SUMMARY PLAN DESCRIPTION OF THE

BOSTON PLASTERERS' and CEMENT MASONS' LOCAL 534 HEALTH and WELFARE FUND

AS RESTATED AND AMENDED THROUGH APRIL 1, 2024

Dear members:

We are pleased to provide you with this updated Summary Plan Description ("SPD") for the Boston Plasterers' and Cement Masons' Local 534 Health and Welfare Fund (the "Fund"). This SPD describes the benefits available to you and your eligible Dependents. It is also intended to constitute the written Plan document under the Employee Retirement Income Security Act of 1974 ("ERISA").

Note that throughout this document, the terms "Fund" and "Plan" have the same meaning.

This Summary Plan Description describes all benefits available to members under the Health and Welfare Fund. If a benefit, treatment, coverage, or other related item is not explicitly described in this document, it is not covered by the Fund.

We all recognize the need for a comprehensive personal medical coverage program that provides hospital, doctor, prescription drug, vision care, and dental benefits. It is also important to have a continuation of income during periods of total disability and to have life insurance. However, many of us would find the cost of such coverage beyond our financial means if we had to pay for it individually. The Trustees are pleased to provide these benefits to you and your family through the Health and Welfare Fund. We will continue to do everything possible to maintain the Fund on a sound financial basis so that the benefits described in this SPD can remain available to you.

You and your family will be able to take full advantage of the benefits available in this Fund only if you are aware of all of the provisions of the Plan and the broad scope of services the Plan covers. This SPD furnishes a description of the benefits to which members are entitled, the rules governing these benefits, and the procedures you must follow when making a claim. In the back of this booklet, we have also included certain information concerning the administration of the Fund as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Trustees reserve the right to amend, modify, or discontinue all or part of this Plan whenever, in their judgment, conditions warrant. The Trustees have complete discretionary authority to determine eligibility for benefits under the Plan or to construe and interpret the terms of the Plan or the Fund, including ambiguous or disputed terms and meanings and any other instruments or policies of the Plan or the Fund. The Trustees have discretionary authority to make all factual findings.

This booklet replaces all other Summary Plan Descriptions previously published by the Trustees. We suggest you read this booklet carefully to fully understand the benefits you may be entitled to. If you have any questions on claims payment, benefit coverage, or eligibility rules, please call the Fund Office at (617) 825-4500.

Sincerely,

Board of Trustees,
Boston Plasterers' and Cement Masons' Local 534 Health and Welfare Fund

IMPORTANT NOTICES

TRUSTEES' AUTHORITY AND DISCRETION

The Trustees have complete discretionary authority to interpret and apply the provisions of the Plan, including, but not limited to, determinations of eligibility for benefits, the right of individuals to participate, how contributions are credited and the level, extension or discontinuance of benefits. The Trustees have complete discretionary authority to construe and interpret the terms of the Plan and/or any other policy or instrument, including ambiguous or disputed terms and meanings. Furthermore, the Trustees have discretionary authority to make all factual findings.

LIMIT ON AUTHORITY OF NON-TRUSTEES

No Local Union, Local Union Officer, Business Agent, Local Union Member, Employer or Employer Representative, Fund Office employee, attorney, or consultant is authorized to speak for or to commit the Board of Trustees of this Fund on any matter without express written authority from the Trustees.

TRUSTEES' RIGHT TO AMEND, MODIFY OR DISCONTINUE BENEFITS AT ANY TIME

The Trustees reserve the right to amend, modify, or discontinue all or part of this Fund provided by the Fund whenever, in their judgment, conditions so warrant. Benefits, rules governing eligibility, and other provisions may change after the date of this SPD booklet. Benefits are not vested.

Contact the Fund Office if you have questions regarding current benefits.

YOUR RESPONSIBILITY FOR SELECTION OF PROVIDERS

The selection of medical professionals and service providers is your responsibility. If the Board has contracted with a network of providers, it has tried to find the best selection of providers available. However, the Board disclaims any responsibility for the qualification or action of any provider of goods or services.

FOREIGN LANGUAGE ASSISTANCE - SI NO HABLA INGLES

If you do not understand English and have a question about the benefits or the rules of the Plan, contact the Fund Office for assistance.

Si usted no entiende inglés y tiene una pregunta acerca de los beneficios o las reglas del Plan, llame la oficina del Fondo de Beneficios para asistencia.

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BASIC INFORMATION

NAME OF FUND

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

ADDRESS OF FUND

7 Frederika Street
Boston, MA 02124

EMPLOYER IDENTIFICATION NUMBER / FUND NUMBER

04-6049991 / 501

FISCAL YEAR OF THE FUND (FUND YEAR)

April 1 through March 31

PLAN SPONSOR

Boston Plasterers' and Cement Masons' Local 534 and the signatory employers established and maintain the Fund. Members of the Fund can receive from the Fund Office, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Fund. If the employer or employee organization is a sponsor of the Fund, the Fund Office will provide the sponsor's address. Under ERISA, the Board of Trustees is considered to be the Plan Sponsor.

TYPE OF ADMINISTRATION OF THE FUND

The Fund is a group health plan, which is administered and maintained by a joint Board of Trustees consisting of [3] Union Trustees and [3] Employer Trustees. The Board of Trustees is governed by the Trust Agreement established and maintained in accordance with Collective Bargaining Agreements.

The Fund Office currently handles the day-to-day administration of the benefits under this Plan, including your medical and hospitalization benefits, on behalf of the Trustees. Most benefits under the Plan are self-insured. Some ancillary benefits, including life insurance coverage, are provided under policies purchased from insurance companies and are "insured benefits."

BOARD OF TRUSTEES

Union Trustees (listed alphabetically)	Management Trustees (listed alphabetically)
James P. Mulcahy – Chairman Boston Plasterers' & Cement Masons' Local 534 7 Frederika Street Dorchester, MA 02124	Stephen Affanato – Secretary Treasurer Building Trades Employers Association 100 Grossman Drive, Suite 300 Braintree, MA 02184
Thomas D. Peckham Boston Plasterers' & Cement Masons' Local 534 7 Frederika Street Dorchester, MA 02124	Michael Frias Associated General Contractors of Mass 888 Worcester Street, Suite 40 Wellesley, MA 02482
William Redmond Boston Plasterers' & Cement Masons' Local 534 7 Frederika Street Dorchester, MA 02124	James Marguerite Master Plasterers Association of Boston 196 Eastbourne Street Methuen, MA 01844

The Trustees have complete discretionary authority to determine eligibility for benefits under the Fund or to construe and interpret the terms of the Fund, including ambiguous terms and meanings and any other instruments or policies of the Fund.

PLAN ADMINISTRATION / FUND OFFICE

Pursuant to ERISA, the Board of Trustees is considered the "Plan Administrator." The Fund is administered by and for the Trustees through the Fund Office:

Gail Mills
Fund Administrator
Boston Plasterers' and Cement Masons' Local 534 Benefit Fund
7 Frederika Street
Boston, MA 02124
Telephone Number: (617) 825-4500

AGENT FOR THE SERVICE OF LEGAL PROCESS

Gail Mills
Boston Plasterers' and Cement Masons' Local 534 Health & Welfare Fund
7 Frederika Street
Boston, MA 02124
Telephone Number: (617) 825-4500
Service of legal process may also be made on any Trustee.

LEGAL COUNSEL

Krakow, Souris, and Landry

90 Canal Street, 4th Floor
Boston, MA 02114

COLLECTIVE BARGAINING AGREEMENTS

This Fund is maintained under Collective Bargaining Agreements between the Boston Plasterers' and Cement Masons Local Union 534 and various employer associations. You may obtain copies of the most current versions of these Agreements upon written request to the Plan Administrator for a nominal charge or from your Local Union. They are also available for examination at the Fund Office.

Members in the Plan can receive from the Fund Office, upon written request, information as to whether a particular employer is a Contributing Employer to the Plan, as well as the Contributing Employer's address. Members can also receive from the Fund Office a complete list of the employers who contribute to the plan.

FUNDING MEDIUM

The Trustees hold the assets of the Health and Welfare Fund and the investment earnings on such assets in a Trust Fund pursuant to the Agreement and Declaration of Trust. Contributing Employers contribute to the Fund at the hourly rates established by and under the Collective Bargaining Agreements.

PLAN CHANGE OR TERMINATION

The Board of Trustees reserves the right to change or discontinue the types and amounts of benefits available under the Plan and the eligibility rules, even for eligibility periods that have already been accumulated. The Board of Trustees also reserves the right to change or increase the cost of coverage charged to all members or any class or classes of members.

Plan benefits and eligibility rules for active, retired, or disabled members:

1. Are not guaranteed;
2. Are not vested;
3. May be changed or discontinued by the Board of Trustees at any time;
4. Are subject to the terms of the Trust Agreement, which establishes and governs the Benefit Fund's operations;
5. Are subject to applicable law;
6. Are subject to the provisions of any group insurance policies purchased by the Board of Trustees.

The nature and amount of benefits under the Plan are always subject to the actual terms of the Plan as it exists at the time the claim for benefits is made.

If the Fund is changed or discontinued, it will not affect you or your eligible dependent's right to the payment of any benefit if and to the extent that the claim for benefits has already been made.

OTHER INFORMATION

This plan is a "non-Grandfathered" plan under the ACA.

From time to time, you may receive a "Summary of Material Modifications (SMM)", the purpose of which is to provide you with notice of amendments that modify this Summary Plan Description. These SMMs are considered to be part of this document. We suggest you keep all SMMs with this SPD.

Note that throughout this Summary Plan Description, the terms "the Plan" and "the Fund" both mean the Boston Plasterers' and Cement Masons' Local 534 Health and Welfare Fund.

Throughout this document, the term "member" means "member of the Local who is covered by the Fund".

SECTION 1. ELIGIBILITY RULES

The Fund's Eligibility rules are important since they describe when coverage begins, when it might end, and related rules, and requirements for coverage under this Fund. It is important that you and your eligible dependents understand the Fund's rules for eligibility.

ELIGIBILITY REQUIREMENTS

COVERED EMPLOYMENT

"Covered Employment" is work for which your employer is required to contribute to the Fund on your behalf under the terms of a Collective Bargaining Agreement.

ACCUMULATION PERIOD

The Fund's ***Accumulation Period*** is a period of 12 consecutive months that begins **April 1st of each year and ending March 31st of the following year**. During this Accumulation Period, a member who works in Covered Employment establishes eligibility for this Fund.

ELIGIBILITY PERIOD

The Fund's ***Eligibility Period*** is a period of twelve (12) consecutive months, beginning **July 1st of each year and ending June 30th of the following year**. During this Eligibility Period, a member and their eligible dependent(s), if any, who comply with the Fund's Eligibility Requirements are covered for benefits under this Fund.

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

HOURS BANK

The Fund maintains an ***Hours Bank System***.

Under this System, if a covered member works more than 1,600 in an Accumulation Period (April 1 to March 31), hours over 1,600 are "deposited" in the member's ***Hours Bank***. A member can have up to 400 hours in an Accumulation Period added to their ***Hours Bank*** and can have up to 1,600 hours in total in their ***Hours Bank***.

Once a member's ***Hours Bank*** reaches 1,600, no additional hours can be added until hours are removed from the member's ***Hours Bank***.

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

EXAMPLE

James works 1,800 hours during the April 1, 2022 to March 31, 2023 *Accumulation Period*.

James will be covered for the *Eligibility Period* July 1, 2023 to June 30, 2024.

In addition, since James has worked more than 1,600 hours during his *Accumulation Period*, the hours over that amount (equal to 200) are "deposited" into James' *Hours Bank*.

James then works 600 hours during the April 1, 2023 to March 31, 2024 *Accumulation Period*.

Even though James has not worked the minimum number of hours for eligibility (800), the hours from James' *Hours Bank* are added to his actual hours: 600 + 200 = 800.

James is covered for the *Eligibility Period* July 1, 2023 to June 30, 2024.

AVAILABLE FOR WORK REQUIREMENT

A participant's health coverage with the Fund will terminate if the participant ceases working for a contributing employer and is no longer available for work with a contributing employer—for reasons other than disability, vacation, caring for a family member with a serious illness, bonding with a new child, or retirement. Coverage will terminate at the end of the month when this occurs. Participants who are unemployed but are on the out-of-work list will continue to receive health coverage and will not be affected by this rule.

Participants are required to inform the Fund Office if they are no longer working and they are no longer available for work with a contributing employer—for reasons other than disability, vacation, caring for a family member with a serious illness, bonding with a new child, or retirement. This notice must be provided within 72-hours from when the participant first becomes unavailable for work. If a participant is required to notify the Fund Office that they are unavailable for work, but the participant fails to do so, this failure will be deemed to be a prohibited, fraudulent omission. If such an omission is discovered, the participant's health coverage may be terminated retroactively to the date that such notice was required.

Any participant whose health coverage is terminated, because they are no longer available for work with a contributing employer, will have their health coverage reinstated if the following conditions are met:

1. The participant returns to work with a contributing employer, or is otherwise available for work as defined above, for a period of thirty (30) calendar days; and
2. The participant is otherwise eligible for health coverage.

A participant who meets these requirements will have their health coverage reinstated on the first of the month following the thirty-day period in which they return to work with a contributing employer or are available for such work.

FORFEITURE OF HOURS BANK

After a one year waiting period, a member who ceases participation in the Plan as a result of leaving the industry and not working in covered employment or retires will forfeit unused hours in their *Hours Bank*.

TERMINATION OF BENEFITS

Upon termination of benefits, a member may elect to continue coverage pursuant to their rights under COBRA.

RECIPROCITY

The Trustees of the Boston Plasterers' and Cement Masons' Local #534 Health and Welfare Fund have 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 the different Funds. Eligibility is determined using both hours reported for work performed within Local 534's jurisdiction and all hours received

under Reciprocal Agreements. The total number of hours (combined) are used to satisfy the hour requirement for Initial or Continuing Eligibility.

The Trustees strongly urge members 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.** This will help ensure that hours reported for the member are properly reciprocated to this Fund.

ELIGIBILITY FOR NEW AND RETURNING MEMBERS

SPECIAL PROVISION

The Fund has a special Eligibility Provision for the following types of members:

a) New members

b) Members who are returning to *Covered Employment* and who have previously met the 800 hour requirement in covered employment during an *Accumulation Period* (April 1 - March 31).

