Bricklayers & Allied Craftworkers International Health Fund

Summary Plan Description

November 2012

Revised 11/16/2012

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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. You may not be eligible for all of the benefits described in the booklet. The specific benefits and levels of benefits you are entitled to will be listed on a Schedule of Benefits which will be distributed to all participants covered by the Fund. Limitations and exclusions are described and instructions are given on how to apply for benefits. Finally, the booklet describes the procedures you can use to appeal a benefit decision and the rights you and other participants are given by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

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 representative 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. The U.S. Treasury has advised that the Fund is exempt from Federal income taxes under provisions of Section 501(c)(9). 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.

The Patient Protection and Affordable Care Act - Disclosure Statement

The BAC International Health Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator:

Anne Codd
620 F St., NW
Washington DC 20004
202-383-3976
acodd@bacweb.org

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Choice of Health Care Professional Requirements

You do not need prior authorization from the BAC International Health Fund or from any other person (including a primary care provider) in order to obtain access to a pediatrician or obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in pediatrics or obstetrics/ gynecology, contact the toll free telephone number on your ID card or visit myuhc.com.

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 the 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 5.
- Employees who are the owner-employee of an incorporated business, a family member of the owner-employee (including a spouse, child, parent or sibling) or any other employee who exercises control over the management of the employer entity who do not pay the non-jobsite premium shall be required to report a minimum of 160 hours per month in order to maintain eligibility for benefits. Benefits are effective on the 1st day of the second month following any given calendar quarter in which a member worked 480 hours or more. Benefits will remain in effect for three consecutive months.

Finally, you are eligible for the coverage provided by this Fund if you are an employee of and employer of an incorporated business 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. The employer must not become delinquent in the payment of contributions as set forth in the 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 premium amount is set by the Fund Office. All non-job site premiums must be reported on the monthly remittance form provided by the fund, on or before the 15th day of each month, prior to eligibility. Any checks received at the Fund Office on behalf of non-job site employees without the current remittance form for covered employees will be returned, which may result in a delay in coverage.

Which Coverage Do You Have?

The IHF provides different levels of benefits to different employee groups depending on, among other factors, the negotiated employer contribution rate, terms of a merger into the IHF and other terms agreed to, as part of participation in this Plan. You may not be entitled to all of the benefits described in this booklet. Your specific benefits and levels of benefits will be summarized in a Schedule of Benefits distributed to all participating groups covered by the Fund.

BAC IHF U.S. PLAN ELIGIBILITY RULES

Benefits are effective on the 1st day of the second month that a member worked 200 hours or more in any given calendar quarter. Benefits will remain in effect for three consecutive months.

Example:
Joe works 95 hours in January, 125 hours in February and 130 hours in March. Since he has more than 200

hours in the 1st calendar quarter, benefits will be effective May, June, and July.

Quarterly Eligibility Rules Schedule

Work Months	Eligibility Months
January/ February/ March	May / June / July
April / May / June	August / September / October
July / August/ September	November / December / January
October / November / December	February / March / April

- In order to initiate, reinstate or maintain benefits, members will need to meet one of the following quarterly eligibility rules.
  - A minimum of 200 hours worked in a calendar quarter, or;
  - A minimum of 500 hours worked in two consecutive calendar quarters, or;
  - A minimum of 1,200 hours worked in four consecutive calendar quarters.
- Members who do not meet any of the above rules will continue to be eligible to participate as a monthly self-pay participant under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Home Local Rule

Your health and welfare benefits are determined by your contribution rate. If you work in the jurisdiction of more than one local union your benefits will be based on your "Home Local" determined as follows:

If you work for several employers under different participating local Collective Bargaining Agreements, the benefit level for which you are eligible may change. To limit the frequency of change between benefit levels, the IHF will continue coverage under the benefit level for which you are most consistently covered pursuant to the following "Home Local Rule." Under this rule, changes between benefit levels may only occur on September 1st of each year based on the plan for which the majority of your hours were worked during the past three calendar years. As with all benefits under the IHF, you must continue to work the necessary hours under the calendar quarter rules to maintain eligibility under any plan level. The determination of your benefit plan coverage under this rule will be determined each July for coverage effective September 1st through August of the following year.

