BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND (CANADA)

SUMMARY PLAN DESCRIPTION

June 1996

GROUP INSURANCE PROGRAM
FOR THE EMPLOYEES COVERED BY
THE BRICKLAYERS AND ALLIED CRAFTWORKERS
INTERNATIONAL HEALTH FUND

This booklet is designed to outline the benefits for which you are eligible and does not create or confer any contractual or other rights.

All rights with respect to the benefits of a member will be governed solely by the Group Master Policy issued by the National Life Assurance Company of Canada.

Dear Participant:

The Board of Trustees of the Bricklayers and Allied Craftworkers International Health Fund (IHF) is pleased to provide you with this booklet describing the benefits of the Fund. The Trustees of the Fund have established this Plan to provide you and your eligible dependents with valuable health care expense benefits. Your employer makes contributions on your behalf; these contributions and the interest earned on them pay for the benefits provided.

This booklet describes how you and your dependents become eligible and continue to remain eligible to receive benefits. It also describes in general the types of benefits provided by the Plan. Limitations and exclusions are described and instructions are given on how to apply for benefits.

This booklet has been written in simple, straightforward language. We encourage you to read it and become familiar with the plan of benefits available to you. Please share this information with your family members.

If you have any questions about your benefits after reading this booklet, please contact the Fund Office.

Fraternally,

BOARD OF TRUSTEES

SUMMARY PLAN DESCRIPTION

Introduction

The Bricklayers and Allied Craftworkers International Health Fund was established in 1988 by the International Union of Bricklayers and Allied Craftworkers and various Contractor Associations. It is financed by employer contributions established in collective bargaining agreements between the Union and employers participating in the International Health Fund (IHF).

The Bricklayers and Allied Craftworkers International Health Fund is administered by a Board of Trustees consisting of an equal number of representatives of the Union and an equal number of representatives of the employers. They serve without compensation.

The Trust Fund is separate from, and not a part of, the International Union or any employers' association.

You are covered by the Health Plan if you are an employee working under a collective bargaining agreement between an employer and the Union providing for contributions to this Fund. When this booklet refers to "you", it assumes that you are an employee covered by this Plan. Participation is not available to any self-employed person, partner or sole proprietor.

CONTENTS

WHO IS ELIGIBLE FOR COVERAGE?

You are eligible for the coverage described in this booklet if you:

- work in a job category covered by a collective bargaining agreement; and

- the agreement requires that contributions are made to the Bricklayers and Allied Craftworkers International Health Fund on your behalf; or

- you are an official or employee of a local union participating in this Plan and contributions are made to this Plan on the same terms and conditions as provided for in the collective bargaining agreement.

- you may also be eligible for coverage as a retired member as noted on page ____.

You are also eligible for the coverage provided by this Fund if you are an owner-employee of an incorporated business which makes contributions on your behalf to this Plan under the terms of a collective bargaining agreement and is not delinquent in the payment of contributions as set forth in the collective bargaining agreement.

Finally, you are eligible for the coverage provided by this Fund if you are an employee of an employer that contributes to this Plan at the required rate on behalf of all employees, whether or not the employee is in a job category covered by the employer's collective bargaining agreement. Employees who are not covered by the collective bargaining agreement are referred to as "non-job site employees". For non-job site employees, the required monthly direct pay amount is set by the Fund Office. The Fund Office must receive the required amount on or before the 15th day of each month prior to eligibility.

Eligibility Requirements

1. You must be a full-time resident of Canada.

2. You are employed in the province of New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland, Alberta, or other provinces as so designed from time to time.

3. **You are insured under the Provincial Hospital and/or Provincial Medicare Plan of your province of residence. (This clause is only applicable to the coverage provided under the Supplementary Health Insurance Benefit).**

**** INSERT PROVINCIAL HEALTH PLAN MATRIX ****

When Does Your Coverage Start?

If you are a new employee, or if you are not currently eligible for your local union's plan of benefits, your coverage starts on the first day of the second month following the month in which you completed at least 300 hours of covered employment during a period not to exceed six consecutive months.

For example:

Bob started working for an employer who was required to make contributions to the Fund on Bob's behalf beginning January 1. On April 30 (four consecutive months later) Bob had worked at least 300 hours of covered employment. He became an eligible Plan participant on June 1.

NOTE: Once you become eligible for benefits, it is necessary for you to enroll in the Plan. This can be done by submitting a completed Enrollment Form to the Fund office. You can experience a delay in benefits if you do not enroll in the Plan.

How Does Your Coverage Continue?

