BAC Local Union 15
Supplemental Plan

SUMMARY PLAN DESCRIPTION

REVISED November 1, 2003

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LETTER FROM THE BOARD OF TRUSTEES

Dear Participants and Beneficiaries:

We are pleased to distribute this new Summary Plan Description (benefit booklet) describing the benefits provided under your Supplemental Plan. This is a good Plan! It should help you enjoy a comfortable, well-earned retirement.

The booklet summarizes the eligibility rules for participation in the Plan, the benefits provided to those who are eligible, and the procedures which must be followed when applying for benefits. If there is any disagreement in interpretation of the Summary Plan Description from the interpretation of the Supplemental Plan document itself, the Supplemental Plan document will govern.

You should **READ THIS BOOKLET CAREFULLY** so that you understand the financial protection provided to you by the Plan.

If the Plan makes an inadvertent, mistaken or excessive payment of benefits, the Trustees or their representatives shall have the right to recover the payments.

This is your Summary Plan Description describing your Plan. Make sure that you read it, then put it in a safe place for future reference. ***If at any time you have any questions about the Plan, don't hesitate to call or write the Fund Office for assistance.***

The Board of Trustees and its duly authorized Committees shall have the authority and full discretion to revise, interpret, construe and apply the provisions of the Plan Document, Summary Plan Description, the Amended Agreement and Declaration of Trust and/or any rules and regulations established by the Trustees including, but not limited to, provisions concerning eligibility for, entitlement to and/or nature, amount and duration of benefits. Only the Board of Trustees and/or its authorized agents are empowered to interpret the Plan of benefits as described in this booklet. No employer or union is authorized to interpret the Plan on behalf of the Board of Trustees nor can any such person or entity act as an agent of the Board of Trustees.

Sincerely,

THE BOARD OF TRUSTEES

WHAT THIS BOOKLET IS

This booklet is the Summary Plan Description (SPD) of your retirement plan. The Plan document is much more detailed. Contact the Fund Office if you have any questions. The address and telephone number of the Fund Office are listed below.

IF YOU MOVE, NOTIFY THE FUND OFFICE IMMEDIATELY

Most information about the Plan is sent to you by mail. For you to receive this information, we must have a correct address on file in the Fund Office at all times.

If you move, it is up to you to let us know your new address. Failure to do so may jeopardize your eligibility and/or benefits because we will have no way to contact you about any changes in the eligibility rules or improvements in benefits.

So don't lose out! Remember, the responsibility for letting the Fund Office know your new address is YOURS.

Just drop a post card or a note in the mail showing your new address. Send the change to:

BAC Local Union 15 Supplemental Plan Fund Office
6405 Metcalf, Suite 200
Overland Park, Kansas 66202
(913) 236-5490

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Only the Board of Trustees and/or its authorized agents are empowered to interpret the Plan of benefits described in this booklet. No Employer, Union, or any representative of an Employer or Union is authorized to interpret the Plan on behalf of the Board of Trustees, nor can any such person or entity act as an agent of the Board of Trustees.

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DEFINITIONS

Definitions of certain terms used in this booklet have been extracted from the Plan document. When used in this booklet such terms have been capitalized. We have used only those terms that help in the understanding of the Plan.

ACCRUED BENEFIT means the balance in your Participant Account.

ASSOCIATION means The Builders' Association.

BENEFICIARY means any person or persons designated by you or by the terms of the Plan to receive a benefit hereunder on or after your death.

DISQUALIFYING EMPLOYMENT means any employment in:

1. any industry covered by the Plan when the Participant's pension payments began;

2. a geographic area covered by the Plan when the Participant's pension began; and

3. any occupation in which the Participant worked under the Plan at any time or any occupation covered by the Plan at any time the Participant's pension payments began.

EMPLOYEE means any employee of an Employer on whose behalf the Employer is obligated, or becomes obligated, to contribute to the Trust Fund.

EMPLOYER means a Member Employer, Participating Employer, the Union, or The Builders' Association, individually or collectively.

EMPLOYER CONTRIBUTIONS means the amounts contributed to the Trust Fund from time to time by an Employer as required by the collective bargaining agreement or other agreement between the Employer and the Union.

NORMAL RETIREMENT AGE means age 62.