For example:

Steve worked for an employer who was required to make contributions to the Fund on his behalf and was eligible for [Option A] coverage for two and a half years. After two and a half years, in December, Steve goes to work for a different employer under a different IHF participating Local Union jurisdiction providing a different level of benefits. Under the Home Local Rule, Steve will continue to be eligible for Option A coverage until the following September 1st. On September 1st, Steve's coverage will be based on the plan for which the majority of his hours were worked during the past three calendar years. In Steve's case, this qualifies him for Option A coverage for the next year ending on August 31st.

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 quarterly eligibility 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 eligibility month that you do not meet the quarterly eligibility rules of the next calendar quarter.

For example:

At the end of October, the Plan used the 3rd calendar quarter to see if Ed's eligibility continues for November/December/January. It was clear that Ed had not worked sufficient hours of covered employment to meet the 200 hour rule. The plan then used the 2nd and 3rd quarter hours and Ed also did not have sufficient hours to meet the 500 hour rule. Finally, the plan used hours from the 4th quarter of the prior year through the 3rd quarter of the current year, and found that Ed also did not have sufficient hours to meet the 1,200 hour rule necessary to maintain coverage. Therefore Ed's eligibility will terminate November 1st. If you return to work, you must work the required number of hours under covered employment to reestablish your eligibility according to the quarterly eligibility rules set forth in this booklet.

SPECIAL NOTES:

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

3. Union of Bricklayers and Allied Craftworkers or one of its affiliates.

4. This plan is terminated.

NOTE: The IHF is structured to be self-supporting. If hours are worked but not reported, the IHF will have no basis on which to pay the insurance claims on behalf of you and your eligible dependents.

Please check with the Fund office periodically to confirm that the correct hours have been reported and credited to your account in a timely manner. Unreported hours may cause you to no longer meet the eligibility requirements. This may cause you to receive a COBRA Continuation self-pay notice.

If you are working for an employer who is delinquent, please submit proof of employment to the Fund office (in the form of paystubs) and contact your local Business Representative. This will initiate collection procedures against your employer.

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

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

4. the employer is delinquent in the payment of contributions as set forth in the collective bargaining agreement.

Eligibility for coverage for non-job site employees and their dependents ends immediately if any of the following events occur:

1. the employer's payment to the Fund on non-job site employees is not made by the 15th day of the month; or
2. the employer makes contributions on some, but not all, non-job site employees.

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 be at least age 55 or eligible for a Disability Pension; and

- You must make self-payments 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 eligible for Medicare Parts A and B, your benefits will be coordinated with Medicare. Medicare will be your primary provider. If you only elect Part A Medicare, all covered health expenses will be paid to you as though you had enrolled in Part B. In other words, reimbursement will be reduced by the Medicare benefits available to you as if you had enrolled. You will be paid the difference between what Medicare pays (or would have paid) and the Medicare allowance for all covered Plan benefits. You should apply for Medicare at your local Social Security office at least three months before you reach age 65.

Your Prescription Drug Coverage and Medicare Part D

Medicare covers prescription drug benefits under Part D. If you and/or your Eligible Dependent(s) are enrolled in either Part A or B of Medicare, you are eligible for Medicare Part D. This Plan offers "Creditable Coverage". This means that the Plan's prescription drug coverage is expected to pay out, on average, as much or more as the standard Medicare prescription drug benefit will pay. Since this Plan's coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan while you have the Plan's prescription drug coverage as an Eligible Participant in order to avoid a late penalty under Medicare. When you lose this coverage, you may enroll in a Medicare Prescription Drug Plan either during a special enrollment period or during Medicare's annual enrollment period (November 15-December 31 of each year). For more information about creditable coverage see the Plan's Notice of Creditable Coverage that will be mailed to you from the Plan. You may request another copy of this Notice by calling the Fund Office and asking for one. For more information about the Medicare prescription drug plans, visit **www.medicare.gov** or call the Fund office at-888-880-8222.

