Plasterers Local 31 Insurance Fund

SUMMARY PLAN DESCRIPTION
and
PLAN BOOKLET

EFFECTIVE AS OF JANUARY 1, 2019

Plasterers Local 31 Insurance Fund

Summary Plan Description
Federal ID# 25-1189104

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NOTICE

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.

As more fully described in the Plan, the Trustees of the Insurance Fund shall have the final discretion to construe and interpret the provisions of this Benefit Plan and may delegate to benefit providers claim review and appeal functions with regard to claims for benefits from the Fund, subject to the general oversight of the Trustees.

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Dear Participants,

We are pleased to provide you with this new and revised booklet, which contains the Rules of Eligibility and the basic information regarding the Plan of Benefits in effect on January 1, 2019.

The Plan provides for Hospitalization, basic Surgical, Medical and Prescription Drug Benefits from Highmark BCBS; dental benefits from Delta Dental of PA, vision benefits from National Vision Administrators, and life insurance from American United Life Insurance. Each of these providers issues a Summary of Benefit Coverage(s)("SBC") which more fully explains these benefits. This booklet plus the applicable SBCs constitute the Summary Plan Description. You will not receive an SBC if you do not select coverage or are not eligible for such coverage.

The assets of the Insurance Fund are the sole source of funding for these benefits. There is no obligation or liability on the Board of Trustees or any other individual or entity to provide benefits and/or payments in excess of the assets in the Insurance Fund, collected and available for such purposes. As a participant, you will be responsible for certain payments - such as co-payments and deductibles – which are described in detail in this summary. Concern for the total benefit security of our participants and their families continues to be the basis for all our benefit programs.

Total benefit security for all participating Plasterers and their Eligible Dependents is the continuing objective of the Trustees of the PLASTERERS LOCAL NO. 31 INSURANCE FUND. The most important benefits provisions relating to benefits provided directly by the Fund, Eligibility Rules, General Claim and Appeal Procedures are described in this booklet. While our complete benefit program is described in detail in this Booklet, we may issue Benefit Program Supplements from time to time to keep you and your family completely informed of all facets of the Plan. We hope that the Plan will be a great help in maintaining your and your Dependents' good health.

We strongly recommend that you familiarize yourself with both the contents of this booklet and that of the specific benefit options selected, 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. If you have any questions, call the OP&CMIA Combined Funds' Office.

Respectfully yours,

BOARD OF TRUSTEES

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SECTION 1.0
GENERAL INFORMATION

1.1 Type of Plan: A Welfare Plan providing Hospital, Medical, Drug, Vision, Dental, and Life Insurance Benefits.

1.2 Source of Benefits: All hospitalization, medical-surgical, and ancillary benefits are provided through group insurance contracts with companies selected by the Board of Trustees.

1.3 Summary of Material Modification: If there is a modification or change, that is a material reduction in covered services or benefits provided under a group health Plan, a summary description of such modification or change shall be furnished to participants and beneficiaries. The Summary of Material Modifications must be furnished not later than 210 days after the end of the Plan Year in which the material modification was adopted.

1.4 Summary of Material Modifications - Summary of Benefits and Coverage (SBC): If a material modification occurs that is not reflected in the most recently provided SBC, a notice of material modification will be provided at least 60 days prior to the effective date of such modification.

1.5 Amendment or Termination of Plan: Neither this Plan nor any of its benefits are guaranteed. Although the Plan is intended to be permanent, the Board of Trustees has the authority to terminate the Plan or eliminate Plan Benefits, in whole or part, as it finds necessary. The Plan shall terminate upon the occurrence of any one or more of the following events: if the Plan assets are, in the opinion of the Board, inadequate to carry out the intent and purpose of the Plan or are inadequate to meet the payments due or which may become due to participants and beneficiaries; if there are no individuals living who can qualify as Employees, if the Union and Employers agree to terminate the Plan; if the Plan is merged into another employee benefit Plan; any other event which may, by law, require termination.

In the event of termination of the Plan, the Board of Trustees shall make provision out of the Plan assets for the payment of expenses incurred up to the date of termination and the expenses incidental to termination; arrange for a final audit and report of the Board's transactions and accounts for the purposes of ending the trusteeship; and apply any surplus in a manner that will inure to the exclusive benefit of the participants and beneficiaries in accordance with the purposes of the Plan and the requirements of law.

1.6 Liability for the Payment of Benefits: The total liability for the payment of any self-insured benefit herein shall be limited to the assets of the Fund.