Members in these two groups are eligible for comprehensive medical benefits[1] for the member and the member's eligible dependents on the *first of the month following receipt in the Fund Office of proof of covered employment* in which the member has worked at least 800 hours in a twelve month period.

Proof of covered employment can consist of either employer remittance reports or pay receipts provided by the member and verification of the area worked.

A returning member is defined as someone who was previously a member 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 member 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.

ELIGIBILITY FOR OWNERS AND INCORPORATED WORKING PARTICIPANT CONTRACTORS

Any Incorporated Working member 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 their own behalf and that of their eligible dependents.

1. Submit to the Fund Office a signed copy of the effective 'Collective Bargaining Agreement entered into with the Union, obligating the contractor to the required contributions as a participating employer, at the then current rate of contributions.

2. To be eligible for coverage under this Fund, any Incorporated Working member Contractor must remit to the Fund Office a minimum of 160 hours at the then-current rate of contribution and have been credited with at least 1,920 hours on their behalf during the prescribed *Accumulation Period* each month.

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

[1] Excludes Life Insurance, AD&D and Weekly Accident and Sickness benefit

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

5. If an Incorporated Working member Contractor notifies (in writing) the Administrator of the Fund of their intention to suspend their contracting business, they will become subject to the eligibility rules pertaining to an actively employed employee as of the beginning of the next *Accumulation Period*, provided they 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:

   a. They are collective bargaining alumni;

   b. They are working for a contributing employer;

   c. They contribute 160 hours per month to all the Funds; and

   d. Contributions are made pursuant to a participation agreement.

   Note that this is a one-time election, so once an owner elects not to participate, they cannot participate in the future.

TRANSFER FROM LOCAL 534 TO A DIFFERENT AFFILIATED LOCAL UNION

Special eligibility rules apply if a participant transfers from Local 534 to a different local union affiliated with the Operative Plasterers' and Cement Masons' International Association ("OPCMIA Local Union"), and the member continues to work for an employer who is a signatory with Local 534.

Any such participant will continue to receive health coverage from the Local 534 Health Fund, if they are otherwise eligible, until the earlier of:

1. The date on which the participant becomes eligible for health coverage from a different health fund, based on work performed by the participant under a collective bargaining agreement of an OPCMIA Local Union; or

2. The expiration of eight months after the month in which the participant ceases performing work for an employer who contributes to the Health Fund on the participant's behalf.

MASSACHUSETTS PAID FAMILY AND MEDICAL LEAVE ACT ("PFMLA") ELIGIBILITY

The Massachusetts Paid Family and Medical Leave Act ("PFMLA") went into effect in 2021 in the Commonwealth, and impacts participants in this Fund.

Effective January 1, 2021, a participant with active health coverage who receives PFMLA leave will receive eligibility credit from the Health Fund that is necessary to maintain eligibility for health coverage during the following coverage period, up to a maximum of 40 hours for each week of the participant's PFMLA leave. A participant who already has sufficient hours to maintain their eligibility for health coverage in the following period will not receive eligibility credit for their leave.

DEPENDENT ELIGIBILITY

ELIGIBLE DEPENDENT

An eligible dependent is a member's lawful spouse and each "eligible child". To qualify for dependent coverage under the Plan, a child must:

1) Be your natural child, stepchild, legally adopted child or foster child; and

2) Be under age 26

The Comprehensive Medical Expense Benefits of this Plan can be continued beyond age 26 for an unmarried child if that child meets all of the following criteria:

- Is incapable of earning their own living because of disability;
- Became incapable of doing so before they reached age 26;
- Is chiefly dependent on the member for support on the date their 26th birthday; and
- Submits proof acceptable to the Fund that the disability existed on their 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 member to provide documentation substantiating an individual's dependency status. Such documentation includes, but is not limited to, a marriage certificate and birth certificate. Failure to provide such documents may result in termination of coverage.

Important Eligibility Limitation: No person may be eligible for benefits both as a member and as a dependent or as a dependent of more than one member.

CHANGE IN FAMILY STATUS AND SPECIAL ENROLLMENT EVENTS

CHANGE IN FAMILY STATUS

After a member's coverage becomes effective, the member must notify the Fund Office of any change in the member's family status including:

- Marriage;
- Birth of a child;
- Adoption of a child;
- Death (although an extension exists; see below);
- Divorce or legal separation.

If any of these events occur, the member should 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 a member and the member's eligible dependents who originally declined medical coverage, if the member or eligible dependents:

- Had other medical coverage and either the member or the member's eligible 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 the member or the member's eligible dependents' COBRA eligibility expired; or
- Had other medical coverage and the member or the member's eligible dependents reached the lifetime maximum for all benefits under that other medical coverage; 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 a member initially did not enroll and declined medical coverage, and the member later marries or has a birth child or children placed for adoption or the member adopts a child, the member is entitled to special enrollment, along with the children placed for adoption or adopted child or birth child and the member's spouse.

If a member initially enrolled, but later marries or has a birth child or children placed for adoption or the member adopts a child, the children placed for adoption or adopted child or birth child and the member's spouse are entitled to special enrollment.

If a member becomes eligible for special enrollment, the member 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. This paragraph presumes that all applications for coverage are received timely.

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.

If a member previously "opted-out" of the Fund's health coverage and enrolls in the Fund due to a status change event or Special Enrollment Event, the member will no longer qualify to receive opt-out contributions to the member's HRA for declining Fund health coverage.

DEATH OF AN ACTIVE PARTICIPANT

If an active participant passes away, the Fund will continue to cover the participants' covered dependents until either (i) the participant's hours bank is exhausted, or (ii) the dependents become eligible for alternative health insurance from a parent or guardian. (For example, if a dependent's parent remarries and the dependent becomes eligible for health coverage from the parent's new spouse, the dependent will no longer be eligible for coverage from the Local 534 Health Fund.) After that period, the Fund will offer these covered dependents COBRA coverage (see SECTION 9).

Note that when a retired participant passes away, the rules under the next Section will apply.

If a participant has failed to designate a Beneficiary to receive any benefits that may be payable after his death, such benefits will be payable based on the Fund's default beneficiary succession. The failure to designate a beneficiary includes situations where the participant's beneficiary designation is void or has been revoked, or if; the Beneficiary previously designated has predeceased the participant and no alternative designation has become effective, such death benefit will be paid in the following order of succession:

(a) To the participant's living Spouse, or if none,

(b) To the participant's living children in equal shares (and if a child predeceased the participant, that child's share to be shared equally by his or her children), or if none,

(c) To the participant's living parents in equal shares, or if none,

(d) To the participant's living brothers and sisters in equal shares, or if none,

(e) To the participant's estate.

RETIREE ELIGIBILITY

ACTIVE EMPLOYEES OVER AGE 65

Members age 65 and who remain actively employed and who qualify for eligibility under the Fund 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 members.

Spouses of such members 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 the member's behalf.

RETIREE ELIGIBILITY

Upon a member's retirement, the member, the member's spouse, or the member's dependents may continue to be eligible through the use of the member's *Hours Bank*. Once the member has exhausted their eligibility under the Plan (including the use of all hour in the member's *Hours Bank*), the member has 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, a retiree must obtain and complete the necessary forms, which are available at any Social Security office, in order to be covered under this section of Medicare.

A member who is eligible for benefits under the Health and Welfare Fund at the time of retirement is entitled to receive reimbursement for Medicare Part B ("standard" Part B, not any additional premium based on the retiree's income) for the member and the member's spouse upon becoming eligible for Medicare Part B.

Following the death of a retired member, Part B coverage ends for the retiree's surviving spouse and the end of the month of the retiree's death. The monthly cost of Part B Medicare will be reimbursed to each eligible retired member and the retiree's spouse, age 65 or over. The level of reimbursement is subject to the Trustees, and can change from time to time.

Reimbursement will be made directly from the Health and Welfare Fund monthly.

A member and member's spouse must contact a Social Security office before the date on which the member plans to enroll in Medicare. Neither the Trustees nor the Administrator can enroll a member under Medicare. The Trustees suggest that if a member has remained in active employment beyond the member's 65th birthday, the member should contact Social Security at least 90 days before the date on which the member plans to retire to make the necessary arrangements for participation under Part B. All former members eligible for benefits should contact the Social Security office before their 65th birthday.

Retirees age 65 or over eligible for coverage based on the retiree's *Hours Bank* will have the deductible waived when the Plan is secondary to Medicare for medical expenses.

MEDICARE REIMBURSEMENT

The Fund's Medicare Part B reimbursement is $157.34 for married retirees and $104.90 per month for single retirees.

The Fund does not provide Medicare premium reimbursements to participants or beneficiaries for whom Medicare is, or would be, secondary to the Local 534 Health Fund, unless the participant or beneficiary is enrolled in active coverage with the Local 534 Health Fund.

TERMINATION OF COVERAGE

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

1. The sum of the number of credited hours in a member's "Hour Bank" and the hours actually worked is less than 800;
2. The member enter active military service (except as required by USERRA);
3. The COBRA coverage period ends or the member does not make a required monthly self-payment; or
4. The Plan terminates.

OPTING OUT OF HEALTH COVERAGE

If a member is eligible for health coverage and is enrolled in the member's spouse's health coverage, the member may opt-out of this Fund's health coverage. This provision only applies if the spouse's coverage is considered "group health coverage", meaning it is provided by an employer or a union. A member may not opt out of coverage from the Fund based on government health insurance programs, such as Medicaid (MassHealth) or an individual marketplace plan.

To opt-out of your Plan coverage, a member must provide the Fund Office with documentary proof that the member's spouse has eligible, family health coverage. In lieu of coverage under the Fund, the member will receive a monthly "opt out" contribution to the member's HRA account.

Once a member has opted-out of Plan coverage and has enrolled in the HRA opt-out program, the Fund will transfer the following amounts to a member's HRA account each month (upon providing the Fund Office with satisfactory evidence of your spouse's continuing coverage):

1. The lesser of the member's spouse's monthly health premium payment and $500; and
2. A dollar amount equal to 1/12 of either 1,000, 1,500, or 2,000, depending on how many hours you worked.
    a. If a member works between 1,000 and 1,499 hours in the previous April 1 through March 31 period, the monthly payment is $83.33 (1,000/12)
    b. If a member works between 1,500 and 1,999 hours in the previous April 1 through March 31 period, the monthly payment is $125.00 (1,500/12)
    c. If a member works 1,500 hours or more in the previous April 1 through March 31 period, the monthly payment is $166.66 (2,000/12)

The amounts shown will be transferred to a member's HRA account each month during the July 1 through June 30 *Eligibility Period*;

If a member opts-out of Plan coverage any time during an *Eligibility Period* (July 1 through June 30) the member will **not** be eligible for coverage during that same *Eligibility Period* unless the member's

spouse loses coverage as a result of the member's spouse's separation from employment, the member's spouse's employer's decision to eliminate health coverage, or if the member experiences a qualified change in family status or Special Enrollment Event.

SECTION 2. MEDICAL BENEFITS

A short description of your medical benefits with Blue Cross Blue Shield is attached to the end of this document as Appendix A. This document has important information, including your **Deductible** amount, **Coinsurance** amounts, **Copays**, and your **Annual Out-of-Pocket Maximum**. This description will have enough information to answer most questions. However, if you require any additional information, you can request a copy of the Blue Cross Blue Shield Benefit Description by requesting it from the Fund Office. This Benefit Description has complete details regarding your medical benefits. In the event of any conflict between the Benefit Description and this SPD, the Benefit Description will control.

WHAT DO "IN-NETWORK" AND "OUT-OF-NETWORK" MEAN?

The Fund has contracted to use Blue Cross's "Network" of medical professionals regarding the cost of the services they provide. As a result, you will pay less out of pocket when you see these professionals or use facilities that are in the network. Any medical professional who is part of the network is considered to be **In-Network**. All other medical professionals are considered to be **Out-of-Network**. You will pay more out of pocket for these providers. Whenever possible, you should visit an In-Network medical professional and use In-Network medical facilities. You can find these by going to the Blue Cross Blue Shield website. Blue Cross Blue Shield determines which professionals are In-Network.

PLAN DEDUCTIBLE

The plan's "deductible" is the amount that a member (and the member's Eligible Dependents, if any) must pay each year. Once the deductible (as shown below) is met in a year, the plan will pay claims for the member (and the member's Eligible Dependents, if any).

IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLE

- Individual deductible $500
- Family deductible.....$500/person; $1,000/family

The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the *individual* Deductible, the Fund will pay claims for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.

EXAMPLE

Jerry has a spouse and two eligible dependent children. In 2024, one of Jerry's children has a medical treatment that costs over $500. Jerry pays $500 (the annual individual deductible) before plan coverage begins. All other medical costs for this child in 2024 will be paid by the plan, subject to the plan's coinsurance (described in the next section).

Later in 2024, Jerry has a medical treatments that cost over $500. Jerry pays $500 (the annual individual deductible) before plan coverage begins. All other medical costs for Jerry in 2024 will be paid by the plan, subject to the plan's coinsurance (described in the next section).

Even later in 2024, Jerry's spouse has a medical treatment that costs over $500. Since Jerry's family has already paid $1,000 in deductible for 2024, the plan covers all medical

costs for Jerry's spouse in 2024, subject to the plan's coinsurance (described in the next section).

When a member reaches their deductible, the participant is eligible for a credit to their HRA Account. The member must submit a written request for this credit to the Fund Office, which includes documentation from Blue Cross Blue Shield showing that the deductible has been reached. The amount of the credit for an individual is $250, and the amount of the credit for a family is $500.

COINSURANCE AND ANNUAL OUT OF POCKET MAXIMUM

Once a member (or the member's Eligible Dependents) satisfies the annual deductible for a year, the plan pays the percent of medical expense (the "**coinsurance**") that would otherwise be paid by the member. The plan limits the amount that a member and the member's family must pay in a year. This is known as the "**Annual out of pocket maximum**".

