CEMENT MASONS'

LOCAL 526

WELFARE FUND

SUMMARY PLAN DESCRIPTION

FOR ACTIVE AND RETIRED PARTICIPANTS

EFFECTIVE

October 1, 2014

THE BOARD OF TRUSTEES

Employer Trustees:	*Union Trustees:*
Robert Czerniewski	Cameron Rupert
Charles Pfeiffer	Ralph Belice
Terrence McDonough	Charles Fischer
Shawn Stevenson	Michael Giammatteo

FUND ATTORNEY

Stephen J. O'Brien & Associates
Attorneys at Law
650 Ridge Road
Suite 400
Pittsburgh, PA 15205

FUND ACCOUNTANT

McElhaney & DiClaudio, P.C.
Certified Public Accountants
1725 Washington Road
Suite 202
Pittsburgh, PA 15241

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.

CEMENT MASONS' LOCAL 526 WELFARE FUND

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 October 1, 2014. This booklet plus the Summary of Benefit Coverage(s) [SBC] distributed upon your benefit(s) election constitutes the Summary Plan Description. You will not receive a SBC if you do not select coverage or are not eligible for coverage. Upon working for an Employer, contributions will be credited to a Member Benefit Account for use in purchasing the various benefit options. The options include health insurance Plans providing Hospitalization, basic Surgical, and Medical; Prescription Drug Benefits, which are underwritten by UPMC; Guardian Insurance underwrites the dental, vision, and life insurance benefits; and Colonial Life Insurance underwrites Accident Coverage, Short Term Disability, and Hospital Confinement benefits. The Plan provides for Weekly Disability Benefits paid directly by the Fund.

The more important benefits provisions relating to benefits provided directly by the Fund, Eligibility Rules, General Claim and Appeal Procedures are described in this booklet. The providing insurer will distribute the Summary of Benefit Coverage (for example, if you have selected an UPMC option, then UPMC will provide a Summary of Benefit Coverage). 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. Should you have any questions or require additional information, please contact the Fund Administrator or the appropriate insuring provider.

Respectfully yours,

Board of Trustees

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SECTION 1.0
SUMMARY OF PLAN INFORMATION

1.1 **Name of Plan & Employer Identification Number:** Cement Masons' Local 526 Welfare Fund. EIN: 25-6103482. Plan No. 501.

1.2 **Name and Address of Union:** Cement Masons' Union, Local No. 526, located at the A.J. Furlan Building, 2606 California Avenue, Pittsburgh, Pennsylvania 15212.

1.3 **Type of Plan:** A Welfare Plan providing Disability, Hospital, Medical, Drug, Vision, Dental, Voluntary Life, Personal Accident Insurance, Hospital Protection, and Long Term Care Benefits.

1.4 **Operation and Administration:** The operation and administration of the Plan is the joint responsibility of the Board of Trustees, consisting of:

Management Trustees	Union Trustees
Robert Czerniewski	Cameron Rupert
Charles Pfeiffer	Ralph Belice
Terrence McDonough	Charles Fischer
Shawn Stevenson	Michael Giammatteo

With offices at the A.J. Furlan Building, 2606 California Avenue, Pittsburgh, Pennsylvania 15212. The Trustees listed above are the Administrator of the Plan and the agent for service of process and notices.

1.5 **Collective Bargaining Agreements and Contributions:** Parties to the Collective Bargaining Agreement relating to the Plan are the Cement Masons' Local Union No. 526 and signatory employers. The Agreement contains a clause providing for the rate of contribution to the Welfare Fund. A copy is available for your examination upon written request to the Board of Trustees.

1.6 Source of Benefits:

(a) All hospitalization, medical-surgical, and ancillary benefits are provided through group insurance contracts with companies selected by the Board of Trustees and by directly by the Welfare Fund. The current benefit programs are designated as follows for:

(b) **Active Participants**

1. UPMC Medical Plans
   a) Option A
   b) Option B
   c) Option C

2. Guardian Insurance: Only available if participating with UPMC Insurance.
   a) Davis Vision
   b) Dental
   c) Life Insurance

3. Colonial Life: Only available if participating with UPMC Insurance.
   a) Accident Coverage
   b) Short Term Disability
   c) Hospital Confinement

4. Weekly Disability Benefits (Sick Pay) - Administered and paid by the Cement Masons' Local 526 Welfare Fund. Such benefits are a self-insured arrangement.

(c) **Retired Participants**

1. Freedom Blue – Medicare PPO
   a) High Option
   b) Low Option

2. UPMC For Life – Medicare PPO
   a) Prime
   b) Standard

1.7 Funding Medium: The Cement Masons' Local 526 Welfare Trust Fund is the funding medium used for the accumulation of assets and through which benefits are provided and which is administered by the Board of Trustees.

1.8 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.

1.9 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.

1.10 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.

1.11 Plan Fiscal Year: June 1st to May 31st.

1.12 Name of Claim Administrators: The nature of the claim will dictate the Administrator, as shown in the Plan of Benefits.