1.7 Liability of Plan: Neither the Plan Sponsors, Trustees, Plan Administrator nor its employees shall be liable to participants or beneficiaries for any injuries or damages as a result of medical malpractice or other medical related damage claims. The Plan Sponsors, Trustees, Plan Administrator and its employees shall have no liability for the practice of medicine.

1.8 Conflicts Between Documents and Ambiguous Terms: Any conflicting statements or provision between the Trust Agreement & Plan Document, the Summary Plan Description (SPD), and the Summary of Benefits Coverage shall be resolved in favor of the Plan Document or Trust Agreement. All ambiguous terms and the intent of the Plan's terms and conditions are subject to the sole, reasonable and discretionary interpretation by the Board of Trustees.

1.9 HIPAA Privacy Compliance: The Plan Sponsors, the Board of Trustees, Plan Administrator and its employees, Claim Administrator and its employees and all service providers of the Fund have verified that they are and shall remain HIPAA compliant with all privacy and confidentiality rules concerning Protected Healthcare Information (PHI).

1.10 Participant or Participating Employee: All employees working under the jurisdiction of the Union for an employer who has executed a Collective Bargaining Agreement requiring Welfare Payments to the Plasterers Local 31 Insurance Fund; the employees of the Union for whom the required Welfare Payments are made; and the employees of the OP&CMIA Combined Funds, Inc., for whom payments are made.

1.11 Participating Employer: Participating Employer means an Employer who is party to a Collective Bargaining Agreement with the Union, which Agreement requires the Employer to make Welfare Payments to the Plasterers Local 31 Insurance Fund.

1.12 Union Or Participating Union: Union or Participating Union means the Operative Plasterers and Cement Masons Local Union No. 526, successor to Operative Plasterers' & Cement Masons' International Association of the United States and Canada, AFL-CIO Local Union No. 31.

1.13 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, and any employee of the OP&CMIA Combined Funds, Inc., for whom payments are made.

1.14 Covered Dependent (also referred to as Eligible Dependent)

Shall include the spouse of an Eligible Employee and any "child" (defined below) through age 25. There shall be no coverage for such child beyond age 25, except in situations where

extended coverage may be available where the child is incapable of self-sustaining employment because of mental or physical handicap, or due to other extended coverage rights.

The term “child,” as used herein, shall include natural children of the Employee. The term “child” shall also include any legally adopted child, any child placed for adoption such that the Employee has assumed and retains a legal obligation for total or partial support of such child in anticipation of adoption of such child, or any stepchild.

Also, if an unmarried dependent child over age 25 is incapable of self-sustaining employment because of mental or physical handicap, and

(a) became incapable while he was a Covered Dependent as defined herein, and

(b) is chiefly dependent upon the Eligible Employee for support and maintenance, and

(c) if the Eligible Employee furnishes due proof of such incapacity, then such dependent child’s eligibility for benefits shall be continued for as long as Employee remains eligible and such dependent child remains in such condition.

Coverage because of mental or physical handicap will cease on the first to occur of:

(a) Cessation of the handicap.

(b) Failure to give proof that the handicap continues.

(c) Failure to have an exam requested by the Fund to determine eligibility.

(d) Termination of Dependent coverage as to your child for any reason other than reaching the maximum age.

A child shall in no event be a Covered Dependent of more than one Active Employee nor shall a dependent be eligible as a Covered Dependent if he or she is also an Active Employee.

Live birth shall be required for death benefit coverage for a child of an Eligible Employee.

The only children who may be considered eligible, despite a failure to meet the above-stated eligibility requirements, are those children whose coverage by this Benefit Plan may be required pursuant to a Qualified Medical Child Support Order, as provided under applicable Federal law, if such an Order has been issued by a court of appropriate jurisdiction.

Coverage of any Covered Dependent will terminate at the end of the month in which the

Covered Dependent last meets the above requirements.

Coverage for any Covered Dependent of a retired former employee not eligible based upon hours of work or current employment for contributing Employers, or a disabled former Employee entitled to coverage under former provisions of the Benefit Plan will terminate when the Covered Dependent:

(a) No longer meets the definition of a Covered Dependent;

(b) Becomes eligible for Medicare Coverage, except where the Covered Dependent is entitled to Medicare solely on the basis of end stage renal disease during the first 30 months (or other period specified by Federal law) of Medicare eligibility; or

(c) Last meets qualification for eligibility or coverage under provisions of the Benefit Plan.