PARTICIPANT means an individual who is eligible to participate in the Plan. An Employee shall become a Participant on the first day on which an Employer is required to make contributions to the Plan on the Employee's behalf. *Participation by self-employed persons, partners, or an Employee of an Employer which is wholly owned by such Employee or by such Employee and his/her spouse is NOT allowed*.

PARTICIPANT ACCOUNT or ACCOUNT means the individual account maintained for a Participant for the accumulation of contributions and net investment earnings allocated to the account.

PLAN means the BAC Local Union 15 Supplemental Plan as set forth in the Plan Document and as it may be amended from time to time.

PLAN YEAR means the 12 month period beginning on April 1 of each year and ending on March 31 of the following year.

TOTAL AND PERMANENT DISABILITY means a physical or mental condition of a Participant which the Trustees find on the basis of medical evidence to totally and permanently prevent the Participant from engaging in any employment within the work jurisdiction of the International Union of Bricklayers and Allied Craftworkers ("BAC employment") (a copy of the definition of "BAC employment" is available upon request from the Fund Office) and will be permanent and continuous during the remainder of the Participant's life.

However, a Participant will *not* be considered to be totally and permanently disabled under the Plan if the Participant's incapacity consists of chronic alcoholism or chronic drug addiction or if the incapacity resulted from the Participant's engagement in a felonious enterprise, from an intentionally self-inflicted injury, from an injury, wound or disability incurred while serving with the armed forces of the United States or from an injury, wound or disability suffered or arising out of a state of war.

TRUST FUND or FUND means the fund established pursuant to the Pension Trust Agreement for the purpose of providing Plan benefits and into which Employer Contributions are to be made, investment earnings are accumulated and from which benefits and expenses are paid.

UNION means Local No. 15 of the International Union of Bricklayers and Allied Craftworkers, AFL-CIO

VALUATION DATE (ALLOCATION DATE) means the date on which the Trust shall be valued and Participant Accounts adjusted accordingly: this date will be each March 31 and any other dates deemed appropriate by the Trustees.

THE PLAN AND HOW IT WORKS

This Plan was established to provide Participants with retirement income to supplement Social Security and other pension benefits. Employers contribute to the Plan on your behalf under the terms of a collective bargaining agreement with the Union. The agreements tell the Employers how much to contribute. **You are NOT allowed to make contributions on your own behalf**. The Plan Year runs from April 1st of each year through March 31st of the following year.

PARTICIPATION IN THE PLAN

You automatically become a Participant in the Plan on the first day on which contributions are first required to be made on your behalf. Once you become a Participant, you will remain a Participant until your Participant Account is distributed either upon retirement, disability or death.

YOUR ACCOUNT AND HOW YOU BECOME VESTED

When Employers start contributing to the Plan on your behalf, the Plan will set up an "Account", also called a "Participant Account", in your name. Contributions made or which should have been made as a result of your work in covered employment will be credited to your Participant Account.

You are fully vested in your Participant Account balance at all times. You cannot lose or forfeit your Participant Account balance.

HOW PLAN EARNINGS AND EXPENSES ARE CHARGED TO YOUR ACCOUNT

Your Participant Account will share in the Plan investment earnings and will be charged with a share of the Plan's expenses on an annual basis. At the end of each Plan Year during which you are a Participant, your Participant Account balance will be equal to: (1) your Account balance at the end of the previous Plan Year; (2) **less** any benefits paid during the current year; (3) **plus** any contributions made on your behalf during the current Plan Year; (4) **plus** any investment earnings or losses credited to your Account at the end of the current Plan Year; (5) **less** any expenses deducted from your Account at the end of the current Plan Year.

At the end of each Plan Year, the amount of money earned on Fund investments and total Fund expenses paid for the year will be determined.

The amount of the allocation is determined in the following manner:

1. total expenses for the current Plan Year are subtracted from the total investment earnings for the current Plan year to determine the Plan's net earnings or investment income;

2. an allocation percentage is determined by dividing the Fund's net earnings or investment income by a dollar amount determined by adding the total of all Participant Account balances **at the beginning of the current Plan Year** (reduced by total benefits paid during the current Plan Year) **plus** one-half of the total contributions made to the Fund during the current Plan Year. This allocation percentage is then applied to your Account balance.