If you are a Retired Member and do not enroll in a Medicare prescription drug plan, your current prescription drug coverage will continue as long as you continue to meet the eligibility requirements (including payment of premiums) of the International Health Fund.

If you enroll in a Medicare Prescription Drug Plan (PDP) or a Medicare Advantage Plan with prescription drugs (MA-PD) and are a Medicare-Eligible Retired Member or the Medicare-Eligible Spouse of a Retired Member, you cannot keep your current prescription drug coverage or your medical coverage with the International Health Fund. Your current coverage pays for other health expenses in addition to prescription drugs. If you choose to enroll in a Medicare prescription drug plan, you will lose both types of coverage. Your dependents will lose their medical coverage and prescription drug coverage, too. Once your coverage ends, you will not be entitled to further self-pay coverage under the International Health Fund unless you reestablish eligibility as an active employee and subsequently retire.[1]

What Happens If Your Coverage Ends?

If your coverage ends and if you meet the requirements for continuation coverage* (described below), you can choose continuation coverage.

[1] Subject to HIPAA Enrollment rules.

Continuation of Coverage
(COBRA[*] continuation)

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 quarterly eligibility rules, described on pages 3. Unless the reason you do not meet any of the eligibility rules is that your employer has failed to accurately report your hours or make the required contributions to the IHF.

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.

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 members have the responsibility to inform the Fund Office of a divorce, legal separation of a child losing dependent status. Your employer or Local Union has the responsibility to notify the Fund Office of an employee's death or termination.

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 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 COBRA, you will continue the health coverage you currently have. Life Insurance, Accidental Death and Dismemberment coverage is excluded from this provision. You will be given an option to continue "all" health coverage or the "core" health program (the plan **without** dental or optical benefits). 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 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 COBRA coverage for the applicable maximum period. Contact the Fund Office for details.
- you become entitled to Medicare
- 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.

[*] COBRA—Consolidated Omnibus Budget Reconciliation Act of 1985

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 children who have not reached the age of 26, and do not have employer sponsored health care.

Children include your natural children, stepchildren or adopted children .

Also, if your dependent children cannot support themselves because of a physical handicap or mental retardation, their coverage can continue beyond age 26 if such incapacity started before they reached age 26. 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.

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 and marriage certificate within **60 days** of the date of the marriage. Coverage for your spouse will begin on the date of marriage.
- **Add Dependent:**
  You need to complete a change form and submit a birth certificate 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 and certificate of coverage 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:**
  For 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.

LIFE INSURANCE

If you die from any cause while you are eligible, the amount of your life insurance benefit will be paid to your beneficiary. The amount of your benefit depends on the specific terms of your local union's participation in the Plan. Refer to the Schedule of Life Benefits for your local plan of benefits.

Your Beneficiary

You may name anyone you wish as you beneficiary. You may change your beneficiary at any time by contacting the Fund Office and completing the correct form.

Total and Permanent Disability

If you become totally and permanently disabled while insured and before age sixty, your Life Insurance will remain in force as long as you remain disabled, subject to continued proof of disability. Please contact the International Health Fund Office if you become permanently and totally disabled.

Conversion

If your life insurance coverage ends for any of the reasons described on pages 4–7 , you can convert to an individual policy. You must apply for the individual coverage within 15 days after you are notified.

The amount of your individual policy cannot be more than the amount of your group coverage. You can choose any type of individual policy except term insurance. The premium will be based on your age and class of risk at the time you convert.

If you die within the 31-day conversion period, your beneficiary will receive the full amount of your coverage.

How To File A Claim

To file a claim for benefits, your beneficiary should contact the Fund Office. A certified copy of the death certificate will be required.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If you die or lose one or more limbs or eyes because of an accidental injury, you or your beneficiary will receive a benefit from this coverage. The amount of the benefit depends upon the specific terms of your local union's participation in the Plan. Please refer to the Schedule of Accidental Death and Dismemberment Benefits for your local plan of benefits.