Any change in marital status, eligibility for Medicare, dependent status, or place of residence will also affect your coverage. Each time a change occurs, please notify the Fund Office promptly so that the changes can be processed to assure coverage.

A Covered Dependent's newborn child will be considered eligible for medical coverages for a period of 31 days commencing on the infant's birth date.

1.15 Changes in Family Status:

For the program to administer consistent coverage for you and your Covered Dependents, you must notify the Fund Office of any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that affect your coverage. Changes must be reported immediately when the event takes place.

If you fail to report a change in family status (like a divorce) which may disclose the loss of eligibility of any dependent for Plan benefits, you can be held personally liable to reimburse all payments and expenses associated with benefits payments made after the date that the person became ineligible for Plan benefits. Likewise, if you fail to report a change in family status (like a birth or marriage) which would make a new dependent eligible, the actual eligibility of such a new dependent will not begin until the change in family status occurs and is reported, and in no case will coverage of such a newly Eligible Dependent be made retroactive for more than 60 days prior to the date of such a report, and the submission of documents (like a marriage license or birth certificate) deemed appropriate by the Welfare Fund to confirm the eligibility of the proposed new Eligible Dependent.

1.16 Trustees' Right To Amend The Plan: The Board of Trustees regularly reviews claims experience, coverage availabilities, costs and the actuarial soundness of the Fund, and the

Trustees reserve the right to modify or cancel any of the benefits, rules or other features of the Fund's Benefit 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 are processed and paid by the applicable insurance carrier. Please refer to the Summary of Benefit Coverage(s)("SBC") issued by the applicable insurance carrier.

2.2 Payment Of Claims: 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

2.3 Errors In Benefit Payments: The Trustees specifically retain the right to recover all monies paid in error to, or on behalf of, any person, from such person. Upon the discovery of a payment "made in error," the Trustees 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.

2.4 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.

2.5 Plan Abuse: Abuse of the Benefit Plan of the Welfare Fund is a serious concern. In the

event that it is determined that any Eligible Employee or Covered Dependent has made misrepresentations, committed fraud, or otherwise acted improperly with respect to any claim for benefits under the Plan, the Trustees may elect to impose limitations or restrictions upon persons involved in such improper conduct, up to and including the suspension of eligibility of such person or persons for benefits otherwise available under the Plan. Furthermore, in appropriate cases, the Trustees may pursue civil or criminal proceedings, as they may deem appropriate, to address such improper conduct.

2.6 Authorization for Release of Information: By the submission of any claim for benefits or the acceptance of any benefits under any aspect of this Benefit Plan, the Eligible Employee or Covered Dependent claiming or accepting such benefits authorizes the release of any and all medical records, documents, reports, files and information as may be requested or desired by the Welfare Fund relative to such claim or acceptance.

2.7 Authority of the Trustees: The Trustees shall have the authority to construe and/or interpret the terms and conditions of the Welfare Fund Trust Agreement, and of the Plan of Benefits, as well as to determine eligibility on any claim for benefits, and any factual and/or legal constructions, interpretations, conclusions or determinations adopted by the Trustees in good faith shall be binding upon Employees, Covered Dependents, and any other person or persons who may be or claim to be interested herein, provided that any construction, interpretation, conclusion or determination made as aforesaid, which shall be in contravention of or inconsistent with any then effective collective bargaining agreement applicable thereto, shall not be binding upon the affected Employer or Association of Employers, or upon Employees or the Union. It is intended that any and all factual and/or legal constructions, interpretations, conclusions or determinations adopted by the Trustees in good faith are to be accorded deference upon judicial or other review.

The Trustees shall also have the authority to modify or cancel any of the benefits, rules or other features of the Fund's Benefit Plan.

2.8 Complaint and Grievance Procedures: The Trustees contract with private providers such as Highmark Blue Cross Blue Shield, American United Life Insurance Company, delta Dental, and Davis Vision in order to afford Employers, Participants and the Union the quality and price options desired for medical, hospitalization, life, dental and vision benefits. Pursuant to these contracts, claims processing and appeal functions are administered by these providers on behalf of the Plan. In response to Federal regulations, the Trustees have taken steps to ensure that all contractual providers of benefits are processing claims in a manner which is consistent with the laws and regulations governing the claims and appeal processes. Since different providers administer claims for specific benefits covered under their respective contracts, the Plan's overall claims and appeal procedure uses generic terms to refer to any representative administering benefit claims as the "Claims Administrator." Each of these providers will use their own claim forms and notices in performing their roles under the claims and appeal processes. Although the language in provider documents may differ

from that used in the Plan's claims and appeal procedures, their handling of claims and appeals is governed by the procedures of the Plan and by federal regulations. If you have questions regarding how to file a claim or appeal an Adverse Benefit Determination, you should refer to the specific review and dispute instructions provided by the entity responsible for administration of the specific benefit.