Your coverage will continue from month to month as long as you meet one of the following minimum employment "Look-Back" rules:

- 400 hours of covered employment in the last four consecutive months; or
- 600 hours of covered employment in the last six consecutive months; or
- 800 hours of covered employment in the last nine consecutive months; or
- 1,000 hours of covered employment in the last twelve consecutive months.

If you do not meet the first Look-Back rule, the Plan will use the next rule, until all of the rules have been tested. If you should meet one of the four Look-Back rules, your eligibility will continue to the next month.

For non-job site employees and their dependents, coverage continues during each month (1) for which the employer has made the required payment covering each non-job site employee employed by the employer **and** (2) during which no event has occurred that ends eligibility (see rules on ending of eligibility below). The Look-Back rules do not apply to non-job site employees.

When Does Your Eligibility for Coverage End?

Your eligibility for coverage ends on the last day of the third month following the month that you do not meet any of the Look-Back rules mentioned earlier.

For example:

At the end of March, the Plan used the Look-Back rules to see if Ed's eligibility continued to April. After using the four rules, it was clear that Ed had not worked sufficient hours of covered employment to meet any of the four rules. If Ed did not earn additional hours, his eligibility for coverage would end on June 30, the last day of the third month following the month that Ed did not meet any of the four Look-Back rules.

If you return to work, you must work the required number of hours under covered employment to reestablish your eligibility according to the rules set forth earlier in this booklet.

SPECIAL NOTE:

Notwithstanding the foregoing rules, coverage for you and your eligible dependents shall end immediately if:

1. You become eligible as an employee for coverage under another employment-related group health plan, or

2. You become employed in the masonry industry and such employment is not covered by a collective bargaining agreement between the employer and the International Union of Bricklayers and Allied Craftworkers or one of its affiliates.

3. This Plan is terminated.

For non-job site employees and their dependents, eligibility for coverage ends immediately when any of the following events occur:

(1) the employee's employer is no longer obligated to contribute to this Plan on behalf of its job site employees;

(2) when the employer's payment to the Fund on non-job site employees is not made by the 15th day of the month prior to eligibility;

(3) on the date that the employer is no longer signatory to a collective bargaining agreement with the BAC or a BAC affiliate;

(4) when the employer makes contributions on some, but not all, non-job site employees; or

(5) when the non-job site employee becomes eligible as an employee for coverage under another employment-related group health plan.

Will You Be Able To Continue Your Coverage As a Retired Member?

Depending on the specific terms covering your local union's participation in this Plan, retired members in good standing may be entitled to continue coverage. Generally, continued coverage is available to pensioners and their dependents on a self-payment basis. The coverage includes the Health and Life insurance benefits. Dental and optical are optional benefits and must be specifically elected by the pensioner.

To be eligible for benefits you must meet the following requirements:

- Your Local Union and former Employer must be participating in the International Health Fund; and

- You must have experienced Active Eligibility prior to Retirement and

- You must be retired, eligible for or be receiving a monthly pension from the Bricklayers and Trowel Trades International Pension Fund, or a pension fund maintained by the International Union or one of its local unions; and

- You must make self-payment to the International Health Fund at rates to be determined by the Board of Trustees from time to time. The self-payment must be made on or before the 15th day of each month prior to the eligibility month. If you stop making self-payments, your coverage will end and you will not thereafter be entitled to further self-payment coverage under the International Health Fund, unless you reestablish eligibility as an active employee and subsequently retire.

  Coverage will terminate immediately if you become employed again in the masonry industry and such employment is not covered by a collective bargaining agreement between the employer and the International Union of Bricklayers and Allied Craftworkers or one of its affiliates.

  A Spouse may elect continued coverage upon the death of the participant. Coverage must be continuous and the self-payment must be made on or before the 15th day of each month prior to eligibility.

If you meet all of the above requirements, you and your eligible dependents will be covered for benefits.

Once you are 65 years old and elect the Provincial Health Plan in your province, your benefits will be coordinated. The Provincial Plan will be your primary provider. If you elect not to participate in the Provincial Health Plan, all covered health expenses will be paid to you as though you had enrolled. In other words, reimbursement will be reduced by the Provincial Health Plan benefits available to you as if you had enrolled. You will be paid the difference between what the Provincial Plan pays (or would have paid) and the Provincial Plan allowance for all covered Plan benefits.

What Happens If Your Coverage Ends?

If your coverage ends you can convert to an individual policy if you apply within the required time limits, or if you meet the requirements for continuation coverage* (described below), you can choose continuation coverage and then convert to an individual policy when the continuation coverage expires.

In order to convert your coverage to an individual policy, you must apply for the coverage within 15 days after you have been notified by the Fund Office that your coverage ended.

