

**BAC LOCAL UNION 15 WELFARE FUND**

**RESTATED PLAN DOCUMENT**

**AND**

**SUMMARY PLAN DESCRIPTION**

**Restated April 2015**

## **Be a Smart Health Care Consumer**

### **USE GENERIC / BRAND FORMULARY DRUGS**

Generic and brand formulary drugs are less expensive than brand name medications and can save you and the Plan money.

### **FOLLOW THE DIRECTIONS ON THE LABEL**

Take your medications as your doctor has prescribed them, especially antibiotics. Don't take other people's medications. If you are taking prescription medications, check with your doctor before taking over-the-counter remedies. They may interact with medications your doctor has prescribed for you or be inappropriate for your illness.

### **REVIEW YOUR EXPLANATION OF BENEFITS FORMS**

Make sure that the services your Plan has paid for were actually provided. If you do not recognize the name of the Provider, or did not go to the doctor on the date of service shown on the form, call the contract claims administrator.

### **USE THE HOSPITAL EMERGENCY ROOM FOR REAL EMERGENCIES**

Your doctor can give you the best care for illnesses and injuries that are not life threatening. Use emergency care clinics - they may be less expensive than the hospital emergency room and take less time to be treated.

### **BE PREPARED WHEN YOU GO TO YOUR DOCTOR'S OFFICE**

Keep your scheduled appointments, especially if you are being treated for a chronic illness. Write down your symptoms and changes in your health since your last visit and keep a log of the prescription and over-the-counter medications you are taking and how often you take them. This way, you won't forget to ask important questions and give your doctor pertinent health information during your appointment.

## A Letter From Your Trustees

Dear Participants and Beneficiaries:

We are pleased to distribute this new restated, combination Plan Document and Summary Plan Description (benefit booklet) describing the Benefits provided under your Plan. If you do not see the information you are seeking in this booklet, please contact the Fund Office.

This booklet contains the general Plan provisions, Eligibility Rules for participation in the Plan, the Benefits provided to those who are eligible, and the procedures which must be followed when filing a claim for Benefits.

There have been a number of changes to the Plan since the last booklet was distributed. As a result, you should **READ THIS BOOKLET CAREFULLY** so that you are up to date on the current Plan rules and Benefits.

From time to time, other changes and improvements to the Plan may be made. When this occurs, we will make every attempt to advise you of them. In order to assist us in keeping you up to date, **IT IS YOUR RESPONSIBILITY TO KEEP THE FUND OFFICE INFORMED OF YOUR CURRENT HOME ADDRESS AT ALL TIMES.** This is the only way to be sure that you receive notice of any Plan changes.

This is your copy of the booklet describing your Plan. Please take the time to read it in its entirety and refer to it when you have any questions about the Plan. You should keep this booklet in a safe (but handy) place for future reference. If, at any time, you have questions about the Plan, please feel free to call or write the Fund Office at:

BAC Local Union 15 Welfare Fund  
6405 Metcalf, Suite 200  
Overland Park, KS 66202  
(913) 236-5490 or (800) 542-4482  
<http://www.bac15benefits.org/>

We look forward to serving you.

The Board of Trustees or designated Committee shall have the full discretion and authority to interpret, amend, construe and apply all terms of the combined Plan Document and Summary Plan Description (SPD), the Amended Trust Agreement and/or any rules and regulations established by the Board of Trustees including, but not limited to, provisions concerning eligibility for, entitlement to and/or nature of 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 Board is final.**

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## **About Your Plan**

Today a working person's life is far more complicated than ever before. In addition to the responsibilities of getting and holding a job, most workers are vitally concerned about planning for some degree of financial security in a fast moving world.

Some of a family's needs such as the purchase of a home, major appliances or a car can be financed over time. Other needs, such as education for the children or security in one's old age, can be provided only through a careful savings plan. In other words, advance planning is required in order to take care of these needs.

However, no amount of personal financial planning can, by itself, provide adequate protection for major financial problems caused by sickness or injury.

To help meet these needs, for you and your fellow workers, your Employer and the Union have established a Plan, which provides a specific, dependable plan of health and welfare benefits. Since its beginning in 1973, the Plan has been managed to provide the best possible benefits consistent with sound financial management.

The Plan, known as the BAC Local Union 15 Welfare Plan, was established and is maintained as a result of Collective Bargaining Agreements (sometimes referred to as "labor contracts") between The Builders' Association and the Union.

The Plan receives the majority of its income through Employer contributions as required under the terms of the Collective Bargaining Agreements. In some cases, Employees are permitted to make self-contributions in order to maintain eligibility for Benefits. The Plan also receives income from investments.

Decisions on Plan operations are made by a joint Board of Trustees which is comprised of an equal number of Employer representatives and Union representatives. Working together, the Trustees establish rules of eligibility, levels of benefits, supervise the investment of the Plan's money and see that the Fund is in compliance with all applicable federal and state laws.

This, then, is a brief description of how your Plan was established, its purpose and how it operates. The following pages describe how you and your family become eligible for Benefits from the Plan and what your responsibilities are under the Plan. Of course, if you have any questions about the Plan, please feel free to contact the Fund Office. The staff will gladly answer your questions.

## Filing an Enrollment Card

**IF YOU HAVE NOT FILED AN ENROLLMENT CARD, DO SO NOW!**

When you first became employed under the terms of the Collective Bargaining Agreement, you should have received an “**ENROLLMENT CARD**” from either the Union or the Fund Office.

This card requests certain basic information that is needed for your records in the Fund Office. This information is your full legal name and the full legal names of all of your Eligible Dependents, your address, your Social Security number and the Social Security number of all of your Eligible Dependents, if applicable, your date of birth and the dates of birth of all of your Eligible Dependents, and the name of your Beneficiary(ies) in the case of your death.

**All of this information is vital!** Without it, the Fund Office will have difficulty knowing what you and your family are entitled to under the Plan and in keeping you informed about Plan changes.

If you are not sure whether you have an enrollment card on file at the Fund Office, contact the office. The staff will tell you whether you have a card on file and verify that it contains current information. If you do not have current information on file, a card will be sent to you for completion and return.

**NOTIFY THE FUND OFFICE PROMPTLY WITH ANY CHANGE IN ADDRESS, BENEFICIARY, DEPENDENTS, MARITAL STATUS, MEDICARE OR RETIREMENT ELIGIBILITY.**

When there are Plan changes, you will be sent notice of the change. This means that, in order to notify you, the Fund Office must have your current address. **IF YOU MOVE**, make sure to notify the Fund Office of your new address. **IF YOUR MARITAL STATUS CHANGES**, don't forget to notify the Fund Office. The Fund Office must receive a complete, signed and dated copy of your marriage certificate, divorce decree or Order of Legal Separation. These documents will be made a permanent part of your file and will be kept in the Fund Office. Failure to send copies of these documents will delay the processing of claims for Benefits.

If you wish to **CHANGE THE NAME OF YOUR BENEFICIARY, DON'T FORGET TO SEND THE CHANGE TO THE FUND OFFICE, IN WRITING.** If you fail to notify the Fund Office of your wishes in writing, the Fund Office will be unable to pay any Death Benefits to anyone other than the person(s) in your latest **written** notification to the Fund Office prior to the time of your death.