Claims should be in writing, stating the basis of the claim. Specific forms setting forth the precise information needed for the various types of benefits are available from the Fund Office, or from your health care provider. The Plan has a specific amount of time to evaluate and respond to claims for benefits, beginning on the date when a complete and proper claim is received. Different timetables apply to the prompt processing of four categories of medical claims, with more prompt handling required for those of a more urgent nature.

SECTION 3.0
ELIGIBILITY RULES

3.1 Qualifying Work Periods: Defined as the period in which a Participating Employee must work in order to qualify for benefits in the corresponding benefit period.

3.2 Benefit Period: Defined as the period in which the Participating Employee may be eligible to receive benefits from the Fund.

QUALIFYING WORK PERIOD	BENEFIT PERIOD
January 1 - June 30	October 1 - March 31
July 1 - December 31	April 1 - September 30

3.3 Lag Period: Defined as the three-month period immediately following the Qualifying work Period and preceding the Benefit Period.

3.4 Eligibility for Benefits: A Participating Employee covered under the Collective Bargaining Agreement of the Union working, and if not working, available for work for a Participating Employer shall be eligible to receive and/or purchase benefits from the Plan. Prior to April 1st each year, the Board of Trustees will send the Participating Employee a work history report reflecting the hours reported by his Participating Employer(s) during the Qualifying Work Period and the amount due from the Participating Employee for the desired level of coverage during the applicable Benefit Period in accordance with 3.6 and 3.7 below.

3.5 Selection of Benefits: Upon notice of eligibility for benefits from the Plan, a Participating

Employee must select the desired level of benefits on a form provided by the Plan. This selection must be returned no later than the first day of the Benefit Period. Once received, the Plan shall issue documentation appropriate to the selection submitted, including payment vouchers if applicable.

3.6 Cost of Coverage Hours: The cost of available Benefit Options, which shall include administrative costs, including collection costs, day-to-day administration costs, insurance costs, legal costs, accounting costs, auditing costs, tax costs, and regulatory costs, will be divided by the Pittsburgh area Collective Bargaining Agreement commercial Health and Welfare contribution rate in effect at the time the options are made available for Participant Selection. Before April 1st, the Fund Office will communicate the Cost of Coverage Hours for the next two (2) Benefit Periods. The Cost of Coverage can be changed by Trustee direction at any time.

3.7 Credit Hours: Credit Hours are hours reported and paid by a Participating Employer for work performed by a Participant in accordance with the Collective Bargaining Agreement between the Union and the Employer, or, hours purchased by a Participant to offset the difference between hours reported and paid by a Participating Employer and the Cost of Coverage Hours required for a particular Benefit Selection.

(a) **Employer Credit Hours:** Employer contributions received for hours worked by a Participant while working for a Participating Employer during the Qualifying Work Period will be credited to the Participant for utilization during the corresponding Benefit Period in accordance with the Section 3.2, 3.4, 3.65, and 3.6 above.

(b) **Participating Credit Hours**: A Participant may purchase Credit Hours at the Pittsburgh area Collective Bargaining Agreement commercial Health and Welfare contribution rate in effect at the time selection is made if a Participant's Employer Credit Hours are less than the Cost of Coverage Hours required for the Participant's Selection of Benefits.

1. Participants may pay the total amount due for the, or, the total amount due may be billed in six (6) equal installments due at the beginning of each month during the applicable benefit period.

2. Upon receipt of the selection the Fund Administrator will provide payment vouchers to the Participant that will include the amount due each month and the date payment is due.

3. Failure to submit Payment on or before the required payment due date will result in the Participating Employee's Benefit Level being reduced to a Benefit Level requiring no Self Payment. Participating Employees who have been reduced for non-payment are prohibited from making a Selection of

Benefits until the next Benefit Period and forfeit payments already made.

(c) **Availability of Credit Hours for Retirees and Deceased Participants.** In the event of the retirement of a Participating Employee, any credit hours earned by the Participating Employee at the time of retirement during a Qualifying Work Period shall be used to qualify for benefits in the corresponding Benefit Period.