(a) UPMC Health Plan
US Steel Tower, 25th Floor
600 Grant Street
Pittsburgh, PA 15219
888-876-2756
www.upcmhealthplan.com

(b) Guardian Life Insurance Company of America
680 Anderson Drive
Foster Plaza 10, Suite 430
Pittsburgh, PA 15220
800-627-4200

(c) UPMC for Life
P.O. Box 2997
Pittsburgh, PA 15230-2997

(d) Colonial Life
P.O. Box 100195
Columbia, SC 29202
1-800-325-4368

(e) Freedom Blue
800-550-8722
Fifth Avenue Place
120 Fifth Avenue Suite P5501
Pittsburgh, PA 15222
www.highmarkbcbs.com

(f) Cement Masons' Local 526 Welfare Fund

1.13 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.

1.14 Plan Sponsors: The Board of Trustees, together with the Participating Employers and Local Union 526, are the Plan Sponsors. A complete list of participating employers may be obtained by written request to the Plan Administrator.

1.15 Legal Notice and Service of Process: All legal notices should be filed with the Board of Trustees of the Cement Masons' Local 526 Welfare Fund, 2606 California Avenue, Pittsburgh, PA 15212. Service of Legal Process may be made on the Plan Administrator (Board of Trustees) at the same address.

1.16 Name, Title and Address of Principal Place of Business of each Trustee:

MANAGEMENT TRUSTEES

Mr. Robert Czerniewski
Mascaro Construction Company
1720 Metropolitan Street
Pittsburgh, PA 15233

Mr. Terrance McDonough
Keystone Contractors
2415 N. Front Street
Harrisburg, PA 17110

UNION TRUSTEES

Mr. Cameron Rupert
Business Manager
2606 California Avenue
Pittsburgh, PA 15212-2699

Mr. Ralph Belice
205 Oak Point Road
Blairsville, PA 15717

MGMT. TRUSTEES CONT.

Mr. Charles Pfeiffer
Mascaro Construction CO., L.P.
1720 Metropolitan Street
Pittsburgh, PA 15233

Mr. Shawn Stephenson
James Construction
243 East Main Street – Suite 203
Carnegie, PA 15106

UNION TRUSTEES CONT.

Mr. Charles Fischer
2606 California Avenue
Pittsburgh, PA 15212-2699

Mr. Michael Giammatteo
2606 California Avenue
Pittsburgh, PA 15212-2699

1.17 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.

1.18 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.

1.19 HIPPA 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 HIPPA compliant with all privacy and confidentiality rules concerning Protected Healthcare Information (PHI).

SECTION 2.0
ELIGIBILITY

2.1 Participant: You will become an eligible participant if you satisfy the Eligibility Requirements of the Plan as outlined in Section 4.0 or Section 5.0. In order to be entitled to benefits you must be eligible at the time a claim is incurred or covered under a benefit option at the time a claim is incurred.

2.2 Dependent: Dependents of an eligible participant are defined as those persons who are enrolled on the Fund records, providing they fall under one of the following categories:

(a) **Dependent Spouse** - is defined as the lawful spouse of an eligible participant. Upon legal divorce, a dependent spouse will no longer be considered a dependent. If a dependent spouse is covered under the terms of another Health Insurance Plan through employment, the coverage provided herein will be limited to the extent outlined in Section 10.0, Coordination of Benefits.

(b) **Dependent Child** - is defined to include an individual who is the son, daughter, stepson or stepdaughter of the employee, including individuals legally adopted by the employee or lawfully placed with the employee for legal adoption by the employee, and eligible foster children until attainment of age 26. The Plan will not cover the spouse or child of an eligible Dependent Child.

2.3 Retiree: is defined as a participant age 55 or older, who has withdrawn from Active employment at the trade or industry and who has applied and is eligible for Normal or Early Retirement Benefits under the Cement Masons' Local 526 Pension Fund of Western Pennsylvania, Social Security, or similar retirement Plan, and such participant qualifies for retirement benefits in accordance with eligibility requirements set forth in Section 5.0.

2.4 **Work Periods:** are defined as the 6 consecutive months of:

(a) August 1st through January 31st, and

(b) February 1st through July 31st.

2.5 **Benefit Periods:** are defined as the 6 consecutive months of:

(a) April 1st through September 30th, and

(b) October 1st through March 31st.

2.6 **Member Benefit Account Credit:** A participant shall be credited with the employer contributions received on his/her behalf:

(a) For each dollar he/she has worked or has been paid (determined by Agreement) by a Contributing Employer, while working under the jurisdiction of Local 526; and/or

(b) For each dollar for which a personal contribution has been made on his/her behalf.

(c) A participant can be provided dollar credit for hours worked in anticipation of payment from a contributing employer. If you have not received credit for hours worked then you must submit pay stubs to the Fund Office to receive credit for such hours when working in the jurisdiction of Local 526. The Trustees reserve the right to change this practice of providing credit for hours worked in anticipation of contributions. The Trustees must administer the Plan in a financially prudent manner and if such practice is determined, in the Trustees discretion, to be detrimental to the Fund then it may be modified, suspended or discontinued.