PREVENTIVE CARE SERVICES (UNDER ACA) PROVIDED BY THE PLAN

The Fund is not "Grandfathered" under the rules of the Affordable Care Act ("ACA") and follows ACA's rules regarding preventive care. You will have **no copayment** for any In-Network services that are considered ***preventive care*** under the ACA. The list of those services is subject to change. For information about what services are considered to be "preventive care" under the ACA, please go to the following link: https://www.healthcare.gov/coverage/preventive-care-benefits/

WELLNESS BENEFITS

WELLNESS BENEFITS	ALL PROVIDERS
Fitness Reimbursement Benefit (*See* Medical Benefits *section for other limitations*)	100% up to a total reimbursement of $150 per family, per Plan Year for monthly fees paid to a facility that provides cardiovascular and strength-training equipment for exercising and improving physical fitness, such as: health clubs, fitness centers, YMCA's, YWCA's; Jewish Community Centers, and municipal fitness centers. A qualified health and fitness club is defined as a facility with cardiovascular and strength-training equipment and facilities for exercising and improving physical fitness. Qualifying facilities include, but are not limited to, fitness studios/ facilities that offer: Yoga, Pilates®, Zumba®, aerobic/group classes, indoor cycling/spinning classes, kickboxing, CrossFit®, strength training, tennis, indoor rock climbing, and personal training taught by a certified instructor. (Reimbursement is available after providing proof of 4 months of membership in that year after enrollment into this Plan)

PRECERTIFICATION

The Fund requires Active and Non-Medicare Retired members to "Pre-certify" all inpatient stays and many outpatient services. The program is designed to help you evaluate the care you need. Unless otherwise noted in the SPD, the Health Fund utilizes the medical and preauthorization policies of Blue Cross Blue Shield and the Modern Assistance Program. Participants must comply with these policies for treatment to be covered.

PRECERTIFICATION REVIEW

The precertification review process will help you and/or your Physician answer important questions, such as:

- Is the treatment appropriate for the diagnosed condition or symptom?
- Is the proposed level of care necessary?
- Is there a less risky, medically appropriate treatment alternative?
- Is the proposed treatment or service a covered benefit under this Plan?
- Are the proposed health care providers considered In-Network providers?

Of course, any decision regarding treatment is left up to you and your Physician. Precertification review can help you make a more informed decision before undergoing any recommended treatments.

HOW THE PRECERTIFICATION REVIEW WORKS

For precertification of mental health and substance use disorder treatment, call the Modern Assistance Program at (800) 878-2004. For all other medical services, the following procedure will apply:

- Precertification is required for any inpatient admission. If your Physician recommends a Hospital admission or certain services that require certification by HealthLink, remind him or her that you will need to obtain this precertification.
- Examples of Services Requiring Pre-Certification
    - Inpatient Services
    - Surgical Procedures
    - Ancillary Services
    - Durable Medical Equipment
    - Diagnostic Imaging
    - Specialty Infusion Drugs
    - NOTE: the list of services are subject to change periodically; contact HealthLink (at the number below)
- You or your Physician should call the precertification phone number (800) 327-6716– before a scheduled treatment. You must call at least one business day before your Hospital admission or treatment; you may want to call as early as seven days before you are admitted. If you are admitted to the hospital on an emergency basis, call the precertification phone number by the second business day following your admission. In most cases, your Physician or the Hospital will make the call for you.
- When you call, the precertification staff will review the diagnosis and the recommended treatment, and the proposed level of care. They will compare proposed procedures to those of medically accepted guidelines for treating your condition.
- If necessary, the review staff will contact your Physician for additional medical information.
- You, your Physician, and/or the Hospital will be notified in writing of the review decision.

CASE MANAGEMENT

As an added benefit, the Plan also provides members with Case Management services. If you or one of your Dependents are hospitalized, a Nurse Case Manager may call to ensure that you are receiving all of the appropriate medical care and to answer any questions you may have.

"TELEMEDICINE" OPTION

You and your dependents will be able to contact a qualified primary care provider, psychologist, or therapist online using Blue Cross Blue Shield's LiveHealth Online. You'll be able to use your smartphone, tablet, or computer (if it has a webcam) to receive a "virtual checkup" without leaving your home.

There is no cost to you (no copayment), so this should be a more convenient and effective way for you and your dependents to receive medical attention for minor medical services. Of course, this service should only be used for services such as allergies, cold, flu, bronchitis, pink eye, rash, and the like. You can also get help for issues like stress, anxiety, depression, and family/relationship concerns. LiveHealth Online doctors can even write prescriptions.

Remember that LiveHealth Online is not for emergencies. If you're experiencing an emergency, call your doctor or 911 immediately.

You'll need high-speed Internet access, a webcam built-in, and audio (microphone/speaker). To learn what computer hardware and software you need, go to LiveHealthOnline, select "Frequently Asked Questions" under the "How it Works" tab.

For a smartphone app, search for "LiveHealthOnline" in the app store for your smartphone.

MENTAL HEALTH SERVICES

Treatment for In-patient Mental Health Conditions and Alcohol and Substance Abuse must be authorized by Modern Assistance Program (MAP). The Modern Assistance Program can be reached by calling (800) 878-2004. Failure to obtain the prior authorization may result in a denial of benefits. (Note: Outpatient Mental Health and Alcohol and Substance Abuse Treatment do not need to be precertified. However, those services performed at the Non-Network level that are precertified by MAP are payable at the In-Network level.)

PRESCRIPTION DRUG COVERAGE

Coverage for prescription drugs is provided and administered by Blue Cross Blue Shield. New and existing drugs are covered based on the Blue Cross Blue Shield formulary and related policies. For more information on what drugs are covered, please contact Blue Cross Blue Shield.

OUT-OF-NETWORK SERVICES

Services received at an out-of-network provider or an out-of-network facility will be paid in accordance with the applicable Blue Cross Blue Shield policy, which is available on request. Under federal law, you are protected from "balance billing" or "surprise billing" (an unexpected balance bill) in certain situations. You cannot be balance billed when you receive:

a. Emergency services

b. Non-emergency services furnished by an out-of-network provider at an in-network facility

c. Air ambulance services.

The Fund utilizes the policies and procedures of Blue Cross Blue Shield with respect to claims for the above services, including the procedures for independent dispute resolution in the event of a dispute over payment with a non-network provider. The Fund will only pay to out-of-network providers the amounts that are determined to be reimbursable under these policies.

For more information regarding your rights, please visit the following website: https://www.bluecrossma.org/disclaimer/member-rights-and-responsibilities/balance-billing

GENE THERAPY

Please note that the Local 534 Health Plan does not cover or provide any reimbursement for any gene therapy drugs or treatments, regardless of whether they have been approved by the U.S. Food and Drug Administration (FDA). Some examples of gene therapy include Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, as well as other therapies such as Luxturna and Zolgensma. This is not a comprehensive list and new applications for gene therapies are submitted every year. You may obtain a list of all FDA approved gene therapies at the following website: https://www.fda.gov/vaccines-blood-biologics/cellular-gene-therapy-products/approved-cellular-and-gene-therapy-products

SECTION 3. HEALTH REIMBURSEMENT ARRANGEMENT ("HRA")

In addition to the benefits described elsewhere in this Summary Plan Description, the Fund offers participants a way to pay for "out of pocket" medical expenses with a "Health Reimbursement Arrangement" or "HRA".

Under this Fund's HRA, a portion of each hourly contribution toward the Health Fund is set aside in a participant's individual HRA. Each participant has an HRA that grows with new contributions, and which decreases as the participant and the participant's eligible dependents use money from the participant's HRA to pay for medical expenses (as discussed elsewhere in this Section).

INITIAL ELIGIBILITY

Members of the Local who have contributions to the Health Fund made on their behalf by for a contributing employer are eligible to participate in the HRA benefit. A member begins participation if the participant has been credited with at least **275 hours** in Covered Employment under the Boston Plasterers and Cement Masons Local 534 Health and Welfare Plan within a Plan eligibility year (April 1 to March 31). Note that the Plan must receive contributions for those hours for a member to participate in the HRA.

CONTINUING ELIGIBILITY

Once a participant meets this general eligibility requirements, the participant and their eligible dependents will remain enrolled in the HRA as long as the participant continues to be available for work with a contributing employer. Participation can continue even if the participant's Account Balance is 0. The plan has a special provision where there is a COBRA Qualifying Event under the Plan, which is discussed elsewhere in this Section.

If a participant loses eligibility for benefits under this Plan because the participant's HRA has been completely distributed after the participant 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 the participant's benefits have been completely distributed, the participant's spouse and eligible dependents as defined in the Plan (see page 11 of this SPD) will be eligible to continue to receive reimbursement from the participant's HRA as long as the account balance is sufficient to cover their claims.

Participants must be enrolled in a group health plan, such as the Health Fund's coverage or coverage provided by a spouse's employer, in order to receive reimbursements from the HRA. Participants may also be enrolled in Medicare and receive reimbursements from the HRA.

RETIREE ELIGIBILITY

Retirees who have a balance in their HRA when retired and who are 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 retiree's account balance is sufficient to cover their claims.

CONTRIBUTION AMOUNTS

The Bargaining Parties determine the allocation of the current hourly Health contribution that goes into a participant's HRA. The Bargaining Parties may reallocate additional or lesser amounts from time to time.

If a participant "opts-out" of the Fund's health coverage (see "Opt-Out Provision" on page 15), the participant may be eligible for additional contributions to the participant's HRA as described elsewhere in this SPD. Only employer contributions are allowed in a participant's HRA; participant contributions are not permitted.

ENROLLMENT

Enrollment information must be provided for all participants and eligible dependents (including Medicare eligible participants and Dependents). Participants must notify the Fund Office in writing to enroll an eligible dependent. The Fund can only enroll those eligible dependents who the Fund Office knows about.

If a participant does not notify the Fund Office of an eligible dependent, the dependent cannot be enrolled. Once a participant meets the HRA eligibility requirements (as outlined in this Section), the Fund Office will mail an enrollment form for the participant to complete. If a participant is already enrolled and has a newly-eligible Dependent, the participant must contact the Fund Office for an enrollment form.

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

If a participant does not provide the required enrollment information after notice by the Fund, the Fund may suspend payments on behalf of the participant and the participant's eligible dependents for whom documentation is missing until documentation satisfactory to the Trustees has been provided.

OPT-OUT PROVISION

As noted previously, if a participant is eligible for Fund Health Coverage and the participant's spouse has medical coverage from an employer or another union, the participant may opt-out of Fund health coverage and receive a monthly contribution to the participant's HRA account. Please see "Opt-Out Provision" on page 15 for more information.

CARRY OVER AND FORFEITURES

There is no maximum that a participant can accumulate in the participant's individual HRA account. A participant will be allowed to carry over their entire account balance from Plan Year to Plan Year.

EXAMPLE

At the end of the 2021 plan year, Michael has an HRA balance of $1,000. During the 2022 plan year, Michael does not use any money from the HRA. Michael receives contributions toward their HRA of $600 during the plan year.

AT the beginning of the 2023 plan year, Michael's HRA balance is $1,600 ($1,000 at the beginning of the prior year plus $600 in contributions during the year.

However, if a participant ceases employment with contributing employers and no longer makes themselves available for work with contributing employers, the participant will forfeit their HRA at the end of the month following notification of dropped membership by the Local Union. The participant will

not be eligible for any further reimbursements of medical expenses, unless COBRA Continuation Coverage is elected.

If a participant retires and are receiving a pension from the Local 534 Pension Fund or if sickness or disability makes a participant unavailable for work, the participant will be allowed to carry over their HRA and will be eligible for reimbursements from their account.

REIMBURSABLE EXPENSES

Federal law limits the expenses that can be paid from an HRA. The HRA can only reimburse eligible medical care expenses incurred by a participant and the participant's eligible dependents retroactive to the date contributions were first made to the HRA on the participant's behalf. Members *cannot* submit a reimbursement request more than eighteen months after the date the expense was incurred.

The expense must be an "eligible medical care expense" under Internal Revenue Code Section 213(d). Please note that the reimbursable expenses allowed under this HRA Plan are not identical to all of the medical expenses that are allowed under the Internal Revenue Code. If a participant has a question about whether a particular expense is eligible for reimbursement under the HRA, contact the Fund Office.

Note that expenses paid from a participant's HRA cannot be covered or reimbursed by any other medical benefit plan.

The following is a *partial* list of medical expenses that are reimbursable under this Plan's HRA, provided they are not covered by any other medical benefit plan:

- Prescription Drug co-payments
- Medical copayments 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 a, nicotine replacement products (nicotine patch, gum and lozenges), Zyban and Chantix. These products require a doctor's prescription for reimbursement.
- Approved weight loss program if the expenses paid to lose weight are for treatment for a specific disease diagnosed by a physician, such as obesity, hypertension, or heart disease. This includes fees paid for membership in a weight reduction group and attendance at periodic meetings.

  As noted in the next Section, a participant cannot use their HRA to pay for membership dues in a gym, health club, or spa. In addition, the cost of diet food or beverages cannot be paid from the HRA. A participant is not allowed to use their HRA for weight loss 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 help, or domestic help,
- Death Benefits or life insurance benefits including the portion of the Plan's COBRA premium that pays for life insurance.
- The cost of diet food or beverages.
- Weight loss if the purpose of the weight loss is the improvement of appearance, general health or sense of well-being.
- 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, a participant 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 a request for benefits to be a claim, and for the Fund to be able to decide the claim.

- Participant's name
- Patient's name
- Patient's date of birth
- Social Security number of participant or retiree
- Date of service
- Address of patient
- 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
- 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. **Canceled checks and balance forward statements cannot be used to document your claims.**

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

Before filing a claim, a participant should ensure that they or their provider submits the expense to any medical benefit plan in which the participant is covered for the same services.

A participant can submit an HRA claim 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 participant's HRA, except the $100 minimum will not apply to 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 participant's 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 all itemized bills have been submitted. By doing so, the processing of a claim will be more efficient. If the claim forms have to be returned for information, delays in payment will result.

A participant does not have to submit an additional claim form if bills are for a continuing disability and the participant has filed a claim within the past calendar year period. Any further bills or statements for any Medical or Hospital services covered by the Plan should be mailed to the Fund Office as soon as received.

Ordinarily, a participant will be notified of the decision on a Post-Service claim within 30 days from the Plan's receipt of the claim. This period may be extended one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the participant 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, the extension notice will specify the information needed. In that case the participant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be denied.

During the period in which a participant is 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 the participant responds 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 a claim is denied in whole or in part, or if a participant disagrees with the decision made on a claim, the participant may ask for a review. Please see the portion of this SPD regarding adverse benefit determinations for further information on the procedures to appeal a claim denial.