In the event of the death of a Participating Employee any credit hours earned by the Participating Employee at the time of death during a qualifying work period shall be used to qualify the deceased participant's dependent(s) for benefits in the corresponding benefit period.

3.8 **Open Enrollment:** Participants will have the opportunity to elect coverage each April 1st for the April through September Benefit Period (and October 1st for the October Benefit Period, if eligible). Such coverage election includes:

(a) the benefit selected (Medical Plan and/or optional benefits);

(b) the number of dependents (if any);

(c) the base coverage election for the April through September Benefit Period. The participant will be allowed to select a lower cost coverage option for the October through March Benefit Periods. Increasing coverage, adding coverage, or adding dependents will not be allowed for the October through March Benefit Period unless experiencing Life Changing Event;

(d) the participant will not be permitted to change their coverage election unless experiencing a Life Changing Event.

3.9 **Life Changing Event:** An event that is limited to the following: newly eligible, marriage, divorce, birth of a child, adoption of a child, and/or a death of a covered participant.

3.10 **Qualified Medical Child Support Order (QMCSO):** Welfare fund plans are required to recognize a A QMCSO must be issued by a court or an agency of a court. A child who is the subject of a QMCSO is defined to be an "alternate recipient" and is treated as a beneficiary under the plan. To qualify as a QMSCO, a Medical Support Order must:

(a) Create or recognize the existence of an alternate recipient's right to receive benefits for which the participant or beneficiary is eligible under a group health plan or to assign those rights;

(b) Clearly specify the name and last known mailing address of the participant and the name and mailing address of each alternate recipient covered by the

order;

(c) Specify a reasonable description of the type of coverage to be provided by the plan to each alternate recipient or the manner in which the type of coverage is to be determined;

(d) Specify each plan that the order applies to and the period to which such order applies; and

(e) Not require a plan to provide any type or form of benefit not otherwise provided under the plan.

The Omnibus Budget Reconciliation Act of 1993 (OBRA), provides that group health plans such as the Welfare Fund cannot consider Medicaid eligibility in enrolling an alternate recipient in the Plan. The Plan must also comply with an alternate recipient's assignment of rights under Medicaid.

COBRA also requires all group health plans, including the Welfare Fund, to provide that from the time a child is placed in a participant's home for adoption, the child is to be treated in the same manner as the natural children of the participant even though the adoption has not become final. Of course, it will be necessary for participants to notify their Employers and the Welfare Fund that a child has been placed in the participant's home for adoption so that the Welfare Fund can enter the child on the Fund's records as an Eligible Dependent.

An individual who is eligible for benefits under this Benefit Plan as an Eligible Employee may not also have eligibility, at the same time, as a Covered Dependent of any other Eligible Employee. An individual who enjoys eligibility as a Covered Dependent of one Eligible Employee may not enjoy multiple coverages or benefits as a Covered Dependent of any other Eligible Employee, at the same time. In any other circumstance, no individual shall be entitled to enjoy multiple coverages or benefits at the same time under this Benefit Plan.

The term "spouse," as used herein, shall mean a legal marriage partner of the Eligible Employee.

Upon divorce, the former spouse of the Eligible Employee is no longer a "spouse" or Covered Dependent.

3.11 Newly Hired Employees: Provided the following requirements have been met, Newly Hired Participating Employees with no work history may purchase Participant Only Benefits from the Tier 2 level of Benefits no earlier than ninety days from the Employees hire date:

(a) Employee must have worked at least ninety (90) days for a Participating Employer under the terms and conditions of a collective bargaining agreement between the

Union and Employer requiring Employer Contributions.

(b) Employee must be eligible for work for a participating employer and actively seeking employment from a participating employer.

(c) Self-Payments made under this section shall be in an amount equal to 2080 hours multiplied by the Employee's wage rate multiplied by .09 (9%). For purposes of this section only, the Employee's wage rate shall be based on the Employee's classification at the time benefits are selected.

3.12 Termination and Payment Requirements: Coverage shall terminate for an eligible participant and his/her dependents on the first day of any Covered Benefit Month 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.

3.13 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 25 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.

