witnessed by a notary public.

You may then elect to have the balance in your account payable in monthly installments not to exceed 10 years or one lump sum or any combination of the two. In the event that you die prior to retirement, your surviving spouse, if you have been married for at least one (1) year prior to your death, will receive a Qualified Pre-Retirement Survivor Annuity. The earliest date that your spouse may receive a payment is the month following the month in which you would have attained the earliest retirement age. However, your spouse may elect to receive a lump sum distribution of your account balance payable upon your death. If you are married and choose anyone other than your spouse to be your beneficiary and die before you start receiving Annuity payments from the Fund, your spouse, if you have been married for at least one (1) year prior to your death, must be the beneficiary for at least one-half of your account.

**1.13 ROLLOVERS AND PENALTIES ON EARLY WITHDRAWALS:** Under current Federal regulations, in an effort to encourage savings for retirement purposes, certain penalties will be charged against any withdrawal or distribution from any qualified plan. The penalty is non-deductible 10% excise tax on the entire taxable amount of the withdrawal or distribution. This penalty is in addition to any income tax you might be liable for on the withdrawal or distribution. The penalty covers withdrawals and distributions due to termination and hardship benefits.

Under your Plan, the only exceptions to this rule (10% excise tax) are as follows

- (a) A distribution or withdrawal after you have reached age 59 ½
  - 1) Unless you terminated employment under the Plan at or after age 55.
- (b) A distribution to your beneficiary due to your death
- (c) A distribution to you due to your total and permanent disability;
- (d) You may also, under most circumstances, transfer your distribution to a "Rollover IRA". If this is done, there is no immediate tax obligation and no penalty. Additional information on Rollovers is available from the Fund Office.

**If you receive a distribution from another qualified retirement plan that permits Rollovers, you may apply to transfer that distribution into a Rollover account in this Fund.**

**1.14 HOW TO APPLY FOR A BENEFIT:** You should file an application for Retirement, Total and Permanent Disability, or Termination Benefits with the Trustees. Your designated beneficiary or the executor of your estate will file an application in case of a death benefit. The proper form will be provided to you upon request at the office of the Pension Plan Administrator.

**1.15 APPEALS PROCEDURE:** If your claim for benefits is denied, you will receive a written notice explaining the reasons for denial. You will then have 60 days after you receive the denial to request in writing an appeal of your case before the Board of Trustees. You can appeal personally or through a representative. The Trustees will review any new evidence or testimony that you may have. After review, the Trustees will notify you in writing of their final decision, which will include explanations and reasons if your claim is denied.

**1.16 QUALIFIED DOMESTIC RELATIONS ORDERS:** The laws governing this type of plan generally provide that a participant's benefits under a qualified plan cannot be assigned, pledged or otherwise encumbered. The Retirement Equity Act, effective January 1, 1985, established an exception to this rule for "qualified" domestic relations orders - under which the plan may be required to pay benefits to a person (alternate payee) other than a participant. The Tax Reform Act of 1986 amended and further clarified this exception for qualified domestic relations orders.

In general, a domestic relations order (DRO) means any judgment, decree, or order that relates to the provision of child support, alimony payments or marital property rights which is made pursuant to a particular state's domestic relations law (including a community property law). If the DRO is found to be a "qualified domestic relations order" (QDRO), the plan must make a payment of all, or part of, a participant's benefits to the alternate payee(s) specified in the DRO. An alternate payee is a spouse, former spouse, child, or other dependent of a participant who is recognized by the DRO as having a right to receive all, or a portion, of the participant's benefits under the plan. An alternate payee may designate a representative for receipt of copies of notices and plan information that are sent to the alternate payee with respect to a DRO. To be "qualified" under ERISA the DRO must satisfy certain requirements.

To be qualified, a domestic relations order **must** clearly specify:

- (a) the participant and each alternate payee covered by the DRO by name and mailing address,
- (b) the amount or percentage of the participant's benefits to be paid to each alternate payee, or the manner of determining the alternate payee's benefit,
- (c) the number of payments to the alternate payee or the period during which payments are to be made to the alternate payee to which the DRO applies, and
- (d) the plan or plans to which the DRO applies
- (e) any other information necessary to properly administer the DRO.
- (f) In addition, the DRO to be qualified **cannot** require the plan to:
  - 1) provide benefits under a form of payment that is not provided for under the plan,
  - 2) provide benefit amounts which would be greater than the participant's account balance, or
  - 3) Pay to an alternate payee benefit amounts which are **required** to be paid to another individual under a prior domestic relations order.
- (g) While an DRO generally may not require a plan to provide a type or form of benefit not otherwise provided under the plan, the law includes special provisions which permit benefits to be paid to an alternate payee **before the participant** begins to receive benefits. However, the following requirements **must** be met:
  - 1) Benefits to the alternate payee may not begin before the participant reaches his or her "earliest retirement age". The participant's "earliest retirement age" is the earlier of:

- 2) the age the participant could have begun to receive benefits under the plan, if he or she were "separated from service" as defined in the Plan (but not earlier than age 50)
  - 3) the earliest age the participant could elect to have his or her payments commence
- (h) The DRO must provide for a benefit form available under the plan to the participant. However, a joint and survivor annuity for the alternate payee and his or her new spouse is not permitted.
  - (i) In no event shall any payments be made to an alternate payee until a qualified person, such as the plan's legal counsel, has determined that the DRO is qualified.
  - (j) **Note:** If the plan administrator is notified that a DRO is being sought, the plan administrator may delay payments to a participant in anticipation of such DRO.
  - (k) The law provides that the plan administrator shall have a reasonable length of time in which to determine whether an DRO is qualified. The plan administrator is to separately account for the amount called for in the DRO which would be payable to the alternate payee during an 18 month period beginning at the time the proposed QDRO requires payments to be made to the alternate payee but not earlier than the receipt by the Plan of the proposed QDRO. If benefits are in pay status, the amounts called for in the DRO will be withheld during this period from the participant's benefit.
  - (l) While the law requires only separate accounting of amounts currently payable to an alternate payee during the determination period, legal counsel may determine that an immediate segregation of the entire potential interest of the alternate payee is required in order to have the account records necessary to enable the plan to comply with the DRO.
  - (m) If the DRO is determined to be nonqualified before the 18 month period ends, the plan administrator may (i) continue any withholding of benefit payments, and (ii) continue any separate accounting until the end of the 18-month period if he or she has notice that the alternate payee is attempting to rectify any deficiencies in the DRO.
  - (n) If the plan administrator is unable to resolve the DRO's qualified status within 18 months of the date payments would first be required under the DRO, then the DRO shall be treated as not qualified with respect to continued withholding of any benefit payments. All payments withheld during this period (together with interest thereon) are to be paid to the individual who would receive them if the DRO was never issued. Furthermore any separate accounting will be eliminated, and if a separate account was established under a defined contribution plan the accu'nulated segregated amounts (together with earnings thereon) must be paid to the participant or transferred to his or her plan account. If the DRO is found to be qualified after the 18-month period, the provisions of the DRO shall only be applied prospectively.

**1.17 PLAN TERMINATION:** The Plan may be terminated by the Board of Trustees and, in such event, all of the funds of the Plan shall be used for the exclusive benefit of Participants as of the date of termination of the Plan and to defray the expenses of the termination. In the event of discontinuance of the Plan, the net value of your individual account shall be determined as of the date of discontinuance. Expenses of terminating the Plan shall be deducted pro-rata from the net value of your individual account, and the balance shall be paid to you in one lump sum or applied to purchase an annuity for you under a group annuity contract as the Trustee shall in their sole discretion determine. Any annuity so purchased may be a fixed dollar or variable annuity, or both, and will be subject in all respect to the terms of the group annuity contract under which it is purchased. Upon Plan termination or partial termination or discontinuance of contributions, your interest in the Plan as of the date of Plan termination, partial termination or discontinuance of contributions will be non-forfeitable. No merger or, consolidation with, or transfer of assets or liabilities to any other plan shall be made unless your benefit after the termination, merger, consolidation or transfer, is equal to or greater than the your benefit immediately before the merger, consolidation or transfer if the Plan had then terminated.

<b>SECTION 2</b> <b>INFORMATION REQUIRED BY ERISA</b>
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- 2.1** Name of Plan: Plasterers Local 31 Pension Plan.
- 2.2** Internal Revenue Service Employer Identification Number (EIN): 25-6130880
- 2.3** Plan Number: 001
- 2.4** Plan Established and Maintained by:  
 Board of Trustees  
 Plasterer Local 31 Pension Plan  
 O.P. & C.M.I.A Combined Funds, Inc.  
 1900 Andrew Street  
 Munhall, PA 15120  
 412-464-2851
- 2.5** Type of Pension Plan: The Plasterers Local 31 Pension Plan is referred to as a defined contribution plan.
- 2.6** Type of Administration of the Pension Plan: The plan is administered and maintained by the Joint Board of Trustees for the Plasterers Local 31 Pension Plan.
- 2.7** Plan Administrator: The Board of Trustees are responsible for the overall administration of the Plan. However, for the purpose of processing certain reports and records, the Trustees have retained the services of O.P. & C.M.I.A Combined Funds, Inc.
- 2.8** Agent for Service of Legal Process: Service of Legal Process may be made on the Plan Administrator (Board of Trustees) or the person designated below:  
 Board of Trustees  
 O.P. & C.M.I.A Combined Funds, Inc.  
 1900 Andrew Street  
 Munhall, PA 15120
- 2.9** Name, Title and Address of Principal Place of Business of each Trustee:
- | <b>MANAGEMENT TRUSTEES</b>   | <b>UNION TRUSTEES</b>                                      |
|--|--|
| Mr. David Balmert<br>P.O. Box 33<br>Oakmont, PA 15139                | Mr. Doug Taylor<br>1900 Andrew Street<br>Munhall, PA 15120 |
| Mr. Fred Episcopo<br>4545 Campbells Run Road<br>Pittsburgh, PA 15205 | Mr. Shawn Potts<br>1900 Andrew Street<br>Munhall, PA 15120 |
- 2.10** Collective Bargaining Agreements: This plan is maintained pursuant to a collective bargaining agreement between Plasterers' Local Union #31 and the