Here is an example of how the formula works:

> Assume that your Account balance at the beginning of the Plan Year is $10,000.00, that the Employers contributed $500.00 on your behalf during the Plan Year and that the allocation percentage for the Plan Year is 5%. The allocation percentage (5%) will be applied to your beginning Account balance ($10,000.00) plus one-half of the contributions ($500.00) or $10,250.00.
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> The net investment income (income less expenses) that is allocated to your Account is 5% of the $10,250.00 or $512.50. Your Account balance at the end of the Plan Year will be your beginning balance ($10,000.00) **plus** contributions ($500.00) **plus** net investment income ($512.50) or $10,000.00 + $500.00 +$512.50. Your Account balance at the end of the year will be $11,012.50.
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> In the event that the expenses for the Plan Year exceed the investment income, the identical procedure set forth above will be used except that the allocated share of the difference between the investment income and the expenses will be *subtracted* from your Account balance.

Federal law limits the amount of total additions which can be made to your Account each year. Generally, the amount credited to your Account for any Plan Year cannot exceed the lesser of (a) $40,000.00 (this amount may be indexed for inflation), or (b) 100% of your annual pay.

Additionally, other limits may apply if you are also a Participant in one or more non-multiemployer defined benefit or defined contribution plans.

YOUR ACCOUNT FINANCIAL STATEMENT

After the end of each Plan Year during which you are a Participant, the Trustees will send you an annual statement which shows your Account balance. These statements will normally be available within 90 days following the end of the Plan Year. If you do not receive a statement, you should contact the Fund Office. It may be that your current address is not on file in the office, or that your Employers did not report the contributions under the correct Social Security number, or there may be some other problem that needs correction.

ELIGIBILITY FOR BENEFITS

Benefits are payable only at the following times:

Retirement On or After Age 55

Normal Retirement Age is 62. If you reach age 62, you may receive your vested benefit upon application, even if you are still working. If you retire at age 62 or later and return to Covered Employment, you will continue to accrue benefits. You may request a new distribution once each year after Normal Retirement Age.

If you retire on or after age 55 but before age 62, you must withdraw from all employment with Contributing Employers and Disqualifying Employment at least for the four months following the March 31 Valuation Date for which you expect to receive benefits. You may not receive another distribution until the earlier of the Valuation Date after you attain age 62, or two consecutive Plan Years without contributions.

Total and Permanent Disability

If you become Totally and Permanently Disabled as defined by the Plan (see page 4 of this booklet) and determined by the Trustees, you may apply for and receive your vested benefit as of the Valuation Date next following your application. You may elect to receive 50% of your benefit immediately upon approval of your application and 50% after the next following Valuation Date.

You must prove to the Trustees that you are Totally and Permanently Disabled by presenting acceptable medical evidence of your disability. Acceptable medical evidence of your disability is either (1) evidence of a determination by the Social Security Administration that you are Totally and Permanently Disabled or (2) two independent doctor's reports stating that you are Totally and Permanently Disabled. The Trustees have the discretion to decide if your medical evidence establishes your disability. The decision of the Trustees as to Total and Permanent Disability shall be final and binding. You may appeal the Trustees' decision in accordance with the Claims Review and Appeal Procedures beginning on page 11 of this booklet. You may obtain the necessary forms to apply for a disability benefit from the Fund Office.

Death

If you die, your designated Beneficiary may apply for and receive your Account balance. If you are married when you die and your Account balance is $5,000.00 or more, and you and your spouse have not chosen a different Beneficiary, your spouse will be your Beneficiary and will be entitled to receive a death benefit in the form of a single lump sum payment or monthly payments. See page 9 of this booklet regarding waiver of the monthly benefit. If your Account balance is under $5,000.00 it will automatically be paid in a lump sum whether you are married or single. Your Beneficiary or a duly authorized representative of your Beneficiary must make an application for the death benefit. Application forms may be obtained from the Fund Office.

Withdrawal from Employment Before Age 55

If no Employer Contributions have been credited to your Account for two consecutive Plan Years and your Account balance is less than $5,000.00, the Trustees shall automatically distribute your Account balance to you.