Continuation of Coverage

If your coverage under this Plan ends, there are circumstances under which you can receive a temporary extension of your health care coverage at group rates. This extension applies to you and your family.

As an employee, you have the right to extend your coverage if your coverage ends because:

- you leave employment with a contributing employer for reasons other than gross misconduct on your part, or
- you no longer meet the eligibility requirements described on pages 2 and 3.

Your spouse has the right to this extended coverage if:

- you die
- you leave employment as described above, or no longer meet the eligibility requirements
- you are divorced or legally separated, or
- you become entitled to Medicare.

---

* **COBRA** - Consolidated Omnibus Budget Reconciliation Act of 1985

Your dependent children have the right to this extended coverage if:

- you die
- you leave employment as described above, or no longer meet the eligibility requirements
- you are divorced or legally separated, or
- you become entitled to Medicare, or
- they are no longer considered dependents under this Plan.

You or the affected family member have the responsibility to inform the Fund Office of a divorce, legal separation or a child losing dependent status. Your employer or Local Union has the responsibility to notify the Fund Office of an employee's death, termination or change to part-time work status (20 or less hours per week).

Once the Fund Office is notified of an event that affects your coverage, you will be notified that you have the right to choose continuation coverage. You have at least 60 days from the date you would lose coverage to let the Fund Office know that you want continuation coverage. If you do not choose it, your group health coverage will end.

If you choose to continue coverage, you will continue the health coverage you currently have. You, your spouse or your dependents may continue coverage for up to a maximum of three years, unless your coverage ended because you left employment, or, you no longer satisfied the eligibility requirements. In this instance, you, your spouse and eligible dependents may continue coverage for up to a maximum of 18 months. This may be extended to 29 months in the case of a determination of disability by the Social Security Administration. Contact the Fund Office immediately for details if you are disabled. This coverage will be extended to 36-months in the event of death or divorce.

These time periods may be shortened if:

- the Fund no longer provides group health coverage for any employees

- you do not pay the required premium

- you are later employed and are covered by another employer-funded group health plan either as an employee or dependent **unless that plan has an exclusion for your pre-existing condition**. In that event you may be able to continue your coverage for the applicable maximum period. Contact the Fund Office for details.

- you become entitled to coverage under the Provincial Health Plan

- you were divorced from a covered employee, subsequently remarry and are covered under your new spouse's group health plan.

You do not have to show evidence of good health in order to continue coverage. However, you will have to pay the cost for continuing your health benefit coverage.

Finally, at the end of the continuation coverage period (18 months or three years), you may be allowed to enroll in an individual conversion health plan.

If you terminate employment due to retirement you can choose retiree continuation.

If you have any questions about this continuation coverage, please contact the Fund Office.

WHO ARE YOUR ELIGIBLE DEPENDENTS?

Your eligible dependents include:

- your spouse, and
- your unmarried children who have not reached the age of 19.
- Common-Law Spouse ???? ("Common-Law spouse" will mean a person of the opposite sex who resides with you and who has resided with you for at least one year and whom you publicly represent as your spouse.)

Children include your natural children, stepchildren or adopted children who depend upon you for support and live with you in a regular parent-child relationship. If your children are full-time students in an accredited school or college, their coverage can continue to age 23.

Also, if your unmarried, dependent children cannot support themselves because of a physical handicap or mental retardation, their coverage can continue beyond age 19 if such incapacity started before they reached age 19. You must submit proof of their incapacity to the Fund Office.

When Does Their Coverage Start?

Coverage for your dependents starts when your coverage starts, or when they become your dependents. However, if one of your dependents is confined in a hospital on the date coverage would otherwise begin, coverage will not start until final discharge from the hospital. If a newborn infant has medical expenses because of disease, injury, congenital abnormality or hereditary complication, coverage begins at birth.

When Does Their Coverage End?

Coverage for your dependents ends when your coverage ends or when they no longer meet the definition of a dependent as described above, whichever occurs first.

How to Change Your Coverage

Initially, when you become eligible for health and welfare benefits with the IHF you must complete an enrollment form indicating the type of coverage, i.e., Single, Family or Parent and Child(ren) and listing the Name, Date of Birth and Social Security Number of each dependent.

Circumstances may change during your eligibility period whereby you need to change your account information. The following procedures should be completed regarding a change to your coverage:

- **Single to Family:**

  Your single coverage can change to family coverage when you marry. To enroll your spouse as a dependent you need to submit a change form within **60 days** of the date of marriage. Coverage for your spouse will begin on the date of marriage.

- **Add Dependent:**

  You need to complete a change form within **31 days** after you acquire a child. Coverage for the child will be effective on the date of birth or the date he or she becomes an eligible dependent. If the change form is received later than the 31st day, coverage will begin the first day of the next eligibility month.