2.7 **Effective Date of Coverage:** A new employee's or reinstated employee's coverage and that of his/her dependents will be effective on the first date of the Benefit Period following the Work Period in which he/she has met the eligibility requirements.

2.8 **Qualified Medical Child Support Order (QMCSO):** Benefits will be provided in accordance with the applicable requirements of a Qualified Medical Child Support Order.

The process begins when the Plan receives a qualified medical child support order (QMCSO). This means any judgment, decree, or order, including approval of a settlement agreement, which:

- Issues from a court of competent jurisdiction pursuant to a state's domestic relations law;
- Requires a participant to provide only the group health coverage available under the Plan for the participant's dependent children, even though the participant no longer has custody; and
- Clearly specifies:
  - The participant's name and last known mailing address and the names and addresses of each dependent child covered by the order;
  - A reasonable description of the coverage to be provided; and
  - The length of time the order applies.

The Plan will provide written notification to the participant and each identified dependent child that it has received a court order requiring coverage. If the order meets the above requirements, the Plan will also provide written notification to the participant and each dependent child of their eligibility for coverage. If the participant does not meet the eligibility requirements of the Plan then no eligibility will be granted. The foregoing is conditioned upon the order being filed on a timely basis and approved in writing by the Trustees.

2.9 **Family and Medical Leave Act**. If you (as an active participant) qualify for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993, (FMLA) then your eligibility will be continued under the Plan

provided your employer makes the required contribution on your behalf. Eligibility may be continued 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 for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement or 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 and your spouse are both covered as eligible employees, the continued coverage under 2.9 (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.

2.10 Newborns' And Mothers' 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 that 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).

2.11 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 edema.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymph edema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call your Insurance Carrier.

2.12 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.

2.13 **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.

2.14 **Consolidate Omnibus Reconciliation Act:** This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. Please read this notice carefully.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the Social Security Administration determination notice must be provided within 60 days of the date of the determination and prior to the end of the 18th month on continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

SECTION 3.0
MEMBER BENEFIT ACCOUNT

3.1 **Member Benefit Account:** This is an accounting mechanism designed to track employer contributions made on behalf of an eligible participant. Each participant, who has monies contributed on their behalf, will have a Member Benefit Account. The Member Benefit Account will be used to track employer contributions and participant payments for Welfare Fund benefits.

3.2 **Member Benefit Account Statements:** At the end of each Benefit Period a member will be sent a Member Benefit Account Statement detailing the Work Record, Account Activity, Payment Schedule, Coverage information, etc. Each participant should examine the statement closely to ensure its accuracy.

3.3 **Cost of Coverage:** A participant must accumulate $1,000.00 in their Member Benefit Account to become eligible for the Cement Masons' Local 526 Welfare Fund Benefits. Cost of Coverage includes benefit premiums for the select benefit options and the administrative cost. Before October 1st, the Fund Office will communicate the Cost of Coverage for the next two (2) Benefit Periods. The Cost of Coverage can be changed by Trustee direction at any time.

3.4 **Open Enrollment:** Participants will have the opportunity to elect coverage each October 1st for the October through March Benefit Period (and April 1st for the April 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 (family to single coverage or dropping optional benefits such as Vision) for the April through September Benefit Periods. Increasing coverage, adding coverage, or adding dependents will not be allowed for the April through September Benefit Period except as outlined in 3.4 (d);

(d) the participant will not be permitted to change their coverage election (other than that outlined in 3.4 (c)) unless experiencing a Life Changing Event.

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

3.6 **Member Benefit Account Cap:** A participant's Member Benefit Account is limited to a balance of $15,000. Any contributions that cause the account to exceed $15,000 will be forfeited.

3.7 **Forfeiture:** A participant's Member Benefit Account balance will be forfeited upon failure of the participant to purchase medical benefits over the course of 2 consecutive benefit periods (currently provided by UPMC). Any balance forfeited becomes part of the General Welfare Fund.

3.8 **Pay Stub Crediting:** If an Employer fails to make required contributions, the participant may provide evidence of work via pay stubs. Pay stubs must be submitted within six (6) months of the date of the pay stub. No pay stub crediting will be provided for late submission. Upon submission of pay stub evidence, the Fund Office will provide a credit equal to the amount shown. A Pay Stub Credit entry will be shown on the Member Benefit Account Statement. Upon collection of delinquent Employer Contribution an Employer Contribution will be made to the Member Benefit Account Statement along with a corresponding Pay Stub Debit. Example: A member discovers that $100 was not contributed and provides pay

stub evidence. A $100 pay stub credit entry is made to the statement. The following month, the employer remits the $100. A $100 Employer Contribution entry is made to the Statement along with a Pay Stub Debit (deduction) of $100. This however, does not apply to members working outside of the Cement Masons' Local 526 jurisdiction and where Reciprocity is involved.