If you need to **ADD OR DELETE DEPENDENTS**, you must notify the Fund Office, **in writing**. You should be prepared to provide documentation in the form of a birth certificate, decree of adoption, marriage license, etc. Since the Plan provides Benefits to Eligible Dependents, the Fund Office must know who your dependents are at all times.

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

### **A Word about Confidential Information**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides stringent requirements for the Fund, its Trustees and its service vendors concerning the use and disclosure of Participants' personally identifiable 'Protected Health Information' (PHI). Broadly speaking, PHI includes demographic information about you and/or your dependents, such as your name, address, telephone number and Social Security Number, in conjunction with information concerning you and/or your dependents, such as: (1) eligibility for Benefits, (2) medical treatment provided or (3) payment for such medical treatment. Specifically, the Plan will use and disclose PHI only for purposes related to health care treatment, payment for health care and health care operations.

The Plan's use and disclosures of PHI is set out in detail in the Privacy Notice previously mailed to you. If you would like another copy of this notice, please contact the Fund Office.

The Plan and the Trustees are committed to observing these privacy rules and in ensuring the confidentiality of your PHI. Your cooperation and understanding in working with the Plan to achieve compliance with these federal requirements is appreciated.

## **Section One – Schedule of Benefits**

The Plan offers benefits to the following groups of Participants:

- A. Active Eligible Employees and Eligible Dependents
- B. Retired Participants and Eligible Dependents

**EXCEPT WHERE OTHERWISE INDICATED, THE SCHEDULE OF BENEFITS COVERS ALL OF THESE GROUPS OF PARTICIPANTS. HOWEVER, BENEFITS FOR DISABLED AND RETIRED PARTICIPANTS WHO ARE ELIGIBLE FOR MEDICARE ARE PAID SUPPLEMENTAL TO MEDICARE BENEFITS.**

**ANY MEDICARE-ELIGIBLE PARTICIPANT OR ELIGIBLE DEPENDENT COVERED BY THIS PLAN WHO ENROLLS FOR MEDICARE PART D COVERAGE WILL LOSE THEIR PRESCRIPTION DRUG COVERAGE UNDER THIS PLAN. YOU WILL ONLY HAVE THE OPPORTUNITY TO HAVE YOUR PRESCRIPTION DRUG COVERAGE REINSTATED UNDER THIS PLAN ONE TIME EACH YEAR – EFFECTIVE THE FOLLOWING JANUARY 1. PLEASE SEE THE PRESCRIPTION DRUG SECTION FOR DETAILS.**

The Fund has negotiated special contracts with a network of area Physicians and Hospitals known as a Preferred Provider Organization (PPO). These participating providers will render services for fees that, in most cases, are below prevailing prices. Providers that are *in* this network are referred to as In-Network. Providers that are *not in* this network are referred to as Out-of-Network. If the Covered Person uses an In-Network provider, the Fund will pay 90% of all allowed charges and the Covered Person will pay the remaining 10%. If the Covered Person uses an Out-of-Network provider, the Fund will pay 70% of all allowed charges and the Covered Person will pay the remaining 30%.

**IN-NETWORK SERVICES**

**FUND PAYS 90%  
YOU PAY 10%**

**OUT-OF NETWORK SERVICES**

**FUND PAYS 70%  
YOU PAY 30%**

There is no Major Medical Benefit Lifetime limit. There are no annual maximums. In addition, the calendar year deductible is \$300 per person / \$600 per family when an In-Network provider is used. When an Out-of-Network provider is used, the calendar year deductible is \$500 per person / \$1,000 per family.

<b>ANNUAL MAXIMUM</b>	<b>NO ANNUAL MAXIMUMS</b>
<b>ANNUAL DEDUCTIBLE</b>	
<b>IN-NETWORK</b>	<b>\$300 (PERSON) / \$ 600 (FAMILY)</b>
<b>OUT-OF NETWORK</b>	<b>\$500 (PERSON) / \$1,000 (FAMILY)</b>

The maximum Out-of-Pocket Limit per family is \$7,500 per calendar year. This Out-of-Pocket Limit applies only to allowed charges. Once the Out-of-Pocket Limit has been reached within a calendar year, allowed charges in that year will be paid at 100% of allowed charges up to the Benefit maximum. The Out-of-Pocket Limit does not apply to all benefits. Please see the table beginning on page 31 for a detailed listing of which benefits do not apply to your annual Out-of-Pocket Limit.

<b>ANNUAL OUT-OF-POCKET (PER FAMILY)</b>	<b>\$7,500</b>
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Some Benefits are only available to certain individuals. Please refer to Section Fifteen for clarification between Participant, Covered Person, Covered Employee and Eligible Dependent.

**YOU ARE NOT REQUIRED TO USE AN IN-NETWORK PPO PROVIDER. COMPLETE FREEDOM OF CHOICE IS YOURS. HOWEVER, CHOOSING AN IN-NETWORK PPO PROVIDER FOR YOUR HEALTH CARE NEEDS WILL SAVE YOU AND THE FUND MONEY.**

"Grandfathered" Covered Persons in the Springfield area are covered by the PHP Networks. All other Covered Persons are covered by the BlueCross BlueShield Kansas City Network. For the most up-to-date provider information for PHP Networks (Freedom Select, Freedom Network and Health Partners of Kansas HPK), you can visit PHP's website at [www.phpkc.com](http://www.phpkc.com) or call their Customer Service Department at (913) 685-6300 or toll-free at (800) 544-3014. For the most up-to-date provider information for BlueCross BlueShield Kansas City (BCBSKC), you can visit BKBSKC's website at [www.bluekc.com](http://www.bluekc.com) or contact the Provider Finder at (800) 810-BLUE (2583). You may also call the Fund Office at (913) 236-5490 or visit the Fund website at [www.bac15benefits.org](http://www.bac15benefits.org).

To speak to a clinical nurse regarding any health-related concern, any participant can call BCBSKC at (877) 852-5422 (24 hours a day)

For up-to-date Prescription Drug information, you may visit Sav-Rx's website at [www.savrx.com](http://www.savrx.com) or you may call the Fund Office at (913) 236-5490 or visit the Fund website at [www.bac15benefits.org](http://www.bac15benefits.org).

For up-to-date Connection Dental Network provider information, you can visit PHP's website at [www.connectiondental.com](http://www.connectiondental.com) or call their Customer Service Department at (910) 685-6300 or toll-free at (800) 544-3014.

