BOSTON
PLASTERERS' & CEMENT MASONS'

LOCAL 534

HEALTH AND WELFARE FUND

[Logo]

SUMMARY PLAN DESCRIPTION

July 1, 2011

BOSTON PLASTERERS' & CEMENT MASONS'

LOCAL #534
HEALTH AND WELFARE FUND
7 Frederika Street
Boston, Massachusetts 02124

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INTRODUCTION

This is the Summary Plan Description (SPD) of the Boston Plasterers' and Cement Masons' Local 534 Health and Welfare Fund (the "Plan"). This booklet describes the Plan as amended through June 30, 2011. This SPD supersedes and replaces all previous SPDs issued regarding this Plan

THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THE PLAN, THE POLICIES OR THIS SPD WHENEVER, IN THEIR JUDGMENT, CONDITIONS SO WARRANT. No benefits or rules described in this Summary Plan Description are guaranteed (vested) for any participant, retiree, spouse, or dependent. All benefits and rules may be changed, reduced, or eliminated prospectively at any time by the Board of Trustees, at their discretion, provided it is not in violation of a collective bargaining agreement already in effect. Any material Plan amendment will be made in writing and must be approved by the Board of Trustees. All such Amendments shall be promptly communicated to you in writing, consistent with applicable federal law.

This Summary Plan Description is a summary of the provisions of the Plan and the insurance policies in effect on the date this booklet was issued. The Plan and the insurance policies take precedence over the SPD; to the extent, if any, that the terms of the Plan and policies differ from the terms of the SPD, the terms of the Plan and policies prevail. This SPD is not meant to interpret, extend, or change any of the provisions of the Plan or policies.

The Plan is maintained pursuant to collective bargaining agreement(s) (CBA) between contributing employers and Local No. 534. The CBA(s) is available upon request at the Local 534 Fund Office. The full cost of the Plan is paid for by the contributing employers and those monies are invested in the Fund to provide benefits to eligible members and pay Fund expenses. As a member, you are not required or permitted to contribute to the Plan.

The contents of the SPD contain only a brief summary of the benefits available to you under the group policies. For full and complete provisions and conditions of your insurance, refer to the insurance certificates.

If you need assistance, contact:

Mary T. Keohan, Fund Administrator
Boston Plasterers' & Cement Masons' Local #534
Health and Welfare Fund Office
7 Frederika Street
Boston, Massachusetts 02124
Telephone: 617-825-4500

Hospitals and Providers can Verify Coverage and Participants' Inquiries about Status of Health Claims Can be Obtained from:

Blue Cross Blue Shield of Massachusetts
100 Hancock Street
North Quincy, MA 02171
Telephone: 1-800-241-0803 for members or
1-800-443-6657 for provider service

Important Telephone Numbers
Benefit Management Program
Blue Cross/Blue Shield of Massachusetts: 1-800-241-0803

Important Reminder:

Your prescription drug benefit program is administered by Blue Cross Blue Shield of Massachusetts. Please refer to your Prescription Benefit Booklet for details. You can also call member services at 1-800-241-0803 for information regarding your pharmacy benefit

Life insurance, accidental death and dismemberment, and Supplemental Accident and Sickness Weekly Benefit claim forms are available from the Fund Office.

Boston Plasterers' & Cement Masons' - Local #534
Health and Welfare Fund Office
7 Frederika Street
Boston, Massachusetts 02124
Telephone: 617-825-4500

November 1, 2011

Dear Participant:

The Board of Trustees of the Boston Plasterers' and Cement Masons' Local 534 Health and Welfare Fund is pleased to issue this updated SPD booklet which describes the Plan's benefits for eligible participants and their dependents.

You and your family should read this SPD together so that the complete Plan is understood. The Fund is funded by contributions from signatory employers and self-administered. We believe this allows the Fund to be more responsive to your needs.

For full details concerning the plan of benefits and how to use them, you should refer to the pertinent section of this SPD which describes each benefit. An easy reference guide has been added to the front of the SPD to assist you.

In addition, this SPD sets out the information that must be made available to Plan participants in order to comply with the Employee Retirement Income Security Act of 1974 (ERISA), including a statement of your rights and protection under the law. This information is located at the back of the SPD.

We urge you and your family to read this Summary Plan Description carefully and to make use of the coverage to which you are entitled.

If you have any questions concerning the benefits or your eligibility, please contact the Fund Office.

Sincerely yours,

BOARD OF TRUSTEES

GENERAL INFORMATION

Payment of Benefits

All eligible participants of the Health and Welfare Fund will be provided with employee identification cards validating their coverage for current eligibility which is retained from year to year. Your identification cards should be kept readily available and accessible. Please present your Blue Cross Blue Shield card to all providers.

As considerable savings for both yourself and the Fund can be achieved by using preferred providers, we recommend you use network facilities whenever possible. BCBS continues to expand their affiliation with participating hospitals and physicians. You can search for BCBS providers on line at: www.bluecrossma.com. If you do not have access to a computer, you can request the BCBS of MA Directory by calling the Fund Office. Please call Blue Cross Blue Shield at 1-800-810-2583 if you are unsure if your hospital, doctor, laboratory facility, chiropractor or other health care provider is within the network.

If you are unable to take advantage of the preferred provider network, out of network coverage is available. After a deductible (Refer to your Blue Cross Blue Shield Summary of Benefits) of $500 per individual and $1,000 per family has been satisfied, all covered expenses are reimbursed at 60/80 percent up to $2,500 (individual) and $5,000 (family) out-of-pocket maximums and at 100 percent thereafter.

SCHEDULE OF BENEFITS

SCHEDULE OF BENEFITS PARTICIPANTS ONLY		
Classification	Active Employee	Retired Participant
Life Insurance	$20,000	$2,000
Accidental Death and Dismemberment Insurance	$20,000	N/A
Supplemental Accident & Sickness Benefit for eligible participants	$100 per week for up to 26 weeks during each disability	N/A

SCHEDULE OF BENEFITS – HIGHLIGHTS OF BENEFITS FOR PARTICIPANTS AND DEPENDENTS

PLEASE REFER TO THE PREFERRED BLUE PPO SUMMARY OF BENEFITS AND THE BLUE CROSS BLUE SHIELD OF MASSACHUSETTS SUBSCRIBER CERTIFICATE

DAVIS VISION VALUE ADVANTAGE PROGRAM

The Value Advantage Program allows participating members to enjoy a discounted fee schedule for eye examinations and eyewear materials. The Value Advantage Program creates much greater savings than a pure discount arrangement. The participant knows the value and cost of the benefit in advance (no surprises), including professional and material fees. The program integrates the quality and cost assurance components of a traditional Davis Vision program.

Participants pay for the Value Advantage Program on an as needed basis. Using this program, participants will be able to receive an eye examination and pair of Designer level eyeglasses (frames and/or spectacle lenses) for a discounted amount as specified on a schedule of benefits. The participant will have their choice of single vision, bifocal, trifocal, or lenticular (post-cataract) lenses. Fashion and gradient tinting of plastic lenses, oversize lenses and polycarbonate lenses for monocular patients are all included at no additional cost. The schedule of benefits will be provided by the Fund Office upon request. The schedule as of 4/1/2011 is $52.00 for eye examination only and $180.00 for eye examination and materials for Option 1 (Designer program) and $200.00 for Option 2 (Premier program).

Under the Value Advantage Program, when vision care services are desired the participant simply calls Davis Vision at 1-800-783-3594 and establishes a vision care authorization using either their VISA or Mastercard. They will also have the option of mailing their payment by check or money order. After payment is received, authorization is electronically established in the system and a list of Participating Network Providers will be sent to the participant. The following information will be required when you call Davis Vision: Member's Identification Number/Date of Birth, Description of Service needed, and Dependent's name/date of birth. The participant will schedule an appointment, at which time they can receive an eye examination and make their eyewear selection. No paperwork or claim forms are needed.

GENERAL ELIGIBILITY REQUIREMENTS

Eligibility Requirements

1. Accumulation Period will be defined as a period of twelve (12) consecutive months, beginning April 1st of each year and ending March 31st of the following and succeeding year, during which an employee who works in Covered Employment establishes eligibility for Plasterers' and Cement Masons' Health and Welfare Plan of Benefits. Covered Employment is work for which your employer is required to contribute to the Fund on your behalf under the terms of the collective bargaining agreement.

2. Eligibility Period will be defined as a period of twelve (12) consecutive months, beginning July 1st of each year and ending June 30th of the following year, during which an employee and his/her eligible dependent(s) who comply with the Rules of Eligibility are covered for the applicable Plan of Benefits by Blue Cross Blue Shield of Massachusetts.

   To qualify for coverage, you must work a minimum of **800 hours** in Covered Employment during an Accumulation Period (April 1 to March 31).

3. Hour Bank System is maintained whereby hours in excess of 1600 hours per Accumulation Period (April 1 to March 31) may be saved to a maximum of 400 hours during any single Accumulation Period, to an overall maximum of 1600 hours.

EXAMPLE:

Accumulation Period(s)	Hours Worked	Bank Hours	Eligible	Eligibility Period
4/1/10 – 3/31/11	1800	+200	Yes	7/1/11 - 6/30/12
4/1/11 – 3/31/12	600	-200	Yes	7/1/12 - 6/30/13

Banked hours are automatically applied if a participant would otherwise lose coverage due to a reduction in hours of employment.