3.9 **Apprentice Crediting:** An apprentice will be credited with contributions to bring the employer contributions on par with that of a journeyman, but not to exceed the Cost of Coverage for the Base Plan Single. For example, a 1st year apprentice paid at 50% of the journeyman rate will be credited with 50% of the journeyman's contribution rate, with the sum total of the Apprentice Employer Contributions and credited contributions not to exceed the Cost of Coverage for the Base Plan Single. If the Apprentice had earned enough contributions to pay for the Base Plan Single, then no credit will be provided. Upon the conclusion of each Work Period, the Fund Office shall examine the Work Record of each Apprentice to determine the exact amount of crediting, if any, to be provided.

SECTION 4.0
ELIGIBILITY REQUIREMENTS FOR ACTIVE PARTICIPANTS

4.1 **Active Eligible Participant**: An Active Eligible Participant is defined as a person who is not retired, and is either actively employed or available for permanent full-time employment.

(a) Is working under the jurisdiction of the Cement Masons' Union; or

(b) Is any employee of an Employer or the Union with respect to whom Health and Welfare payments have been properly made to the Welfare Fund, providing such Employer has executed an Agreement with the Trustees to make Welfare Payments on behalf of such employees

4.2 **New Employees:** New employees who reside and are normally employed at the Trade with a Contributing Employer within the jurisdictional area of the Fund may become insured for the first time:

(a) If they work under the jurisdiction of the Union; and

(b) Have worked for a Contributing Employer in a Work Period; and

(c) Have accumulated $1,000 in their Member Benefit Account.

4.3 **Continued Eligibility For Active Employees:** Any participant actively employed at the Trade on a full-time permanent basis for a Contributing Employer and having already met the conditions of a New Employee (Section 4.2) in a previous benefit period, shall continue to be eligible in the following Benefit Period if the participant:

(a) Has worked at least one hour in the preceding Work Period; and

i) Has a sufficient balance in his Member Benefit Account to meet the Cost of Coverage; or

ii) Has an insufficient balance in Member Benefit Account to meet the Cost of Coverage and makes a self-payment to meet the Cost of Coverage;

(b) The participant has purchased **medical benefit coverage** (at a minimum the Base Single Plan) at least once over the prior two (2) benefit periods.

(c) An employee on Workers' Compensation will be permitted to make a self-payment until the employee returns to work or Workers' Compensation ceases.

Participants who fail to work an hour in the preceding Work Period will be classified as Inactive. If they had insurance in the preceding Benefit Period, they will be offered COBRA (see Section 4.11).

4.4 **Active Employees Working at the Trade Outside the Fund's Geographical Jurisdiction:** Employees working at the Trade outside the Fund's Jurisdictional (for an employer who is not obligated to make welfare contributions to the Fund on his/her behalf) will have to monitor their Member Benefit Account. As employer contributions may not be made to their Member Benefit Account, the employee may have to make a personal contribution to maintain coverage.

4.5 **Non-Members Working in the Fund's Geographical Jurisdiction:** Non-Members of the Cement Masons' Local 526 Welfare Fund working in the Fund's Geographical Jurisdiction are not eligible to make self-payments or become eligible in the Fund unless they become Local 526 members and qualify under the initial eligibility requirements.

4.6 **Disabled Employees Under Age 65 Eligible for Workers' Compensation Benefits (referred to as a "Waive"):** Eligible employees under age 65 who become disabled as a result of an occupational related injury or illness, and who are unable to work for at least 1/2 of the Work Period shall have their coverage (employee only) continued during the following Benefit Period (for 1 benefit period only).

4.7 **Disabled Employees Under Age 65 Not Eligible for Workers' Compensation Benefits (referred to as a "Waive"):**

(a) Eligible employees under age 65 who become disabled as a result of an occupational related injury or illness, and who are unable to work for at least 1/2 of the Work Period shall have their coverage (employee only) continued during the following Benefit Period (for 1 benefit period only). The coverage provided will consist of the Base Single Benefit Option. No other benefit coverage will be provided by the Fund. The eligible employee will be granted the option to purchase an upgrade to the Base Single and any other additional benefit options. At the conclusion of the waive period, an active may be offered COBRA (see Section 2.14).

(b) The waiver of Cost of Coverage requirements shall be extended to only those employees who become disabled while eligible for benefits under this Fund. Such disabled employees must submit satisfactory evidence of the continuance of such disability as may be requested from time to time by the Trustees.

(c) Employees under sixty-five (65), whose disability:

i) Is the result of a non-occupational injury or illness; and

ii) Whose disability continues beyond one (1) Work Period; and

(d) iii) Who apply and are granted a Monthly Disability Retirement Benefit under the Cement Masons' Local 526 Pension Fund may have their eligibility continued under the COBRA Self Payment Provisions (see Section 4.11) while they remain totally disabled.

4.8 **Disabled Employees Under age 65 Not Eligible for Worker's Compensation Benefits and who do not qualify for Disability Retirement Benefits under the Cement Masons' Local 526 Pension Trust Fund:** Employees under age 65 whose total disability continues beyond one (1) Work Period, but who do not qualify for Disability Retirement Benefits under the Cement Masons' Local 526 Pension Trust Fund, will be provided the option of selecting COBRA.