COBRA CONTINUATION OF COVERAGE

Because the HRA is part of the Health and 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 the participant's eligible dependents lose eligibility for Health and 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 the participant's eligible dependents have a "Qualifying Event" (as noted in SECTION 9 of this SPD). If eligibility is not otherwise extended under one of the Plan's rules, the participant and the participant's eligible dependents will be offered the opportunity to extend eligibility under the Health and 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, the participant may elect COBRA Continuation Coverage in their HRA. The participant must pay COBRA premiums for this

coverage on an "after-tax" basis. However, the participant will continue to be eligible to receive reimbursements from their HRA using those COBRA contributions plus any outstanding account balance at the time of the Qualifying Event. (The participant is not required to elect COBRA Continuation Coverage to continue to receive reimbursements from their HRA for any nonforfeited HRA balance.)

As described above, a participant must be offered the opportunity to elect COBRA and continue to contribute to their HRA on an "after-tax" basis after a Qualifying Event. If a participant elects COBRA and contribute to their HRA from their personal funds, those amounts are subject to HRA rules and may only be paid to the participant as described in this Section.

LOSS OF ELIGIBILITY DUE TO DEATH OF PARTICIPANT

If an eligible dependent loses eligibility for Health and 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 and 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 eligible dependents 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 as long as the HRA 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 and Welfare Plan benefits if that coverage is elected.

A surviving eligible dependent 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 ELIGIBILITY IS LOST BECAUSE OF DIVORCE OR AN DEPENDENT NO LONGER MEETS THE DEFINITION OF "ELIGIBLE DEPENDENT"

If eligibility is lost 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, the affected dependent has a Qualifying Event. If eligibility is not otherwise extended under one of the Plan's rules, the affected dependent will be offered the opportunity to extend eligibility under the Health and Welfare Plan by electing COBRA Continuation Coverage and paying COBRA premiums.

COBRA Continuation Coverage in the HRA and pay COBRA premiums may be elected, and reimbursements from the HRA for those COBRA contributions (plus any outstanding balance at the time of the Qualifying Event) may be continued. Access to the HRA will continue and reimbursements from the HRA will continue if COBRA is elected and COBRA premiums are continued to be paid, as long as the HRA balance is sufficient to cover claims.

SECTION 4. LIFE INSURANCE BENEFIT

If an active participant dies (due to any cause) while eligible, the Plan provides a life insurance benefit. The life insurance will be paid to the participant's elected beneficiary as a lump sum.

DEFINITIONS

BENEFICIARY

A participant may name anyone as their beneficiary by completing the appropriate Beneficiary form, which is available from the Fund Office. A participant can change their beneficiary at any time by completing the proper form. The change will be effective when the Fund Office receives the completed form.

> Note that if there is no Health & Welfare beneficiary on file, the Deferred Income Fund primary beneficiary will be considered the participants beneficiary for the Health & Welfare life insurance benefit.

TOTAL AND PERMANENT DISABILITY

If a participant becomes "totally and permanently" disabled before age 60, the participant's life insurance will continue at no cost to the participant for twelve (12) months from the date to which premiums were paid on the participant's behalf.

The Plan will consider a participant to be "totally and permanently disabled" if the participant is not working at any job for wage or profit and the participant is unable to work in any job that is reasonably suited to them by their education, training, or experience due solely to illness or injury.

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

- The participant sends written proof of disability to the insurer no later than twelve (12) months after the start of your disability; and
- The proof shows that the participant was "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 a participant submits proof of continuing "total and permanent" disability each year, within three (3) months of the anniversary date the initial proof of disability was received by the insurer.

THE AMOUNT OF INSURANCE THAT IS CONTINUED

The amount of life insurance that will be continued to a "totally and permanently" disabled participant will be the amount which was in force at the time premium payments were discontinued on the participant's behalf as a result of disability.

Benefits will continue under this extension until the earliest of:

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

b. The date the participant fails to furnish the insurer with proof of 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);

c. The date a participant fails 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 insurance has been continued under this extension for two (2) full years.

CONVERSION PRIVILEGE

If a participant is no longer eligible for group life insurance because the participant is no longereligible or if the participant terminates employment, the participant may convert that benefit to any form of individual life insurance usually offered by the insurer, except for term life insurance.

The participant will not need a medical examination for this conversion, but must complete the application form and send it with the first premium payment to the insurer no later than thirty-one (31) days after the Plan's group life insurance has terminated.

The face value of the converted policy cannot be more than the amount under the Plan's insurance benefit. The rate the participant pay will depend upon age (at the nearest birthday to the date of issue of the individual policy), class of risk at the time of conversion, and the face amount of the new policy.

A participant may also convert if life insurance benefits terminate because the policy terminates or because life insurance benefits for a participants class terminate. In this case, however, a participant must have been covered under the group plan for at least five (5) years.

In this situation, conversion may be to the lesser of:

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

e. $2,000

SECTION 5. VISION AND DENTAL BENEFITS

In addition to the health benefits provided by Blue Cross Blue Shield and the Modern Assistance Program, the Health Fund offers vision and dental benefits.

The vision benefit covers all or a portion of the cost of routine eye exams, contacts, glasses. A summary of the vision benefit is attached to this document as Appendix B. You may also request from the Fund Office a copy of the complete benefit description or policy for the vision benefit.

The dental benefit covers all or a portion of the cost of cleanings, braces, and dental procedures. A summary of the dental benefit is attached to this document as Appendix C. You may also request from the Fund Office a copy of the complete benefit description or policy for the dental benefit.

SECTION 6. ACCIDENTAL DEATH AND DISMEMBERMENT ("AD&D") INSURANCE

BENEFIT

If, as the result of an accidental injury which occurs while a participant is covered by this Plan, the participant incurs the loss of life, limb, or sight within ninety (90) days following the injury, the Plan offers an "Accidental Death and Dismemberment" benefit.

The Plan will pay the benefit specified in the following "Schedule of Losses and Benefits" for these unfortunate circumstances. Benefits are payable to the participant except in the event of loss of life were the benefit will be paid to the participant's 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	Benefit
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	Principal Sum
Loss of Two Hands Loss of Two Feet Loss of Sight of Two Eyes Loss of One Hand and One Foot Loss of One Hand and Sight of One Eye Loss of One Foot and Sight of One Eye Loss of One Hand	Principal Sum
Loss of One Foot Loss of Sight of One Eye	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

A participant alone has the right to designate their beneficiary, and they may change that designation at any time by written notice to the Fund Office. The participant should ensure to clearly identify their beneficiary. If two or more individuals are to share a death benefit, the participant must specify the portion that is to be paid to each person.

If a participant has named a beneficiary, the chosen beneficiary is no longer living, or the beneficiary is unable to give a valid release, the benefit will be paid to the participant's named Deferred Income Fund beneficiary or in accordance with applicable law.

This discussion of "beneficiary" is similar to the discussion of "beneficiary" in SECTION 4.

LIMITATIONS

No AD&D 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.

SECTION 7. SUPPLEMENTAL ACCIDENT AND SICKNESS BENEFIT

BENEFIT

If a participant becomes "totally disabled" due to accidental bodily injury or disease while insured, the Fund will pay the participant 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 fewer than two weeks of continuous full-time active work are considered to be *one period* in determining the benefits available, 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 will 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 either of the following causes:

(1) Injury or disease for which the participant is not under treatment by a doctor licensed to practice medicine.

(2) Disease for which the participant is entitled to benefits under any Workers' Compensation Law or Act or accidental injury arising out of or in the course of the participant's employment.

SECTION 8. MEDICAL LIMITATIONS AND EXCLUSIONS

The following are excluded from Covered Services and no benefits shall be paid for:

(1) Expenses incurred prior to the effective date of coverage under the Plan, or after coverage is terminated

(2) Claims submitted more than one (1) year after the Expense Incurred Date, unless the claim was delayed due to a Covered Person's legal incapacitation

(3) Physician travel or transportation expenses or broken appointments, except for benefits specifically stated as covered under the Plan

(4) Amounts in excess of the Contracted Rate for In-Network Providers or in excess of the Allowed Amount for Out-of-Network Providers

(5) Services or supplies that are not considered Medically Necessary, whether or not prescribed and recommended by a Physician or covered provider, except for benefits specifically stated as covered under the Plan

(6) Experimental or Investigational drugs, devices, medical treatments or procedures

(7) Services, supplies or treatment not recognized as generally accepted standards of medical practice for the diagnosis and/or treatment of an active Illness or Injury

(8) Treatment which is not the result of an Injury or Illness, except for benefits specifically stated as covered under the Plan

(9) Expenses incurred outside the United States if the Covered Person traveled to such location for the primary purpose of obtaining medical services, drugs or supplies

(10) Services, supplies and treatment which a Covered Person is entitled to receive without charge from any municipal, state or federal program. This exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare

(11) Expenses for which there is no legal obligation to pay, such as that portion of any charge which would not have been made if the patient did not have this coverage, or any charge for services or supplies which are normally furnished without charge

(12) Expenses incurred in connection with an Injury arising out of, or in the course of, any employment for wage or profit, or disease covered with respect to such employment, by any Worker's Compensation Law, Occupational Disease Law or similar legislation, with the exception of when a Covered Person is not covered by Worker's Compensation Law and lawfully chose not to be

(13) Expenses incurred in connection with an Injury arising out of, or in the course of, the commission of a crime by the Covered Person or while engaged in an illegal act, illegal occupation or felonious act, or aggravated assault for which the Covered Person is convicted of a felony charge. This exclusion does not apply to

a. Injuries sustained by a Covered Person who is a victim of domestic violence or

b. Injuries resulting from a medical condition (including both physical and mental health conditions)

(14) Medical expenses incurred on account of Injury or Illness resulting from war or any act of war, whether declared or undeclared, or expenses resulting from active duty in the Uniformed Services of any international armed conflict or conflict involving armed forces of any international authority

(15) Physician's fees for any treatment which is not rendered by or in the physical presence of a Physician except as specifically stated as covered under this Plan or provided by a Plan service provider, such as Blue Cross Blue Shield

(16) Communication, transportation, time spent traveling, or for expenses connected to traveling that may be incurred by a Physician, Covered Person, or covered provider, in the course of rendering services, except for benefits specifically stated as covered under the Plan

(17) Court-ordered treatment or any treatment not initiated by a Physician or covered provider of any kind

(18) Treatment, services or supplies provided by a member of the Covered Person's immediate family, any person who ordinarily resides with the Covered Person, or the Covered Person. The term immediate family includes, but is not limited to, the Covered Person's Spouse, child, brother, sister, or parent.

(19) Biofeedback

(20) Chelation therapy

(21) Childbirth classes

(22) Cochlear implants

(23) Cosmetic or reconstructive surgery, except for benefits specifically stated as covered under the Plan

(24) Custodial Care designed essentially to assist the Covered Person, whether disabled or not, in meeting the activities of daily living, including services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets and supervision over medication which can normally be self-administered. Such services and supplies are deemed to be Custodial Care whenever and wherever furnished, without respect to the practitioner or provider by whom or by which they are prescribed, recommended or performed, except for the Custodial Care described under benefits titled "Hospice Care."

(25) Dentures, dentistry, oral surgery, treatment of teeth and gum tissues or dental x- rays, except for benefits specifically stated as covered under the Plan

(26) Eyewear, routine (including lenses, frames and contact lenses, and their fitting)

(27) Fluoride and fluoride varnish, for Covered Persons age 6 and older

(28) Food supplements, except for benefits specifically stated as covered

(29) Hypnosis, hypnotherapy, homeopathic treatment, Rolfing, Reiki, massage therapy, aromatherapy and alternative medicine, except for benefits specifically stated as covered

(30) Medical supplies that are incidental to the treatment received in a Physician or other provider's office or are provided as take-home supplies

(31) Naturopathic medicine

(32) Orthoptics and visual therapy for the correction of vision

(33) "Over-the-counter" drugs or medical supplies which can be purchased without a prescription or when no Injury or Illness is involved, except for benefits specifically stated as covered under this Plan

(34) Pastoral counseling, music or art therapy (unless part of an inpatient program), assertiveness training, dream therapy, recreational therapy, stress management or other supportive therapies

(35) Personal comfort, hygiene or convenience items such as televisions, telephones, radios, air conditioners, humidifiers, dehumidifiers, physical fitness equipment, whirlpool baths, education, or educational aids or training whether or not recommended by a Physician

(36) Podiatry services for routine care, including care for bunions, corns, calluses, toenails, flat feet, fallen arches and chronic foot strain

(37) Private duty nursing

(38) Reverse sterilization

(39) Sex therapy

(40) Surrogate parenting, any expenses related to use of a gestational carrier

(41) Visual refraction surgery, including radial keratotomy

(42) Vitamins, except for benefits specifically stated as covered under this Plan

(43) Weight loss programs

SECTION 9. CONTINUATION OF COVERAGE UNDER COBRA

IN GENERAL

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") is a law that entitles members and their eligible dependents to continue certain coverage provided by the Plan on a self-pay basis if their coverage would otherwise terminate due to the occurrence of a "Qualifying Event" (defined below).

When a member or an eligible dependent notifies the Fund Office that a Qualifying Event has happened, the Fund Office will notify him of his right to choose continuation of coverage. Satisfactory evidence of good health will not be required to purchase continued coverage.

The rules concerning eligibility to elect COBRA continuation coverage follow:

1. If a covered member loses coverage under the Plan due to the termination of employment (for other than gross misconduct) or a reduction in work hours, the covered member may purchase continued coverage for up to eighteen (18) months. If the spouse or dependent child would also lose coverage under the Fund, each of them may separately elect to purchase coverage for the 18 months. If during the 18-month period, another Qualifying Event occurs, an eligible dependent may elect another continuation. However, the length of the combined continuation periods may not exceed 36 months from the date of the original Qualifying Event.
2. If the member entitled to the COBRA continuation coverage is disabled (as determined under the Social Security Act), the Fund provides COBRA continuation coverage for 29 months, rather than 18 months. The disability extension applies if the member is disabled at the time of the termination of employment or if the member becomes disabled at any time during the first 60 days of COBRA continuation coverage. If the member entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the 29-month disability extension. Note that the monthly COBRA premium will be 150% of the current monthly premium throughout this eleven (11) month extension.
3. To be eligible for COBRA, the person must have been eligible for coverage under the Plan at the time of the Qualifying Event, i.e., the termination of employment or reduction in hours. However, a child who is born to or placed for adoption with a member while the member is on COBRA continuation coverage may make an election to go on COBRA continuation coverage (or the member may make an election to cover the child if the child is a minor), if the member enrolls the new child upon birth or adoption.
4. If the spouse or dependent child of any covered member is covered by the Plan and loses coverage due to one of the following Qualifying Events, they may purchase continuing coverage under the Fund for up to thirty-six (36) months:
    a. Death of the employee in Covered Employment
    b. Divorce of the employee and spouse
    c. A dependent child is no longer considered a dependent child as defined by the Plan; or

d. A dependent child or spouse loses coverage because the employee becomes entitled to Medicare.