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 25 (as provided under the Plan), may maintain their Group Health Benefits by making Cobra Payments. 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
MEDICAL AND PRESCRIPTION DRUG PLAN BENEFITS
(Administered by Highmark)

5.1 <u>Medical and Prescription Drug Benefits:</u> The Plasterers' Local Union No. 31 Insurance Fund provides for comprehensive medical benefits for participants through Highmark to provide you and your dependents with certain health and prescription drug insurance benefits. Please review Sections 3.0 and 4.0 to determine how and when to obtain these benefits.. These plans are explained in detail in Summaries of the benefits are outlined in the Summary of Benefits Coverage (SBC) issued to you by Highmark and include the following information, if applicable:

- A detailed schedule of benefits and cost-sharing provisions
- Any annual or lifetime caps or other limits on benefits
- The extent to which preventive services are covered
- Whether (and under what circumstances) existing and new drugs are covered
- Details of coverage for medical tests, devices and procedures
- Provisions regarding the use of network and out-of-network providers and services
- Circumstances under which coverage is provided for out of network services
- Conditions or limits on the selection of primary care providers (PCPs)
- Conditions or limits on the selection of providers of specialty medical care
- Conditions or limits applicable to obtaining emergency care
- Requirements for pre-authorization and utilization review
- Circumstances that may result in disqualification or ineligibility under the plan, or

in the denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by subrogation or reimbursement rights) of any benefits under the plan.

SECTION 6.0
VISION PROGRAM
(Administered by National Vision Administrators - NVA)

6.1 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.

6.2 **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 25 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 NV A 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 NV A 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 LENSES - 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 NV A card. For out-of-network services, you will have to pay the claim and submit a claim form to NV A for reimbursement. Claim forms can be obtained by calling NV A at 1-800-672-7723.

SECTION 7.0
DENTAL PROGRAM
(Administered by Delta Dental of Pennsylvania)

7.1 **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 copayments shall apply, subject to a maximum annual allowance of$1,000.00 per eligible person.

7.2 **Covered Dental Services:**

	% Paid by Delta Dental[1]	% paid by Patient
DIAGNOSTIC (exam & x-rays)	80%	20%
PREVENTIVE (flouride treatments to age 19, teeth Cleaning - children, adults, space maintainers to age 14 & sealants to age 14)	80%	20%
BASIC RESTORATIVE (fillings)	80%	20%
ORAL SURGERY (routine removal of teeth)	80%	20%
ENDODONTICS (root canal therapy)	80%	20%
PERIODONTICS (treatment of gum disorders)	80%	20%
MAJOR RESTORATIVE (crowns	50%[2]	50%
PROSTHODONTICS (dentures)	50%[2]	50%
ORTHODONTICS (straightening teeth)	50%[3]	50%

IMPLANTS	50%	50%

1 Percentage is based on Delta Dental' s applicable Maximum Plan Allowance or the dentist's fee, whichever is less (the Allowed Amount). The Delta Dental payment under the program, plus the patient payment, equals the Allowed Amount, which is accepted by Delta Dental participating dentists as full payment. Participating dentists are paid directly by Delta Dental, and by agreement cannot bill you more than the applicable copayment, deductible or charges where maximums have been exceeded for covered services. By selecting a participating dentist, you always limit your out-of-pocket costs. For services performed by non-participating dentists, Delta Dental sends the benefit payment directly to you. You are responsible for paying the non-participating dentist's total fee, which may include amounts in addition to your share of Delta Dental's Allowed Amount. Out-of-pocket costs may also include applicable copayments, deductibles, charges where maximums have been exceeded, and services not covered by the Group Dental Service Contract.

2 Benefit available once every five years.

3 $1,500 lifetime maximum per patient up to age 19.

7.3 **PREGNANCY:** Enhanced benefits for pregnancy, which include an additional oral evaluation and periodontal scaling, root planing or prophylaxis, or additional periodontal maintenance procedure, are covered.

7.4 **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 Dental'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.

7.5 **DENTISTS:** A number of licensed dentists in Pennsylvania have entered into agreements with Delta Dental to abide by Delta Dental's policies regarding services, your portion of the charged fees and other matters pertinent to Delta Dental's obligations to its subscribers. These dentists, known as participating dentists, will send claim forms to Delta Dental and will be paid directly by Delta Dental. You pay only for services not covered, co-payment amounts as stated in the notification of payment form, or charges over the annual maximum, which Delta Dental will send you with each claim. Other dentists not participating in Delta Dental also regularly perform services for Delta Dental subscribers; in such cases, payment is made directly to you. Payout by Delta Dental is the same in either case. While Delta Dental 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.

7.6 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.