4.9 **Benefit Limitations for Disabled Employees:** Disabled employees who qualify for benefits in accordance with the foregoing provisions, shall be eligible for active employee benefits, except that:

(a) Weekly Disability Benefits will be excluded after the employee has drawn the maximum benefit, and

(b) Upon retirement under Disability Retirement Benefits provided by the Cement Masons' Local 526 Pension Fund, all hospital, surgical, and medical benefits will be provided to a participant dependent upon their age and category. Please refer to Section 5.0 of the Plan.

4.10 **Termination of Eligibility:** A participant's eligibility and that of his dependents will terminate the first of the month in which they have failed to have met the eligibility requirements of Section 4.0.

4.11 **COBRA Self Payment Provision:** In the event of termination due to a "Qualifying Event", participant and/or dependents will be permitted to maintain their health benefits by making monthly self-payments directly to the Fund. See **SECTION 2.14** for a complete description of your rights under COBRA.

SECTION 5.0
ELIGIBILITY REQUIREMENTS FOR RETIRED PARTICIPANTS

5.1 **Eligible Retiree**: A formally Active participant of the Cement Masons' Local 526 Welfare Fund, who has retired from active employment, who has applied and has satisfied the Eligibility Requirements herein, and who has maintained membership in the Cement Masons' Local 526 Union by paying the required dues. There are several different categories of requirements for retirees based on age, service, eligibility status, etc. **ALL** requirements must be met to be eligible for the **applicable** benefits.

(a) **For Retired Persons Under Age 65:** Upon retiring prior to age 65, you will be offered COBRA coverage. Please refer to Section 2.14 for a complete description of your rights under COBRA. Upon attainment of age 65, you may be afforded the right to select Retired Insurance coverage offered by the Fund if;

i) You provide a Proof of Continuous Coverage for the period of time you were not covered by the Cement Masons' Local 526 Welfare Fund; and

ii) You provide evidence of coverage for Medicare Part A and Medicare Part B.

(b) **For Retired Persons Age 65 and Older:** All persons age 65 or older, who have a minimum of five (5) years of continuous participation in the Fund; and

i) Who are eligible and entitled for Medicare, may continue eligibility by making a benefit selection defined in Section 1.6 (c) **Retired Participants**; or

ii) Who have retired prior to age 65 and can provide proof of:

1. coverage for Medicare Part A and Part B, and
2. Proof of Continuous Coverage for the period of time the Retired Participant were not covered by the Cement Masons' Local 526 Welfare Fund.

If after meeting the criteria stated above the Retired Participant must have sufficient funds in their Member Benefit Account or make the required self-payment to meet the Cost of Coverage as defined in Section 3.3.

5.2 **Retiree Member Benefit Account:** Active participants who retire with an existing balance in their Member Benefit Account will be permitted to use the Member Benefit Account to make self-payments (including COBRA), until the account is exhausted. All rules applicable to Active Participants regarding the Member Benefit Account will apply to Retiree Participants.

5.3 **Retiree Open Enrollment:** All persons who satisfy the requirements of Section 5.0 and who do not elect to continue eligibility within the Cement Masons' Local 526 Welfare Fund, may reapply for eligibility upon attaining Medicare Eligibility. You must apply for Medicare Part A and Part B for to be granted Medicare coverage. Retiree Open Enrollment will be held each January 1st for those persons who are Medicare Eligible. You will be permitted to participate in the Plan at that time. If a person attains Medicare Eligibility prior to January 1st due to the passage of a birthday, then that person may apply prior to the month in which the birthday falls. For example, a person turns 65 on June 7th, that person must have applied for admittance on or prior to that date for an effective Eligibility Re-admittance Date of July 1st. **Once an Early Retiree does not elect to continue coverage with the Cement Masons' Local 526 Welfare Fund, then that person will not be permitted to participate in the Cement Masons' Local 526 Welfare Fund until attaining Medicare Eligibility.** Please contact the Center for Medicare Services to determine your earliest Eligibility Date.

5.4 **Termination of Eligibility:** Coverage as a retiree under Sections 5.2 and 5.3 will be terminated upon failure to make the required Self Payment by the required payment date which is the 24th of each billing month. Once coverage is terminated it cannot be reinstated until the next Open Enrollment period, January 1st of the next year.

IMPORTANT:

Retiree Benefits are not absolute and the Trustees retain the right to change, modify, or terminate the benefits at any time without advance notice to participants or providers.

SECTION 6.0
PLAN BENEFITS
FOR ACTIVE EMPLOYEES ONLY

6.1 **Medical and Prescription Drug Benefits:** The Cement Masons Local 526 Welfare Fund has contracted with UPMC to provide you and your dependents with certain health and prescription drug insurance benefits. Please review Sections 4.0 and 5.0 to determine how and when to obtain these benefits. Summaries of the benefits are outlined in the Summary of Benefits Coverage (SBC) issued to you by UPMC 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.