## Schedule of Benefits

**All Co-Payment percentages apply to the allowable amount of Usual, Customary and Reasonable Charges for In-PPO-Network charges.**

**All Co-Payment percentages apply to the Usual, Customary and Reasonable Charges for Out-of-Network charges.**

**The calendar year deductible and out-of-pocket limits apply to all listed Benefits unless otherwise stated.**

<u>BENEFIT</u>	<u>AMOUNT</u>
----------------	---------------

### Major Medical Benefit

*The Co-Payment percentages apply only after the deductible has been met.*

Co-Payment ( <i>Fund pays</i> )	
In-PPO-Network .....	90%
Out-of-Network.....	70%
Co-Payment ( <i>Employee pays</i> )	
In-PPO-Network .....	10%
Out-of-Network.....	30%
Calendar Year Deductible	
In-PPO-Network .....	\$300 per person \$600 per family
Out-of-Network.....	\$500 per person \$1,000 per family
Emergency Room Co-Payment.....	\$100
<i>Allowed charges over \$100 subject to deductible and coinsurance.</i>	
<i>Co-Payment waived if person is admitted to the hospital.</i>	
Maximum Annual Benefit .....	NONE
Maximum Out-of-Pocket Limit (Calendar Year) .....	\$7,500 per family

### Executive Physical Examination Benefit (through December 31, 2014)

*Provided through Concentra only.*

*Executive Physical Examination Benefit coordinates with Routine Care Benefit.*

Co-Payment ( <i>Fund pays</i> )	
Benefit provided through Concentra only.....	100%
Co-Payment ( <i>Employee pays</i> )	
Benefit provided through Concentra only.....	0%
Deductible for Eligible Retirees and their Spouses only (per exam).....	\$50
Frequency of Exam	
Eligible Employee and Spouse under age 50.....	1 exam every 2 years per person
Eligible Employee and Spouse age 50 and over .....	1 exam per year per person

**Routine Care Benefit** (through December 31, 2014, then covered under Preventive/Routine Care Benefit)

*Routine Care Benefit coordinates with Executive Physical Examination Benefit through December 31, 2014.*

Co-Payment (*Fund pays*)

In-PPO-Network or Out-of-Network..... 100%

Co-Payment (*Employee pays*)

In-PPO-Network or Out-of-Network..... 0%

Deductible for Eligible Retirees and Spouses only (Calendar Year).....\$50

Maximum Covered Routine Physical Exams

Under age 50 ..... 1 exam every 2 years per person

Age 50 and over ..... 1 exam per year per person

Co-Payment (*Fund pays*)

In-PPO-Network ..... 100% of the first \$315, 90% thereafter

Out-of-Network..... 100% of the first \$315, 70% thereafter

Co-Payment (*Employee pays*)

In-PPO-Network ..... 0% of the first \$315, 10% thereafter

Out-of-Network..... 0% of the first \$315, 30% thereafter

**Preventive/Routine Care Benefit** (a broad range of preventive services that have been approved by the Trustees on or after January 1, 2015)

Co-Payment (*Fund pays*)

Co-Payment (*Fund pays*)

In-PPO-Network ..... 100%

Out-of-Network..... 70%

Co-Payment (*Employee pays*)

In-PPO-Network ..... 0%

Out-of-Network..... 30%

**Flu Shot Benefit** (through December 31, 2014, then covered under Preventive/Routine Care Benefit)

Co-Payment (*Fund pays*)

In-PPO-Network ..... 100% of the first \$30 per shot, 90% thereafter

Out-of-Network..... 100% of the first \$30 per shot, 70% thereafter

Co-Payment (*Employee pays*)

In-PPO-Network ..... 0% of the first \$30 per shot, 10% thereafter

Out-of-Network..... 0% of the first \$30 per shot, 30% thereafter

\*For a current list of covered Preventive Services contact the Fund Office.

**Colorectal Cancer Screening Wellness Benefit (Employee & Spouse Only, Age 50 and Over)** (through December 31, 2014, then covered under Preventive/Routine Care Benefit)

*Employee Co-Payment does not apply to Deductible.*

**Co-Payment (Fund pays)**

In-PPO-Network .....	100% of the first \$500, 90% thereafter
Out-of-Network.....	70%

**Co-Payment (Employee pays)**

In-PPO-Network .....	0% of the first \$500, 10% thereafter
Out-of-Network.....	30%

**Frequency of Covered Colorectal Cancer Screening Wellness Exams and Tests**

Colonoscopy .....	1 exam every 10 years per person
Flexible Sigmoidoscopy.....	1 exam every 5 years per person
Fecal Occult Blood Test (FOBT).....	1 test every year per person

**Prescription Drug Benefit**

*Employee Co-Payment does not apply to Deductible or Out-of-Pocket Limits.*

**Retail Co-Payment (Employee pays)**

Level 1 – Generic, up to 34 days .....	Lesser of \$10 or 100% of cost of drug
Level 1 – Generic, up to 90 days .....	Lesser of \$20 or 100% of cost of drug
Level 2 – Preferred Brand Name .....	Greater of \$25 or 25% of cost of drug
Level 3 – Non-Preferred Brand Name .....	Greater of \$40 or 25% of cost of drug
Maximum days of Brand medication allowed .....	34 days per person per Co-Payment

**Mail Order Co-Payment (Employee pays)**

Level 1 – Generic.....	Lesser of \$20 or 100% of cost of drug
Level 2 – Preferred Brand Name .....	Greater of \$50 or 20% of cost of drug
Level 3 – Non-Preferred Brand Name .....	Greater of \$80 or 20% of cost of drug
Maximum days of medication allowed.....	90 days per person per Co-Payment

**THE ANNUAL INDIVIDUAL AND FAMILY DEDUCTIBLES DO NOT APPLY TO THE PRESCRIPTION DRUG BENEFIT.**

**Mental Health Benefit**

*The Co-Payment percentages apply only after the deductible has been met.*

**Co-Payment (Fund pays)**

In-PPO-Network .....	90%
Out-of-Network.....	70%

**Co-Payment (Employee pays)**

In-PPO-Network .....	10%
Out-of-Network.....	30%

**Alcohol and Drug Treatment Benefit**

*The Co-Payment percentages apply only after the deductible has been met.*

Co-Payment ( <i>Fund pays</i> )	
In-PPO-Network .....	90%
Out-of-Network.....	70%
Co-Payment ( <i>Employee pays</i> )	
In-PPO-Network .....	10%
Out-of-Network.....	30%

**Acupuncture Treatment Benefit**

*The Co-Payment percentages apply only after the deductible has been met.*

*Employee Co-Payment does not apply to Out-of-Pocket Limits.*

Co-Payment ( <i>Fund pays</i> )	
In-PPO-Network .....	90%
Out-of-Network.....	70%
Co-Payment ( <i>Employee pays</i> )	
In-PPO-Network .....	10%
Out-of-Network.....	30%
Maximum visits (per Calendar Year) .....	30 per person

**Chiropractic Expense Benefit**

*The Co-Payment percentages apply only after the deductible has been met.*

*Employee Co-Payment does not apply to Out-of-Pocket Limits.*

Co-Payment ( <i>Fund pays</i> )	
In-PPO-Network .....	90%
Out-of-Network.....	70%
Co-Payment ( <i>Employee pays</i> )	
In-PPO-Network .....	10%
Out-of-Network.....	30%
Maximum number of manipulations (per Calendar Year).....	30 per person

**Hearing Aid Benefit (effective September 1, 2014)**

Co-Payment ( <i>Fund pays</i> )	
In-PPO-Network .....	90%
Out-of-Network.....	70%
Co-Payment ( <i>Employee pays</i> )	
In-PPO-Network .....	10%
Out-of-Network.....	30%
Maximum Benefit (Every Four Calendar Years).....	\$1,500 per person

**Hospice Benefit**

*The Co-Payment percentages apply only after the deductible has been met.*

Co-Payment ( <i>Fund pays</i> )	
In-PPO-Network .....	90%
Out-of-Network.....	70%
Co-Payment ( <i>Employee pays</i> )	
In-PPO-Network .....	10%
Out-of-Network.....	30%
Maximum Counseling Visits per Bereavement .....	5 (in 6 months period) per person

**Maternity Benefit (Employee or Dependent Spouse Only)**

*The Co-Payment percentages apply only after the deductible has been met.*

Co-Payment ( <i>Fund pays</i> )	
In-PPO-Network .....	90%
Out-of-Network.....	70%
Co-Payment ( <i>Employee pays</i> )	
In-PPO-Network .....	10%
Out-of-Network.....	30%