5. A covered employee's spouse or dependent child's right to elect COBRA continued coverage is subject to limitations and may be terminated before the period stated above. In no event will the maximum period of continued coverage for any Qualifying Event, or any combination of Qualifying Events, exceed thirty-six (36) months from the first Qualifying Event.

QUALIFYING EVENT AND TIMING OF COBRA CONTINUATION

The following table has been prepared to summarize the length of COBRA continuation coverage under the plan due to the Qualifying Event shown:

QUALIFYING EVENT	WHO MAY PURCHASE
Member loses eligibility due to a termination of employment or a reduction in hours of employment (including retirement)	Member and each dependent
Member becomes entitled to Medicare	Each dependent
Member dies	Each dependent
Member is divorced or legally separated from spouse	Spouse
Child ceases to be a dependent child as defined under the Plan	Dependent child
Member loses eligibility due to a termination of employment or a reduction in hours of employment (including retirement)	18 Months
Member becomes entitled to Medicare	36 Months
Member dies	36 Months
Member is divorced or legally separated from spouse	36 Months
Child ceases to be a dependent child as defined under the Plan	36 months

NOTIFYING THE FUND OFFICE

A covered member must notify the Fund Office within 60 days after a divorce or a dependent child's loss of Fund eligibility. Your right to COBRA coverage depends on this notice. Also, failure to notify the Fund Office regarding your divorce or a dependent child's loss of eligibility will make you financially responsible for all claims which may have been paid on behalf of your ineligible family member.

If the member has been determined by the Social Security Administration to be disabled and wishes to purchase up to 29 months of continued coverage, they must provide a copy of the Social Security Administration's determination to the Fund Office within 60 days after the date such a determination is

made and in no event later than the expiration of the 18 month period. The notices should be sent certified mail to the following address:

Boston Plasterers' & Cement Masons'

Local 534 Benefits Office

7 Frederika Street

Boston, MA 02124

Important: Be sure to provide the notice in such a manner to ensure that the Fund Office receives your notice within the time limits. If the covered member fails to notify the Fund Office within sixty (60) days of the date of disability determination, date of the divorce, or the dependent child's loss of eligibility, the covered member will forfeit any right to elect continued coverage. Once the Fund Office has been so notified, the Fund Office will then respond as described herein. The Fund Office intends to notify you (or your eligible dependent) of the loss of active coverage by first-class mail to the last known address on file at the Fund Office.

The Fund assumes no responsibility or liability if you or your eligible dependent allows coverage to terminate. It is the member's or eligible dependent's responsibility to contact the Fund Office to verify eligibility status.

HOW COBRA COVERAGE IS PROVIDED

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

ELECTION PERIOD

You must elect COBRA continuation coverage within 60 days of the date you are notified of your right to elect COBRA continuation coverage or the date that your coverage ends, if later.
You must complete and return the election form provided to you by the Plan Administrator. Your coverage under the Plan will be continued under COBRA from the day that you would have lost coverage provided that:

1. The election form is completed and received by the Plan Administrator within 60 days of the date you were notified of your right to elect COBRA continuation coverage, 60 days from the end of coverage based on the Bank of Hours or 60 days from the date of your "qualifying event," whichever is later, and
2. The initial required premium is paid to the Plan within 45 days following the date of your COBRA election and is thereafter remitted to the Plan when due on the first of each month.

COBRA PREMIUM PAYMENT

COBRA is paid in monthly installments. The amount of the monthly COBRA premium will be provided to you when eligibility for COBRA continuation coverage has been determined. Monthly premiums must be paid on time. If payments are not made on time (including any grace period), coverage will terminate. The first payment must be received by the Fund Office 45 days from the date of the COBRA election and must cover the entire period of time going back to when your coverage terminated. For

example, if you lose coverage as of March 1 and elect to take COBRA coverage on April 15, you have until May 31 to make your first premium payment, but it must cover the period going back to March 1—the date you had to begin to self-pay for COBRA coverage—which is three months.

Under no circumstances will the option to make self-payment to the Fund be permitted on a retroactive basis, except as described in this Section of the Summary Plan Description. The rates charged for individual and family COBRA continuation coverage will be established by the Trustees from time to time and may be modified by the Trustees.

NOTE: Payments after the first COBRA payment must be made on or before the first day of each month. You will not be billed monthly. You will have a grace period to pay the required monthly premium until the end of the month or 30 days, whichever is longer. It is recommended that COBRA payments be received in the Fund Office the month before the coverage month: for example, January's COBRA payment should be mailed so that it is received by the Fund Office on December 20th. This will avoid any interruption of claim and/or prescription coverage.

Failure to pay the required monthly premium by the end of the grace period will result in the termination of your COBRA continuation coverage back to the beginning of the month. All claims submitted for services rendered in that month will be denied. Once terminated, your COBRA continuation coverage cannot be reinstated.

> **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 without interruption. Failure to make the monthly payment when due (including the grace period) will result in the termination of your cobra health coverage.

The type of coverage will generally be the same as the type of coverage the covered member had the day before the Qualifying Event. The type of coverage, however, may be reduced or modified if such coverage is reduced or modified in the same manner to similarly situated beneficiaries under the Fund concerning whom a Qualifying Event has not occurred. Your COBRA coverage will include coverage of Accident and Sickness benefits, as described in this SPD. Your monthly COBRA premium includes a premium for coverage of this benefit.

If, during a COBRA continuation of coverage period, a member whose coverage was based on his or her employment marries and wishes to enroll their new spouse in the Plan, the member should notify the Plan. The member may then elect to change from single to family coverage. Change in coverage status will take effect the 1st day of the month following the notice to the Fund Office.

COBRA LENGTH OF COVERAGE

Your continuation of coverage with COBRA may end earlier than the 18, 29, or 36 months (whichever is applicable) if any of the following situations occur:

1. You do not pay the required premium on time (including any grace period required under COBRA); or
2. You or your eligible dependent who is continuing coverage first becomes covered under any other group health plan (in a plan without pre-existing condition limitations as defined in the federal law known as HIPAA) after the date of the election to continue coverage; or
3. You or your eligible dependent who is continuing coverage first becomes eligible for Medicare after the date of the election to continue coverage; or
4. Your employer no longer provides coverage under any group health plan to any employee; or

5. You obtained COBRA continuation coverage because of disability under Title II or XVI of the Social Security Act and have been given a final determination by Social Security that you are no longer disabled. You must notify the Fund Office of such determination no later than thirty (30) days after the date Social Security has deemed the member as no longer disabled; or

6. The Plan terminates.

IF YOU HAVE QUESTIONS

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

KEEP THE FUND OFFICE INFORMED OF ADDRESS CHANGES

To protect your family's rights, you should keep the Fund Office up to date on any changes to the addresses of your family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

TRADE ACT OF 2002 AND COBRA

The Trade Act of 2002 created a special second COBRA election period, of up to 60 days, for individuals whose employment was displaced by import competition or shifts of production to other countries. In addition, the Act provided that the Treasury Department could advance Health Care Tax Credit ("HCTC") directly to a group health plan for qualified workers. The Trade Act of 2002 was signed into law on August 6, 2002, and was effective as of November 4, 2002.

The Act provides for this second election period so that people who did not elect to take COBRA benefits during their initial election period could have another opportunity to elect extended benefits after becoming eligible for the HCTC (or state assistance for medical benefits).

The US Department of Labor (DOL) must certify that individuals are eligible. Employers may apply to the DOL for certification of a group of workers, or an individual worker may apply for individual certification. The DOL determines if the worker's job was lost for trade-related reasons.

HEALTH CARE TAX CREDIT

The Health Care Tax Credit ("HCTC") is a federal income tax credit of up to 65% of the premiums paid for qualified health insurance coverage, including COBRA coverage, by eligible "trade-displaced workers" who do not have other specified coverage. Workers are generally eligible for the HCTC if they are receiving trade assistance under the Trade Act of 1974 or getting a pension paid for by the Pension Benefit Guaranty Corporation (PBGC). "Qualified health coverage" means coverage of immediate family members for qualified coverage that excludes dental benefits.

The Trade Act of 2002 provides for the advance payment of HCTC directly to the qualified insurers for credit-qualified workers beginning on August 1, 2003. However, regardless of the payments from the Treasury Department, the worker would still have to pay at least 35% of the COBRA premium in keeping with the terms of the Plan.

SECOND ELECTION PERIOD

The second COBRA election period of up to 60 days begins the first day of the month in which a worker becomes eligible for federal trade adjustment assistance. However, the period may not extend beyond six months after the worker's original qualifying event.

An individual is eligible for this second election period if the individual (1) is receiving trade adjustment assistance (which requires government certification); (2) lost health coverage because they lost his job in a way that triggered his eligibility for trade adjustment assistance; and (3) failed to elect COBRA during the regular COBRA election period.

If the individual elects extended benefits during this second election period, coverage begins on the first day of the second election period. There is no retroactive coverage for the gap between the initial loss of coverage and the first day of the second election period. However, the second COBRA election period does not extend the original COBRA benefit period, which is still measured from the loss of coverage due to a qualifying event. Individuals seeking to elect COBRA coverage during this second election period must prove that they are certified to receive assistance.

Only a former worker may take advantage of the second election period, though the participant may do so on behalf of his eligible dependents. Dependents do not have an independent right to elect COBRA coverage in the second election period.

The Trade Act of 2002 does not create any new COBRA rights. Only workers who received COBRA notices after their qualifying event can elect COBRA during the second election period.

When the Fund Office receives the election form, the worker's coverage begins on the first day of the second election period. Please note that the workers' period of coverage runs from the date of his qualifying event, even though coverage is not retroactive to that date.

SECTION 10. OTHER LEGAL REQUIREMENTS

FAMILY AND MEDICAL LEAVE ACT ("FMLA")

The Family and Medical Leave Act of 1993 ("FMLA") allows a member to take up to 12 weeks of unpaid leave during any 12-month period due to any of the following situations:

- The birth of a child and to care for the newborn child within one year of birth;
- The placement with the member of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- To care for the member's spouse, child, or parent who has a serious health condition;
- A serious health condition that makes the member unable to perform the essential functions of their job;
- Any qualifying exigency arising out of the fact that the member's spouse, child, or parent is a covered military member on "covered active duty;"

(Military caregiver leave) If the eligible member is the service member's spouse, son, daughter, parent, or next of kin, the number of weeks of unpaid leave is *twenty-six* work weeks of leave during a single 12-month period to care for a covered service member with a serious injury or illness.

The Fund's health coverage will be maintained for the duration of a member's FMLA leave. A member is eligible for a leave under FMLA if the member:

- Has worked for a covered employer for at least 12 months;
- Has worked at least 1,250 hours during the previous 12 months; and
- Works 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 a member's eligibility until the end of the FMLA leave, provided the member's employer properly grants the leave and makes the required notification and payment to the Fund.

To maintain eligibility, the member 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.

A member's FMLA leave will end on the earlier of the member's return to work or 12 weeks. If a member does not return to work within 12 weeks, the member may qualify for COBRA Continuation Coverage.

For more information about the FMLA, contact the Fund Office.

CONTINUATION OF HEALTH COVERAGE UPON MILITARY LEAVE ("USERRA")

The Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 continues the protection of civilian job rights and benefits for veterans and members of Reserve components. If you are absent from employment due to service in the United States Armed Forces, you may be eligible to

continue medical coverage under this Fund for you or your eligible dependents on a self-pay basis for the period of your military service (to a maximum of 24 months). Please contact the Fund Office for additional information.

THE NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT ("NMHPA")

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Fund or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT ("WHCRA")

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan as described in the Schedule of Benefits.

Contact the Fund Office for further information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Fund Office shall enroll for immediate coverage under the Fund any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") or a National Medical Support Notice ("NMSN") if such an individual is not already covered by the Plan as an eligible dependent once the Fund Office has determined that such order meets the standards for qualification set out in the paragraph below.

The following definitions shall apply for these purposes:

- "Alternate Recipient" means any child of a member who is recognized under a Medical Child Support Order as having a right to enrollment under the Fund as the Employee's eligible dependent. For purposes of the benefits provided under The Fund, an Alternate Recipient shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as an employee.
- "Medical Child Support Order" means any judgment, decree, or order (including approval of a domestic relations settlement Agreement) issued by a court of competent jurisdiction that (1) provides for child support with respect to an employee's child or directs the employee to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a

community property law), or (2) enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

- "Qualified Medical Child Support Order" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which an employee or eligible dependent is entitled under the Fund. In order for such an order to be a QMCSO, it must clearly specify

  (1) the name and last known mailing address (if any) of the employee and the name and mailing address of each such Alternate Recipient covered by the order;

  (2) a reasonable description of the type of coverage to be provided by the Fund to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

  (3) the period of coverage to which the order pertains; and

  (4) the name of this Fund and the other Fund. However, such an order need not be recognized as "qualified" if it requires the Fund to provide any type or form of benefit or any option, not otherwise provided to employees and Eligible Beneficiaries without regard to this Section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

- "National Medical Support Notice" is a notice issued by an appropriate agency of a state or local government similar in form, content, and legal effect to a Qualified Medical Child Support Order that directs the Fund Office to effectuate coverage for an Alternate Recipient as the dependent child of the noncustodial parent who is (or will become) an employee covered by the Fund pursuant to a domestic relations order that includes a provision for health care coverage.

Upon receiving a Medical Child Support Order or National Medical Support Notice, the Fund Office shall act-as soon as administratively possible

(1) notify the employee and each Alternate Recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Fund's procedures for determining whether the order qualifies as a QMCSO, and

(2) make an administrative determination if the order is a QMCSO and notify the employee, and each affected Alternate Recipient of such determination.

To give effect to this requirement, the Fund Office shall

(1) establish reasonable, written procedures for determining the qualified status of a Medical Child Support order; and

(2) permit any Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to the order.