How the Benefit Is Paid

If you die as the result of an accident, your beneficiary will receive the full amount of your benefit. This is in addition to your life insurance benefit.

If you lose two arms or feet, the sight of both eyes, or lose one arm or foot and the sight of one eye, you will receive the full amount of your benefit.

If you lose one arm, one foot or the sight of one eye, you will receive one-half of your benefit amount.

The loss must occur within 90 days of the accident.

Loss of an arm means dismemberment at or above the wrist joint;

Loss of a foot means dismemberment at or above the ankle joint;

Loss of sight means the total and irrecoverable loss of sight.

No more than the full benefit amount will ever be paid for all losses due to one accident.

What Is Not Covered

Payment will not be made for any loss due to:

- bodily or mental infirmity
- disease, ptomaines or bacterial infection,
- medical or surgical treatment
- suicide, attempted suicide or intentionally self-inflicted injury, or
- war or any act of war, declared or undeclared.

However, if the loss is due to an infection resulting directly from an injury or by surgery needed because of the injury, benefits will be paid.

Conversion

Accidental death and dismemberment benefits cannot be converted to an individual policy.

How To File A Claim

To file a claim for benefits, you or your beneficiary should contact the Fund Office.

INTERNATIONAL HEALTH FUND NATIONAL PLAN

The IHF has arrangements with a network of carefully screened health care providers who have agreed to provide top quality health care at a low cost. You also have the freedom to seek care from any other doctor you choose.

The choice is always open. Whenever you require medical care, you can pick either a network physician or facility or an out of network one.

When you select network physicians, facilities or other health care services, such as X-ray or diagnostic labs, you have easy access to health care and pay fewer out of pocket costs than if you choose out of network providers. For instance, for physician home and office visits there are no deductibles and you pay only a modest co-payment. There are no claim forms to fill out if you use in network providers or facilities.

If you choose out of network medical care, you pay a higher deductible and a higher percentage of the cost of each medical service. After paying for the service directly, you must complete and submit a claim form.

Please refer to the Schedule of Health Benefits for your Local Plan of Benefits.

DENTAL BENEFITS

Depending on the terms of your Local's participation in the IHF, dental benefits may be available.

If you are eligible for dental benefits, you and your dependents will be reimbursed according to the Schedule of Benefits for many of your dental expenses. You may use any dentist you wish.

Covered Dental Expenses

The dental benefit reimburses you for covered dental expenses according to the limits and maximum shown in the Schedule of Dental Benefits for your Local Plan of Benefits.

The covered charges for services and supplies must be necessary. They must be used by dentists in the United States to treat your particular problem, and they must meet professionally recognized national standards of quality.

If alternate services or supplies may be used to treat a dental condition, covered expenses will be limited to the maximum amount for services and supplies that meet the above requirements.

For example:

> If a tooth can be filled with a material like amalgam and you and the dentist select another type of material, the Plan will reimburse you the amount from the Schedule for filling a tooth with amalgam or similar material. You will be required to pay any additional expenses.

What Is Not Covered

Benefits are not paid for:

- Orthodontics, including correction of malocclusion, unless listed as a covered benefit in the Schedule of Benefits;

- services or supplies covered under any other provisions of the Plan;

- treatment by anyone other than a dentist except that scaling or cleaning and application of fluoride may be performed by a licensed dental hygienist if supervised by a dentist;

- initial installation of dentures or fixed bridgework (including crowns and inlays forming the abutments) for replacing congenitally missing teeth or replacing teeth lost before you were insured;

- cosmetic services and supplies, including charges for personalization or characterization of dentures; and

- replacement of a lost, missing, or stolen denture or any other prosthetic device or appliance.

In addition, charges for any replacement of an existing partial or full removable denture or fixed bridgework by a new denture or new bridgework, or the addition of teeth to a partial removable denture or to bridgework to replace extracted teeth are normally not covered.