**Rehabilitative Therapy Benefit**

*The Co-Payment percentages apply only after the deductible has been met.*

*Treating Physician must submit a Plan of Treatment to the Fund Office for approval prior to beginning therapy.*

Co-Payment ( <i>Fund pays</i> )	
In-PPO-Network .....	90%
Out-of-Network.....	70%
Co-Payment ( <i>Employee pays</i> )	
In-PPO-Network .....	10%
Out-of-Network.....	30%

**Dental Benefit**

Co-Payment ( <i>Fund pays</i> )	
Covered Dental Charges .....	80%
Co-Payment ( <i>Employee pays</i> )	
Covered Dental Charges .....	20%
Maximum Benefit (Calendar Year) – <i>prior to September 1, 2014</i> .....	\$1,500 per person
Maximum Benefit (Calendar Year) – <i>on or after September 1, 2014</i> .....	\$1,750 per person
Additional Maximum Benefit (Calendar Year) .....	\$3,500 per person
<i>Additional Benefit for pre-approved treatment related to life threatening illness.</i>	
Maximum Prophylactic Dental Exam (per Calendar Year).....	2 per person
Orthodontia (Lifetime)	
Covered Person through age 18 .....	\$1,000 per person

Dental Benefit limits do not apply to pediatric dental services (Eligible Dependents under age 19) as required by law.

**Vision Benefit**

*Employee Co-Payment does not apply to Deductible or Out-of-Pocket Limits.*

**All Covered Persons Except for Eligible Dependents Under Age 19**

Co-Payment ( <i>Fund pays</i> )	
Covered Vision .....	80%
Co-Payment ( <i>Employee pays</i> )	
Covered Vision .....	20%
Maximum Benefit (Calendar Year) – <i>prior to September 1, 2014</i> .....	\$200 per person
Maximum Benefit (Calendar Year) – <i>on or after September 1, 2014</i> .....	\$250 per person

**Eligible Dependents Under Age 19**

Co-Payment ( <i>Fund pays</i> )	
Covered Vision .....	100%
Co-Payment ( <i>Employee pays</i> )	
Covered Vision .....	0%
Co-Payment ( <i>Fund pays</i> )	
Covered Vision Hardware (lenses and frames).....	100%
Co-Payment ( <i>Employee pays</i> )	
Covered Vision Hardware (lenses and frames).....	0%
Maximum Hardware Benefit (Calendar Year) – <i>prior to 9/1/2014</i> .....	\$200 per person*
Maximum Hardware Benefit (Calendar Year) – <i>on or after 9/1/2014</i> .....	\$250 per person*

\*Or the covered charge on one (1) pair of eyeglasses with basic frames, or non-disposable contact lenses, which meet the minimum specifications to allow for necessary vision correction, whichever is greater per Calendar Year.

**Death Benefit**.....\$10,000  
*Active Eligible Employee Only*

**Accidental Death and Dismemberment Benefit**

*Active Eligible Employee Only*

Loss of:

Life .....	\$10,000
Both Hands or Both Feet.....	\$10,000
Entire Sight of Both Eyes .....	\$10,000
One Hand <b>and</b> One Foot.....	\$10,000
One Hand <b>or</b> One Foot <b>and</b> Entire Sight of One Eye.....	\$10,000
One Hand <b>or</b> One Foot .....	\$ 5,000
Entire Sight of One Eye .....	\$ 5,000

**Surgery – Second Surgical Opinion**

Co-Payment ( <i>Fund pays</i> )	
In-PPO-Network or Out-of-Network .....	100%
Co-Payment ( <i>Employee pays</i> )	
In-PPO-Network or Out-of Network .....	0%

**Well Child Benefit (Eligible Dependents of Active Employees only)** (through December 31, 2014, then covered under Preventive/Routine Care Benefit)

*The Co-Payment percentages apply only after the deductible has been met.*

Co-Payment ( <i>Fund pays</i> )	
In-PPO-Network or Out-of-Network .....	100%
Co-Payment ( <i>Employee pays</i> )	
In-PPO-Network or Out-of-Network .....	0%

Maximum Well Child Benefit (birth through age 17)

Eligible Dependent children age birth up to age 1 year.....	All visits per year
Eligible Dependent children age 1 year up to age 3 years.....	5 visits per year
Eligible Dependent children age 3 years through age 17 years.....	1 visit per year
Eligible Dependent children age 18 years and over.....	0 visits per year

## Section Two – Eligibility

The following topics are discussed under this Section on Eligibility:

- 
- |   |   |
|---|---|
| A. Initial Eligibility                                | H. Termination of Eligible Employees                                  |
| B. Continuation of Eligibility (Hours Test)           | I. Reestablishment of Eligibility                                     |
| C. Eligibility Under the Family and Medical Leave Act | J. Termination of Eligibility for Dependents                          |
| D. Eligibility for Active Disabled Employees          | K. Short Hour Self Pay  |
| E. Eligibility for Retirees and Eligible Dependents   | L. Continuation of Coverage (COBRA)                                   |
| F. Effective Date of Dependent Coverage               | M. Service in the Armed Forces  |
| G. Exception to Dependent Coverage                    | N. Uniformed Services Employment and Reemployment Rights Act (USERRA) |
- 

All Employees working for a contributing Employer or Employers within the various jurisdictions of the Plan for whom sufficient contributions have been paid shall be eligible to receive Benefits after meeting the following eligibility requirements.

A. Initial Eligibility

The following rule governs obtaining initial eligibility:

An Employee who has worked at least 400 hours in a four consecutive month period will become initially eligible for Benefits on the first day of the third month following the month in which the 400 hours have been accumulated. The Employee remains eligible for Benefits until the end of the Benefit Period in which he/she initially becomes eligible.

B. Continuation of Eligibility (Hours Test)

The following rule governs continuation of eligibility (Hours test):

Once an Employee has satisfied the Initial Eligibility requirements, he/she will remain eligible for Benefits for the duration of that Benefit Period. Thereafter, he/she will remain eligible for Benefits as long as he/she is credited with at least 350 hours in a four month period or 700 hours in an eight month period as set forth in the table below.

Eligibility Periods for continued eligibility shall be divided into Work Periods and Benefit Periods as follows:

**TABLE OF HOURS WORKED FOR BENEFIT PERIODS**

Benefit Period	Work Period	Hours Required
April 1 thru July 31	Oct 1 – Jan 31 or June 1 – Jan 31	At least 350 hours or At least 700 hours
August 1 thru November 30	Feb 1 – May 31 or Oct 1 – May 31	At least 350 hours or At least 700 hours
December 1 thru March 31	June 1 – Sept 30 or Feb 1 – Sept 30	At least 350 hours or At least 700 hours

C. Eligibility Under the Family and Medical Leave Act

Pursuant to the requirements of the Family and Medical Leave Act of 1993 (FMLA), eligibility for Benefits shall be extended to Covered Employees and their Eligible Dependents if the Covered Employee has been granted unpaid leave by his/her Employer pursuant to the FMLA and if the Employer makes the required contributions to the Fund. Covered Employees and their Eligible Dependents shall be entitled to leave available under the FMLA for qualified family, medical and/or military-related reasons.