6.2 **Additional Benefit Options:** Please refer to section 1.6 to find out the complete list of benefit options available to eligible participants.

SECTION 7.0
DISABILITY BENEFITS (SICK PAY) AND DEATH BENEFITS FOR ACTIVE EMPLOYEES ONLY

7.1 **Eligibility for Disability Benefits(Sick Pay):** The Weekly Disability Benefit (Sick Pay) will be payable to you, while eligible under the Plan, if you become disabled and unable to work because of a non-occupational accident or sickness. No Disability Benefits(Sick-Pay) will be paid for any period for which an employee is entitled to or receiving either Workers' Compensation Benefits or Unemployment Compensation Benefits.

Injuries or sickness sustained on the job are not covered.

7.2 **Payment of Disability Benefits (Sick-Pay):** Benefits will begin as of the 8th day of disability and will be limited to a maximum of 26 weeks during any period of disability and also limited to a maximum of 26 weeks during any 12 consecutive months.

Successive period of disability separated by less than 250 credited hours of employment shall be considered as 1 continuous period of disability.

7.3 **Disability Benefits (Sick-Pay) Requirements:** You do not have to be confined to your home to collect benefits, but you must be under the care of a physician.

NO DISABILITY:

a) Will be considered as beginning prior to the first visit or treatment by a physician;

b) Benefits are payable for disabilities due to injury resulting from the commission of a crime or felony.

c) Benefits are payable during any period in which you are receiving unemployment benefits or benefits from an Industry Pension Plan.

7.4 **Amount of Weekly Disability Benefits (Sick Pay):** The amount of Weekly Disability Benefits is shown below.

Weekly Disability Benefit (Sick-Pay) $ 150.00*

*As mandated by Federal Statute, Social Security Taxes will be withheld on this benefit.

7.5 **Applying for Weekly Disability Benefits (Sick Pay):** To apply for these benefits, you must obtain a Claim Form from the Fund Office, complete your portion of the form, and have your doctor complete his portion. The form then must be returned to the Fund Office within 90 days from the initial date of disability. **No assignment of Weekly Disability Benefits will be accepted.**

7.6 **Death Benefits:** All Active Participants of the Cement Masons Union Local 526 Welfare Plan are eligible for a Death Benefit. To be considered an Active Participant for the purposes of the Death Benefit, you must have medical coverage through the Cement Masons Local 526 Welfare Fund at the time of your death.

a) The Death Benefit is payable by Guardian Insurance; and

b) The Death Benefit amount is $10,000.

SECTION 8.0
CLAIM AND APPEAL PROCEDURES

8.1 **Filing Claims:** All medical claims must be filed with the insuring provider of the benefit. For the most part, the medical provider will automatically submit the claim (especially for in-network claims). Claim forms must be obtained from the insuring provider (see Section 1.12 for contact information). Claims for Weekly Disability Benefits (Sick Pay) must be submitted to the Fund Office.

8.2 **Claim Forms:** Claim Forms will be accepted by the Fund Office for Weekly Disability Benefits (Sick-Pay) only. The appropriate claim form can be obtained upon request, and are to be returned to the Funds Office. Claim forms for all other benefits may be obtained from the appropriate insurer.

8.3 **Payment of Claims:** The Fund Office will only pay claims for Weekly Disability Benefits (Sick-Pay). Weekly Disability Benefits under this Plan will be paid directly to the eligible participant. In no event may the participant assign Weekly Disability Benefits under this Plan. For all other benefits, the insuring provider is responsible for paying all other claims.

8.4 **Claim Appeals:** 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 above (in Section 8.1).

8.5 **Claim Administrators:**

(a) **All hospital, medical, prescription drug, and other benefits:** The Claim Administrator for all hospital, medical, prescription drug is UPMC. You or your authorized representative should contact UPMC if you require further information.

(b) **For Dental, Life, and Vision**: The Claim Administrator for eligible Dental, Life, and Davis Vision claims is Guardian.

(c) **For Accident Coverage, Short Term Disability, and Hospital Confinement**: The Claim Administrator for eligible Accident Coverage, Short Term Disability, and Hospital Protection claims is Colonial Life.

(d) **Active Weekly Disability:** The Claim Administrator for Weekly Disability Benefits (Sick Pay) is the Cement Masons' Local 526 Welfare Fund, however you must be a participant in the Welfare Fund Insurance Plan. If you require assistance, please contact the Fund Office.

(e) **Active Death Benefit:** The Claim Administrator for Active Death Benefit is Guardian, however you must be a participant in the Welfare Fund Insurance Plan.

8.6 **Initial Claim Determination:**

(a) Definitions:

i) **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.

ii) **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.

iii) **Post-service claim** is a request for a benefit following the claimant's receipt of services.

iv) **Disability claim** is a request for a disability benefit as described in Section 7.