However, if one of the following applies, benefits will be paid:

- The replacement or addition of teeth is required to replace one or more natural teeth extracted after the existing denture or bridgework was installed, and while the individual was covered; or

- The existing denture or bridgework cannot be made serviceable and was installed at least five years before its replacement; or

- The existing denture is an immediate temporary denture which cannot be made permanent; replacement by a permanent denture is required and takes place within 12 months from the date of initial installation of the immediate temporary denture.

OPTICAL BENEFITS

Depending upon the terms of your Local's participation in the IHF, Optical Benefits may be available. Please refer to the Schedule of Optical Benefits for your Local Plan of Benefits.

The IHF provides comprehensive vision care for eligible members and their dependents.

After you pay a deductible, you will be reimbursed for eye exams every twelve months.

Provisions for lenses and frames are also found in the Schedule of Optical Benefits for your Local Plan of Benefits.

If you have any further questions regarding these optical benefits or your eligibility for them, please do not hesitate to call the Fund Office.

PRESCRIPTION DRUG BENEFITS

If you are eligible for prescription drug benefits, you will be reimbursed for expenses incurred by you or your eligible dependents for covered prescription drugs according to the Schedule of Prescription Drug Benefits.

The following prescription drugs are covered under this plan:

- prescriptions which require compounding, that is, preparation by a pharmacist; and
- insulin, when prescribed.

The following drugs are not covered:

- drugs which are not prescribed by a licensed medical doctor, dentist or osteopathic physician;
- drugs which are not dispensed by a licensed pharmacist;
- hypodermic syringes, needles and similar equipment;
- drugs which can be purchased without a doctor's prescription (i.e., over the counter medications);
- any medication which is to be taken while the patient is in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution;
- routine immunizing agents;
- drugs administered to you in the office of the person who prescribes the drugs;
- expenses for medical which can be reimbursed under any governmental program or employee liability law, including Workers' Compensation; and
- vitamins, except those which by law require a prescription.

VACATION BENEFITS

Depending upon the terms of your Local's participation in the IHF, Vacation Benefits may be available. If the collective bargaining agreement which covers your employment calls for contributions to be made to the IHF for Vacation Benefits, then you are eligible for vacation benefits.

If you are eligible for vacation benefits, the Fund will record all contributions that are made on your behalf toward vacation benefits. At the beginning of each quarter (in January, April, July and October), you will receive the amount which has been contributed on your behalf as long as the total is at least $100. If your balance is lower than $100, you will not receive a benefit until it totals at least $100. You may also request payment of vacation benefits at any time during the year. In addition, the balance of your benefits will be paid to you at the end of the calendar year, regardless of the amount to which you are eligible. If you die and there is a balance of benefits, the amount will be payable to your beneficiary. If you have any questions regarding vacation benefits or your eligibility for them, please do not hesitate to call the Fund Office.

IMPORTANT INFORMATION WHICH APPLIES TO ALL YOUR HEALTH BENEFITS

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

- Claims/Appeal Procedures
- Coordination of Benefits
- Extended Benefits
- Foreign Employment
- Reciprocity

BAC INTERNATIONAL HEALTH FUND HOW TO FILE A CLAIM

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. Network providers are responsible for filing claims. We pay these providers directly.

- If you receive Covered Health Services from a non-Network provider, you are responsible for filing a claim.

IF YOU RECEIVE COVERED HEALTH SERVICES FROM A NETWORK PROVIDER

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any covered health service, contact the Claims Administrator. However, you are responsible for meeting any annual deductible and any co-payments to a Network provider at the time of service, or when you receive a bill from the provider.

FILING A CLAIM FOR BENEFITS

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a non-Network provider, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a format that contains all the information required, as described below.