If a Covered Employee has been granted FMLA leave, the Employer shall notify the Fund Office at least 14 days before the onset of the leave, except in an emergency, and then no later than seven days after the leave begins, to prevent a loss of eligibility. The Fund Office shall obtain a certificate of the Covered Employee’s FMLA eligibility from the Employer. The Employer shall advise the Fund Office of the beginning date and ending date of the leave. The Employer shall notify the Fund Office of the date a Covered Employee advises the Employer that he/she does not intend to return to work.

The Employer will be required to pay the cost of continuing coverage in an amount equal to contributions for 25 hours of work per week for each week the Covered Employee is on FMLA leave. The Employer shall remit payment monthly, in arrears, upon billing by the Fund Office.

Eligibility will not be extended during the FMLA leave if the Employer does not make the required contributions to the Fund. The usual procedures of the Fund will be followed if the Employer does not make timely contributions and a loss of eligibility will result.

If you have any questions regarding the FMLA, please contact the Fund Office.

D. Eligibility for Active Disabled Employees

If an active eligible Employee becomes Totally Disabled from a Sickness or accidental bodily injury which prevents the Employee from engaging in any occupation or employment for wage or profit, the Employee will receive credit for 30 hours worked per week for a maximum of 13 weeks; provided that:

1. A claim form is submitted to the Fund Office that certifies the dates of disability and is signed and dated by a Physician,
2. A new form is submitted for each new period which certifies the dates of disability and is signed and dated by a Physician, and
3. Disabled Employees on Workers Compensation must submit Proof of Compensation and be unable to engage in any occupation or employment for wage or profit.

E. Eligibility for Retirees and Eligible Dependents

The following rules govern eligibility for Retirees and their Eligible Dependents:

1. Retirees under age 55, eligible for Medicare and with at least 17 Years of Service

An eligible Employee who: (a) is under age 55; (b) is eligible for Medicare; (c) has at least 17 Years of Service under the BAC Local Union 15 Pension Plan, the International Pension Fund, or the OCI Pension Fund, and (d) has exhausted extended coverage under COBRA, is eligible to continue Benefits provided under this Plan by making the required self-payments.

2. Retirees between ages 55 and 62

An eligible Employee who: (a) is receiving benefit payment under the BAC Local Union 15 Pension Fund; (b) is between ages 55 and 62; (c) has been eligible under the BAC Local Union 15 Welfare Fund for at least 12 consecutive months prior to retirement; (d) loses eligibility as an active Eligible Employee under the BAC Local Union 15 Welfare Fund; and (e) has at least 17 Years of Service under the BAC Local Union 15 Pension Plan, the International Pension Fund, or the OCI Pension Fund, will become eligible for continuing Benefits provided under this Plan by making the required self-payments.

In the event of the merger of another health plan with this Plan, or the transfer of a group of participants from another health plan to this Plan, pension credits

earned by such participants under the other health plan's related pension plan will count towards the fulfillment of the 17 Years of Service requirement in the preceding paragraph. Evidence of these pension credits will be required. No other pension credits besides the aforementioned (such as those earned by an individual transferring to this Plan) may be used to fulfill the 17 Years of Service requirement.

3. Retirees between ages 62 and 65

An eligible Employee who is: (a) receiving benefit payments under the BAC Local Union 15 Pension Fund; (b) who is between ages 62 and 65; and (c) who has been eligible under the BAC Local Union 15 Welfare Fund for 12 consecutive months prior to retirement will become eligible for continuing Benefits provided under this Plan by making the required self-payments.

4. Retirees age 65 and Over

An eligible Employee who: (a) retires under the BAC Local Union 15 Pension Fund, (b) who is age 65 or older and (c) has been eligible under the Plan during the complete 12 months prior to retirement will remain eligible for continuing Benefits provided under this Plan by making the required self-payments. The Benefits available to Retirees over age 65 will be paid as a supplement to Medicare benefits. i.e. Medicare coverage is primary and the Plan secondary.

F. Effective Date of Dependent Coverage

Benefits for Eligible Dependents will become effective on the **latest** of the following dates:

1. The date the eligible Employee's Benefits become effective, or
2. The date the eligible Employee or Retiree acquires an Eligible Dependent, or
3. The date specified in a Qualified Medical Child Support Order.

If an eligible Employee or Retiree acquires a dependent while eligible for benefits, the Employee or Retiree should notify the Fund Office as soon as possible, but no later than 60 days. Provided such dependent meets the definition of Eligible Dependent as provided herein, the dependent shall automatically become covered.

If an Eligible Employee or Retiree fails to notify the Fund Office within the 60 day time limit, coverage for the dependent will begin on the first day of the month following receipt of the notice.

G. Exception to Dependent Coverage

Active Employees and Retirees with spouses who have coverage under an employer-sponsored health plan or government health program may waive coverage for the spouse under this Plan. For this waiver to become effective, the spouse must provide the Fund Office with written evidence of employer-sponsored health plan

coverage or government health program coverage. The waiver will last until the spouse's employer-sponsored coverage or government health program coverage terminates. The spouse must notify the Fund Office when the spouse's employer-sponsored coverage terminates. The spouse will then become covered under the Plan again, **provided the Fund Office is notified of the termination of the employer-sponsored coverage within 31 days of the termination. A spouse for whom the Employee or Retiree waives spousal coverage under the Plan due to the spouse having coverage under a government health program is not eligible to again be covered under the Plan until coverage under the government health program is terminated.**

**An Employee or Retiree may only waive coverage for his/her spouse one time.**

H. Termination of Eligibility for Eligible Employees

1. Eligibility will terminate on:

- a. The first day the Employee works for an Employer whose contractual obligation to contribute to the Fund has terminated (termination does not occur if the Employer is negotiating for a new contract and making contributions to the Fund); or
- b. The first day the Employee works in employment in the jurisdiction of the Fund for an employer that does not have a contractual obligation to contribute to the Fund, or effective April 1, 2015, in the jurisdiction in which the Fund has a reciprocal agreement in place.

If within 30 days of receiving a termination notice under Paragraphs 1.a. or 1.b. of this Subsection H., an Employee provides acceptable proof, as determined by the Trustees, that he is no longer working for an Employer who does not have a contractual obligation to contribute to the Fund, coverage will be reinstated.

2. A review of the hours contributed on behalf of an Employee shall be made prior to April 1, August 1 and December 1 of each year. Eligibility will terminate on any of these dates if:
  - a. The Employee fails to satisfy the requirements set forth under the Continuation of Eligibility (Hours Test) as explained in Section Two B.,
  - b. The Employee fails to elect Continuation of Coverage (COBRA),
  - c. The Employee fails to make a required self-payment, or
  - d. The Employee dies.

I. Reestablishment of Eligibility

If, after becoming eligible, a Participant loses his/her eligibility and has been ineligible for less than 24 months and the Participant has been available for work under the jurisdiction of the Fund, the Participant may re-establish his/her eligibility after at least 350 hours of Employer contributions have been received on the Participant's behalf in a four-month Work Period. A Participant will become eligible for coverage on the first day of the third month following the month in which the 350 hours have been accumulated and will remain eligible for benefits until the end of the Benefit Period in which he/she reestablishes eligibility.

If, after becoming eligible, a Participant loses his/her eligibility and has been ineligible for more than 24 months, the Participant will be considered a new Employee and must satisfy the Initial Eligibility Rules (400 hours of Employer contributions in a consecutive four-month period).