(b) Time Limits for Initial Claim Determinations:

Your Claim Administrator must comply with the following time requirements:

i) **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 Claim Administrator 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 8.7). The Claim Administrator shall notify the claimant of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of

a) The Claim Administrator's receipt of the specified information

b) The end of the period afforded the claimant to provide the specified additional information

ii) **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 Claim Administrator may take an additional fifteen (15) days, if it is determined an extension is necessary due to matters beyond the control of the Claim Administrator 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 Claim Administrator expects to render a decision. The Claim Administrator will advise of a defective or incomplete filing of a pre-service claim within five (5) work 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.

iii) **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 Claim Administrator's control, in which case the Claim Administrator 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.

iv) **Disability Claim:** Disability claims are submitted directly to the Fund Office. 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.

(c) Concurrent Care Decisions:

i) If the Claim Administrator 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 Claim Administrator of such course of treatment before the end of the period or number of treatments previously agreed to will be considered a denial. The Claim

Administrator 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.

ii) 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 Claim Administrator 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.

8.7 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:

i) The specific reason(s) for the denial;

ii) The specific Plan provision on which the determination is based;

iii) A description of additional information or information necessary for you to perfect the claim and an explanation of why this additional information is necessary;

iv) 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;

v) 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

vi) A description of the Claim Administrator's or 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.

vii) For urgent care claim denials, a description of the expedited review process applicable to urgent care claims.

8.8 **Claim Appeal Procedures:**

A claimant whose claim has been denied may take an appeal to the Claim Administrator. There is a toll-free telephone number on the back of your enrollment card - **call this number to start the appeal process on urgent claims.** There may not be more than two levels of appeal for denied claims. If more than one level of appeal is used, then both levels must be completed within the aggregate time frame applicable to the particular type of appeal, described above.

(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:

i) Must be in writing and can be made by you or your duly authorized representative;

ii) Should be mailed or delivered to:

a) The Fund Office for Disability claims at the address shown in the Summary Plan Description; or

b) For all other claims to the Claim Administrator at the address listed on the insurance coverage card issued by the health care provider;

iii) Should state the reasons you believe the initial determination was incorrect;

iv) Should include any written comments, documents, records and other information relating to the claim for benefits; and

v) 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 for Appeal**: As set forth above, with respect to urgent and non-urgent health care claims, no appeal of a denial of a claim shall be considered unless it is submitted within 180 days of the denial. After receipt of such appeal, the claimant will be notified of the date, time and place of hearing, and will be advised to furnish any records of employment or other data he thinks will substantiate his claim of eligibility for benefits.

(c) **Your rights on Appeal:** The claimant or his authorized representative must be permitted to review pertinent documents including all records and expert reports "relevant" to the benefit claim, even if those records were not relied upon; copies will be provided free of charge upon request. Further, Participants may review all of the Insurer's internal rules, guidelines, and scientific or statistical research relevant to the benefit claim, and, for those health benefit claims involving a reduction in physician fees, Participants may review the Insurer's schedule of usual and customary fees. The Insurer must disclose the name of any medical professionals who were consulted during the claim review process, even if the Insurer declined to follow their advice.

In addition, Participants may submit any written comments, documents or other information to support their claim, and the Insurer has an obligation to consider all this information. The Insurer must review every appeal on a de novo basis, without any deference to the initial decision-maker's choice. Any appeal must be

reviewed by a different decision-maker than the initial decision and he or she may not be the subordinate of the initial reviewer. Similarly, if a health care professional is consulted on the initial benefit decision, neither that health care professional nor his or her subordinate may be consulted on an appeal.

No fees may be charged to appeal benefit claims, and no prior approval is needed to appeal benefit claims. Further, Participants may not be barred from using representatives (including physicians) as advocates during the claim review process. However, the Insurer may establish reasonable procedures for determining whether a representative has been authorized to act on behalf of a Participant.

Additionally, claimants must be notified of any decision to terminate or reduce previously granted benefits for an ongoing course of treatment ("concurrent care decisions") early enough to complete an appeal before the reduction or termination becomes effective.

(d) **Notice of Determination on Appeal:** Upon completion of the hearing, and the checking of any further records required, the Claim Administrator will render a decision on the claims for benefits, and will notify the claimant of their decision in writing. The Board of Trustees will render decisions on Disability Claims.

The decision will include specific references to any provisions on which the decision is based.

If a claim is wholly or partially denied, written notice of the decision will be furnished to the claimant. The notice will contain:

i) The specific reason or reasons for the denial;
ii) Specific reference to pertinent Insurer provisions on which the denial is based;
iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
iv) An explanation of the Insurer's claim review procedure, applicable time limits, and the right to sue.

All decisions of the Insurer on appeal will be final and binding.

(e) **Time Periods for Decisions on Appeals:**

i) A determination of an **urgent care claim** will be made within seventy-two (72) hours after receipt of your request for review.

ii) A determination of a **pre-service claim** will be made within thirty (30) days of receipt of your request for review.

iii) A determination of a **post-service claim** will be made during the course of the regular appeal meetings of the Claim Administrator following receipt of the request for review and you will be notified of the decision within five (5) working days of the date of such meeting. If special circumstances require an extension of time, a decision will be rendered not later than the next regularly scheduled appeal meeting of the Claim Administrator. You will be advised of the special circumstances and the date the decision is expected to be made.

iv) 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 Plan pro-

vides you with notice and an explanation of the circumstances resulting in the delay prior to the expiration of the initial 45-day period. If the request for review of a Disability is received within thirty (30) days of the next regular quarterly Trustees' meeting, the decision on review will be made not later thirty (30) days following the date of the Trustees' meeting.