If your Account balance is more than $5,000.00, you have not yet attained age 55, you have not been credited with any Employer Contributions for five consecutive Plan Years and you have not worked in Disqualifying Employment as defined in the Plan (see page 3 of the booklet), you may request and receive a special rollover distribution. If you wish to receive the special rollover distribution, you must provide proof that you have not worked in Disqualifying Employment for the preceding five (5) consecutive Plan Years. Social Security records, tax returns, pay stubs, or other similar methods may be acceptable proof.

BENEFICIARIES

If You Are Married

If you are married when your benefit payments begin or when you die, whichever first occurs, your spouse will automatically be your Beneficiary. If you wish to name someone else as your Beneficiary, your spouse must give written consent. The Beneficiary can be anyone you choose as long as your spouse gives written consent. The consent form must be witnessed by a Fund representative or be notarized. The consent form can be obtained from the Fund Office.

If You Are Single

If you are not married, you may choose any person as your Beneficiary. If you later become married prior to the time your benefit payments begin or when you die, whichever first occurs, your prior Beneficiary election will be canceled and your spouse automatically becomes your Beneficiary. If you wish to name someone else as your Beneficiary, your spouse must give written consent. The Beneficiary can be anyone you choose as long as your spouse gives written consent. The consent form must be witnessed by a Fund representative or be notarized. The consent form can be obtained from the Fund Office. If you are not married at the time of your death or are not survived by a legal spouse, your estate will automatically be your Beneficiary.

FORMS OF BENEFITS

If you are married

Monthly Benefit
If you are married at the time of any distribution (except for a distribution for under $5,000.00), you will automatically receive monthly benefits in a 50% Husband and Wife Annuity unless both you and your spouse have chosen in writing to receive the benefit in the form of a single lump sum payment. Benefits payable as a 50% Husband and Wife Annuity will be paid under the terms of an insurance policy obtained from an insurance company selected by the Trustees. The amount of the monthly benefit will be determined by the insurance company based on your Account balance at the time of the annuity starting date.

The benefit paid in this form is the actuarial equivalent of your Account balance when you begin receiving benefit payments. If your spouse should die before you, you will continue to receive the same monthly benefit for the rest of your life. If you should die before your spouse, you spouse will begin receiving a monthly benefit after your death equal to 50% of the amount you were receiving before your death.

Lump Sum
To receive a single lump sum payment, your spouse must sign a written waiver of his or her right to receive the 50% Husband and Wife Annuity. The waiver must be notarized. You can obtain both the application form and the waiver form from the Fund Office. The notarized waiver form must be signed no earlier than 90 days before you elect to begin receiving benefits.

Rollover
The IRS has adopted rules which affect certain distributions (called "eligible rollover distributions"). Distributions that qualify are subject to a 20% withholding for federal income tax purposes unless a "direct rollover" is made. An example of a direct rollover is a payment from the Plan made directly to an Individual Retirement Account (IRA) or other qualified employee retirement plan.

The Plan must withhold 20% of an eligible rollover distribution if you elect to have it paid to you personally. If you receive a direct payment of such monies personally, you have 60 days following receipt of payment to roll over the entire amount (including the 20% withheld) into an IRA or other qualified employee retirement plan that accepts rollovers. The amount paid to you, including the 20% withholding, must be rolled over to avoid taxation. Other sources, such as your personal savings, may have to be used to replace the 20% withholding.

If you are single

If you are not married at the time your benefit is payable, you will automatically receive your benefit in a single lump sum payment. You may elect to roll over this lump sum as discussed above.

FROZEN ACCOUNTS AND FORFEITURE

If your Account balance is less than $5,000.00, and has not been credited with Employer Contributions for two consecutive Plan Years, the Trustees may automatically distribute your benefit. If the Trustees cannot locate you after a reasonable search, your Account balance will be frozen and it will not share in future earnings or losses of the Plan. Your frozen Account balance will be paid to you if you are later located.

If your Account balance is less than $500 after two consecutive Plan Years without Employer Contributions, and the Trustees are unable to locate you, your Account balance will be forfeited.

CLAIMS REVIEW AND APPEAL PROCEDURES

These Claims Review and Appeal Procedures ("Procedures") apply to the BAC Local Union 15 Supplemental Plan ("Plan"). They are effective for Claims filed on or after January 1, 2002.