J. Termination of Eligibility for Dependents

The eligibility for Benefits for Eligible Dependents will terminate upon the occurrence of the first of the following:

1. The individual fails to satisfy the definition of Eligible Dependent as defined in Section Fifteen J.,
2. The individual fails to elect Continuation of Coverage (COBRA),
3. The individual fails to make a required self-payment.
4. In the case of an eligible spouse of a deceased Retiree, the spouse remarries, or
5. In the case of an eligible spouse of a deceased Retiree, the spouse becomes eligible for Medicare.

Upon the death of an eligible Employee, the eligibility of that Employee's Eligible Dependents shall be extended to the end of the eligibility period based upon the deceased eligible Employee's accrued hours. Thereafter, the eligibility for Benefits will be governed by the Continuation of Coverage (COBRA) provisions and the following surviving spouse coverage rules.

*Surviving Spouse of an Active Participant*

Upon the death of an active Participant with at least 17 years of service at the time of death, the active Participant's covered spouse will be allowed to continue coverage under the Plan by self-paying the prevailing COBRA contribution rate until remarriage. Once the covered spouse is eligible for Medicare, rates will be adjusted to allow the covered spouse to continue coverage by self-paying the prevailing Medicare-Primary Retiree self-payment rate until he or she remarries.

Surviving Spouse (Not Eligible for Medicare) of a Retiree

Upon the death of an eligible Retiree, the eligible spouse who is not eligible for Medicare shall be allowed to continue coverage for the later of 36 months or when he or she remarries by self-paying the lesser of:

- the prevailing Retiree contribution self-payment rate; or
- the prevailing COBRA rate.

Once the eligible spouse is eligible for Medicare, the Plan’s self-payment rates will be adjusted to allow the covered spouse to continue coverage under the Plan by self-paying the prevailing Medicare-primary Retiree self-payment rate until he or she remarries.

Surviving Spouse (Eligible for Medicare) of a Retiree

Upon the death of an eligible Retiree, the eligible spouse who is eligible for Medicare shall be allowed to continue coverage by self-paying the prevailing Medicare-primary Retiree self-payment rate until he or she remarries.

K. Short Hour Self Pay

Participants may make *Short Hour Self Payments* in the amount that is the difference between the required number of hours (in either the four month Work Period or eight month Work Period) and the actual number of hours that you worked in the same Work Period multiplied by the current contribution rate. **The Short Hour Self Pay option may be utilized for any Benefit Period with 0 hours in the most recent Work Period provided that at least 350 hours were reported in the preceding Work Period.** The Short Hour Self Pay option is limited to two Benefit Periods in a consecutive 12 month period. Please note, COBRA will still be available if coverage is lost in a subsequent period because of failure to meet the continuation of eligibility rules in Section Two B, after use of the Short Hour Self Pay option.

Participants who return to work after having been disabled and who have received up to the maximum of 120 hours of credit due to disability, may make short-hour self-payment if coverage is subsequently lost. Participants shall pay the difference between the credited disability hours and the actual hours worked.

**Example #1**

<b>Benefit Period</b>	<b>Required Hours in Work Period</b>	<b>Actual Hours Worked in Work Period</b>	<b>Difference in Required Hours and Actual Hours</b>
12/1/10 – 3/31/11	350 Hours from 6/1/10 – 9/30/10	100 Hours	-250 Hours
	Or 700 Hours from 2/1/10 – 9/30/10	500 Hours	-200 Hours

In **Example #1**, the *Short Hour Self Payment* would be based on the requirement of 700 hours in the eight month Work Period because that creates the lower *Short Hour Self Payment*. The amount of the *Short Hour Self Payment* would be 200 hours multiplied by the current contribution rate.

**Example #2**

Benefit Period	Required Hours in Work Period	Actual Hours Worked in Work Period	Difference in Required Hours and Actual Hours
12/1/10 – 3/31/11	350 Hours from 6/1/10 – 9/30/10  Or	250 Hours	-100 Hours
	700 Hours from 2/1/10 – 9/30/10	400 Hours	-300 Hours

In **Example #2**, the *Short Hour Self Payment* would be based on the requirement of 350 hours in the four month Work Period because that creates the lower *Short Hour Self Payment*. The amount of the *Short Hour Self Payment* would be 100 hours multiplied by the current contribution rate.

**Example #3**

Benefit Period	Required Hours in Work Period	Actual Hours Worked in Work Period	Difference in Required Hours and Actual Hours
12/1/13 – 3/31/14	350 Hours from 6/1/13 – 9/30/13	0 Hours	-350 Hours
	And  350 Hours from 2/1/13 – 5/31/13	600 Hours	+250 Hours
	Total Hours Needed to Meet Eligibility		100 Hours

In **Example #3**, the Participant may utilize the *Short Hour Self Payment* even though no hours were reported in the most current Work Period because over 350 hours were reported for the preceding Work Period. In this example, even though no hours were reported in the current Work Period, the amount of the *Short Hour Self Payment* would be 100 hours multiplied by the current contribution rate due to the number of hours reported in the previous Work Period.

L. Continuation of Coverage (COBRA)

Federal law requires that sponsors of group health plans such as the BAC Local Union 15 Welfare Fund offer Covered Employees and their families a temporary extension of their health care coverage under the Plan, (called “COBRA Continuation Coverage”) in exchange for self-contribution payments to the Plan. The right to an extension of health care coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you and to other members of your family (the Covered Employee’s spouse and dependents under the terms of the Plan) who are covered by the Plan when you would otherwise lose your group health coverage, referred to as “qualified beneficiaries.”

What is COBRA Continuation Coverage?

If a Covered Employee or Eligible Dependent loses health care coverage due to a reduction in hours, termination of employment, or certain other events (called qualifying events), the Covered Employee and the Eligible Dependent(s) have the right to elect to continue health care coverage by making premium payments to the Plan.

1. COBRA Continuation Coverage will be offered to a Covered Employee if coverage under the plan ends for the following reasons:
  - a. The Covered Employee’s hours of employment are reduced, or
  - b. The Covered Employee is terminated from employment for any reason other than the Covered Employee’s gross misconduct.
2. COBRA Continuation Coverage will be offered to the spouse of a Covered Employee if coverage under the Plan ends for the following reasons:
  - a. The Covered Employee’s hours of employment are reduced;
  - b. The Covered Employee is terminated from employment for any reason other than the Covered Employee’s gross misconduct;
  - c. The Covered Employee dies;
  - d. The Covered Employee becomes enrolled in Medicare; or
  - e. The Covered Employee and spouse become legally separated or divorce.
3. COBRA Continuation Coverage will be offered to an Eligible Dependent child if coverage under the Plan ends for the following reasons:
  - a. The Covered Employee’s hours of employment are reduced;
  - b. The Covered Employee is terminated from employment for any reason other than the Covered Employee’s gross misconduct;

- c. The Covered Employee dies;
- d. The Covered Employee becomes enrolled in Medicare;
- e. The Covered Employee and spouse become legally separated or divorced; or
- f. The dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

How long will COBRA Continuation Coverage last?

1. 18 months

If the Covered Employee and/or the Eligible Dependent lose coverage due to a reduction in the Covered Employee's hours or due to the end of the Covered Employee's employment, COBRA Continuation Coverage is available for a maximum of up to 18 months.