However, for any Eligibility Period (1) a participant will forfeit his banked hours and not be able to use them to obtain coverage he works as a plasterer or a cement mason for a contractor who is not obligated to make contributions to the Local 534 Health & Welfare Fund on his behalf; and (2) if a participant is covered by the Health & Welfare Fund based on the utilization of banked hours he will forfeit that coverage if during the Eligibility Period he works as a plasterer or cement mason for a contractor who is not obligated to make contributions to the Local No. 534 Health & Welfare Fund on his behalf. An unemployed, retired, or disabled participant is still entitled to use his banked hours, provided he does not work as a plasterer or cement mason for a contractor who is not obligated to contribute to the Local No. 534 Health and Welfare Fund on his behalf.

After a one (1) year waiting period, upon ceasing participation in the Plan as a result of leaving the industry and not working in covered employment, or as the result of retirement, unused hours in the hours bank otherwise insufficient for coverage are forfeited.

Upon termination of benefits, you may elect to continue coverage through the COBRA Self-Payment Provision (see page 19).

Reciprocity

The Trustees of the Boston Plasterers' & Cement Masons' Local #534 Health and Welfare Fund has entered into Reciprocal Agreements with most of the various surrounding Locals engaged in the Masonry and Plasterers' Trades. Under these arrangements, hours are transferred between funds on a quarterly basis. Eligibility is determined not only on the basis of hours reported for work performed within Local 534's jurisdiction, but also all hours received under Reciprocal Agreements are used to satisfy the hour requirement for Initial or Continuing Eligibility.

The Trustees strongly urge you to notify either the Business Manager, Secretary-Treasurer of the Fund or the Administrator if you are employed in a jurisdiction outside of Local 534 so that arrangements may be made to ascertain that hours reported for you are reciprocated to Local 534. This is very important for your continued protection under the Health and Welfare Program.

ELIGIBILITY FOR NEW AND RETURNING PARTICIPANTS

Special Provision:

If you are a new participant or a returning participant who has previously met the 800 hour requirement in covered employment during an accumulation period (April 1 - March 31), you will become eligible for comprehensive medical benefits* for yourself and eligible dependents on the first (1st) of the month following receipt in the Fund Office of proof of covered employment in which a participant has worked at least 800 hours in a twelve (12) month period. Proof of covered employment can consist of either employer remittance reports or pay receipts provided by the participant and verification of the area worked.

A returning participant is defined as someone who was previously a participant in the Fund but who has not worked within the jurisdiction of Local 534 or areas covered under reciprocal agreements for a five (5) year period.

The purpose of this provision is to provide health protection for the new or returning participant who could otherwise have to wait to become eligible during the eligibility period (July 1 - June 30).

Hours do not roll over between accumulation periods.

* Excludes Life Insurance, AD&D and Weekly Accident & Sickness benefit.

ELIGIBILITY FOR OWNERS AND INCORPORATED WORKING PARTICIPANT CONTRACTORS

Any Incorporated Working Participant Contractor who is an Officer, Director, or Principal and who chooses to participate in the Fund, must comply with the following provisions to be eligible for benefit coverages on his own behalf and that of his eligible dependents.

1. Submit to the Fund Office a signed copy of the effective collective bargaining agreement entered into with the Union, obligating said contractor to the required contributions as a participating employer, at the then current rate of contributions.

2. To be eligible for the benefit coverages of this Fund, any Incorporated Working Participant Contractor must remit each month to this Fund Office a minimum of 160 hours at the then current rate of contribution and have credited 1,920 hours on his behalf during the prescribed Accumulation Period; and

3. Said contributions must be made directly to this Fund, and such required contributions will have no bearing on contributions due any other Health and Welfare Fund for work performed in a jurisdiction other than Local 534.

4. All contributions must be received in the Fund Office on or before the 20th day of the following month; and

5. If an Incorporated Working Participant Contractor notifies the Administrator of this Fund in writing of his intention to suspend his contracting business, he will become subject to the eligibility rules pertaining to an actively employed employee as of the beginning of the next Accumulation Period, provided he remits the required minimum hours (1,920) until the end of the current Accumulation Period (April 1st to March 31st).

6. Owners are allowed to participate in the Fund provided that: they are collective bargaining alumni; they are working for a contributing employer; they contribute 160 hours per month to all the Funds; and contributions are made pursuant to a participation agreement. Note that this is a one-time election, so once an owner elects not to participate, he/she cannot participate in the future.

DEPENDENT ELIGIBILITY

Eligible Dependent

(a) Your dependents are your lawful spouse as defined as a marriage between a man and a woman, and each eligible child as defined below.

(b) To qualify for dependent coverage under the Plan, a child must:

- meet the definition of "Child" in paragraph (c) below
- be under age twenty-six (26)

(c) "Child" means your natural child, stepchild, legally adopted child or foster child.

(d) The Comprehensive Medical Expense Benefits of this Plan can be continued beyond age 26 for an unmarried child if that child:

- is incapable of earning his/her own living because of disability;
- became incapable of doing so before he/she reached age 26;
- is chiefly dependent on the participant for support on the date he/she attains age 26; and
- submits proof acceptable to the Fund that the disability existed on his/her 26th birthday.

The Fund Office may, from time to time, require proof that the child continues to be incapacitated.

The Trustees reserve the right to require the participant to provide documentation substantiating an individual's dependency status. Such documentation includes, but is not limited to, a marriage certificate and birth certificate.

IMPORTANT ELIGIBILITY LIMITATION: No person may be eligible for benefits both as a participant and as a dependent or as a dependent of more than one participant.

CHANGE IN FAMILY STATUS & SPECIAL ENROLLMENT EVENTS

Change in Family Status

After your coverage becomes effective, you must notify the Fund Office of any change in your family status due to marriage, birth, or adoption of a child, death, divorce, or legal separation. Contact the Fund Office and complete a new enrollment form. Failure to do so may result in a delay in the payment of claims.

Special Enrollment Events

Special enrollment is allowed for you and/or your dependents who originally declined medical coverage, if you or your dependents:

- Had other medical coverage and either you or your dependents later had a loss of eligibility for such coverage or employer contributions toward such other coverage were terminated, or
- Were on continuing coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) under another plan, but you or your dependents' COBRA eligibility expired; or
- Had other medical coverage and you or your dependents reached your lifetime maximum for all benefits; or
- Had other coverage under Medicaid or the State Children's Health Insurance Program ("CHIP") and later had a loss of eligibility for such coverage; or
- Became eligible to participate in a financial assistance program through Medicaid or CHIP for coverage under the Plan.

If you initially did not enroll and declined medical coverage, and you later marry or have a birth child or children placed for adoption or you adopt a child, you are entitled to special enrollment, along with the children placed for adoption or adopted child or birth child and your spouse.

If you initially enrolled, but you later marry or have a birth child or children placed for adoption or you adopt a child, the children placed for adoption or adopted child or birth child and your spouse are entitled to special enrollment.

Provided your (or your dependent's) application is received on time, if you become eligible for special enrollment, you will become eligible for coverage on the first day of the month following receipt of the properly completed application form, subject to the Fund Office's approval. A dependent eligible for special enrollment, including a spouse, birth child, children placed for adoption, or an adopted child, will become an eligible to participate on the date the dependent is acquired.

Special enrollments must be requested within the later of 30 days of the date of the event described above, or within 60 days of the date of the event if that event is the loss of eligibility for Medicare or CHIP coverage or becoming eligible to participate in a financial assistance program through Medicaid or CHIP.

NOTE: If you previously opted-out of the Fund's health coverage and enroll due to a status change event or Special Enrollment Event, you will no longer qualify to receive opt-out contributions to your HRA for declining Fund health coverage.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A QMCSO is any court judgment, decree or order (including the approval of a settlement agreement) that creates or recognizes an alternative recipient, such as a child or stepchild, to be eligible under this Plan. As required by ERISA, the Plan will recognize a QMCSO that:

1. provides for child support of child(ren) under these plans,

2. provides for health coverage to child(ren) under state domestic relations law (including a community property law), and

3. relates to benefits under this plan.

To qualify, a QMCSO must include the names and mailing addresses of the participant and each alternative recipient covered by the order. It must also provide a reasonable description of the type of coverage to be provided and specify the name of the plan and the period to which the order applies.

A QMCSO may not require the Plan to provide any type or form of benefits or option which it does not otherwise provide, except as necessary to meet certain requirements of the Social Security Act relating to the enforcement of state child support laws and reimbursement of Medicaid.

Once the Fund Office receives a QMCSO, it will promptly notify the participant and each alternative recipient named in the order in writing, including a copy of the order and of the Plan's procedures for determining whether the order qualifies as a QMCSO. The Fund Office will also allow the alternative recipients to designate representatives to receive copies of notices sent to them. Finally, the Fund Office will determine within a reasonable time whether the order qualifies, notify the appropriate parties of the determination, and ensure that the alternative recipients are treated as beneficiaries under ERISA reporting and disclosure requirements.

RETIREE ELIGIBILITY

Active Employees Over Age 65

Employees age 65 and over who remain actively employed and who qualify for eligibility under the Plan as a result of hours currently being reported will continue to be eligible under Local 534 Health and Welfare on the same basis as all other employees.