If you are a Participant or Beneficiary (called a "Claimant" for purposes of these Procedures) and you wish to receive a benefit from the Plan, you must file a Claim with the Plan. You may obtain the application and any other necessary forms by telephoning or writing the Fund Office at 6405 Metcalf, Cloverleaf Building 3, Suite 200, Overland Park, Kansas 66202, 913-236-5490 or fax at 913-236-5499. You can also visit the Fund Office to obtain application forms. If you visit the Fund Office, a representative can help you complete the forms and answer any questions regarding the application process. You should submit all required forms, documents and information in advance of the date you wish payment of your pension benefit to begin.

If you are a Claimant, you may choose another person to file or appeal a Claim for you. This person will be called your Authorized Representative. The Trustees have the right to require that you give the Plan a signed statement, advising the Trustees that you have authorized that person to act on your behalf regarding your appeal. Any representation by another person will be at your own expense.

If you choose an Authorized Representative to act on your behalf, the Trustees will send all information and notifications regarding your Claim or appeal to that person. If you do not want your Authorized Representative to receive this information, you must submit a written statement to the Trustees stating you wish to receive all information and notifications.

An Authorized Representative will be able to act in any manner regarding your Claim or appeal as you would.

You may decide at any time that you no longer want your Authorized Representative to act on your behalf. In this case, you must submit a written statement to the Trustees canceling that person's status as Authorized Representative.

A Claim for a benefit is considered to have been received on the date the signed application form is received at the Fund Office. An inquiry over the phone is not considered a Claim.

Notice Of Denial Of Benefits

The following rules shall apply in the event a Claim for benefits is not approved:

A. Timing of Notice of Denial of Claims Other Than Disability Claims.
If a Claim, except for a Claim for disability benefits, is wholly or partially denied, the Plan Administrator shall notify you, in accordance with subsection D. of this Section, of the Plan's denial of benefits within a reasonable period of time, but not later than 90 days after receipt of the Claim by the Plan, unless the Plan Administrator determines that special circumstances require an extension of time for processing the Claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 90 day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

B. Timing of Notice of Denial of Disability Claims.
In the case of a denial of a Claim concerning disability benefits, the Plan Administrator shall notify you, in accordance with subsection D. of this Section, of the Plan's denial of benefits within a reasonable period of time, but not later than 45 days after receipt of the Claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 45 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30 day extension period, the Plan Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies you, prior to the expiration of the first 30 day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

C. Calculation of Time
In the case of any extension under subsections A. or B., the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the Claim, and the additional information needed to resolve those issues, and that you shall be afforded 45 days within which to provide the specified information. The period of time within which a benefit determination is required to be made shall begin at the time a Claim is filed in accordance with the reasonable procedures of a Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

In the event that a period of time is extended as permitted pursuant to subsections A. and B. of this Section due to a Claimant's failure to submit information necessary to decide a Claim, the period for making the benefit determination on review shall be suspended from the date on which the notification of the extension is sent to the Claimant until the earlier of the date on which the Claimant responds to the request for additional information or the deadline for providing additional information. The Plan will then have the remainder of the time period to make the benefit determination on appeal. **If the Plan requests additional information and you do not provide it within the necessary period, your appeal will be denied.**

D. Content of Notice

The Plan Administrator shall provide the Claimant with written or electronic notification of any denial of benefits. Any electronic notification shall comply with the standards imposed by the Health Insurance Portability and Accountability Act (HIPAA) and any regulations promulgated thereunder. The notification shall set forth, in a manner calculated to be understood by the Claimant:

1. The specific reason or reasons for the denial of benefits;

2. Reference to the specific Plan provisions on which the determination is based;

3. A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary;

4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of benefits on review;

5. In the case of a denial of benefits concerning disability benefits:

    a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, a statement specifically referencing the rule, guideline, protocol, or other similar criterion that was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided to you, free of charge, upon request;

    b. If the denial of benefits is based on a medical necessity or experimental treatment or similar exclusion or limit, a specific reference to the provision and a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances will be provided to you, free of charge, upon request.