You must submit a request for payment of Benefits within one year after the date of service. If a non-Network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you don't provide this information to us within one year of the date of service, benefits for that health service will be denied or reduced, in the Plan Administrator's or the Claims Administrator's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

If a participant or employee provides written authorization to allow direct payment to a provider, all or portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the participant employee. We will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

REQUIRED INFORMATION

When you request payment of Benefits from us, you must provide us with all of the following information:

- Participant's name and address

- The patient's name, age and relationship to the participant

- The member number stated on your ID card and Group number

- An itemized bill from your provider that includes the following:
  1. patient diagnosis
  2. place of service
  3. date(s) of service (s)
  4. procedure code(s) and descriptions of service(s) rendered
  5. charge for each service rendered
  6. provider of service name, address and tax identification number
- The date the injury or sickness began

- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

PAYMENT OF BENEFITS

Through the Claims Administrator, we will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

A. The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider.
B. You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

BENEFIT DETERMINATIONS
Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claim Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the

needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and follow the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 days period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and follow the claim appeal procedures.

URGENT CLAIMS THAT REQUIRE IMMEDIATE ACTION

Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause sever pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.

- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent care claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after

- The Claim Administrator's receipt of the requested information.

- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and follow the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

BAC INTERNATIONAL HEALTH FUND QUESTIONS AND APPEALS

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Service or your Benefits

- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such a determination.

To resolve a question or appeal, just follow these steps:

What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

If you are appealing an Urgent Care Claim denial, please refer to the “Urgent Claim Appeals that Require Immediate Action” section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your ID card(s). Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. Your request should include:

- The patient’s name and the identification number from the ID card(s).
- The date(s) of service(s).
- The provider’s name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the original decision will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator (first level appeals) and the Plan Administrator (second level appeals) may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of **pre-service claims,** the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of **post-service claims**, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see “Urgent Claims Appeals that Require Immediate Action” below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from us, the Plan Administrator. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

Please note that the Plan Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause sever pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the Plan. The Claims Administrator's decisions are conclusive and binding.

Voluntary External Review Program

If a final determination to deny Benefits is made, you may choose to participate in our voluntary external review program. This program only applies if the decision is based on either of the following:

- Clinical reasons.

- The exclusion of Experimental, Investigational or Unproven Services.

The external review program is not available if the coverage determinations are based on explicit Benefit exclusions or defined Benefit limits.

Contact the Claims Administrator at the telephone number shown on your ID card(s) for more information on the voluntary external review program.

Coordination of Benefits (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

- if parents have joint custody the birthday rule will be used.

However, if the specific terms of a QMSCO (Qualified Medical Child Support Order) state that one of the parents is responsible for the child's health care expenses is the insurer obligated to pay the benefits of

that parent's plan and has actual knowledge of those terms, that plan is primary, under OBRA*.

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 hose 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, the insurance company shall have the right to recover expenses paid from the covered member amounts received by judgement, settlement or any other person or entity claim for medical expenses will be made.

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 contributing 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 Job Information Center now indicates whether or not locals requesting manpower participate in the International Health Fund. Members in danger of losing IHF coverage due to lack of hours available in their local can use the Job Information Center to find work in other locals which participate in IHF.

The BAC International Health Fund is signatory to the International Reciprocal Agreement for BAC Health and Welfare Funds, including signatory to appendix "1" 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.

COVERAGE FOR ELIGIBLE MEMBERS AFTER AGE 65

If you are still working when you reach age 65, you will continue to be eligible for full benefits under this Plan and, in addition, you are also eligible for Medicare coverage beginning at age 65.

If you are an Eligible Member under this Plan and become covered by Medicare, Part A, B or D, while actively working whether because of end-stage renal disease (ESRD), disability or age, you may either retain or drop all coverage under this Plan. If you are covered under this Plan and by Medicare, as long as you remain actively employed, your medical and prescription drug coverage will continue. In that case,

*COBRA—Omnibus Budget Reconciliation Act of 1993

your coverage under the BAC International Health Fund pays first. After you receive benefits from the Plan, you can submit your claims to Medicare for additional benefits.