Spouses of such employees will also be under Local 534 Health and Welfare as long as their spouse is actually employed and eligible as a result of hours being reported on his behalf.

Retiree Eligibility

As previously noted, upon retirement, a participant, his spouse, or his dependents may continue to achieve eligibility through the use of the hours bank. Once you have exhausted your eligibility under the Plan, including the use of all previously acquired banked hours, you have the option of continuing coverage under COBRA.

Medicare

Medicare makes available two plans of health insurance to those age 65 and over. Part A of Medicare covers hospital expenses, and Part B covers other medical expenses.

Part A is automatically provided to eligible individuals who are receiving Social Security Benefits. All other eligible individuals may enroll by signing the necessary forms available at any Social Security office.

Part B is also provided by Social Security and is available to all eligible individuals who wish to enroll. Benefits under Part B are not automatic. Therefore, you must obtain and complete the necessary forms, available at any Social Security office, in order to be covered under this section of Medicare.

A participant who is eligible for benefits under the Health and Welfare Fund at the time of retirement (i.e., is receiving a pension from Local 534) is entitled to receive reimbursement for Medicare Part B ("standard" Part B, not any additional premium based on retiree's income) for himself and his spouse upon becoming eligible for Medicare Part B. Part B coverage ends for the surviving spouse the month following the death of the retired participant. The monthly cost of Part B Medicare will be reimbursed to each eligible retired participant and his spouse age 65 or over. Reimbursement will be made directly from the Health and Welfare Fund on a monthly basis. Active eligible employees and their spouses will be reimbursed for Medicare Part B as long as the Plan continues to be eligible for the Medicare "Small Employer Exception" and the active eligible employee and spouse are enrolled in Part B.

Please keep in mind that you and/or your spouse must contact a Social Security office prior to the date on which you wish to enroll in Medicare. Neither the Trustees nor the Administrator can enroll you under Medicare, and the Trustees suggest that, if you have remained in active employment beyond your 65th birthday, you contact Social Security at least 90 days prior to the date on which you plan to retire to make the necessary arrangements for participation under Part B. All inactive employees should contact the Social Security office prior to their 65th birthday.

Retirees age 65 or over eligible for coverage based on banked hours will have the deductible waived when the Plan is secondary to Medicare for medical expenses.

TERMINATION OF HEALTH COVERAGE

Your coverage under the Plan will terminate on the last day of an Eligibility Period if:

1. The number of credited hours in your "Hour Bank" plus the hours actually worked totals less than 800 hours;

2. You enter active military service (except as required by USERRA; see page 17);

3. The COBRA coverage period ends or non-payment of monthly self-payment amount; or

4. The Plan terminates.

OPTING OUT OF HEALTH COVERAGE

If you are eligible for Health & Welfare Coverage and you are enrolled in your spouse's family health coverage, you may opt-out of your Fund health coverage and receive a monthly contribution to your HRA account. In order to opt-out of your Plan coverage, you must provide the Fund Office with documentary proof that your spouse has family health coverage.

Once you have opted-out of your Plan coverage and enroll in the HRA opt-out program, each month, upon providing the Fund office with satisfactory evidence of your spouse's continuing coverage, the Fund will transfer the following amounts to your HRA account: (1) the amount of your spouse's monthly payment through payroll deductions for health coverage, but not to exceed $300; and (2) a dollar amount equal to 1/12 of either 1000, 1500 or 2000, depending on how many hours you worked.

For example: if you worked between 1000 and 1499 hours in the previous April 1 through March 31 period, $83.33 (1000/12) will be transferred to your HRA account each month during the July 1 through June 30 eligibility period; if you worked between 1500 and 1999 hours in the previous accumulation period, $125 (1500/12) will be transferred to your account each month; and if you worked 2000 hours or more in the previous accumulation period, $166.66 (2000/12) will be transferred to your account each month.

If you opt-out of Plan coverage any time during a Plan eligibility period (July 1 through June 30) you will **not** be eligible for coverage during that same eligibility period unless your spouse loses coverage as a result of his or her separation from employment, your spouse's employer's decision to eliminate health coverage, or you experience a qualified change in family status or Special Enrollment Event (as described previously).

CONTINUING HEALTH COVERAGE DURING FAMILY AND MEDICAL LEAVE OF ABSENCE

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth or adoption of a child or placement of a child with you for foster care or adoption;
- The care of a seriously ill spouse, parent, or child;
- Your serious illness; or
- Effective when final regulations have been adopted by the Department of Labor, you have an urgent need for leave because your spouse, son, daughter, or parent is on active duty in the armed services.

In addition, under the FMLA, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a Uniformed Services member. The member of the Uniformed Services must:

- Be your spouse, son, daughter, parent, or next of kin;
- Be undergoing medical treatment, recuperation, or therapy, for a serious illness or injury incurred in the line of duty while in the Uniformed Services; and
- Be an outpatient, or on the temporary disability retired list of the armed services for a serious illness or injury.

Your Plan's health coverage will be maintained for the duration of your FMLA leave. You are eligible for a leave under FMLA if you:

- Have worked for a covered employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months; and
- Work at a location where at least 50 employees are employed by the employer within a 75-mile radius of the employer's location.

The Plan will maintain your prior eligibility until the end of the FMLA leave, provided your employer properly grants the leave and makes the required notification and payment to the Fund.

You may be required to provide:

- 30-day advance notice of the leave, if possible;
- Medical certifications supporting the need for a leave; and/or
- Second or third medical opinions and periodic recertification (at your employer's expense) and periodic reports during the leave regarding your status and intent to return to work.

Your FMLA leave will end on the earlier of your return to work or 12 weeks. If you do not return to work within 12 weeks, you may qualify for COBRA Continuation Coverage. For more information about the FMLA, contact the Fund Office.

CONTINUING HEALTH COVERAGE UNDER USERRA

If you are called into the Uniformed Services for up to 31 days, your health coverage will continue as long as you make the required self-payment. If you are called into the Uniformed Services for more than 31 days, you may continue your coverage by paying the required self-payments for up to 24 consecutive months or, if sooner, the end of the period during which you are eligible to apply for reemployment in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Uniformed Services, as used in this section, means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Coverage under USERRA will run concurrently with COBRA Continuation Coverage. The cost of continuation coverage under USERRA will be the same cost as COBRA Continuation Coverage. The procedures for electing coverage under USERRA will be the same procedures described in the *COBRA* section, except that only the Employee has the right to elect USERRA coverage for himself or herself and his/her Dependents, and that coverage will extend to a maximum of 24 months.

Your coverage will continue to the earliest of the following:

- The date you or your dependents do not make the required self-payments;
- The date you reinstate your eligibility for coverage under the Plan;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA;
- The date you lose your rights under USERRA (for instance, for a dishonorable discharge);
- The last day of the month after 24 consecutive months; or
- The date the Fund no longer provides any group health benefits.

You need to notify the Fund Office in writing when you enter the Uniformed Services. For more information about self-payments under USERRA, contact the Fund Office.

If You Do Not Continue Your Health Coverage Under USERRA

If you do not continue coverage under USERRA, your coverage will end immediately when you enter the Uniformed Services. Your dependents will have the opportunity to elect COBRA Continuation Coverage.

Reinstating Your Health Coverage - When you are discharged or released from the Uniformed Services, you may apply for reemployment with your former Employer in accordance with USERRA. Reemployment includes the right to elect reinstatement in the existing health coverage provided by your Employer. According to USERRA guidelines,

reemployment and reinstatement deadlines are based on your length of service in the Uniformed Services.

When you are discharged or released from service in the Uniformed Services that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a participating Employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a participating Employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for participating Employer.

When you are discharged, if you are hospitalized or recovering from an illness or injury that was incurred during your service in the Uniformed Services, you have until the end of the period that is necessary for you to recover to return to, or make yourself available for, work for a participating Employer. Your prior eligibility status will be frozen when you enter the Uniformed Services until the end of the leave, provided your Employer properly grants the leave under the federal law and makes the required notification and payment to the Fund.

CONTINUING HEALTH COVERAGE UNDER COBRA (SELF-PAY)

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, also called "COBRA," you and/or your dependents may continue your medical and dental benefits past the date when coverage normally would end due to a "qualifying event." In general, COBRA continuation coverage is identical to the health coverage you had under the Plan when enrolled as an active employee. COBRA continuation coverage may last for 18, 29 or 36 months, depending on the qualifying event and who elects the coverage.

Qualified Beneficiaries

By law, only "Qualified Beneficiaries" are entitled to COBRA Continuation Coverage independent of your enrollment in COBRA. Qualified Beneficiaries are individuals covered at the time your COBRA Continuation Coverage begins. Qualified Beneficiaries are considered to be you, your spouse and your dependent child(ren) who were covered by the Plan on the day before the Qualifying Event.

A child who becomes a dependent child by birth, adoption or placement for adoption with you during a period of COBRA Continuation Coverage is also a "Qualified Beneficiary." Refer to the paragraph in this section entitled "Special COBRA Enrollment Rights" for more information.

One or more of your family members may elect COBRA even if you do not. However, to independently elect COBRA Continuation Coverage, the family member(s) must be "Qualified Beneficiaries" covered by the Plan on the day before the Qualifying Event. A parent may elect or reject COBRA Continuation Coverage on behalf of dependent children living with him or her.