2. 29 months

If the Covered Employee and/or Eligible Dependent is disabled (as determined under Titles II or XVI of the Social Security Act) at the time his or her coverage would otherwise terminate because of a reduction of hours or termination of employment, or who becomes disabled during the initial 60 days of COBRA Continuation Coverage, and the Fund Office has been notified in writing of the disability prior to the expiration of the initial 18 month period of COBRA Continuation Coverage, the Covered Employee and/or Eligible Dependent can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months of COBRA Continuation Coverage. However, if a Covered Employee (not an Eligible Dependent) has made self-payments for 29 months, and the Social Security Disability application is pending on appeal, such Covered Employee may continue to make COBRA payments until final resolution of the appeal. The Fund shall request such documentation as is necessary to substantiate the status of the appeal.

3. 36 months

COBRA Continuation Coverage lasts up to a maximum of 36 months if the Covered Employee's spouse or Eligible Dependent child's health care coverage ends due to:

- a. The Covered Employee and spouse become legally separated or divorce;
- b. The Covered Employee becomes enrolled in Medicare;
- c. The Covered Employee dies; or
- d. A dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

4. Second Qualifying Event

COBRA Continuation Coverage may also be extended for up to 36 months if your family experiences another event, called a “qualifying event” while receiving COBRA Continuation Coverage. If, while receiving COBRA Continuation Coverage, one of the following events occur, an Eligible Dependent is eligible for an extension of COBRA Continuation Coverage up to a maximum period of 36 months:

- a. The Covered Employee and spouse become legally separated or divorce;
- b. The Covered Employee becomes enrolled in Medicare;
- c. The Covered Employee dies; or
- d. A dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

Keeping the Fund Office Informed of Changes

In order to protect your family’s rights, the Fund Office should be informed of any changes concerning your family. The Covered Employee and any Eligible Dependent has the responsibility to notify the Fund Office within 60 days of a divorce, legal separation or a dependent child’s loss of dependent status. **Failure to keep the Fund Office informed of these changes may affect your rights to COBRA Continuation Coverage.** While it is the responsibility of the Employer to notify the Fund Office of a reduction in the Covered Employee’s hours, termination of employment, enrollment in Medicare, or Covered Employee’s death, the Covered Employee or Eligible Dependent should also notify the Fund Office of the event in order to prevent a delay in the start of the COBRA Continuation Coverage.

In the event the Covered Employee or Eligible Dependent becomes disabled during the initial 60 day COBRA continuation period, it is the responsibility of the Covered Employee or Eligible Dependent to notify the Fund Office of the determination of disability. **Failure to notify the Fund Office of a disability determination may affect your right to extend the COBRA Continuation Coverage period due to disability.**

Electing to Continue Coverage

When the Fund Office is notified that coverage will end due to a qualifying event, the Covered Employee and Eligible Dependent(s) will be notified of their right to choose the Continuation Coverage. The Fund Office will send you and your family a COBRA Election Notice containing information on how to continue your health care coverage and the applicable COBRA premiums. The Covered Employee and Eligible Dependent(s) will then have the **later** of **60** days from the date on which coverage under the Plan would otherwise terminate, or **60** days from receipt of the Election Notice to elect the Continuation Coverage. If the Covered Employee or Eligible Dependent(s) does not elect the Continuation Coverage within the 60 day election period, coverage under the Plan will end as of the date the coverage would have otherwise ended without regard to the 60 day election period.

Each Eligible Dependent has an independent right to elect COBRA Continuation Coverage. Parents may make the election on behalf of their Eligible Dependents.

If a Covered Employee or Eligible Dependent has a newborn child, or adopts a child, or has a child placed with him or her for adoption during the COBRA continuation period, this child will be eligible for COBRA Continuation Coverage. The Fund Office must be notified as soon as possible after the birth or placement in order for the child to be added to the COBRA Continuation Coverage.

The COBRA Continuation Coverage offered by the Fund is the same coverage provided under the Plan at the time of termination except that Accidental Death and Dismemberment Benefits are not available.

#### Payments

The amount of the COBRA Continuation Coverage premiums shall be determined by the Trustees. For the first Benefit Period payments for COBRA Continuation Coverage, the Covered Employee will be given credit for the actual hours contributed on the Covered Employee's behalf during the four month Work Period covered under the Eligibility Periods as set forth in Section Two. After the first Benefit Period, all subsequent payments shall be determined by the Trustees but no deduction for hours shall be credited after the first Benefit Period.

After the Covered Employee or Eligible Dependent elects to receive COBRA Continuation Coverage, the first premium must be made within 45 days of the election. Failure to make the required premium payments within the initial 45 day period will result in the loss of the COBRA Continuation Coverage.

#### Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will end if any of the following occur:

1. A required self-payment premium for COBRA Continuation Coverage is not made on a timely basis;
2. The Covered Employee or Eligible Dependent becomes covered under another group health plan;
3. The Covered Employee or Eligible Dependent becomes entitled to Medicare;
4. The Fund no longer provides group health care coverage; or
5. The maximum number of months of COBRA Continuation Coverage has been reached, as explained above.

M. Service in the Armed Forces

Each Covered Employee, whose eligibility terminates because of entrance into active duty with the Armed Forces of the United States and who returns to active work with a contributing Employer within the time periods described in N.4 below shall become eligible under this Plan on the date of commencement of such active work, subject to USERRA.

If a Covered Employee's eligibility terminates because of entry into active duty with the Armed Forces of the United States, any Benefits hereunder with respect to any Eligible Dependent of such Covered Employee on the date of such termination shall be continued in force while such dependent continues to be an Eligible Dependent but not beyond the end of the Benefit Period, subject to USERRA.

N. Uniformed Services Employment and Reemployment Rights Act (USERRA)

The following rules govern your rights under USERRA:

1. Effective Date

The Uniformed Services Employment and Reemployment Rights Act of 1994 was signed into law on October 13, 1994 to protect the eligibility of an Employee and to offer continuation coverage to the Employee and the Employee's Eligible Dependents after the Employee enters into Military Service.

2. Return to Work Coverage Guaranteed

USERRA requires an Employer, or a multiemployer health care plan, to protect any health care Benefits an Employee has already earned up to the time an Employee enters Military Service if the Employee re-applies for work within prescribed time periods after an honorable discharge.

The Employee's eligibility status must be "frozen" when the Employee enters Military Service and must be fully restored when the Employee re-applies for work with the same Employer or, in the case of a multiemployer plan, with any Employer who is signatory to the Collective Bargaining Agreement.

When an Employee returns from Military Service, no exclusion or waiting period may be imposed in connection with the restoration of health care coverage that would not otherwise apply if the Employee had not entered Military Service.

3. Continuation of Coverage While in the Military

USERRA requires a group health care plan to offer identical health care coverage **up to 24 months** to persons who have coverage in connection with their employment but who are absent from such employment due to Military Service.

**THE EMPLOYEE MUST NOTIFY THE FUND OFFICE IMMEDIATELY WHEN THE EMPLOYEE KNOWS HE/SHE IS ENTERING MILITARY SERVICE.**

If notification of the Fund Office is delayed for several months, the extension of coverage for a maximum of 24 months still begins with the initial date of entry into Military Service and a retroactive payment to that date may be charged. The Employee has an obligation to notify the Fund Office, as soon as the Employee knows he/she is entering Military Service **if the Employee wishes to take advantage of continued coverage. Failure to notify the Fund Office may be taken as an indication that the Employee does not wish to purchase coverage for the Employee or the Employee's Eligible Dependents.**

4. Re-employment Requirements when Returning from Military Service  
The application period for re-employment is based on a time schedule keyed to the length of time spent in Military Service.