various participating employers. You may obtain a copy of the collective bargaining agreement by writing to the plan administrator or you may examine it at the Fund Office.

**2.11** Sources of Contributions: This plan is funded through contributions by the employers on behalf of their employees, under the terms of a collective bargaining agreement and by investment income earned on a portion of the Fund's assets.

**2.12** Statement of Plan Termination Insurance: The Pension Benefit Guaranty Corporation (PBGC) insures benefits under this plan if the plan terminates. Generally, the PBGC guarantees most vested normal age retirement benefits, early retirement benefits and certain disability and survivor pensions. However, PBGC does not guarantee all types of benefits under covered plans, and the amount of benefit protection is subject to certain limitations.

**2.13** The PBGC guarantees vested benefits at the level in effect on the date of plan termination. However, if a plan has been in effect less than five years before it terminates, or if benefits have been increased within the five years before plan termination, the whole amount of the plan's vested benefits or the benefit increases may not be guaranteed. In addition, there is a ceiling on the amount of monthly benefit that PBGC guarantees, which is adjusted periodically.

**2.14** For more information on the PBGC insurance protection and its limitations, ask your Plan Administrator or the PBGC. Inquiries to the PBGC should be addressed to:

Office of Communications  
PBGC  
P.O. Box 151750  
Alexandria, VA 22315

The PBGC Office of Communications may also be reached by calling (800) 400-7242.

Under ERISA, the insurance described above does not apply to multi-employer plans until July 1, 1979. If a multi-employer plan terminates prior to that date, PBGC may at its discretion extend coverage, but only under specific conditions set forth in ERISA.

**2.15** Funding Medium for the Accumulation of Plan Assets: Assets are accumulated and invested by the registered financial advisor, which is currently Fifth Third Bank Advisors, Inc.

**2.16** Date of the Plan's Fiscal Year End: December 31.

Termination of the Plan: It is the intention of the Union and the Employers that this Plan shall be continued indefinitely. If the Plan were to be terminated by the Trustees, the accrued benefits are non-forfeitable and would be payable upon retirement, death or termination of employment in accordance with the Plan provisions.

### **SECTION 3 ERISA RIGHTS**

The Pension Plan is covered by the Employee Retirement Income Security Act of 1974 (ERISA), a federal law intended to protect employee's rights under their benefit plans. As a participant, you have certain rights and protection under ERISA.

You may review, without charge, by contacting the Board of Trustees, all supportive documents, including the plan document, the trust agreement, and the annual return/reports filed with the U.S. Government. If you would like copies, you may request them in writing from the Board of Trustees. Copies will be sent to you for a reasonable charge. In addition, you will receive a summary of the annual return/report each year which briefly describes the financial activities of the Pension Plan.

Once each year you may request a statement about the status of your pension under the Pension Plan. The statement will show the amount of your accrued pension and whether you are vested in your accrued pension. The statement must be requested in writing from the Board of Trustees and will be provided without charge.

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have a denied claim reviewed and reconsidered. See the "Claim Appeal Procedures" section of the summary plan description for a more detailed explanation.

ERISA also protects you from being discharged or discriminated against in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Pension Plan. The people who operate the Plan, called "fiduciaries", have a duty to do so prudently and in the interest of all participants and beneficiaries.

There are steps you can take under ERISA to enforce your rights. For instance:

- If your claim for benefits is denied or ignored, you may file suit in a state or federal court.
- If the Board of Trustees fails to provide you with requested documents within 30 days, you may file suit in federal court. The court may require the Board of Trustees to provide the documents and pay you up to \$100 a day until you receive them, unless the documents were not provided for reasons beyond the Board's control.
- If the fiduciaries of the Pension Plan misuse the assets of the Pension Plan, or if you are discriminated against for asserting your rights under ERISA, you may seek assistance from the U.S. Department of Labor or file suit in a federal court.

In any court action under ERISA, the court will decide who should pay the court costs and legal fees. If you are successful, the court may require the other party to pay those costs and fees. If you lose, the court may order you to pay.

The Board of Trustees is available to answer any questions you may have about the Plan. The nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, is available to answer any questions you may have about your rights under ERISA.