Within 20 business days after the date of the NMSN, the Company shall provide the Fund Office with the notice. Within 40 business days of the date of the notice, the Fund Office shall:

(1) notify the state or local agency issuing the NMSN whether coverage is available to the child who is the subject of the notice and, if so, whether the child is covered under the Fund, and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by an official of the issuing agency) to effectuate coverage, and

(2) provide to the custodial parent (or official of the governmental agency involved in the notice) a description of the coverage available and any forms or documents necessary to effectuate the coverage.

Contact the Fund Office to obtain, without charge, a copy of the Fund's QMCSO procedures and further information.

SECTION 11. ADVERSE BENEFIT DETERMINATIONS

If you believe benefits provided for under the Plan have been improperly denied or if your eligibility was improperly rescinded, you are entitled to a full and fair review of your claim.

NOTICE OF CLAIM DENIAL

If a claim for benefits is denied, in whole or in part, or if your eligibility is rescinded, the Fund or its vendor (such as Blue Cross Blue Shield of Massachusetts), with the authority granted by the Board of Trustees, will give written notice to the claimant of such denial or rescission. Such notice will include the following:

1. A clear explanation of the reason for the denial or rescission;
2. Reference to the specific provisions of the SPD, policy, or document on which the denial or rescission is based;
3. A description of any additional material or information, if necessary for you to pursue your claim and, where appropriate, an explanation of why the material or information is necessary; and
4. An explanation of the Fund's claim review procedure, including applicable time limits, a statement of your right to sue under federal law following an adverse determination or review, and a statement that you may make an appeal if your claim is denied, if your eligibility has been rescinded or if you have not been notified of action taken on your claim within the applicable time period.

REQUEST FOR AN APPEAL

If a claim is denied with respect to any benefits administered by Blue Cross Blue Shield, the member may appeal the decision through the Blue Cross Blue Shield "Appeal and Grievance Program." A copy of this document is attached as Appendix D.

In addition to the above procedures, members may file a voluntary appeal to the Board of Trustees if their first appeal is denied by BCBS. A member must submit a written request to the Fund Office for a voluntary appeal no later than ninety (90) days after the later of (i) the date on which the first appeal was denied by BCBS or (ii) the date on which the appeal was denied on an external review. Participants are not required to submit a health claim appeal to the Board of Trustees.

In the event that an eligible member is denied any other benefit or claim in whole or in part (including an HRA reimbursement request), or if the member is determined to be ineligible for health coverage under the Fund, the Fund will follow the following notice and appeal procedure.

1. The Fund (or its vendor) will notify the member of the denial or rescission in writing by First Class United States mail, addressed to the member's last address on record with the Fund. Such notice will include the specific reason or reasons for the denial and will be written in a manner anticipated to be understood by the member.
2. The member (the claimant) will have 180 days following receipt of notification of the denial of the benefit or rescission of eligibility to file an appeal. Such appeal shall be made by letter addressed to the Fund Office.

3. The claimant's letter of appeal must state, in general terms, the grounds on which the appeal is being made and what is considered to be erroneous in the original decision. The claimant also may submit written comments, documents, records, and other information relating to the claim. Claimants shall be provided, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the claim.

4. Upon request, the Fund will provide, free of charge, any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the appeal, as soon as possible and sufficiently in advance of the date on which the claims adjudicator will review the appeal to give the claimant a reasonable opportunity to respond before that date. Additionally, before the Fund can act on an appeal based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the Trustees must act on the appeal to give the claimant a reasonable opportunity to respond before that date.

5. If the appeal is denied, the denial will contain the same information as described above for an initial adverse benefit decision. 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 a request for review. However, if the request for review is received within 30 days of the next regularly scheduled meeting, the 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 a request for review may be necessary. A participant will be advised in writing in advance if this extension will be necessary. Once a decision on review of the claim has been reached, the participant will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

The Fund is required to maintain your coverage until a decision is made on your appeal of a rescission. If you are not notified within the appropriate time period of the action taken of review of your appeal, you may treat the appeal as "denied" and may initiate a lawsuit as described under "Your Rights under ERISA," of this SPD.

LIMITATION ON HOW A LAWSUIT MAY BE FILED

A participant may not start a lawsuit to obtain benefits until after the participant has requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since the participant filed a request for review and has not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits a participant to pursue remedies under ERISA §502(a) without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than six months after the exhaustion of the plan's appeal procedures, absent a demonstration that the Plan has failed to follow its procedures.

Any claim or action relating to the payment or reimbursement of healthcare services, or any other benefit provided under this Plan, may only be brought by the participant or beneficiary who received or allegedly should have received the service or benefit at issue. No claim or action of a participant or

beneficiary may be assigned to a third party, including the medical provider who performed the service or may perform such service in the future.

Any claim or action by a participant or beneficiary relating to or arising under the Plan shall only be brought in the US District Court for the District of Massachusetts, and this court shall have personal jurisdiction over any participant or beneficiary named in the action.

SECTION 12. PLAN INFORMATION REQUIRED BY ERISA

The following information together with the information contained in this Summary Plan Description is being provided to you in accordance with government regulations

REFERENCE TO COLLECTIVE BARGAINING AGREEMENTS

This Fund is maintained pursuant to Collective Bargaining Agreements between Boston Plasterers' & Cement Masons' Local 534, and the Employers who subsequently become parties to the Trust Agreement. A copy of these Collective Bargaining Agreements may be obtained by members and beneficiaries upon written request to the Trustees and are available for examination by members and beneficiaries at the Fund Office. Members and beneficiaries may receive from the Trustees, upon written request, information as to whether a particular employer or employee organization is a Contributing Employer and/or a sponsor of the Fund.

TYPE OF PLAN

The Plan provides medical benefits, prescription drug benefits, dental benefits, vision benefits, hearing benefits, short-term disability benefits, and life insurance.

FUNDING MEDIUM/SOURCE OF CONTRIBUTION OF THE BENEFITS FUND

The assets and reserves of the Fund are held in trust by the Trustees in a trust fund pursuant to an Agreement and Declaration of Trust.

The Fund is funded through contributions to the Fund by Contributing Employers at the hourly rates established by the Collective Bargaining Agreements between the Union and participating employers and in accordance with the provisions of such Agreements, and by investment income earned on a portion of the Fund's assets. Contributions are held in a trust fund for the purpose of providing benefits to covered members and defraying reasonable administrative expenses. Under certain circumstances, members and beneficiaries losing eligibility under the Plan may maintain eligibility for a limited period of time on a self-pay basis.

ELIGIBILITY

The Plan's requirements with respect to eligibility for members and for beneficiaries, as well as circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, or suspension of any benefits, are described in this SPD. Also, please note any restrictions or requirements in relation to particular benefits are set forth in the Sections of this SPD that describe those benefits.

DESCRIPTION OF BENEFITS

The benefits provided by this Plan are set forth in this SPD. The complete terms of any insured benefits provided through an insurance company engaged by the Fund are provided in a certificate of coverage. This certificate, if applicable, is available to members and beneficiaries from the Fund Office upon request.

TERMINATION PROVISIONS

The Boston Plasterers' and Cement Mason's Local 534 Health and Welfare Fund shall continue during the term of the Collective Bargaining Agreements referred to herein and during the term of any renewal or extension of the Agreements as long as there are available assets. In the event that the obligations of all the participating employers to make contributions and negotiations therefore terminate, the Trustees, by unanimous agreement, will determine how any assets, which may remain after expenses have been

paid, will be disposed of. The distribution made by the Trustees shall be made only for the benefit of former eligible members and for legitimate Fund purposes; for example, the purchase of insurance benefits, the provision of benefits in any other form, or the transfer to another trust fund.

CLAIMS PROCEDURE

The procedure for filing a claim for benefits is set forth in this Summary Plan Description. If all or any part of your claim is denied, you may appeal that decision. A member or eligible dependent must submit the claim within one (1) year of the date on which the services were rendered.

AMENDMENT TO THE PLAN/TRUSTEES RIGHT TO CHANGE OR DISCONTINUE THE PLAN

The provisions of this Plan may be modified or amended by the Trustees at their sole discretion at any time. Without limiting the foregoing, the Trustees expressly reserve the right to add to, subtract from, modify, or discontinue any benefits hereunder, and to modify eligibility rules for all benefits hereunder. Such amendments may be retroactive at the discretion of the Trustees. The Trustees also reserve the right to adopt and amend from time to time any rules, policies, or regulations they may deem appropriate.

SECTION 13. STATEMENT OF RIGHTS UNDER ERISA

As a member in the Fund, you are entitled to certain rights and protections under ERISA[1]. ERISA provides that all Plan members shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine (without charge) at the Fund Office and at other specified locations - such as worksites and union halls - all documents governing the Fund. These may include insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of documents governing the operation of the Fund, including insurance contracts, Collective Bargaining Agreements, and copies of the latest Form 5500 annual report and updated SPD by writing to the Fund Office. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Fund's administrator is required by law to furnish each member with a copy of the summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

- Continue health care coverage for you, your spouse, or your Dependents if there is a loss of coverage under the Plan due to a qualifying event. You, your spouse, or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Fund for the rules regarding your COBRA continuation rights.
- Reduce or eliminate 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 such plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your coverage enrollment date. This Plan does not exclude coverage for pre-existing conditions.

PRUDENT ACTION BY PLAN FIDUCIARIES

In addition to creating rights for Fund members, ERISA imposes duties upon the people who are responsible for the operation of the Fund, including the Trustees. The people who operate the Fund, called "fiduciaries," have a duty to do so prudently for the purpose of providing benefits and in the interest of you and other Fund members 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 benefit or exercising your ERISA rights.

[1] The Employee Retirement Income Security Act of 1974

ENFORCE YOUR RIGHTS

If your claim for a 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 within certain time schedules.

Under ERISA, there are steps you can take to enforce your above rights. For instance:

- If you request a copy of the Fund documents or the latest annual report from the Fund Office 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 Fund's 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 that is denied or ignored - in whole or in part - you may file suit in federal court.
- If you disagree with the Fund's decision or lack of response to your request concerning the qualified status of a medical child support order, you may file suit in federal court.
- If it should happen that Fund fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

If you file suit against the Fund, 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 if, for example, it finds your claim to be frivolous.

HELP WITH YOUR QUESTIONS

If you have any questions about the Fund, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund's administrator, you should contact the nearest office of the Employee Benefits Security 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, DC 20210.

You may also obtain certain publications regarding your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration's Employee and Employer Hotline at (866)444-EBSA(3272), by logging on to the Internet at http://www.dol.gov/ebsa/publications/main.html, or by contacting the EBSA field office nearest you.

SECTION 14. HIPAA PRIVACY AND SECURITY RULES

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

The Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 (as amended) provides privacy protection of your verbal, written, and electronic records under a health care benefits plan. On April 14, 2003, in compliance with HIPAA requirements, this Fund introduced new privacy policies and procedures to protect you and your family's health information under the various health plans maintained at the Fund Office. Please read the privacy notice carefully and share the information with family members as appropriate. If you have any questions, please call the Fund Office at 617-825-4500.

INTRODUCTION

Title II of HIPAA imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as "Protected Health Information," or "PHI," includes virtually all individually identifiable health information held by the Fund, whether received in writing, in an electronic medium, or as oral communication. This notice describes the privacy practices of the Boston Plasterers' and Cement Masons' Local 534 Health and Welfare Fund.

THE FUND'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Fund is required by law to maintain the privacy of your health information and to provide you with this notice of the Fund's legal duties and privacy practices with respect to your health information. It is important to note that under Title II of HIPAA, these rules apply to the Fund, not to any participating union or any contributing sponsor to this Fund. Different policies may apply to other Fund programs or to data unrelated to this Health Fund.

HOW THE FUND MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an "authorization") for purposes of health care treatment, payment activities, and health care operations. Here are some examples of these purposes:

Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party and consultation and referrals between providers. For example, the Fund may share health information about you with Physicians who are treating you.

Payment activities include activities by this Fund, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing, as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the Fund may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.

Health care operations include activities by this Fund (and in limited circumstances, other plans, or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include

vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Fund may use information about your claims to review the effectiveness of wellness programs.

The amount of health information used or disclosed will be limited to the "Minimum Necessary" for these purposes, as defined under the HIPAA rules. The Fund may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other people you identify who is involved in your care or payment for your care.

Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the opportunity to agree or object to these disclosures (although exceptions may be made, for example, if you are not present or if you are incapacitated). In addition, your health information may be disclosed to your legal representative without authorization.

The Fund is also allowed to use or disclose your health information without your written authorization for the following activities:

Workers' Compensation	Disclosures to Workers' Compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws
Necessary to prevent a serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to the public or personal health or safety if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Fund reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Fund believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Fund's disclosure if informing you won't put you at further risk)

Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful processes (the Fund may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if the disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Fund's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine the cause of death, and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards and subject to certain assurances and representations by researchers regarding the necessity of using your health information and treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Fund's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization if the Fund has taken action relying on it. In other words, you cannot revoke your authorization with respect to disclosures the Fund has already made.

It is the Fund's procedure, upon request for assistance, to disclose your health information to your spouse or your domestic partner (if applicable), and your spouse's or your domestic partner's (if applicable) health information to you, and to disclose the health information of your over-age enrolled Dependent (for example, your child who is over the age of 21) to you or your spouse or your domestic partner (if applicable) unless the person whose health information would otherwise be disclosed chooses to opt-out of this default procedure. For example, if you and your spouse are enrolled for Fund benefits and believe that the Fund has paid only a portion of the service fee it should have for a service provided to your spouse, the Fund will work with you to obtain the correct payment for the service rendered, even if doing so requires sharing with you some health information about your spouse. (And the reverse would be true: your health information would be shared with your spouse in such a situation.) You may

request the Fund not share your health information with your spouse or your domestic partner (if applicable) by opting out of this default procedure. To opt-out, you must contact the Fund Office at 617-825-4500. Your spouse, domestic partner (if applicable), and/or your over-age enrolled Dependent may also opt-out of this procedure by contacting the Fund Office at 617-825-4500. Once an individual has opted out of this default, the Fund generally will not disclose any of the individual's health information to family members unless some other part of the HIPAA regulations permits or requires it (for example, that individual becomes incapacitated). Any individual may change the opt-out election at any time by contacting the Fund Office at 617-825-4500.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Fund maintains. These rights are subject to certain limitations, as discussed below. This Section of the Summary Plan Description describes how you may exercise each individual right.

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE FUND'S RIGHT TO REFUSE

You have the right to ask the Fund to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Fund to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Fund to restrict use and disclosure of health information to notify those persons of your location, general condition, or death, or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Fund must be in writing.