If you are still not satisfied with the action taken on your Claim, you have the right to appeal. The procedures for appeal are set forth below. These procedures have been established in accordance with the requirements of the Employee Retirement Income Security Act (ERISA). **IF YOU DO NOT APPEAL A DENIAL OF BENEFITS WITHIN 60 DAYS (180 DAYS FOR DISABILITY CLAIMS), THE DENIAL BECOMES FINAL.**

Appeal Of a Denial of Benefits

In the event that your or your Beneficiary's application for benefits is denied, you may appeal to the Trustees within 60 days (180 days for Disability Claims) of receipt of notice denying the benefits. Any request for appeal after 60 days (180 days for Disability Claims) will be denied. Your request for an appeal must be in writing. You should contact the Fund Office for more information on the appeal process. You should also read the information on the Claims Appeal and Review Process which follows.

The following rules shall apply to Appeals of a Denial of Benefits:

A. You shall have 60 days (180 days for Disability Claims) following receipt of a notification of a denial of benefits within which to appeal the determination.

B. You shall have the opportunity to submit written comments, documents, records, and other information relating to the Claim for benefits.

C. You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim for benefits.

D. The review on appeal shall take into account all comments, documents, records, and other information submitted by you relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

E. In deciding an appeal of any Adverse Benefit Determination for a Disability Claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:

    1. Consult with a health care professional who:

        a. has appropriate experience in the field of medicine involved in the medical judgment; and

        b. is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and

    2. Provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the Adverse Benefit Determination.

F. The Trustees shall be empowered to hold a hearing, at which you shall be entitled to present the basis of your appeal. You may be represented by an attorney at any stage in the appeal process, at your own expense.

G. The Trustees shall designate an Appeal Committee, which shall hold regularly scheduled meetings once each calendar quarter. The Appeal Committee shall make a benefit determination no later than the date of the meeting of the Appeal Committee that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Trustees following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall provide you with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify you, in accordance with subsection J. of this Section, of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

H. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to subsection G. of this Section due to your failure to submit information necessary to decide a Claim, the period for making the benefit determination on review shall be suspended from the date on which the notification of the extension is sent to the Claimant until the earlier of the date on which the Claimant responds to the request for additional information or the deadline for providing additional information. The Plan will then have the remainder of the initial time period to make the benefit determination on appeal. **If the Plan requests additional information and you do not provide it within the necessary period, your appeal will be denied.**

I. In the case of a denial of benefits on appeal, the Plan Administrator shall provide you access to, and copies of, documents, records, and other information described in subsection J. of this Section, as is appropriate.

J. The Plan Administrator shall provide a Claimant with written or electronic notification of the Plan's benefit determination on appeal, whether adverse or not. Notification shall be made in accordance with paragraphs D.1 through D.5 on page 13 of this booklet, as appropriate.

The Board of Trustees, the Appeal Committee or its designated representative shall have the authority and all discretion to interpret, construe and apply all terms of the Supplemental Plan, Summary Plan Description, the Plan Document, and Amended Agreement and Declaration of Trust and/or any rules and regulations established by the Trustees, including, but not limited to, provisions concerning eligibility for, entitlement to and the nature, amount and duration of benefits, in reaching a decision on the Claimant's request for review of the denial of the Claim. The decision of the Trustees shall be final.

If you have exhausted the Claims and Appeal process or if the Plan fails to follow the reasonable Claims and Appeal Procedures as described above, you may proceed with any legal action available to you pursuant to ERISA §502 or other applicable law.

You may, at your expense, have legal representation at any stage of these review procedures.

In reviewing your Claim, every effort will be made by the Trustees to handle interpretations of the Plan and Claims disputes in a consistent and equitable manner, treating similarly situated Claimants similarly. In addition, the Trustees will make every effort to assure that you receive a full and fair review if your Claim is denied.

IF YOU HAVE ANY QUESTIONS ABOUT THESE REVIEW PROCEDURES, PLEASE CONTACT THE FUND OFFICE.

Hearing Procedures

The following procedures are established for hearings by the Trustees:

A. You or your Authorized Representative shall be afforded an opportunity to appear before the Trustees and shall have the right and opportunity to examine witnesses, produce documents and other evidence material to the Claim.

B. The proceedings of the hearing shall be preserved.

C. In conducting the hearing, the Trustees shall not be bound by the usual common law or statutory rules of evidence.

D. You or your Authorized Representative shall have the right to review the records of the hearing and obtain a copy thereof, and review and obtain a copy of all documents and records introduced or referred to therein. Copies of documents shall be available at a reasonable cost. However, copies requested with respect to Disability Claims shall be made available free of charge.