Qualifying Events/How Long Does Continuation Coverage Last?

When Plan coverage is lost due to any of these qualifying events, the participant and each eligible dependent may self-purchase group health benefits:

QUALIFYING EVENT	WHO MAY PURCHASE
Participant loses eligibility due to a termination of employment or a reduction in hours of employment (including retirement)	Participant and each dependent
Participant becomes entitled to Medicare	Each dependent
Participant dies	Each dependent
Participant is divorced or legally separated from spouse	Spouse
Child ceases to be a dependent child as defined under the Plan	Dependent child

QUALIFYING EVENT	MAXIMUM LENGTH OF CONTINUATION
Participant loses eligibility due to a termination of employment or a reduction in hours of employment (including retirement)	18 Months
Participant becomes entitled to Medicare	36 Months
Participant dies	36 Months
Participant is divorced or legally separated from spouse	36 Months
Child ceases to be a dependent child as defined under the Plan	36 months

Upon the occurrence of a qualifying event, as defined by COBRA, the required COBRA buy-in period will be tolled and shall not begin until exhaustion of coverage through worked hours, including coverage achieved through the use of banked hours.

Disability Extension

If you or your eligible dependent(s) are disabled (as determined by Social Security) at any time within the first 60 days of your COBRA coverage, and you notify the Fund in writing within 60 days of Social Security's disability determination and before the end of the initial 18-month COBRA coverage period, you and your eligible dependent(s) will be eligible to continue COBRA for up to an additional 11 months (for a total of 29 months).

Remember, to qualify for this 11-month extension of COBRA coverage, you must notify the Fund Office of the Social Security determination of disability:

1. Within 60 days after the determination *and*

2. Before the end of the first 18 months of COBRA coverage.

If you (or your dependent) are eligible for the 11-month disability extension, your COBRA premiums may be as high as 150% of the regular premiums for the additional 11 months of coverage.

This disability extension period of COBRA coverage will end on the earlier of:

- The last day of the month that occurs 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled;
- The end of the 29 months of COBRA Continuation Coverage; or
- For the disabled person, the date the disabled person becomes entitled to Medicare.

If you recover from your disability before the end of the initial 18 months of COBRA Continuation Coverage, you will not have the right to purchase extended coverage. In addition, you must notify the Fund Office within 30 days of:

- The date that you receive a final Social Security determination that you and/or your dependent(s) are no longer disabled; or
- The date that the disabled person becomes entitled to Medicare.

Second Qualifying Events

If you're covered under COBRA for 18 months because of your termination of employment or reduction in hours, your affected spouse or dependent may extend coverage for another 18 months if:

- You get divorced or legally separated;
- You become entitled to Medicare;
- You die; or
- Your child is no longer a dependent under the Fund's definition.

For example, suppose a member stops working (termination of employment - the first qualifying event), and enrolls himself and his family in COBRA Continuation Coverage for 18 months. Three months after his COBRA Continuation Coverage begins, the member's child reaches the Fund's maximum age limit and no longer qualifies as a dependent child under the Fund's definition (loss of dependent eligibility – the second COBRA Qualifying Event). Provided the member (or the dependent) gives the Fund timely notice of the second qualifying event, the child can continue on COBRA coverage for an additional 33 months, for a total of 36 months of COBRA Continuation Coverage.

Keep in mind, however, that under COBRA, the maximum period of coverage for a spouse or dependent is 36 months, even if the individual experiences a second qualifying event while already covered under COBRA. The maximum coverage period for a member/participant is 18 months (unless you or a family member are entitled to an additional COBRA Continuation Coverage because of a disability, in which case the maximum coverage period will be 29 months.)

You (or your spouse or dependent) must notify the Fund Office, in writing, within 60 days of the date a second qualifying event occurs. If you do not notify the Fund of the event within this timeframe, your spouse's and/or dependent's COBRA coverage will not be extended.

When COBRA Continuation Coverage May Be Cut Short
The law also provides that COBRA Continuation Coverage may be cut short for any of the following reasons:

1. The Employer no longer provides group health coverage to any of its similarly situated participants;
2. You do not pay the applicable premium for your COBRA Continuation Coverage on time;
3. After electing COBRA, the covered person is or becomes entitled to Medicare;
4. After electing COBRA, the covered person is or becomes covered under another group health plan that does not contain an exclusion or limitation that applies to any pre-existing condition of that covered person, or by law, may no longer apply its preexisting condition limitation or exclusion to that covered person; or
5. The Employer that you worked for before the qualifying event has stopped contributing to the Fund; and the Employer establishes one or more group health plans covering a significant number of the Employer's participants formerly covered under the Plan; or the Employer starts contributing to another multiemployer plan that is a group health plan.

How Does the COBRA Election Take Place?
Step 1. You or your family must inform the Fund Office within 60 days of the following qualifying events:

- divorce or legal separation, or
- a child's losing dependent status.

To notify the Fund of your qualifying event, send a letter to the Fund Office with your name, the type of qualifying event and the date of the Qualifying Event.

Your employer is responsible for notifying the Fund Office within 30 days of the other qualifying events. Those events are the employee's termination of employment or reduction in work hours; the employee's death; and the employee's entitlement to Medicare.

Upon receipt of notice of a qualifying event, the Fund Office will then send you, your spouse and/or dependent child an election form and information about continuation coverage. **Important: If you don't notify the Fund Office of a qualifying event within 60 days of the date of the event, you will lose your right to elect COBRA coverage entirely.**

If you and/or your dependents become eligible to self-purchase this coverage due to any other event, the Fund Office will notify you and will send the election form and information.

Within 60 days of the event that would cause you to lose your health coverage, you must inform the Fund Office that you want continuation coverage by electing COBRA coverage. No evidence of insurability is required. If you do not elect COBRA continuation coverage, your group health insurance coverage will end. (See "Termination of Health Coverage" on page 14.)

Step 2. Once the Fund Office sends you your COBRA election materials, you have **60 days** to make an election of coverage. This 60-day period is measured from the later of the date you lost coverage due to the qualifying event or the date you received the COBRA election notice and related information.

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. You may elect COBRA continuation coverage on behalf of your spouse, and parents may elect COBRA continuation coverage on behalf of their children.

Step 3. Once the Fund Office receives your election material, they will notify you of the amount of premium you owe. You will have 45 days from the date you made your COBRA election to make payment for all premiums owed for the period. If payment is not received, COBRA coverage will be cancelled retroactively to the date your coverage under the Plan terminated.

Step 4. Your monthly payments are due on the 1st day of each month. You will have a 30-day grace period in which to pay. Payments should be mailed to the Fund Office. If you do not make payment by the end of the grace period, your coverage will be cancelled retroactively to the last day of the previous month.

NOTE: UNDER NO CIRCUMSTANCES WILL THE OPTION TO MAKE SELF-PAYMENT TO THE FUND BE PERMITTED ON A RETROACTIVE BASIS. COBRA PAYMENTS MUST BE MADE CONTINUOUSLY AND WITHOUT INTERRUPTION. FAILURE TO MAKE THE MONTHLY PAYMENT WHEN DUE (INCLUDING THE GRACE PERIOD) WILL RESULT IN THE TERMINATION OF YOUR COBRA HEALTH COVERAGE.

Confirmation of Coverage Before Election or Payment of COBRA Premiums

If a health care provider requests confirmation of coverage and

1. you, your spouse or dependent children have elected COBRA but have not yet paid the premium (and the grace period is still in effect); or
2. you, your spouse or dependent children are within the COBRA election period, but have not yet elected COBRA;

COBRA coverage will be confirmed to your health care provider but with notice that the premium has not been paid and that no claims will be paid until the amount due has been received by the Fund. Additionally, your provider will be informed that if the amount due is not received by the end of the grace period, your coverage will terminate retroactively.

What Coverage is Available if I Elect COBRA?

The benefits available to individuals eligible to elect to continue coverage are identical to the health benefits available to active employees and their eligible dependents. If there are any changes in coverage for active participants, the same changes will apply to you and your dependents at the same time and in the same manner. More specific information will be provided to you when you become eligible for continuation coverage.

Special COBRA Enrollment Rights

If, during the period of COBRA Continuation Coverage, you marry, have a newborn child, or have a child placed with you for adoption, that Spouse or Dependent child may be enrolled for coverage for the balance of the period of COBRA Continuation Coverage on the same terms available to active participants. Enrollment must occur no later than 30 days after the marriage, birth or placement for adoption.

In addition, if you are enrolled for COBRA Continuation Coverage and your spouse or dependent child loses coverage under another group health plan, you may enroll that spouse or child for coverage for the balance of the period of COBRA within 30 days after the termination of the other coverage. To be eligible for this special enrollment right, your spouse or dependent child must have been eligible for coverage under the terms of the Plan but declined when enrollment was previously offered because they had coverage under another group health plan or had other health insurance coverage.

Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage. To find out about COBRA rates, contact the Fund Office.

The Cost

Participants and/or their dependents may be required to pay the entire cost of continued group coverage at group rates. The cost will not exceed 102% of the cost of these benefits to the Fund. However, if participants and/or their dependents become eligible for the 11-month extension due to disability, the monthly cost for each of those additional 11 months will not exceed 150% of the cost of providing benefits to individuals in the same benefits selection situation as yourself.