The Fund is not required to agree to a requested restriction. And if the Fund does agree, a restriction may later be terminated by your written request, by agreement between you and the Fund (including an oral agreement), or unilaterally by the Fund for health information created or received after you are notified that the Fund has removed the restrictions. The Fund may also disclose health information about you if you need emergency treatment, even if the Fund has agreed to a restriction.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION

If you think that disclosure of your health information by the usual means could endanger you in some way, the Fund will accommodate reasonable requests to receive communications of health information from the Fund by alternative means or at alternative locations.

If you want to exercise this right, your request to the Fund must be in writing, and you must include a statement that disclosure of all or part of the information could endanger you.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider, enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Fund uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although, in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Fund must be in writing. Within 30-days of receipt of your request (60 days if the health information is not accessible on-site), the Fund will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Fund expects to address your request.

The Fund may provide you with a summary or explanation of the information instead of access to or copies of your health information if you agree in advance and pay any applicable fees. The Fund may also charge reasonable fees for copies or postage.

If the Fund does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

You have a right to request that the Fund amend your health information in a Designated Record Set; however, there are certain exceptions. The Fund may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Fund (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Fund must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Fund will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Fund expects to address your request.

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to a list of certain disclosures the Fund has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for 6 years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

- For Treatment, Payment, or Health Care Operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;

- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Fund must be in writing. Within 60 days of the request, the Fund will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Fund expects to address your request. You may make one request in any 12-month period at no cost to you, but the Fund may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

CHANGES TO THE INFORMATION IN THIS NOTICE

The Fund must comply with these new privacy requirements as of April 14, 2003. However, the Fund reserves the right to change the terms of its privacy policies as described in this notice at any time and to make new provisions effective for all health information that the Fund maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Fund's privacy policies described in this notice, you will be provided with a revised privacy notice that will be sent to you in the same manner as this notice was provided.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of Health and Human Services and or with the Fund. You will not be retaliated against if you file a complaint. To file a complaint with respect to a violation of your privacy rights, please contact the Privacy Official or its designee.

CONTACT

For more information on the Fund's privacy policies or your rights under HIPAA, please call the Fund Office at 617-825-4500

The Fund supports your right to the privacy of your protected health information. The Fund will not retaliate against you in any way for filing a complaint with it or the U.S. Department of Health and Human Services.

SECTION 15. FREQUENTLY ASKED QUESTIONS

1. WHAT IS A "COPAYMENT"?

A Copayment is an amount you pay to an In-Network doctor, hospital, or pharmacy for services you receive. After you have paid your copayment, the Plan pays 100% of all remaining charges for the doctor, hospital, or pharmacy; you pay nothing more. When you have either In-Patient or Out-Patient hospital stays, the Copayment is larger than the standard amount because you are paying for a broad range of services and many doctors. So, instead of paying a copayment for each service or to each doctor, you pay a one-time (per stay) Copayment. See the Schedule of Benefits in SECTION 2 for more information.

2. DO I NEED A REFERRAL TO SEE A SPECIALIST OR ANOTHER DOCTOR?

No. The Fund contracts with Blue Cross, which is a Preferred Provider Network, not HMO. You may use any doctor within the network or outside the network. However, if you choose to use a provider outside the network, you will incur more out-of-pocket expenses.

3. WHAT IF I HAVE A BALANCE DUE FROM THE HEALTH CARE PROVIDER AFTER THE FUND HAS PAID MY BILL?

Please call the Fund Office should you receive a balance due bill from a provider.

4. MY WIFE JUST HAD A BABY. HOW DO I ENROLL THE NEW BABY FOR HEALTH COVERAGE?

First, notify the Fund Office and inform them of the baby's name and date of birth. You must submit a copy of the baby's full birth certificate as soon as it becomes available.

5. WHICH CARD IS MY HEALTH PLAN CARD?

You should have one card, which will enable providers to identify the type of health plan you have for medical and dental services, and prescriptions:

This card is printed with the member's name and Alternate Identification Number and identifies the Plan's medical network. All covered family members may use this card. Give this card to your doctor, hospital, pharmacist, dentist, etc., at the time of service.

If you do not have a card or find incorrect information printed on it, please contact the Fund Office.

6. IF I GET INJURED ON THE JOB, WHO PAYS MY MEDICAL BILLS?

Any injury that has occurred on the job should be reported immediately to your employer. An accident report should be filled out promptly. Please notify the Fund Office about work-related injuries as soon as possible. We will be alerted to any medical bills that were incurred because of a work-related. All work-related charges should be covered with your employer's Workers' Compensation carrier. The Fund does not cover work-related charges.

7. IF I TRAVEL OUT OF STATE OR OUT OF THE COUNTRY, WILL I HAVE COVERAGE FOR ANY MEDICAL CARE?

Yes, if it is a covered medical service under the Plan. You may have to pay for services up front if the provider refuses to submit billing to the Fund Office. Please be sure to ask for an itemized bill in English.

8. HOW OFTEN DO I NEED TO FILL OUT A CLAIM FORM?

The Fund Office requires one claim form be submitted each year for each family member. Only the top portion of the claim form needs to be completed. You do not need to bring this form to your physician.

9. HOW LONG WILL MY DEPENDENT CHILDREN BE COVERED UNDER THE FUND?

A dependent child is covered until age 26.

10. WHY DO I NEED TO GIVE THE FUND OFFICE DETAILS OF ANY ACCIDENT I MAY HAVE BEEN IN?

The Fund Office will request from time to time, how, when, and where an injury may have occurred to yourself or a member of your family. The Fund Office needs detailed accident information to determine if this is a work-related injury that would be covered by your employer's Workers' Compensation carrier or an auto accident that would be covered by your auto insurance carrier.

If the Fund Office determines that the accident is related to the actions or inactions of a third party, you will have to complete a "Reimbursement Agreement and Consent to Lien" form. This means that the Fund has the right to be reimbursed for its expenses related to the accident, should you receive any judgment, settlement, or repayment for such expenses.

SECTION 16. HINTS FOR EFFECTIVELY USING THE HEALTH AND WELFARE FUND

SEE YOUR DOCTOR REGULARLY

There is no substitute for preventive care, such as annual physicals, annual flu shots, and having your children receive immunizations. By visiting your doctor regularly, you help your doctor notice any early signs of problems, which will allow you to receive preventive treatment and review before the problem becomes more severe.

CONSIDER USING GENERIC EQUIVALENTS TO NAME-BRAND DRUGS

Generic drugs are equally as effective as their name-brand counterparts and cost both you and the Fund less.

CONSIDER USING "MAIL-ORDER" TO FILL YOUR PRESCRIPTIONS

This is especially true if you are on a maintenance drug or one that you are regularly taking. Examples include drugs intended to reduce high levels of cholesterol and those intended to reduce high blood pressure. Our plan encourages your use of mail-order by making your cost of prescriptions less if you have your prescriptions filled in this way.

USE EMERGENCY ROOMS FOR ONLY TRUE MEDICAL EMERGENCIES

Our plan is designed to encourage you to use your regular physician because we believe treatment from your own doctor is more cost-effective and personalized than in an Emergency Room. Receiving Emergency Room care is only appropriate when your symptoms are life-threatening or severe.

REVIEW YOUR MEDICAL CHARGES AND ALL BILLS AND INVOICES FROM YOUR PROVIDERS

Although mistakes from your providers are probably rare, you can help the Fund by reviewing all bills and invoices to ensure that the listed services were actually performed.

MAKE SURE YOU UNDERSTAND WHAT IS AND IS NOT COVERED BY THIS FUND

Your health is important, and knowing what coverage you have can help you be a smart health consumer.

WHEN YOU TRAVEL, MAKE SURE TO REVIEW THE IN-NETWORK HOSPITALS UNDER THIS PLAN

The Blue Cross/Blue Shield program applies to hospitals and physicians across the country. These providers are considered "In-Network" for this Plan. By reviewing the hospitals available at your destination before you leave, you will help yourself by using In-Network facilities and care. You can find additional information about which hospitals are part of the Blue Cross/Blue Shield network by logging on to www.bcbs.com and following the directions given.

USE IN-NETWORK DOCTORS, HOSPITALS, AND SERVICES WHENEVER POSSIBLE

The Fund has negotiated with In-Network providers to provide high-quality, cost-effective service. Your costs are less when you use In-Network care, so choosing this option benefits both you and the Fund.

LIVE A HEALTHY LIFESTYLE

Many medical problems can be traced to poor eating habits, excessive smoking, lack of exercise, and other poor habits. By taking control of your own health, you will feel better and could reduce your need for medical services.

SECTION 17. DEFINITIONS

ACCIDENT

An unfortunate occurrence or mishap especially resulting in an injury that occurs suddenly and at a definite place and time.

ADVERSE BENEFIT DETERMINATION

A denial, reduction, termination of or failure to make payment (in whole or in part) for a benefit, including but not limited to, a negative decision regarding eligibility to participate in the Fund or a negative decision by the Fund's provider networks or the Fund's medical or dental review consultants.

ALTERNATE IDENTIFICATION NUMBER

An identification number, in lieu of a member's Social Security number, that uniquely identifies a plan member.

ANESTHESIOLOGIST

A currently licensed Physician trained in the administration of anesthetics and in the provision of respiratory and cardiovascular support during anesthetic procedures.

CHILDREN

See "Dependent Eligibility"

CHIROPRACTOR

Any person currently trained and licensed in chiropractic medicine who treats disease or injury by manipulation of the vertebral column.

COINSURANCE

The amount the Fund and the member will share for a covered expense, usually defined as a percentage.

CONCURRENT CLAIM

A claim for additional treatment or hospital days that is being considered concurrently with the provision of treatment and results in a reduction, termination, or extension of a benefit. It also means a claim that is reconsidered after an initial approval was made.

COORDINATION OF BENEFITS

"Coordination of Benefits" or "COB" is a provision that establishes the order in which health insurance plans pay claims when more than one plan exists. The terms "primary" and "secondary" insurance indicate, respectively, the first and second (plan) that will provide insurance coverage.

CONTRACTUAL RATE

The Fund's payment for covered medical services, which have been agreed upon by medical providers and Blue Cross, the Fund's PPO network and dental providers, and the Blue Cross.

CONTRIBUTING EMPLOYER OR PARTICIPATING EMPLOYER OR EMPLOYER

An employer having a Collective Bargaining Agreement with the Participating Union requiring contributions to the Health and Welfare Fund for participation in this Plan and any other employer approved for participation by the Trustees. Contributing Employer also means the Participating Unions

to the extent they have agreed to contribute to the Fund on behalf of their employees for participation in this Plan.

COPAYMENT

The portion of a covered medical bill for which the patient will be responsible.

COVERED EMPLOYMENT

Work performed under a Collective Bargaining Agreement or agreement with the Trustees providing for contributions to the Health and Welfare Fund for participation in this Plan or work performed for a Participating Union for which it has agreed to contribute to the Health and Welfare Fund for participation in this Plan.

COVERED EXPENSES

That part of expenses that the Fund will pay for.

COVERED SERVICES AND SUPPLIES

To be covered by this Fund, the services or supplies must be for the treatment of non-occupational accidental bodily Injury or disease and described in this Summary Plan Description. Expenses not described in this Summary Plan Description or specifically excluded are not covered.

CUSTODIAL CARE

Any service or supply, including room and board, which: (1) is furnished mainly to help a covered person meet that person's daily needs; and (2) can be furnished by someone who has no professional health care training or skills. Custodial Care is excluded from coverage even if a covered person is confined to a hospital or other recognized facility.

DEDUCTIBLE

The amount of covered medical charges incurred from January 1 to December 31 for any calendar year through a non-network provider for which the patient will be responsible before payment by the Fund will begin. For example, if the Fund has an out-of-network deductible of $1,000, a member will pay the first $1,000 of such out-of-network coverage, after which the plan will begin payment (subject to any coinsurance percentages). Note that this is just an example of a deductible; the Plan's current deductible is noted in SECTION 2.

DENTAL HYGIENIST

A person who is currently licensed to practice dental hygiene by the government authority having jurisdiction over the licensing and practice of dental hygiene and who works under the direct supervision and direction of a Dentist.

DENTIST

A currently duly licensed dentist practicing within the scope of the dentist's license and any other Physician furnishing any dental services that the Physician is licensed to perform.

DURABLE MEDICAL EQUIPMENT

Equipment that has been prescribed by a physician and which: (1) can withstand repeated use; (2) serve a medical purpose; (3) is not useful to the patient in the absence of illness or injury; (4) can be used in the home.

ELIGIBLE DEPENDENT

Family members and others besides the member who are eligible for coverage (See "Eligibility Rules for Spouses/Dependents").

EMPLOYEE ASSISTANCE PROGRAM

This program is designed to provide prompt, professional assistance for members and eligible Dependents needing treatment for mental health-related problems, alcohol and drug abuse, family concerns, illness of a family member, financial pressure, and job stress.

EMERGENCY ADMISSION/MEDICAL EMERGENCY

The immediate admission of a patient to a hospital for treatment of the sudden and acute onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could endanger health and result in permanent disability. Examples include but are not limited to heart attack, stroke, serious burns, and poisoning. Hospital admission or surgery made or performed for the convenience of the physician or patient is not a medical emergency.

EXPERIMENTAL TREATMENT/PROCEDURE

Generally, the Plan does not cover treatments that are deemed to be "experimental" in nature. Before a treatment is determined to be medically necessary, appropriate, and non-experimental, the following minimum criteria must be met:

1. There must be an appropriate governmental regulatory agency giving final approval. The item must be used in accordance with the final guidelines.
2. There must be conclusive scientific evidence of the technology's or treatment's positive effect on the medical care and treatment of the health condition. Such evidence would include publication in scientific review journals, evidence that treatment favorably altered the health outcome, and substantiation of facts by nationally recognized medical publications, medical panels, opinions, and evaluations.
3. There must be evidence of general acceptance by physicians within the relevant medical specialty of the efficacy of the technology or treatment.
4. There must be a demonstrated improvement in the health outcome that must clearly outweigh any harmful effects.
5. The evidence must demonstrate that the new technology or therapy improves the health outcome as much, if not more than established methods.
6. While the outcome in the investigational setting may have demonstrated acceptability, there must be the same outcome outside of the investigational setting.
7. The Trustees of the Fund have determined that the experimental treatment/procedure is an eligible expense.