If you are covered under this Plan and covered by Medicare and drop coverage under this Plan, coverage of your Eligible Dependent(s) will terminate, but they may be entitled to COBRA Continuation Coverage. See the Continuation of Coverage chapter for further information about COBRA Continuation Coverage. If any of your Dependents are covered by Medicare and you cancel that Eligible Dependent's coverage under this Plan, that Dependent will not be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare beneficiary is your responsibility. Neither this Plan nor your Employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

Information about the Plan and Medicare Part D

Medicare covers prescription drug benefits under Part D. If you and/or your Eligible Dependent(s) are enrolled in either Part A or B of Medicare, you are eligible for Medicare Part D. This Plan offers "Creditable Coverage". This means that the Plan's prescription drug coverage is expected to pay out, on average, as much or more as the standard Medicare prescription drug benefits will pay. Since this Plan's coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan while you have the Plan's prescription drug coverage as an Eligible Participant in order to avoid a late penalty under Medicare. When you lose this coverage, you may enroll in a Medicare Prescription Drug Plan either during a special enrollment period or during Medicare's annual enrollment period (November 15-December 31 of each year). For more information about creditable coverage see the Plan's Notice of Creditable Coverage that will be mailed to you from the Plan. You may request another copy of this Notice by calling the Fund Office and asking for one. For more information about Medicare prescription drug plans, visit www.medicare.gov or call the Fund office at 1-888-880-8222.

Coverage Under Medicare and This Plan When Totally Disabled: If a Participant under this Plan who is actively working becomes Totally Disabled and entitled to Medicare because of that disability, the Participant will no longer be considered to remain actively employed. As a result, once entitled to Medicare because of that disability, Medicare pays first and this Plan pays second.

Coverage Under Medicare and This Plan for End-Stage Renal Disease: If, while actively employed, a Participant under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

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 are self-funded. **All of the types of benefits provided by this Fund are set forth in the Certificate of Coverage attached to this booklet**, which is incorporated by reference. The complete terms of the benefits are set forth in the group certificate of coverage, 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 benefits are paid out of the Trust Fund, which is used solely for that purpose. If you have any questions or problems about benefits payments, you have the right to get answers from the Trustees who administer the Plan. A description of your rights under ERISA follows.

If you receive a notice that your claim has been denied, please refer to page 10 regarding appeals procedures.

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	**Employer**
James Boland	Eugene George
Henry Kramer	Matthew Aquiline
Ken Lambert	Fred Kinateder
Gerard Scarano	Gregory Hess
Tim Driscoll	Robert Hoover
John Flynn	

Fund Office
Bricklayers and Allied Craftworkers
International Health Fund
620 F Street, N.W.
Washington, DC 20004
(888) 880-8BAC
(202) 383-3905 (FAX)

Legal Counsel
O'Dwyer & Bernstien, LLP

Actuary
Cheiron, Inc.

Auditor
Calibre CPA Group, PLLC

Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the Plan or Certificate of Coverage. 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.

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

As a participant in this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

> Examine, without charge, at the Fund Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
>
> Obtain copies of all Plan documents and other Plan information upon written request to the Fund Administrator. The Administrator may make a reasonable charge for the copies.
>
> Receive a summary of the Fund's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days after a repeated request, you may file suit in a federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

Or, if you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the Fund fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor.

Contact: U.S. Department of Labor
Pension and Welfare Administration
Washington District Office
1730 K Street, N.W. Suite 556
Washington, DC 20006

You may also file suit in a federal court. The court will decide who should pay for court costs and legal fees. If the court decides in your favor, it may order the person you have sued to pay these costs and fees. If the court decides against you, it may order you to pay these costs and fees. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area Office of the U.S. Labor Management Services Administration, Department of Labor.

Identification of Organizations Through Which Benefits are Provided

United Healthcare - Administrative Service Only Agreement - receives administrative fees from the Fund to provide medical claims processing, medical management, and other benefits described in the Certificate of Coverage booklet available from the Administrator.

Vision Service Plan - Administrative Service Only Agreement - receives administrative fees from the Fund to provide vision claim processing and benefits which are described in a separate booklet available from the Administrator.

Standard Dental - receives premiums from the Fund to provide dental benefits which are described in a separate booklet available from the Administrator.

Standard Life Insurance Company - receives premiums from the Fund to provide life insurance benefits, which are described in a separate booklet available from the Administrator.