- **Add Spouse:**

  When coverage is needed for a spouse following termination under their employer plan, you need to complete a change form within **60 days** after coverage is terminated. Coverage will be effective the first day of the next eligibility month following the receipt of the change form.

- **Status Change:**

  Any other status change, such as a child ceases to be an eligible dependent, death, divorce, or Medicare eligibility becomes primary, notify the Fund Office and changes will be effective the first day of the next eligibility month.

IMPORTANT INFORMATION WHICH APPLIES TO ALL OF YOUR HEALTH BENEFITS

There are six important topics which apply to all of your health benefits:

- Claims Procedures
- Coordination of Benefits
- Extended Benefits,
- Conversion
- Foreign Employment
- Reciprocity

How To File A Claim

There are no claim forms to fill out when you select network physicians, facilities or other health care services, such as X-ray or diagnostic labs under the medical plan.

If you or one of your eligible dependents has out-of-network medical expenses, contact the Fund Office as soon as possible for the correct claim forms.

For optical or dental claims, contact the Fund Office for the correct claim forms.

Claim forms should be completed and returned within 12 months; included with the claim forms should be any other information needed to properly process your claim. It is your responsibility to file all claims on a timely basis.

Coordination of Benefit (COB)

Occasionally, a patient entitled to receive benefits under this Plan will also be eligible to get similar benefits under another group health insurance plan. Generally, this coverage is available from their spouse's plan.

If this happens, the two plans will coordinate their benefit payments so that the combined payments of both plans will not be more than the actual expenses. One plan (the Primary Plan) will pay its full benefits. The other plan (the Secondary Plan) will pay any expenses over the Primary Plan benefits up to the maximum amount that it would pay if this provision were not in force.

The order of payment is determined as follows:

- If one plan does not have a Coordination of Benefits provision, it is the Primary Plan.
- If the other plan includes a Coordination of Benefits or non-duplication provision, the plan covering the patient as an employee will be considered the Primary Plan.

The insurance company may obtain or release any information necessary to implement these procedures. You must declare your coverage under other plans.

With respect to dependent children, the plan covering the parent whose birthday falls earlier in the calendar year will be considered the Primary Plan. If both parents have the same date of birth, the plan which covers one of the

parents longer will be considered primary. (A person's year of birth is not relevant to application of this rule.)

When parents are separated or divorced, the order of coverage is as follows:

- the plan of the parent with custody is primary;
- the plan of the spouse of the parent with custody pays secondary; and
- the plan of the parent without custody pays last

However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses and the insurer obligated to pay the benefits of that parent's plan has actual knowledge of those terms, that plan is primary.

Reimbursement

If you or an eligible dependent file a claim for medical expenses related to an injury which was caused by another person (or entity), you or your eligible dependent must agree to assign to the Plan your right of recovery against the person (or entity) who caused your injuries by using a Reimbursement Agreement before the payment of the claim for medical expenses will be made. This means that you or your eligible dependent must reimburse the Plan for your medical expenses out of **any** amounts you recover from another source, regardless of how these amounts are characterized.

For example:

Amy, who is covered by the Plan, is injured in an automobile accident involving another car, driven by Joe. Amy files a claim for medical expenses with the Plan. Amy also hires an attorney to sue Joe. Amy

must reimburse the Plan for her medical expenses out of any recovery she may obtain in her lawsuit against Joe.

When you or your eligible dependent submit a claim, you or your eligible dependent will be asked to provide information about whether your illness or injury is the result of an accident. If the illness or injury is the result of an accident, you and/or your eligible dependent must sign a reimbursement agreement before payment of the claim for medical expenses will be made.

Conversion

If your coverage ends as described on pages _____, you can convert to an individual health insurance policy. You must apply for this policy within 31 days after you've been notified by the Fund Office that your group coverage has terminated.

If coverage for your dependents ends, they too can convert to an individual policy.

Please contact the Fund Office for the correct application form if you wish to convert.

Foreign Employment

If a Canadian Participant works for an Employer in the United States who is obligated to contribute to the Bricklayers and Allied Craftworkers International Health Fund on his behalf as if he was a U.S. Participant, his hours of Covered Employment for which contributions have been made to the Bricklayers and Allied Craftworkers International Health Fund at this rate shall be treated as hours of Covered Employment under IHF Canada for the purposes of eligibility for benefits.