Specific cost information will be provided to you when you become eligible for COBRA.

If You Are Not Sure About Electing COBRA Coverage

In considering whether or not to elect COBRA Continuation Coverage, you should take into account that not continuing your group health coverage will affect your future rights under federal law.

First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and the election of COBRA continuation coverage may help you avoid such a gap.

Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you.

Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the Qualifying Events listed above. You will also have the same special enrollment right at the end of the maximum COBRA continuation coverage period.

If You Have Questions

If you have any questions or need additional information about COBRA coverage, please contact the Fund Administrator:

Mary T. Keohan, Fund Administrator
Boston Plasterers' and Cement Masons'
Local 534
Health and Welfare Fund
7 Frederika Street
Boston, Massachusetts 02124
Telephone: (617) 825-4500

IMPORTANT: If you change your marital status or add new dependents, or if you or your spouse or other dependents change addresses, please notify the Fund Office immediately.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

A Health Reimbursement Arrangement (HRA) Account allows you to set aside pretax dollars in an account to pay for eligible out-of-pocket health care expenses incurred by you, your spouse or eligible dependents. The IRS allows you to deduct medical expenses on your income tax return if they exceed 7.5% of your adjusted gross income. Most people do not reach this threshold. With a Health Reimbursement Arrangement (HRA) Account you can save money in taxes on your health care expenses even though they are not significant enough to deduct on your federal income tax return. Note if you have medical expenses which exceed 7.5% of your adjusted gross income for federal purposes, you can still use a Health Reimbursement Arrangement Account, but you must subtract the amount you contribute to such an Account from the amount you can deduct on your federal tax return. You will need to satisfy the requirements of the Fund to participate in the HRA. If you need tax advice regarding this or another benefit, you should consult with your financial advisor.

Eligibility - An employee who works for an employer who contributes to the HRA on his behalf is a Participant. An active Participant will be eligible for participation on the first day of the calendar month after he has been credited with at least 275 hours in Covered Employment under the Boston Plasterers and Cement Masons Local 534 Health & Welfare Plan within a Plan eligibility year between April 1 and March 31, provided the Plan actually receives the contributions for those hours.

Once an active Participant meets the general eligibility requirements, he and his eligible dependents will remain enrolled in the HRA as long as the Participant continues to be available for work with a contributing employer even if his/her account balance is reduced to zero. There is also a special provision where there is a COBRA Qualifying Event under the Plan. This is discussed below.

If a Participant loses eligibility for benefits under this Plan because his account has been completely distributed after he has stopped working in Covered Employment, the Participant may re-establish eligibility by satisfying the initial eligibility requirements.

In the event a Participant dies before his benefits have been completely distributed, the spouse and dependents as defined in the Plan (those who qualify for tax-free medical care under the Internal Revenue Code) will be eligible to continue to receive reimbursement from the HRA as long as the account balance is sufficient to cover their claims.

Retiree Eligibility - Retirees who have a balance in their HRA when retired and receiving a pension from the Boston Plasterers and Cement Masons Local 534 Pension Fund may continue to receive reimbursements from the HRA as long as the account balance is sufficient to cover their claims.

Contribution Amounts - The Bargaining Parties reallocated $0.41 per hour of the current Health & Welfare Fund contribution towards the HRA and may reallocate additional or lesser amounts in the future. In addition, if you opt-out of the Fund's health coverage, you may be eligible for additional contributions to your HRA as described elsewhere in this SPD. Only employer contributions are allowed in your HRA. Participant contributions are not permitted.

Enrollment - Enrollment information must be provided for all Participants and Dependents including Medicare eligible Participants and Dependents. Participants must notify the Fund Office in writing to enroll a Dependent. The Fund can only enroll those Dependents of whom the Fund Office has knowledge. If you do not notify the Fund Office of a Dependent, the Dependent cannot be enrolled. Once a Particpant meets the HRA eligibility requirements (as outlined in this section), the Fund Office will mail an enrollment form for the Participant to complete. If you are already enrolled and have a newly eligible Dependent, please contact the Fund Office for an enrollment form.

All Participants are required to provide the enrollment information required by the Fund. If you do not have a required document (for example, a marriage certificate or birth certificate), you should contact the Department of Vital Statistics of the state involved. If you are unable to obtain a copy of the record after contacting the applicable Department of Vital Statistics, you should contact the Fund Office concerning alternative ways to document the required information.

If you do not provide the required enrollment information after notice by the Fund, the Fund may suspend payments on behalf of you and/or your Dependents for whom documentation is missing until documentation satisfactory to the Trustees has been provided.

Opt-Out Provision - As noted previously, if you are eligible for Fund Health Coverage and your spouse has family health coverage, you may opt-out of your Fund health coverage and receive a monthly contribution to your HRA account. Please see the section entitled "Opting Out of Health Coverage" for more information.

Carry Over and Forfeitures - There is no maximum that a Participant can accumulate in his individual HRA account. A Participant will be allowed to carry over his or her entire account balance from Plan Year to Plan Year. However, if you cease employment with contributing employers and no longer make yourself available for work with contributing employers, you will forfeit your account balance at the end of the month following notification of dropped membership by the Local Union and you will be ineligible for any further reimbursements of your medical expenses, unless COBRA Continuation Coverage is elected. Also, if you retire and are receiving a pension from the Local 534 Pension Fund or if sickness or disability makes you unavailable for work, you will be allowed to carry over your account balance and will be eligible for reimbursements from your account.

Reimbursable Expenses - The HRA can only reimburse eligible medical care expenses incurred by you, your spouse and/or your eligible dependents retroactive to the date contributions were first made to the HRA on the participants behalf. The expense must be an eligible medical care expense under IRC§213(d). Please note that the reimbursable expenses allowed under *this* HRA Plan are not identical to all of the medical expenses which are allowed under the Internal Revenue Code. If you have a question about whether a particular expense is eligible for reimbursement under the HRA, contact the Fund Office. Finally, these expenses cannot be covered or reimbursed by any other benefit plan.

The following is a partial list of medical expenses which are reimbursable under the HRA provided they are **not** covered by a health care plan:

- Prescription Drug co-payments
- Medical co-payments and annual deductibles
- Medicare Part "B" monthly premiums
- COBRA monthly premiums
- Premium payments to a spouse's or other health plan
- The portion of medical, dental and/or vision expenses that exceeds the reasonable and customary limits or plan maximums
- Smoking cessation products such as, nicotine replacement products (nicotine patch, gum & lozenges), Zyban and Chantix. These products require a doctors prescription for reimbursement.
- Approved weight loss program if the expenses you pay to lose weight are for treatment for a specific disease diagnosed by a physician (such as obesity, hypertension or heart disease). This includes fees you pay for membership in a weight reduction group and attendance at periodic meetings. You cannot include membership dues in a gym, health club or spa and cannot include the cost of diet food or beverages in medical expenses. You cannot include if the purpose of the weight loss is the improvement of appearance, general health or sense of well-being. A letter from a physician prescribing a weight loss program is required.

Ineligible Expenses - Expenses that do not meet the definition of "medical care" under IRC § 213 (d) are excluded from reimbursement. The following are examples of expenses that are not eligible for reimbursement:

- Cosmetic Surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.
- Long-term care services (excluding premiums)
- Funeral and burial expenses
- Massage therapy
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Marijuana and other controlled substances the possession of which are in violation of federal laws, even if prescribed by a physician.
- Maternity clothes, diaper service or diapers, salary of nurse to care for healthy newborn at home, babysitting, child care
- Bottled water, cosmetics, toiletries, toothpaste, vitamins and food supplements (even if prescribed by a physician).
- Transportation expenses of any sort, including transportation expenses to receive medical care, automobile insurance premiums, and automobile improvements.
- Home improvements, Household and domestic help,
- Death Benefits or life insurance benefits including the portion of the Plan's COBRA premium that pays for life insurance.
- Any item that does not constitute "medical care" as defined under Code § 213.

Over-the-Counter Purchases - Over-the-counter expenses are not reimbursable with the exception of smoking cessation products for which there is a prescription, as mentioned previously.

When and How to File a Claim for Reimbursement - All claims for eligible expenses must be submitted no later than **eighteen (18) months** from the date the expense was incurred.

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you must submit a completed claim form. Simple inquiries or phone calls about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

A claim form may be obtained from the Fund Office by calling (617) 825-4500.

The following information must be completed in order for your request for benefits to be a claim, and for the Fund to be able to decide your claim.

- Participant name
- Patient name
- Patient Date of Birth
- SSN of participant or retiree
- Date of Service
- Address
- Relationship to participant or retiree
- Name of service provider
- Amount of out-of-pocket expenses
- Signature certifying request is not or will not be reimbursed by any other source
- Provide an itemized bill and receipt from a doctor or healthcare provider indicating the name of patient, date(s) of service and the type of service or supply

HRA claims for eligible expenses should be sent to the Fund Office, including name, address and telephone number.

Before filing a claim, make sure that you or your provider submits the expense to any benefit plan in which you are covered for the same services. Canceled checks and balance forward statements cannot be used to document your claims. You can submit claims as often as necessary. The minimum claim payment is $100. Disbursements are made only when at least $100 in reimbursable expenses has been submitted and when at least $100 is available in the Health Care Reimbursement Account, except the $100 minimum shall not apply if you are a retired participant who is receiving a pension from the Local 534 Pension Fund, or the spouse or dependents of a deceased Participant.