Fiscal Year End Date:

The fiscal year end date is December 31.

BAC International Health Fund
Privacy Notice

Section 1: Purpose of This Notice and Effective Date

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

Effective date. The effective date of this Notice is April 1, 2003.

This Notice is required by law. The BAC International Health Fund, (the “Fund”), is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

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

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term “Protected Health Information” (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

When the Fund May Disclose Your PHI

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

- ***At your request.*** If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect and/or copy it.
- ***As required by HHS.*** The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund’s compliance with the privacy regulations.
- ***For treatment, payment or health care operations.*** The Fund and its business associates will use PHI in order to carry out:
  - Treatment,
  - Payment, or
  - Health care operations.

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

For example, the Fund may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

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

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

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

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

Disclosure to the Fund's Trustees. *The Fund will also disclose PHI to the Fund Sponsor the Board of Trustees of the BAC International Health Fund, for purposes related to treatment, payment, and health care operations, and has amended the Fund Documents to permit this use and disclosure as required by federal law. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.*

When the Disclosure of Your PHI Requires Your Written Authorization

Although the Fund does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Fund will use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you.
Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

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

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI For Which Consent, Authorization or Opportunity to Object Is Not Required

The Fund is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

1. ***When required by applicable law.***
2. ***Public health purposes.*** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

4. ***Health oversight activities.*** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
5. ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).
7. ***Law enforcement emergency purposes.*** For certain law enforcement purposes, including:
   a. identifying or locating a suspect, fugitive, material witness or missing person, and
   b. disclosing information about an individual who is or is suspected to be a victim of a crime.
8. ***Determining cause of death and organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.
9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.
10. ***Research.*** For research, subject to certain conditions.
11. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

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

Other Uses or Disclosures

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

The Fund may disclose protected health information to the sponsor of the Fund for reviewing your appeal of a benefit claims or for other reasons regarding the administration of this Fund. The "Fund sponsor" of this Fund is the BAC International Health Fund, Board of Trustees.

Section 3: Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

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

The Fund, however, is not required to agree to your request [if the Fund Administrator or Privacy Official determines it to be unreasonable.] Make such requests to: Privacy Official, BAC International Health Fund, 620 F St., N.W. Washington DC 20004. Telephone 202-783-378

You May Request Confidential Communications

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

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to: Privacy Official
BAC International Health Fund, 620 F St., NW., Washington, DC 20004
Telephone: (202) 783-3788

You May Inspect and Copy PHI

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

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

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. A reasonable fee may be charged. Requests for access to PHI should be made to the following officer: Privacy Official
BAC International Health Fund
620 F St., N.W.
Washington, DC 20004 Telephone: (202) 783-3788

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

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

You Have the Right to Amend Your PHI

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

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

Privacy Official
BAC International Health Fund
620 F St., N.W. Washington, DC 20004
Telephone: (202) 783-3788

You or your personal representative will be required to complete a form to request amendment of the PHI.

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

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

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

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

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

To obtain a paper copy of this Notice, contact the following officer:

Privacy Official
BAC International Health Fund
620 F St., N.W. Washington DC 20004
Telephone: (202) 783-3788

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI

or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

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

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

You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Fund will automatically consider an individual to be a personal representative.

Section 4: The Fund's Duties

Maintaining Your Privacy

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

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

Notice will be provided by first class mail to the address on record.

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

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Fund, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

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

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

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

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

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

In addition, the Fund may use or disclose "summary health information" to the Fund Sponsor for obtaining premium bids or modifying, amending or terminating the group health Fund. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Fund Sponsor has provided health benefits under a group health Fund. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Your Right to File a Complaint with the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the following officer:

Privacy Official
BAC International Health Fund
620 F St., N.W. Washington DC 20004
Telephone: (202)783-3788

You may also file a complaint with:

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

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

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer at the Fund Office:

Privacy Official
BAC International Health Fund
620 F St., N.W. Washington DC 20004
Telephone: (202) 783-3788

Section 7: Conclusion

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

NOTES