7.7 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 "3214". Sections 11 through 15 are to be completed since they are used to assist Delta Dental 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 Dental's Customer Service Department at: Delta Dental, One Delta Drive, Mechanicsburg, Pennsylvania 17055, Phone Number: 717-766-8500, Toll-Free Number: 1-800-932-0783.

SECTION 8.0
LIFE INSURANCE
(Administered by American United Life Insurance Company)

8.1 Benefit: As more fully described in SBC and Schedule of Benefits issued by American United Life Insurance Company, Participating Employees are eligible for a life insurance benefit of $10,000.00, and related benefits in accordance with the **CERTIFICATE OF INSURANCE, GROUP TERM LIFE INSURANCE, WITH AN ACCELERATED LIFE BENEFIT** issued by the carrier.

SECTION 9.0.
ERISA AND OTHER FEDERAL RIGHTS

9.1 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:

(a) 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;

(b) 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;

(c) 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 orders 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.

9.2 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:

(a) you have worked for your employer for at least one year;

(b) you have worked at least 1,250 hours over the previous 12 months for such employer;

(c) your employer employs at least 50 employees within 75 miles from your worksite; and

(d) 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:

(a) the day you return to work;

(b) the day you notify your employer that you are not returning to work;

(c) the day your coverage would otherwise end under the plan; or

(d) the day coverage has been continued for 12 weeks.

9.3 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.

9.4 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.

9.5 Military Service (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), Participants who enter military service may be entitled to continue health coverage for themselves and their families while they are on active duty or away from work as a reservist. However, in order to secure such benefits, a Participant must notify the Fund Office and the Union before he leaves work for military service. The Participant election for coverage will require self payment for any shortage of hours.

To Secure Your Benefits You Must:

First: Notify the Fund Office and the Union before you leave work for military service. The notice may be oral or written. Failure to notify due to military necessity, impossibility or unreasonable circumstances will not automatically disqualify you.

Second: Notify the Fund Office and the Union of your intention to return to work upon your discharge from military service. The notice to the Fund Office shall include a copy of your discharge papers. An Honorable Discharge is required. A time limitation exists to return to work. Failure to follow the re-employment time limits will disqualify you. The applicable time limits are as follows:

Length of Military Service	Re-employment Deadline:
Less than 31 days	1 work day after discharge (allowing 8 hours for travel)*

31 through 180 days	14 days after discharge**
More than 180 days	90 days after discharge

*or as soon as possible after the expiration of the 8 hours travel time if such is impossible or unreasonable.

** or if such is impossible, then the next day when it becomes possible after the 14 days.

An absence for examination for service is treated as a period for less than 3 1 days. If hospitalization occurs during service, then the time period above apply after recovery, but such time shall not exceed 2 years.

9.6 Mental Health Parity: Any financial requirements such as deductibles, copayments, coinsurance and out of pocket expenses) and any treatment limitations (such as frequency of treatment, medical necessity determinations, number of visits and days of coverage) applied to mental health and substance abuse coverage under the Health Plan may not be more restrictive than the limitations applied to comparable medical and surgical coverage under the Health Plan.

9.7 Genetic Information Nondiscrimination Act: The Genetic Information Nondiscrimination Act prohibits using genetic information to discriminate with respect to health benefits. The Health Plan is prohibited from (1) restricting enrollment or adjusting premiums based on genetic information; and (2) requiring or requesting genetic information or genetic testing prior to or in connection with enrollment.

These rights have limitations and you should contact the Fund Office for further details. This notice is not intended to explain all rights and limitations of USERRA .

SECTION 10.0
RIGHT OF RECOVERY AND SUBROGATION

10.1 Right of Recovery of Overpayments

When payments have been made by the Welfare Fund or any of its insurance carriers with respect to allowable benefits in a total amount, at any time, in excess of the maximum amount of payments due under this Benefit Plan, irrespective of to whom paid, the Welfare Fund shall have an equitable interest, an equitable lien and/or a constructive trust with respect to all such benefits and payments, and shall have the right to recover such payments from: (1) any person to, for, or with respect to whom payment was made; (2) any person or party who could be held responsible for such payment or reimbursement of it; and/or (3) any insurance company which may be responsible for such payments. The Welfare Fund, at its

option, may also offset, recoup, and/or recover the amount of any overpayment from payments due or thereafter becoming due to you or a Covered Dependent, in such installments, and to such extent, as the Fund shall determine to be appropriate.

You, on your own behalf, or on behalf of your Covered Dependents, shall upon request execute and deliver such instruments and papers as may be requested or required, and do whatever else is necessary to secure such rights to and for the Welfare Fund or any of its insurance carriers.