All reimbursements will be made payable to the Participant, except those made to the spouse, dependents or guardian of dependents of a deceased Participant.

Claims for reimbursement are processed weekly. Account balance statements will be mailed to Participants at the end of each Plan Year. Participants will receive an Explanation of Benefits for each claim that is processed.

Post-Service Claim

The following procedure applies to HRA claims, which are always **Post-Service Claims**. A **Post-Service Claim** is a claim that is not a **Pre-Service Claim** (for example, a claim submitted for payment after health services and treatment have been obtained).

1. Submit a completed HRA claim form.

2. Attach all itemized Hospital bills, doctor's statements, and/or other claims documentation (e.g., itemized receipt of payment for services) that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar year period. Mail any further bills or statements for any Medical or Hospital services covered by the Plan to the Fund Office as soon as you receive them.

Ordinarily, you will be notified of the decision on your **Post-Service claim** within *30 days* from the Plan's receipt of the claim. This period may be extended one time by the Plan for up to *15 days* if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Plan then has *15 days* to make a decision on a **Post-Service Claim** and notify you of the determination.

Request For Review Of Denied Claim (Appeals)

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Fund Office within 180 days after you receive notice of denial.

Review/Appeals Process

The review process works as follows:

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon);it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made based on the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Notice of Decision on Appeal for Post-Service Claims

Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination
- Reference to the specific plan provision(s) on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge

- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Limitation on When a Lawsuit may be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than 3 years after the end of the year in which medical or dental services were provided.

COBRA Continuation of coverage - Because the HRA is part of the Health & Welfare Plan, the law requires that the Plan must offer Qualified Beneficiaries the opportunity to continue to contribute money to the HRA after a Qualifying Event, with additional amounts paid under COBRA coming from personal funds. Please read below concerning the different rules for access to the HRA after a Qualifying Event.

If you are no longer eligible for coverage - If a Participant and his/her Dependents lose eligibility for Health & Welfare Plan benefits because of the Participant's termination of employment covered by the Plan or a reduction in hours of employment covered by the Plan, the Participant and his or her Dependents have a Qualifying Event. If eligibility is not otherwise extended under one of the Plan's rules, the Participant and his or her Dependents will be offered the opportunity to extend eligibility under the Health & Welfare Plan by electing COBRA Continuation Coverage in the HRA and paying COBRA premiums.

If there is a COBRA Qualifying Event because the Participant has terminated Covered Employment or because of a reduction of the Participant's hours of Covered Employment, you may elect COBRA Continuation Coverage in your HRA. You must pay COBRA premiums for this coverage on an after-tax basis. However, you will continue to be eligible to receive reimbursements from your HRA using those COBRA contributions plus any outstanding account balance at the time of the Qualifying Event. (You are not required to elect COBRA Continuation Coverage to continue to receive reimbursements from your HRA for any nonforfeited account balance.)

As described above, you must be offered the opportunity to elect COBRA and continue to contribute to your HRA on an after-tax basis after a Qualifying Event. If you elect COBRA

and contribute to your HRA from your personal funds, those amounts are subject to HRA rules and may only be paid to you as described in this section.

If you lose eligibility because of death of the Participant - If a Spouse or Dependent loses eligibility for Health & Welfare Plan benefits because of the death of the Participant, they have a Qualifying Event. If eligibility is not otherwise extended under one of the Plan's rules, they will be offered the opportunity to extend eligibility under the Health & Welfare Plan by electing COBRA Continuation Coverage and paying COBRA premiums.

If there is a COBRA Qualifying Event because of the death of the Participant, the surviving Spouse and eligible Dependent(s) are NOT required to elect COBRA Continuation Coverage in the HRA or pay COBRA premiums to continue to receive reimbursements from the HRA. They will continue to have access to the HRA and receive reimbursements from the HRA so long as the account balance is sufficient to cover their claims. In fact, any outstanding balance in the HRA may be used to pay the required COBRA premiums for the Health & Welfare Plan benefits if that coverage is elected.

A surviving Spouse and eligible Dependent(s) must be offered the opportunity to continue to contribute to the HRA on an after-tax basis after a Qualifying Event. If they elect COBRA and contribute to the HRA from their personal funds, those amounts are subject to HRA rules and may only be paid to them as described in this section.

If you lose eligibility because of divorce of the Participant and Spouse or because you no longer meet the definition of "Dependent " under the Plan - If you lose eligibility for Health and Welfare Plan benefits because of the divorce of the Participant or because you no longer meet the definition of "Dependent" under the Plan, you have a Qualifying Event. If eligibility is not otherwise extended under one of the Plan's rules, you will be offered the opportunity to extend eligibility under the Health & Welfare Plan by electing COBRA Continuation Coverage and paying COBRA premiums.

You may elect COBRA Continuation Coverage in the HRA and pay COBRA premiums, and continue to receive reimbursements from the HRA for those COBRA contributions, plus any outstanding balance at the time of the Qualifying Event. You will have access to the HRA and will be able to receive reimbursements from the HRA if you elect COBRA and continue to pay COBRA premiums so long as the account balance is sufficient to cover your claims.

LIFE INSURANCE BENEFIT

If you die from any cause while you are eligible, the proceeds will be paid to your beneficiary. The proceeds will be paid as a lump sum.

Beneficiary

You may name anyone you wish as your beneficiary by completing a H & W enrollment form. You may change your beneficiary at any time by completing the proper form. The change will be effective when the Fund Office receives the completed form. If there is no Health & Welfare beneficiary on file, the Deferred Income Fund primary beneficiary will be considered your beneficiary for the Health & Welfare life insurance benefit.

Total and Permanent Disability

If you become totally and permanently disabled before age 60, your life insurance will continue at no cost to you for twelve (12) months from the date to which premiums were paid on your behalf. The Plan will consider you totally and permanently disabled if you are not working at any job for wage or profit and you are unable to work in any job that is reasonably suited to you by your education, training, or experience due solely to illness or injury.

Coverage will further continue during such disability without payment of premium if:

a. you send written proof of your disability to the insurer no later than twelve (12) months after the start of your disability; and

b. the proof shows that you were totally and permanently disabled for at least nine (9) months, and that such disability will presumably continue to exist.

Premiums will be waived every twelve (12) months if you submit proof of continuing total and permanent disability each year, within three (3) months of the anniversary date the initial proof of your disability was received by the insurer.

The Amount of Insurance that is Continued

The amount of life insurance that will be continued while you are totally and permanently disabled will be the amount which was in force at the time premium payments were discontinued on your behalf as a result of your disability.

Benefits will continue under this extension until the earliest of:

a. Thirty-one (31) days after the date you are no longer totally and permanently disabled;

b. the date you fail to furnish the insurer with proof of your continued disability (which must be within the three (3) months prior to the anniversary date the initial proof of disability was received by the insurer); or

c. the date you fail to be examined by a physician designated by the insurer if so requested by the insurer. Such an examination will not be required more than once a year after your insurance has been continued under this extension for two (2) full years.

Conversion Privilege

If you are no longer eligible for group life insurance because you no longer belong to an eligible insured class or if you terminate your employment, you may convert that benefit to any form of individual life insurance usually offered by the insurer, except for term.

You will not need a medical examination. However, you must complete the application form and send it with the first premium payment to the insurer no later than thirty-one (31) days after your group life insurance has terminated.

The face value of your new policy cannot be more than the amount you had under the group plan. The rate you pay will depend upon your age (at the nearest birthday to the date of issue of the individual policy), your class of risk at the time of your conversion and the face amount of your new policy.

You may also convert if your life insurance benefits terminate because the policy terminates or because life insurance benefits for your class terminate. In this case, however, you must have been covered under the group plan for at least five (5) years. You may convert the LESSER of the following amounts:

a. the amount of life insurance you had under this plan, less any new amount you may have or for which you may become eligible under another group plan within thirty-one (31) days of the termination; or

b. $2,000.00.

If you should die during the thirty-one (31) day period after your group life insurance has terminated, the insurer will pay the group life insurance benefits to the last beneficiary you named, whether or not you applied for an individual life insurance policy.

PERSONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Benefit

If, as the result of an accidental injury which occurs while you are insured, you incur the loss of life, limb or sight within ninety days following the injury, the insurer will pay the benefit specified in the following Schedule of Losses and Benefits. Benefits are payable to you except that, in the event of loss of life, the benefit will be paid to your beneficiary.

Payment will be made for each loss without regard to previous losses, except as provided in this paragraph. The total amount payable for all losses resulting from any single accident will not exceed the Principal Sum shown in the Schedule of Insurance, except that in the event of loss of life as described in the Schedule of Losses and Benefits, the total amount payable for all losses incurred in that accident will be as described there.

SCHEDULE OF LOSSES AND BENEFITS	
Loss of Life due to injury sustained while a passenger in or upon a public conveyance being operated by a common carrier to transport passengers for hire.	Principal Sum plus an amount equal to the Principal Sum.
Loss of Life as the result of injury which occurs under circumstances other than as provided above	
Loss of Two Hands	Principal Sum
Loss of Two Feet	Principal Sum
Loss of Sight of Two Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Sight of One Eye	Principal Sum
Loss of One Foot and Sight of One Eye	Principal Sum
Loss of One Hand	Principal Sum
Loss of One Foot	One-half the Principal Sum
Loss of Sight of One Eye	One-half the Principal Sum
	One-half the Principal Sum
Loss of a hand or foot means severance at or above the wrist or ankle joint, respectively, and loss of sight means total and irrecoverable loss of sight.	