E. Copies shall be made of all documents and records introduced at the hearing, and they shall be attached to the record of the hearing and made a part thereto.

F. All information upon which the Trustees based their decision shall be disclosed to the Claimant or Authorized Representative at the hearing.

G. In the event that additional evidence is introduced by the Trustees at the hearing which was not made available to you or your Authorized Representative prior to the hearing, you or your Authorized Representative shall be granted a continuance of so much time as you desire, not to exceed 30 days. (For purposes of this section, evidence discovered upon examination of your own witnesses shall not be considered "new evidence".)

H. You or your Authorized Representative shall be afforded the opportunity of presenting any evidence on your behalf. If you or your Authorized Representative offers new evidence, the hearing may be adjourned for a period not to exceed 30 days to allow the Trustees to investigate the additional evidence or determine the accuracy of your new evidence.

The written decision of the Trustees shall be final, binding and conclusive. All review procedures described above must be followed and exhausted before you may institute any legal action including an action or proceeding before any court, administrative agency or arbitrator, unless the Plan fails to follow the reasonable Claims and Appeal Procedures, as set forth herein.

The Trustees shall have the authority to interpret, construe and apply all terms of the Summary Plan Description, the Plan Document, the Amended Agreement and Declaration of Trust and/or any rules and regulations established by the Trustees including, but not limited to, provisions concerning eligibility for, entitlement to and/or nature, amount and duration of benefits, in reaching a decision on your request for review of the denial of the Claim.

OTHER INFORMATION ABOUT BENEFITS AND THE PLAN

Protection Of Your Retirement Benefits

Under normal circumstances, your benefits are safe from creditors. You cannot pledge or assign your benefit to obtain a loan or to satisfy your debts. However, under some circumstances, all or a portion of your benefit may be used to satisfy a legal obligation. One of these instances is to satisfy a federal income tax obligation. The Internal Revenue Service may obtain payment of your tax obligation from your Account balance. You cannot sell or transfer your benefits except in the case of a Qualified Domestic Relations Order (QDRO).

Qualified Domestic Relations Orders

A court order may award a portion of your benefit to another person to satisfy a support obligation or a settlement in a divorce proceeding. This order is normally called a Qualified Domestic Relations Order (QDRO) and must be obeyed by the Fund. A copy of the procedure adopted by the Trustees to qualify a Domestic Relations Order is available, without charge, from the Fund Office.

In The Event You Become Incompetent

The Trustees or their authorized agent will decide, based upon medical or other evidence, whether you are physically or mentally unable to handle your benefits. If you are, the Trustees or their authorized agents will give your benefits to the persons or institutions they determine are caring for you, unless you have a legally appointed guardian or other legal representative.

Social Security and Your Benefits

Your benefits from this Plan are in addition to any benefits you receive from Social Security or any other plan. Application for Social Security benefits should be made within the three month period prior to the month in which your 65th birthday occurs.

Because of the complexities of the Social Security laws, and because the amounts of benefits vary in individual cases due to differences in employment periods and changes in salary, please contact your local Social Security Office for any information concerning your Social Security benefits.

Plan Amendment Or Termination

Amendment

The Board of Trustees may alter or amend the Plan in any respect at any time. However, the Trustees will not change the Plan in any way that causes you to lose your vested benefit. Any amendment will be made by action of the Board of Trustees in accordance with the Trust Agreement.

Termination
The Trustees intend that the Plan will continue indefinitely, but the Trustees have the authority to terminate the Plan if conditions require. If the Plan is terminated, the rights of all affected Participants to benefits accrued to the date of such termination are nonforfeitable. The procedures for allocating the Plan assets in the event of termination of the Plan are as follows:

1. First, payment of all expenses incurred by the Plan;

2. Benefits payable to those retired Participants and beneficiaries;

3. To all other vested benefits under the Plan;

4. To any other benefits payable under the Plan.

If The Plan Is Unable To Locate You To Distribute Benefits
If the Fund cannot locate either you or your Beneficiary at the time benefits should be distributed, your Account balance (if less than $5,000) will be frozen and will NOT be credited with either income or loss after the Valuation Date following two (2) Plan Years without contributions to your Account and your Account balance will be forfeited and reallocated. If you later return and apply for your benefit, the amount forfeited will be restored and distributed in accordance with the Plan provision.