10.2 **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 Highmark benefits for injuries caused by another person or organization, Highmark has the right, through subrogation, to seek repayment from the other person or his/her insurance company for benefits already paid.

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

For more information regarding subrogation, please refer to the information provided by Highmark.

SECTION 11.0
COORDINATION OF BENEFITS

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 Highmark 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:

(a) If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.

(b) 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.

(c) 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:

(a) 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

(b) 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 Highmark.

SECTION 12.0
DENIAL AND APPEAL CLAIM PROCEDURES:

Denial and Appeal Claim Procedures

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.

12.1 Claim Administrators:

(a) Inpatient Hospital: The Claim Administrator for inpatient hospital administration is Highmark. Claims for inpatient hospital administration must be pre-certified as shown under the Highmark Plan of Benefits and in the Highmark 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. 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.

(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) Life Insurance Benefits: The Claims Administrator for Life Insurance Benefits is American United Life Insurance Company. You or your authorized representative may contact the Fund Office to obtain information regarding American United Life Insurance Company.

12.2 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.

(c) 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.

12.3 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.

12.4 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) Time frame 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 that 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 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.

12.5 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 be not be connected in any way with the medical reviewer utilized in 10.5 (a).

12.6 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 13.0
INFORMATION REQUIRED BY EMPLOYEE
RETIREMENT INCOME SECURITY ACT OF 1974

13.1 PLAN NAME, ADDRESS AND TELEPHONE NUMBER:
Plasterers Local 31 Insurance Fund
c/o OP&CMIA Combined Funds of Western PA, Inc.
1900 Andrew Street, Suite 200
Munhall, PA 15120
Telephone: (412) 464-285~
Toll Free: (800) 628-7914
Fax: (412) 461-9923

13.2 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	**FOR THE EMPLOYER**
Eugene Benedict	David Balmert
Shawn Potts	Fred Episcopo

13.3 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.

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

13.5 LEGAL NOTICE: All legal notices should be filed with the Board of Trustees of the Plasterers Local 31 Insurance Fund (c/o OP&CMIA Combined Funds of Western PA, Inc., I 900 Andrew Street, Suite 200, Munhall, PA 15120).

13.6 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.

13.7 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.

13.8 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 Union No. 526 of the OP&CMIA
2606 California A venue
Pittsburgh, PA 15205

13.9 PLAN YEAR: The financial records of the Plan are maintained on a fiscal year commencing January 1 and ending on the following December 31. 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.

13.10 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.

13.11 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.

13.12 ELIGIBILITY FOR BENEFITS: The Plan's requirements with respect to eligibility for benefits is shown in Section 3 of this booklet.

13.13 PROCEDURE FOR FILING CLAIMS: Claim filing procedures are described in Section 2 of this booklet.

13.14 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.

13.15 CLAIM APPEALS: The procedures for appealing a claim which has been denied appear in Section 12 of this booklet.

SECTION 14
PARTICIPANTS’ 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:

1. 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.

2. 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.
3. Receive a summary of the Plan's annual financial report.

4. Continue Group Health Plan Coverage: Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

5. Creditable Coverage: The Creditable Coverage Certificate can reduce or eliminate any exclusionary periods of coverage for preexisting conditions under your new group health plan or Medicare. You will be provided a certificate of creditable coverage, free of charge, from the plan when you lose coverage, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. This Certificate of Coverage will allow you to enroll in a new health plan including Medicare without any restrictions for late enrollment.

6. Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under this Plan or exercising your rights under ERISA.

7. Enforce Your Rights. If your claim for a welfare benefit under this Plan 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 the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan which you are entitled to receive, and do not receive them within 30 days, you may file suit in a Federal Court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a Federal Court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a Domestic Relations Order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR PLAN, YOU SHOULD CONTACT THE PLAN ADMINISTRATOR. IF YOU HAVE QUESTIONS ABOUT THIS STATEMENT OR ABOUT YOUR RIGHTS UNDER ERISA, YOU SHOULD CONTACT THE NEAREST OFFICE OF THE PENSION AND WELFARE BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF LABOR, LISTED IN YOUR TELEPHONE DIRECTORY OR THE DIVISION OF TECHNICAL ASSISTANCE AND INQUIRIES, PENSION AND WELFARE BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF LABOR, 200 CONSTITUTION AVENUE N.W., WASHINGTON, D.C. 20210.