Beneficiary

You alone have the right to designate your beneficiary, and you may change that designation at any time by written notice to the Fund Office. Be sure to clearly identify your beneficiary. If two or more individuals are to share a death benefit, you must specify the portion that is to be paid to each person.

If you have not named a beneficiary or if your beneficiary is no longer living or if your beneficiary is unable to give a valid release, your insurance will be paid to your named Deferred Income Fund beneficiary or in accordance with applicable law.

Limitations

No Personal Accidental Death and Dismemberment Insurance benefit will be payable for a loss resulting from or caused directly, wholly or partly by any of the following causes:

1. Disease or bodily or mental infirmity or medical or surgical treatment of such conditions.

2. Suicide or intentionally self-inflicted injury.

3. Participation in the commission of a felony.

4. Any act of war, whether declared or undeclared.

SUPPLEMENTAL ACCIDENT AND SICKNESS BENEFIT

Benefit

If you become totally disabled due to accidental bodily injury or disease while you are insured, the Fund will pay you the amount of Supplemental Accident and Sickness weekly benefit. Benefits will begin with the day of disability and will continue during the total disability up to a maximum of 26 weeks.

Successive periods of disability separated by less than two weeks of continuous full-time active work shall be considered as one period in determining the benefits available to you, unless the subsequent disability is due to an injury or disease entirely unrelated to the causes of the previous disability and commences after your return to full-time active work. This benefit shall not to exceed a total of twenty-six (26) weeks in a plan year.

Limitations

Supplemental Accident and Sickness benefits will not be payable for disability due to any of the following causes:

1. Injury or disease for which you are not under treatment by a doctor licensed to practice medicine.

2. Disease for which you are entitled to benefits under any Workers' Compensation Law or Act or accidental injury arising out of or in the course of your employment.

DISCRETIONARY AUTHORITY OF THE PLAN - ADMINISTRATOR AND ITS DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

INFORMATION YOU OR YOUR DEPENDENTS MUST FURNISH TO THE PLAN

In addition to information you must furnish in support of any claim for Plan Benefits under this Plan, you or your covered Dependents must furnish, within **60 days** after the event, any information you or they may have that may affect eligibility for coverage under the Plan. This includes, but is not limited to:

1. Change of name.

2. Change of address.

3. Marriage, divorce, or death of you or any covered Spouse or Dependent Child.

4. Any information regarding the status of a Dependent Child, including, but not limited to:

    - The Dependent Child reaching age 26;or
    - The existence of any physical or mental Handicap.

5. Medicare enrollment or disenrollment.

6. The existence of other medical or dental coverage.

OBLIGATION TO PROVIDE FUND WITH TRUTHFUL AND ACCURATE INFORMATION

The Plan is authorized to rescind coverage of participants (including the coverage of dependents) or dependents in cases where participants or dependents provide false information to the Plan in order to obtain coverage or benefits to which they or their dependents are not entitled, or fail to immediately notify the Plan if a person who is enrolled as an eligible dependent no longer satisfies the requirements for eligible dependent status under the Plan.

The Plan may recover from any participant or eligible dependent any payments made by the Plan on behalf of a participant or eligible dependent for benefits to which they were not entitled. The Trustees may offset, recoup or deny future claims of a participant or eligible dependent which would otherwise be payable under the Plan until the plan has been reimbursed in full by such participant or eligible dependent. In the event the Trustees are required to institute a civil action to recover any such amounts paid in error as a result of erroneous information, misrepresentation, non-disclosure or concealment by the participant or eligible dependent, the Plan shall be entitled as a remedy under the Plan all losses to the Plan, interest at a rate of twelve percent per annum from the date of the payment, its reasonable attorneys' fee incurred in collection and all other remedies provided under ERISA and applicable federal and state law.

If you or your dependents do not cooperate with Blue Cross Blue Shield HMO Blue with respect to the recovery of money paid for benefits for an injury caused by an act or omission of another person as required in Part 7 of the Blue Cross Blue Shield HMO Blue Subscriber Certificate, the Trustees of the Fund may take whatever action they deem appropriate, including the withholding of future health coverage from you as well as all of your dependents.

NOTICE OF PRIVACY PRACTICES

Section 1: Purpose Of This Notice And Effective Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice applies to the protected health information received and maintained by the Fund Office of the Boston Plasterers' and Cement Masons' Local 534 Health and Welfare Fund (the "Fund"), and the services that the Fund provides through Blue Cross Blue Shield of Massachusetts ("BC/BS") and other business associates of the Fund. It does not pertain to how your medical providers, including your treating physician, may use, disclose or protect such information.

Effective date: The effective date of this Notice is April 2003.

The Fund needs to create, receive, and maintain records that contain health information about you to administer the Fund and provide you with health care benefits. This notice describes the Fund's health information privacy policy with respect to your medical benefits. The notice tells you the ways the Fund may use health information about you, describes your rights, and the obligations the Fund has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

This Notice is required by law. The Fund is required by law to take reasonable steps to ensure the privacy of your PHI and to inform you about:

1. The Fund's uses and disclosures of Protected Health Information (PHI),
2. Your rights to privacy with respect to your PHI,
3. The Fund's duties with respect to your PHI,
4. Your right to file a complaint with the Fund and with the Secretary of the United States Department of Health and Human Services (HHS), and
5. The person or office you should contact for further information about the Fund's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The Fund's privacy policy and practices protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). PHI includes information maintained by the Fund in oral, written or electronic form. Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

When the Fund May Disclose Your PHI

Under the law, the Fund may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases:

- ***For treatment, payment or health care operations.*** The Fund and its business associates will use PHI in order to carry out:
  1. Treatment,
  2. Payment, or
  3. Health care operations.

- ***Treatment*** is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

  For example, the Fund may disclose to a treating surgeon the name of your treating physician so that the surgeon may ask for necessary health information.

- ***Payment*** includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

  For example, the Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund. If we contract with third parties to help us with payment operations, such as a doctor that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

- ***Health care operations*** includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

  For example, the Fund may use information about your claims to refer to a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

- ***Disclosure to the Fund's Trustees.*** The Fund will also disclose PHI to the Plan Sponsor, the Board of Trustees of the Boston Plasterers' and Cement Masons' Local 534 Health & Welfare Fund, for purposes related to treatment, payment, and health care operations, and has amended the Summary Plan Description to permit this use and disclosure as required by federal law. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal.

  In addition, the Fund may disclose "summary health information" to the Board of Trustees for obtaining premium bids or modifying, amending or terminating the Fund's group health plan. Summary information summarizes the claims history, claims expenses or type of claims experience by individuals for whom a Plan Sponsor

such as the Board of Trustees has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with federal privacy rules.

- ***To a Business Associate*.** Certain services may be provided to the Fund by third party administrators known as "business associates." In that event, the Fund will require its business associates, through contract, to appropriately safeguard your health information.

- ***At your request.*** If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect and/or copy it.

- ***When required by applicable law.***

- ***As required by HHS.*** The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.

- ***Public health purposes.*** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

- ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

- ***Health oversight activities.*** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).

- ***To an individual involved in your care or payment for your care.*** The Fund may disclose PHI to a close friend or family member involved in or who helps to pay for your medical care. The Fund may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

- ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

- ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).

- ***Law enforcement emergency purposes.*** For certain law enforcement purposes, including:
  1. identifying or locating a suspect, fugitive, material witness or missing person, and

2. disclosing information about an individual who is or is suspected to be a victim of a crime.

- ***Determining cause of death and organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

- ***Military and Veterans***. If you are or become a member of the U.S. Armed Forces, the Fund may release medical information about you as deemed necessary by military command authorities.

- ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.

- ***Research.*** For research, subject to certain conditions.

- ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

- ***Workers' Compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

When the Disclosure of Your PHI Requires Your Written Authorization

Although the Fund does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Fund will use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

When You Can Object and Prevent the Fund from Using or Disclosing PHI

Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and

- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Other Uses or Disclosures

The Fund may contact you to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Section 3: Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You may ask the Fund to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to:

Privacy Official
Boston Plasterers' and Cement Masons' Health & Welfare Fund
7 Frederika Street
Boston, Massachusetts 02124
Tel.: (617) 825-4500

You May Request Confidential Communications

The Fund will accommodate an individual's reasonable request to receive communications of PHI **by alternative means or at alternative locations** where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Fund's Privacy Official (at the address listed above).

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI.

The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. A reasonable fee may be charged. Requests for access to PHI should be made to the Fund's Privacy Official (at the address listed above).

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and HHS.

Designated Record Set: includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Fund's Right to Amend Policy (available on request from the Fund's Privacy Official) for a list of exceptions.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You should make your request to amend PHI to the Fund's Privacy Official (at the address listed above). You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of certain disclosures by the Fund of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. See the Fund's Accounting for Disclosure Policy (available on request from the Fund's Privacy Official) for the complete list of disclosures for which an accounting is not required.