Administration Of Your Plan
There a few other things you should know about how the Plan is managed.

The Plan was established and is administered under federal laws. It is managed by a joint Board of Trustees consisting of an equal number of Union Trustees and Employer Trustees.

The Trustees have the responsibility for decisions regarding the eligibility rules, types of benefits, administrative policies and procedures, management of Plan assets and discretionary interpretation of Plan provisions.

The Trustees are also responsible for the safe investment of all the assets of the Fund.

The Trustees are required to have an annual audit performed by an independent certified public accountant and to file annual reports with the Internal Revenue Service.

YOUR RIGHTS UNDER FEDERAL LAW

As a Participant of the BAC Local Union 15 Supplemental Pension Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at Normal Retirement Age (age 62) and if so, what your benefits would be at Normal Retirement Age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ADMINISTRATIVE INFORMATION

Name Of Plan
BAC Local Union 15 Supplemental Plan

Type Of Plan, Administration and Source of Contributions
This Plan is a defined contribution pension plan. It is maintained and funded pursuant to a trust fund created by a collective bargaining agreement between the Union and the Association. A copy of the agreements may be obtained upon written request to the Fund Office. This Plan is funded through contributions by the Employers on behalf of their Employees paid to the Trust Fund. A copy of the collective bargaining agreement is available for examination at the Fund Office. You may also request the Fund Office to confirm whether a particular Employer is required to make contributions to the Trust Fund. The Plan is administered by a joint Board of Trustees, one-half (1/2) of whom are appointed by the Union and one-half (1/2) of whom are appointed by the Association.

Funding Medium for the Accumulation of Plan Assets
All contributions and investment earnings are accumulated in the Trust Fund, which is utilized to pay benefits to eligible Participants and Beneficiaries and to defray the reasonable costs of administration.

Employer Identification Number (EIN)
The Employer Identification Number (EIN) assigned to the Plan by the Internal Revenue Service is 43-6102453.

Plan Number
The Plan Number is 002.

Plan Administrator
Board of Trustees
BAC Local Union 15 Supplemental Plan
6405 Metcalf, Suite 200
Overland Park, KS 66202
Telephone number: (913) 236-5490

Plan Administrative Manager
The Trustees have hired a contract administrative manager to perform the day to day operations of the Plan, such as maintaining records, making benefit payments and handling general administrative matters. The contract administrative manager is:

OBA Midwest, Ltd.
6405 Metcalf, Suite 200
Overland Park, KS 66202
(913) 236-5490

Plan Consultant
United Actuarial Services, Inc.
11590 North Meridian Street, Suite 610
Carmel, 1N 46032-4529

Agent For Service Of Legal Process
Linda N. Winter, Esq.
Arnold, Newbold, Winter, Jackson & Jacoby, P.C.
1125 Grand Boulevard, Suite 1600
Kansas City, MO 64106-2503

Service of legal process may also be made on any Trustee.

Plan Year
April I of each year and ends on March 31 of the following year.

Fiscal Year
April 1 of each year and ends on March 31 of the following year.

BOARD OF TRUSTEES

MANAGEMENT TRUSTEES

Jeffrey Chaikin
The Builders' Association
632 West 39th Street
Kansas City, MO 64111

Jerry Daugherty
Reinhardt Construction Company
627 N. Rollins, P.O. Box 88
Centralia, MO 65240

Robert A. Svoboda
S&W Waterproofing
3302 Terrace
Kansas City, MO.64111

Robert A. Treuner
Robert A. Treuner Masonry Company
29190 McCormick Road
Sedalia, MO 65301

Robert Jacquinot (Alternate)
J.E. Dunn Construction Company
929 Holmes Street
Kansas City, MO 64106

UNION TRUSTEES

Steve Mullen
BAC Local Union 15
2020 Wyandotte
Kansas City, MO 64108

John Creller
BAC Local Union 15
414 S. Grant Street
Springfield, MO 65806

Kelly L. Wideman
BAC Local Union 15
209 Flora
Jefferson City, MO 65101

James Woolery
BAC Local Union 15
2020 Wyandotte
Kansas City, MO 64108

Tom Murillo (Alternate)
BAC Local Union 15
2020 Wyandotte
Kansas City, MO 64108