8.9 Claim Reviewers:

(a) **Initial Claim Review** will be conducted by the Fund Administrator or staff for Disability Claims. The Claim Administrator of record will conduct all other reviews. 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 for Disability Claims. The Claim Administrator will conduct all other reviews. If medical judgment is required, a qualified medical reviewer will be not be connected in any way with the medical reviewer utilized in 8.9 (a).

8.10 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 Claim Administrator or 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 Claim Administrator's or 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 CLAIM ADMINISTRATOR OR 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.

8.11 Errors in Benefit Payments: The Trustees specifically retain the right to recover all moneys 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 result in suspension or denial of any future benefits which such participant or his dependents or beneficiary may become entitled to under this Plan.

8.12 Physical Examination: The Trustees, at their expense, shall have the right and opportunity to have any participant or dependent examined when and as often as it may reason-

ably require during the pendency of a claim hereunder and thereafter while a claim continues. Failure without reasonable cause, to report to the physician designated by the Trustees or Claim Administrator after notice to do so, may, at the Trustees' discretion, disqualify a claimant for initial or further benefit payments.

8.13 **Fraud:** Any person attempting to submit false, misleading or incomplete information, or who in anyway attempts to defraud the Fund, may be prosecuted in such manner as the Trustees deem advisable.

SECTION 9.0
SUBROGATION

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. The Plan can regain from the person who caused the injury, or that person's insurance company, the benefits paid on your behalf for that injury, including, but not limited to, claims compensable under state workers' compensation laws, medical malpractice or tortuous conduct by a third (3rd) party. The right to Subrogation is not subject to reduction for your attorney fees or litigation expenses. This Plan will take advantage of its right to Subrogation if you or your dependents are paid benefits for expenses due to accidental injuries for which someone else may be liable. You remain responsible for repayment to the Plan for Subrogation if you receive payment from a third party.

For example, if you or one of your dependents receives benefits for injuries caused by another person or organization, the insuring provider has the right, through Subrogation, to seek repayment from the other person or his/her insurance company for benefits already paid or from you if you have received payment or compensation for such injuries.

The insuring provider (such as UPMC, Freedom Blue, or Guardian) will provide eligible benefits when needed, but you may be asked to show documents or take other necessary actions to support the insurer 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 each insurer (if applicable).

This Plan will take advantage of its right to Subrogation if you or your dependents are paid benefits for expenses due to accidental injuries for which someone else may be liable.

Your claims and benefit payments will normally continue to be paid in the same way as they always have been. However, you or your dependent will have certain responsibilities to the Plan. When you or your dependents submit a claim for injuries, you should notify Fund Office and the Claim Administrator information as to how the injuries occurred and the identity of any potentially responsible third (3rd) parties. You are responsible to continue to update the Fund Office and Claim Administrator of the status of your potential third (3rd) party claim and you must notify the Plan whenever you have commenced litigation, or any administrative proceeding in connection with any illness or injury for which the Plan or Claim Administrator has paid benefits. You must notify the Fund Office of any attorney that is engaged to represent you in any such proceeding. Further, you shall notify the Plan of the discharge of such attorney and the further employment of any successor attorney. When an attorney is retained, your attorney shall acknowledge the existence of the Plan's right of Subrogation. You must not do anything to impair or negate this Right of Subrogation, and if any of your acts or omissions to act compromise this Right of Subrogation, the Plan will seek reimbursement of all appropriate benefits paid directly to you and/or your eligible dependents. You are required to sign any documentation or acknowledgments requested to protect the Plan's Right of Subrogation and do whatever else is reasonably necessary to secure the Plan's Right of Subrogation. Your eligibility in the Plan is conditioned upon your continuing obligation to subrogate the Plan fully for benefits received from third parties or workers' compensation providers. Self contributions for coverage does not affect the Plan's right to full Subrogation.

All terms and conditions of this Summary Plan Description and the Agreement and Declaration of Trust for the Fund are hereby incorporated, including but not limited to those provisions setting forth the Fund's priority in Subrogation.

SECTION 10.0
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 generally 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.

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 applicable insurer.

SECTION 11.0
PARTICIPANT'S AND BENEFICIARIES' RIGHTS UNDER ERISA

As a Participant in the Cement Masons' Local 526 Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive **Information** About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest Annual Report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest Annual Report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this Annual Report.

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.

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

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.

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.

Assistance with Your Questions

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.

SECTION 12.0
MILITARY SERVICE

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 31 days. If hospitalization occurs during service, then the time period above apply after recovery, but such time shall not exceed 2 years.

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 .