If a U.S. Participant works for an Employer in Canada who is obligated to contribute to the Bricklayers and Allied Craftworkers International Health Fund on his behalf as if he was a Canadian Participant, his hours of Covered Employment for which contributions have been

made to the Bricklayers and Allied Craftworkers International Health Fund at this rate shall be treated as hours of Covered Employment under IHF-US for the purposes of eligibility for benefits.

Reciprocity

One of the advantages of the IHF is "Portability". Members may travel to different areas while continuing to earn hours for eligibility. However, when a member travels to a local jurisdiction which does not participate in the IHF, then reciprocity becomes important to ensure continued eligibility.

The BAC International Health Fund is signatory to the BAC International Reciprocal Agreement for BAC Health and Welfare Fund, including Exhibit "B" of that agreement, which provides for "money follows the man" reciprocity. Please contact the Fund Office for a list of Local Funds signatory to the agreement and a form to transfer your hours to the IHF when you work in a Local which does not participate in the IHF.

In cases where a fund has merged with the International Health Fund and had a reciprocal agreement with local health funds, it is the policy of the IHF to grant international reciprocity as the successor plan, retroactive to the date the former fund merged with the International Health Fund once the local health fund signs the International Reciprocal Agreement for BAC Health and Welfare Funds.

GENERAL INFORMATION

This Fund is administered by a joint Board of Trustees consisting of an equal number of Union and Employer representatives. The Board of Trustees has been designated as the agent for the service of legal process. All contributions to the Fund are made by Employers according to their agreements with the International Union of Bricklayers and Allied Craftworkers and/or its Local Unions, District Councils and Conferences.

The Fund Office will provide you, upon written request, with information as to whether a particular employer is contributing to this Fund on behalf of employees working under the collective bargaining agreements. The collective bargaining agreements require contributions to the Fund at fixed rates per hour worked.

Benefits are provided from the Fund's assets which are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. Most of the benefits are provided through insurance policies. All of the types of benefits provided by this Fund are set forth in the Schedule of Benefits portion of this descriptive booklet, which is incorporated by reference. The complete terms of the insured benefits are set forth in the group insurance policies or contracts, which are incorporated by reference. The terms of this plan, including those relating to coverage and benefits, are legally enforceable. This plan is maintained for the exclusive benefit of employees covered under this plan.

The procedures to follow for filing a claim for benefits are set forth on page ____ of the booklet. If all or any part of your claim is denied, you may request a review of that decision. To request a review, contact the Fund Office for the procedure to submit an appeal. You will be advised of the outcome of the decision upon review.

The benefits are paid out of the Trust Fund which is used solely for that purpose. If you have any questions or problems about benefit payments, you have the right to get answers from the Trustees who administer the Plan.

If you receive a notice that your claim has been denied, you may request a review of the denied claim within 90 days of the receipt of the notice of denial. If you do not receive a decision on a claim for benefits within 90 days (or 180 days in special circumstances), you may request a review of your claim. You or your authorized representative may request a review, may have the opportunity to review pertinent documents, and may submit issues and comments in writing. Requests for review must be made in writing and should be sent to the Fund Office.

Decision on the review will be made by the insuring organization on any question involving the terms of an insurance contract and by the Board of Trustees on any other question. The decision of the Board of Trustees will be in writing and will include the specific reason(s) for the decision and specific references to plan provisions on which the decision is based. The Trustees have the sole and absolute discretion at all times to construe the provisions of the plan and to determine all questions of coverage and eligibility, methods of providing or arranging for benefits, and all other related matters.

No Union Office, Employer, Trustee, Administrator or any employee of the Administrator has the power to vary any of the written provisions of this Plan.

TRUSTEES

Union

John T. Joyce
John J. Flynn
Thomas J. Uzzalino
Frank Stupar
James Boland

Employer

Eugene George
Walter W. Kardy
Paul J. Songer
John P. Wallner
Daniel Schiffer
Joseph Speranza, Jr.

Fund Office

Bricklayers and Allied Craftworkers
International Health Fund
815 15th Street, N.W.
Washington, DC 20005
(202) 783-3788
(202) 383-3905 (FAX)

Legal Counsel

Vladeck, Waldman, Elias & Engelhard, P.C.

Actuary

The Segal Company

Auditor

Thomas Havey & Company

Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the Plan or insurance policies. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. If you wish to obtain additional information about the plan, write to the Plan Administrator at the Fund Office.

Identification of Organizations Through Which Benefits are Provided

NATIONAL LIFE OF CANADA receives premiums from the Fund to provide medical, major medical, surgical, and other benefits described in a separate booklet available from the Administrator.

Humana receives premiums from the Fund to provide medical, major medical, surgical, and other benefits described in a separate booklet available from the Administrator.

Fiscal Year End Date:

The fiscal year end date is December 31.