The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Fund's Privacy Official (at the address listed above).

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Fund will automatically consider a spouse of a member to be the personal representative of an individual covered by the plan. In addition, the Fund will consider a parent or guardian as the personal representative of a dependent child covered by the plan, unless applicable law requires otherwise. A spouse or parent of a dependent covered child may act on an individual's behalf, including requesting access to their PHI. Spouses and dependent covered children may, however, request that the Fund restrict information that goes to family members as described above at the beginning of Section 3 of this Notice.

You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives (available upon request from the Fund's Privacy Official) for a more complete description of the circumstances where the Fund will automatically consider an individual to be a personal representative for purposes of exercising your rights under this Privacy Notice.

Section 4: The Fund's Duties

Maintaining Your Privacy

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This notice is effective beginning on April 14, 2003 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is materially changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI.

The Privacy Notice will be provided via first class mail to all named participants. Any other person, including dependents of named participants, may receive a copy upon request.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

1. The uses or disclosures of PHI,
2. Your individual rights,

3. The duties of the Fund, or
4. Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

1. Disclosures to or requests by a health care provider for treatment,
2. Uses or disclosures made to you,
3. Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
4. Uses or disclosures required by law, and
5. Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

1. Does not identify you, and
2. With respect to which there is no reasonable basis to believe that the information can be used to identify you.

Section 5: Your Right To File A Complaint With The Fund Or The Secretary of HHS

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the following Privacy Official (at the address listed above).

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Fund will not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the Fund Office.

Section 7: Conclusion

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

This Plan is administered by a joint Board of Trustees, consisting of Union representatives and Employer representatives. The Board of Trustees has been designated as the agent for service of legal process. The Board of Trustees is also the Claims Review Fiduciary.

All contributions to the Plan are made by employers in accordance with the Collective Bargaining Agreements between the Boston Plasterers' & Cement Masons' Local #534 Health and Welfare Fund and the Building Trades Employers Association, the Associated General Contractors, and The Master Plasterers Association. The Collective Bargaining Agreements require contributions to the Health Benefits Plan at fixed rates for each hour worked for which an employee is covered by an agreement.

Upon written request, the Fund Office will provide you with information as to whether a particular employer is contributing to this Plan on behalf of participants working under a Collective Bargaining Agreement and, if so, with the employer's address.

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. Some of the benefits are provided through insurance policies.

The Fund's assets and reserves are held in custody and invested by Boston Trust & Investment Management Co. The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of any benefits are fully described beginning on page 4 of this descriptive booklet.

All of the types of benefits provided by the Plan are set forth in the Schedule of Benefits beginning on page 2 of this booklet. The complete terms of the insured benefits are set forth in the group insurance policies or contracts with BCBS.

As someone who is or may be eligible for benefits from this Plan, you are no doubt aware of the fact that the benefits are paid in accordance with Plan provisions out of a trust fund which is used solely for that purpose. If you have had any questions or problems as to benefit payments, you have, as you know, had the right to get answers from the Trustees who administer the Plan.

The same basic rights have now been incorporated in the Employee Retirement Income Security Act, which Congress adopted in 1974, for application to all benefit plans. Those rights are set forth in the following statement.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a participant in the Boston Plasterers' & Cement Masons' Local 534 Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security act of 1974. 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 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 and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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 summary 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have "creditable coverage" from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage or 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. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date of your coverage.

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 or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan 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 state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of 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 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 any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, 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, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of Employee Benefits Security Administration.

If you do not understand English and have questions about the benefits or the rules of the Plan, contact the Fund Office to find out how to obtain such help.

No Local Union, Local Union Officer, Business Agent, Local Union Employee, Employer, Employer Representative, Fund Office personnel, consultant or attorney is authorized to speak for, or on behalf of, or to commit the Trustees of this Fund on any matter relating to that Fund without the express authority of the Trustees.

Only the Trustees of the Fund have the authority to determine eligibility for benefits and the right to participate in the Fund, including the manner in which hours are credited, eligibility for any benefit, discontinuance of benefits, status as a covered or non-covered participant, the level of benefits and the interpretation and application of Rules and Regulations to a particular claim or applicant.

IMPORTANT ADMINISTRATIVE INFORMATION

All requests for eligibility and questions regarding the payment of claims relative to the Health and Welfare Fund should be directed to the Fund Office either in writing or by a telephone call. Any person calling the Fund Office must be able to supply the participant's name and Social Security number and date of birth.

The Fund Office is open to participants Monday through Friday from 8:00 a.m. to 5:00 p.m.

The office is located at 7 Frederika Street, Boston, Massachusetts, 02124. The phone number is 617-825-3302 or 1-888-825-5340 (outside the 617 area code).

Legal Name of Plan

Boston Plasterers' and Cement Masons' Local 534 Health and Welfare Fund

Plan Sponsor

The Board of Trustees of the Boston Plasterers' & Cement Masons' Local 534 Health and Welfare Fund is the plan sponsor. The Plan Sponsor's address is:

Board of Trustees
Boston Plasterers' & Cement Masons'
Local # 534
Health and Welfare Fund
7 Frederika Street
Boston, MA 02124

(617) 825-4500

Plan Administrator

A joint Board of Trustees, consisting of three Union representatives and three Employer representatives is the administrator of the Plan.

Names, Titles and Business Addresses of Trustees

Union Trustees	Employer Trustees
Harry C. Brousaides Boston Plasterers' and Cement Masons' Local 534 Trust Funds 7 Frederika Street Boston, MA 02124	Thomas S. Gunning Building Trades Employers' Association 100 Grossman Dr. Ste 300 Braintree, MA 02184
David M. Ferron Boston Plasterers' and Cement Masons' Local 534 Trust Funds 7 Frederika Street Boston, MA 02124	Stephen P. Affanato 1266 Furnace Brook Pkwy Quincy, MA 02169
James P. Mulcahy Boston Plasterers' and Cement Masons' Local 534 Trust Funds 7 Frederika Street Boston, MA 02124	Joseph B. Farina, Jr. J.L. Marshall & Sons, Inc. P.O. Box 2210 Pawtucket, RI 02861

Plan Sponsor's Employer Identification Number: 04-6049991

Plan Number: 501

Plan Year End Date: March 31

Type of Plan

A welfare benefit plan that provides medical, prescription drug, life insurance, accidental death and dismemberment and supplemental accident and sickness benefits to eligible employees and their qualified dependents.

Type of Administration

Fully-funded, insured Fund, governed by the Employee Retirement Income Security Act of 1974 (ERISA); a collectively-bargained, jointly-trusteed labor management trust.

Funding Medium

Benefits are provided from the Fund's assets which are accumulated under the provisions of Collective Bargaining Agreements between contributing employers and the Union and the Trust Agreement, and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

The Fund's assets and reserves are invested in accordance with the instructions of the Board of Trustees. Boston Trust and Investment Management Company is the Fund's custodian.

Source of Contributions

All Employers contributions to the Plan are made in accordance with a Collective Bargaining Agreement between the Boston Plasterers' & Cement Masons' Local 534 and employers in the industry. The collective bargaining agreements require contributions to the Plan at fixed rates per hour worked.

The Fund Office will provide you, upon written request, with information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the Collective Bargaining Agreement and, if so, with that employer's address. You are also entitled to receive copies of the collective bargaining agreements upon request.

Organizations Accumulating Fund Assets

The Fund's assets and reserves are managed by Boston Trust & Investment Management Co. per investment guidelines accepted by the Trustees.

Agent for the Service of Legal Process

The Board of Trustees has been designated as the agent for the service of legal process. Process may be served at the Fund Office address. You may also serve legal process upon any of the Trustees individually.

Plan Information

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of benefits are described in this SPD beginning on page 4.

Insurance Policies and Plan Regulations

The complete terms of the insured benefits are set forth in the insurance policies or contracts with the following organizations:

Blue Cross Blue Shield of Massachusetts 100 Hancock St. N. Quincy, MA 02171

CIGNA Group Insurance, P.O. Box 22328, Pittsburgh, PA 15222-0328

Misrepresentation and Fraud

If a participant or his/her dependent receive benefits as a result of any sort of misrepresentation, false information or other fraudulent representation to the Fund, (s)he is liable to repay all amounts paid by the Fund as a result. (S)he is also liable for all costs of collection, including interest and attorney's fees.

In addition, the Trustees reserve the right to deny payment for any subsequent claims incurred by such participant and his/her dependents for a time period or amount determined by the Trustees. In such case, the participant will be notified of any such periods of denial and amounts.

No Liability for Practice of Medicine

The Fund, Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine and do not have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Fund, Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Third Party Administrators (TPAs) and Insurance Carriers

Medical Benefits & Pharmacy Benefits

Blue Cross Blue Shield of Massachusetts
100 Hancock Street
North Quincy, MA 02171
Tel.: 1-800-327-6717

Life Insurance

Cigna Group Insurance
1600 W. Carson Street, Suite 300
Pittsburgh, PA 15219

Personal Accidental Death and Dismemberment Insurance

Cigna Group Insurance
1600 W. Carson Street, Suite 300
Pittsburgh, PA 15219

Supplemental Accident and Sickness Benefit Administrator

Boston Plasterers' & Cement Masons' Local 534
Health & Welfare Fund
7 Frederika Street
Boston, MA 02124

SPD Date: July 1, 2011