EXPLANATION OF BENEFITS ("EOB")

A statement that details the claim(s) you have submitted and the amount of benefits payable by the Fund, including an explanation of the reason for any particular charge's not being covered.

EXTENDED CARE FACILITY

An institution that:

1. Operates pursuant to law and is primarily engaged in providing room and board and skilled nursing care to inpatients who are convalescing and require medical care due to injury, illness, or disease;
2. Provides 24-hour-a-day nursing service under the supervision of a full-time employee/licensed registered nurse;
3. Maintains clinical records on all patients;
4. Requires that every patient must be under the supervision of a physician, and provides for having a physician available to furnish necessary medical care in case of emergency;
5. Is licensed if an institution is in any state in which state or applicable local law provides for the licensing of institutions of this nature. In no event shall "Extended Care Facility" include any institution or part of any institution primarily for the care of mental illness, drug addiction, alcoholism, or tuberculosis, or which is primarily engaged in providing domiciliary, custodial, or educational care, or care of the aged.

FUND OR HEALTH AND WELFARE FUND

The Boston Plasterers' and Cement Masons' Local 534 Benefit Fund is a 501(c)(9) Trust as defined by ERISA

HOSPITAL

An institution that meets each of the following requirements:

1. Holds a license as a hospital if a license is required in the domicile of the state;
2. Is operated primarily for the reception, care, and treatment of sick, ailing, or injured persons as inpatients;
3. Provides 24-hour-a-day nursing service by registered or graduate nurses;
4. Has a staff of one or more licensed physicians available at all times;
5. Provides organized facilities for diagnostic and major surgical procedures;
6. Is not primarily a clinic, nursing or convalescent home, or similar establishment nor, other than incidentally, a place to treat persons suffering from alcohol addiction, drug addiction, or a mental illness.

ILLNESS OR SICKNESS

Any bodily disorder or disease that manifests symptoms that require treatment by a physician. Illness includes any birth defects of a newborn child covered by the Fund of benefits. All such conditions existing concurrently or successively that are due to the same or related causes shall be considered as one sickness or illness.

INJURY

All damage to a person's body due to an accident or accidental means, and all complications arising from that damage.

INTENSIVE CARE SERVICE

Services of a physician and of a hospital, rendered for the treatment of an unusual aspect or complication of an illness or injury.

INDEPENDENT REVIEW ORGANIZATION (IRO)

An entity that conducts independent external reviews of Adverse Benefit Determinations and final internal Adverse Benefit Determinations.

MEDICARE

The federal government's health care program for those individuals totally disabled before age 65, and those retired individuals age 65 and over provided by Title XVII of the Social Security Act, as amended from time to time.

MEDICARE PART D

The Prescription Drug Benefit offered under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA")

MEDICAL NECESSITY

The Fund utilizes the medical necessity definitions and procedures of its service providers, as described in this SPD. Generally, however, "Medical Necessity" is defined as a specific surgical procedure, medical care, treatment, service, or supply incurred upon the advice and approval of a physician is reasonably consistent, commonly and customarily recognized by physicians as appropriate, essential, and medically required for the treatment or management of a diagnosed medical condition, illness or injury; other than for educational, experimental, or cosmetic purposes, and not solely for the patient's convenience or the patient's family or the medical provider, and furnished in the least intensive type of medical care setting or facility required by the patient's condition. The fact that the patient's physician or some other provider has furnished, prescribed, ordered, recommended, or approved a service, treatment, surgical procedure, or prescription does not of itself make the aforementioned service, treatment, etc. medically necessary.

MENTAL HOSPITAL

An institution (other than a hospital or separate Part of a hospital as defined by this Fund of Benefits) that specializes in the diagnosis and treatment of mental illness or functional nervous disorders that is operated pursuant to the law in which it is domiciled and meets all of the following requirements: (a) It is approved by Medicare to give medical treatment; (b) It is operated under the supervision of a physician; (c) Provides nursing services by registered graduate nurses or licensed practical nurses; (d) Provides, on the premises, all necessary facilities for medical treatment; (e) It is not, other than incidentally, a place of rest, a place for the aged, a place for convalescent, custodial or educational care.

NETWORK PROVIDER - PREFERRED PROVIDER MEDICAL NETWORK OR PPO

Those providers or facilities that have fee payment contracts that have been negotiated on behalf of the Fund. All covered charges billed by a network provider are generally paid at 100% minus the contractual discount and/or appropriate Copayment. Please call the Fund Office if you are balance billed by a network provider for charges.

NON-MEDICAL NETWORK OR NON-PPO

Providers, services, or facilities that do not have payment contracts with our preferred provider network. All covered charges billed by a non-network provider are applied to the deductible and paid at 50% of Reasonable and Customary charges. All balance billing, after the Fund's payment, is the patient's responsibility.

OCCUPATIONAL THERAPIST

A person who is currently licensed in using purposeful activity to maximize independence, prevent disability, and maintain health with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, poverty, and cultural differences, or the aging process.

OPTOMETRIST

A person duly licensed to practice optometry by the governmental authority having jurisdiction over the licensing and practice of optometry in the locality where the service is rendered.

OPTOMETRY

The practice or profession of examining the eyes, by means of suitable instruments or appliances, for defects in vision and eye disorders in order to prescribe corrective lenses or other appropriate treatment.

ORTHODONTIA

The branch of dentistry concerned with irregularities of teeth and malocclusion.

ORTHODONTIC PROCEDURES

Movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

OTHER HOSPITAL SERVICES AND SUPPLIES

Services and supplies furnished to the individual and required for treatment, other than Room and Board, the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

OUT-OF-POCKET

The dollar amount a member will pay for medical expenses for a calendar year. It does not include payments made for:

- Expenses the Fund does not cover
- Charges in excess of the Reasonable and Customary charge
- Reductions in benefits due to Fund limitations
- Penalties the member must pay due to non-compliance with the Fund.

(ACTIVE) MEMBER

A person who is eligible under the Fund's provisions, as described in *0*,

ELIGIBILITY RULES.

PHYSICAL THERAPIST

A person who is currently licensed to assist in the examination, testing, and treatment of physically disabled or handicapped people through the use of special exercise, application of heat or cold, use of sonar waves, and other techniques.

PHYSICIAN

The term "Physician" includes, with respect to any particular medical care and services, any holder of a certificate or license authorizing the holder or licensee to perform the particular medical or surgical services. This definition of Physician includes a licensed psychologist for the treatment of mental and/or nervous disorders only, and treatment by a licensed social worker with a Master's degree under the direct supervision of a psychiatrist, and including a registered psychiatric nurse as required by state statute.

PLAN OR FUND

The Boston Plasterers' and Cement Masons' Local 534 Health and Welfare Fund as set forth and described in this Summary Plan Description.

POST-SERVICE CLAIM

A claim that is not a Pre-Service, Urgent Care, or Concurrent Claim (for example, a claim submitted for payment after health services and treatment have been obtained).

PRE-SERVICE CLAIM

A claim for a benefit for which pre-approval of the benefit (in whole or in part) is required before medical care is obtained. The Fund does not require pre-certification for any services.

PODIATRIST

A person currently trained and licensed in podiatry (the study and care of the foot, including its anatomy, pathology, medical and surgical treatment).

PLACEMENT FOR ADOPTION OR BEING PLACED FOR ADOPTION

The assumption and retention by a health plan member or beneficiary of the legal duty for the total or partial support of a child to be adopted. The child's placement with such person terminates whenever the legal duty likewise terminates.

RADIOLOGIST

A Physician certified by the American Board of Radiology who specialized in the branch of medicine concerned with radioactive substances and various techniques of visualization, with the diagnosis and treatment of disease using any of the various sources of radiant energy.

REASONABLE AND CUSTOMARY

The charges incurred for the services, treatment, and supplies that are medically necessary, to the extent that such charges are within the median range of charges made by physicians of similar training and experience for the same treatments, services, and supplies. The Trustees shall determine the reasonableness of the charges incurred and the amount of payment to be made to a provider. The determination of whether a charge meets these requirements shall take the following into consideration: (a) fees and prices charged; (b) treatment rendered; (c) therapeutic practice followed; (d) supplies furnished according to the usual practice of physicians; (e) locality where the treatment is rendered.

ROOM AND BOARD

Room, board, general duty nursing, and any other services regularly furnished by a hospital or other facility as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians or intensive care by whatever name called.

SECOND SURGICAL OPINION

An opinion of a qualified independent physician for evaluating the medical necessity and advisability of a specific surgical or diagnostic procedure proposed by another physician. The second examination must be performed after the first qualified physician has produced a diagnosis, including a diagnosis that no surgical or diagnostic procedure be performed. Each physician must be an independent practitioner, neither associated with each other nor a member of the same professional medical corporation.

SKILLED NURSING FACILITY

A facility that is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare, except for a Skilled Nursing Facility that is part of a Hospital, as defined.

An institution fully meets the definition of "Skilled Nursing Facility" if it meets all the following tests:

1. It is operated in accordance with the applicable laws of the jurisdiction in which it is located; and
2. It is under the supervision of a licensed Physician or registered graduate nurse (RN), who is devoting full-time to such supervision; and
3. It is regularly engaged in providing Room and Board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Sickness; and
4. It maintains a daily medical record of each patient who is under the care of a duly licensed physician; and
5. It is authorized to administer medication to patients on the order of a duly licensed physician; and
6. It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics, drug addicts, or the mentally ill; and
7. It is not a Hospital, as defined, or part of a Hospital.

SPEECH THERAPIST

A person currently trained and licensed in speech pathology who treats people with disorders affecting normal oral communication.

THIRD-PARTY REIMBURSEMENT

Any direct or indirect payments to a covered person for injury or illness from any source, by way of settlement, judgment, or any other manner including, but not limited to, reimbursement from Workers' Compensation insurance, uninsured motorist, and no-fault automobile insurance coverage.

URGENT CARE CLAIM

A claim for pre-certification of benefits for treatment that, if not received, (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (2) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

SECTION 18. SUBROGATION

You or one of your eligible dependents may incur medical expenses in a situation where a third party—for example, Workers' Compensation or an auto insurance carrier—may be held responsible for their payment. In this case, the Fund has all rights of recovery that you or your dependents would have, including the right to bring suit in your name. In most cases, the Fund utilizes the third-party recovery and subrogation procedures of Blue Cross Blue Shield of Massachusetts. Those policies and procedures are incorporated as if fully incorporated herein, and you may obtain a copy of these documents by requesting them from the Fund Office. In any case where Blue Cross Blue Shield of Massachusetts or its vendor does not pursue the recovery, the procedures and rules of this section will apply.

You must cooperate with the Fund to secure the recovery of the payment, and you must do nothing before or after payment by the Fund to prejudice its rights. If you recover from the third party or its insurer, you must reimburse the Fund for expenses that it has paid. When you and/or your eligible dependents incur medical expenses where a third party may be held responsible for payment you must:

1. Notify the Fund Office, and
2. Execute a Subrogation and Reimbursement Agreement.

The Subrogation and Reimbursement Agreement must be executed by you and/or your covered dependent and received by the Fund Office within 90 days from the date of the incident and in no event later than 12 months from the date of the incident. The amount of reimbursement due to the Fund is based on the following schedule:

TOTAL RECOVERY	**FUND'S SHARE OF RECOVERY**
Equal or less than benefits	50% of the benefits
Greater than one times, but less than two times benefits	65% of the benefits
Greater than two, but less than three times benefits	75% of the benefits
Greater than three, but less than four times benefits	85% of the benefits
Greater than four times	100% of the benefits

In no event shall the Fund's share of recovery be greater than 50% of the total recovery following the deduction of the participant's reasonable attorney's fees (not to exceed 33% of the total recovery).

Before paying benefits for expenses that may be the responsibility of a third party, you and/or your dependents will be required to sign an agreement affirming the Fund's lien rights and the obligation of you and your dependents to reimburse the Fund from the proceeds of any recovery. The Fund may withhold payments on any claim until a reimbursement agreement is executed. The Fund's lien rights and your obligation to reimburse the Fund, however, are not dependent on whether you sign a reimbursement agreement. By accepting the payment of benefits, you and your dependents agree to the Fund's subrogation and reimbursement policies.
You and/or your eligible dependent must execute the reimbursement agreement and submit it for receipt by the Fund Office within 90 days of the date of the accident or injury. If it is not reasonably possible to

submit the executed reimbursement agreement within 90 days, it must be received by the Fund Office as soon as reasonably possible but in no event later than one year from the date of the accident or injury. If you fail to comply with this obligation to sign and submit the reimbursement agreement within the deadline, the Fund will deny claims relating to the accident or injury.

If you receive payment from a third party under any circumstances, the Fund has a lien on that payment and you must reimburse the Fund in accordance with the schedule above from the proceeds. Reimbursement is mandatory regardless of whether:

- a claim was ever asserted for the amount received.
- the proceeds were paid by way of settlement, judgment, arbitration award or otherwise.
- you feel that you were "made whole" for your losses by recovery.
- the amount received is characterized as attributable to medical expenses, lost income, pain and suffering, loss of consortium or otherwise.
- part of the recovery is received by family participants other than the primary injured party such as on a loss of consortium; in such cases the "total recover" is the combined recoveries of all such family members.

The Fund has an equitable interest and lien in the amount that you receive, and you, your dependents, and those acting on your behalf, including your attorneys, are under obligation to keep the amounts received in a separate segregated account until your obligations to the Fund are satisfied and all disputes concerning those obligations are settled. The Fund may enforce this obligation by seeking equitable relief in court against you and your representatives, including your attorneys.

In the event that the participant or dependent submits additional claims for benefits following settlement of a liability claim and reimbursement to the Fund, the Fund will withhold future benefits, but only to the extent that the additional benefits would have been reimbursable under the formula had the settlement occurred later.

If you or your dependents or your agents or representatives, including your attorneys, do not reimburse the Fund after receiving payment from a third party or otherwise fail to comply with the obligations set forth here, the Fund may institute legal and/or equitable action in court. In such event, you will be responsible for all the costs and attorney's fees associated with that court proceeding, and will be obligated to pay all interest on all amounts owed from the date they were due. If you or a dependent fails to reimburse the Fund, or fails to reimburse the Fund for litigation and costs and attorneys' fees in accordance with this section, the Fund may withhold payment of future benefits from you as well as all of your dependents up to the amounts due plus interest.