*Military Service Less than 31 Days*

For Military Service of less than 31 days, a Service member must apply for re-employment with a signatory Employer at the beginning of the next regular scheduled work period on the first day after release from Service with an honorable discharge, taking into account safe transportation plus an eight hour rest period.

*Military Service More than 31 Days but Less than 181 Days*

For Military Service of 31 days or more but less than 181 days, an application for re-employment must be filed within 14 calendar days (not work days) after the Service member's release from the Service with an honorable discharge.

*Military Service Over 181 Days*

For Military Service over 181 days, an application for re-employment must be submitted within 90 calendar days (not work days) after an honorable discharge.

5. Definitions

**“Health Coverage”** means Hospital, surgical, medical, dental or vision coverage provided under the Plan. Health Coverage is subject to change as a result of Plan modification.

**“USERRA”** means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to USERRA and any interpretive regulations or rulings).

**“Covered Person”** means a Covered Employee or Eligible Dependent as defined in Section Fifteen of this Plan.

**“Service in the Uniformed Services” or “Military Service”** means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for

training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

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

6. Continuation of Group Health Coverage

If Health Coverage ends because of Service in the Uniformed Services, a Covered Person may elect to continue such Health Coverage, if required by USERRA, until the **earlier** of:

- a. The end of the period during which the Covered Employee is eligible to apply for reemployment in accordance with USERRA, or
- b. 24 consecutive months after coverage ended.

To continue coverage, a Covered Person must pay the required premium, unless Service in the Uniformed Service is for fewer than 31 days. The Fund Office shall inform the Covered Person of the procedures to pay premiums. The USERRA premium shall be equal to the COBRA premium.

A Covered Person’s continued Health Coverage under USERRA will end at midnight on the **earliest** of:

- a. The day the Plan is terminated,
- b. The day a premium is due and unpaid,
- c. The day the Covered Person again becomes covered under the Plan, or
- d. The day the Health Coverage has been continued for the period of time provided above (or any longer period provided in the Plan).

7. Conflict Resolution

In the event of a conflict between this provision and USERRA, the provisions of USERRA shall apply.

### **Section Three – Life Events at a Glance**

There are several significant events that may occur while you are covered under the Plan. Please contact the Fund office, in writing, if any of the following occurs:

- **YOUR ADDRESS OR TELEPHONE NUMBER CHANGES.**
- **YOU MARRY, DIVORCE OR OBTAIN A LEGAL SEPARATION FROM YOUR SPOUSE.** You must also submit the appropriate legal documents (for example: marriage certificate, divorce decree, custody agreement).
- **YOU CHANGE YOUR BENEFICIARY.**
- **YOUR DEPENDENT CHILD NO LONGER QUALIFIES AS AN ELIGIBLE DEPENDENT UNDER THE TERMS OF THE PLAN.**
- **YOU BECOME A PARENT.** You must also submit the child's state-certified birth certificate, decree of adoption or placement for adoption, a Qualified Medical Child Support Order or other legal documentation.
- **YOU GO INTO OR RETURN FROM MILITARY SERVICE.**
- **YOU BEGIN RECEIVING WORKERS' COMPENSATION BENEFITS.**
- **BEFORE YOU TURN AGE 65 AND BECOME ELIGIBLE FOR MEDICARE.**
- **YOU RETIRE.**

You may contact the Fund Office at:

BAC Local Union 15 Welfare Fund  
6405 Metcalf, Suite 200  
Overland Park, KS 66202  
(913) 236-5490 or (800) 542-4482

<http://www.bac15benefits.org/>

## Section Four – Medical Benefits

The Benefits listed in the table below are described in this Section. This table is only intended to give you a brief summary of Benefits available. Please refer to the description of Benefits that begins on page 33 immediately after the table to fully understand the benefit and any specific maximums or limitations.

There are separate sections that describe the Plan’s Prescription Drug Benefit, Vision Benefit, Dental Benefit, Vision Benefit, Death Benefit or Accidental Death and Dismemberment Benefit.

**NOT ALL BENEFITS ARE AVAILABLE TO ALL COVERED PERSONS. PLEASE CONSULT THE APPLICABLE SCHEDULE OF BENEFITS TO DETERMINE IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR ANY PARTICULAR BENEFIT.**

Description of Covered Benefit	Fund Co-Payment Amount		Does your Co-Payment amount help meet your Out-of-Pocket Limit?	Do you need to meet your calendar year Deductible before receiving Benefit?
	In-PPO-Network	Out-of-Network		
Major Medical Benefit	90%	70%	Yes	Yes
Executive Physical Examination Benefit <i>(Active Eligible Employee and Spouse Only)</i> <i>Coordinates with Routine Care Benefit Through December 31, 2014</i>	100% provided through Concentra Services only		No	No
Routine Care Benefit <i>See Benefit Description for Specific Limitations</i> <i>Coordinates with Executive Physical Examination Benefit</i>	100% up to \$315, 90% thereafter	100% up to \$315, 70% thereafter	Yes	Yes, for charges over \$315 per calendar year
Flu Shot Benefit <i>See Benefit Description for Specific Limitations</i>	100% up to \$30 per shot, 90% thereafter	70%	Yes	No

**ANY PARTICIPANT CAN CALL TOLL-FREE (877) 852-5422 AND SPEAK TO A CLINICAL NURSE FOR ANY HEALTHCARE CONCERN 24 HOURS A DAY / 7 DAYS A WEEK / 365 DAY A YEAR.**

Description of Covered Benefit	Fund Co-Payment Amount		Does your Co-Payment amount help meet your Out-of-Pocket Limit?	Do you need to meet your calendar year Deductible before receiving Benefit?
	In-PPO-Network	Out-of-Network		
Colorectal Cancer Screening Wellness Benefit <i>See Benefit Description for Specific Limitations</i>	90%	70%	Yes	Yes
Preventive/Routine Care Benefit (preventive services as approved by the Trustees on or after January 1, 2015) <i>See Benefit Description for Specific Limitations</i>	100%	70%	Yes	No
Mental Health Benefit <i>See Benefit Description for Specific Limitations</i>	90%	70%	Yes	Yes
Alcohol and Drug Treatment Benefit <i>See Benefit Description for Specific Limitations</i>	90%	70%	Yes	Yes
Acupuncture Treatment Benefit <i>See Benefit Description for Specific Limitations</i>	90%	70%	No	Yes
Chiropractic Expense Benefit <i>See Benefit Description for Specific Limitations</i>	90%	70%	No	Yes
Hearing Aid Benefit <i>See Benefit Description for Specific Limitations</i>	90%	70%	Yes	Yes
Hospice Benefit <i>See Benefit Description for Specific Limitations</i>	90%	70%	Yes	Yes
Maternity Benefit (Employee or Dependent Spouse Only)	90%	70%	Yes	Yes
Rehabilitative Therapy Benefit <i>See Benefit Description for Specific Limitations</i>	90%	70%	Yes	Yes
Surgery – Second Surgical Opinion	90%	70%	Yes	Yes

<b>Description of Covered Benefit</b>	<b>Fund Co-Payment Amount</b> Co-Payment amounts are based on a percent of UCR Charge		<b>Does your Co-Payment amount help meet your Out-of-Pocket</b>	<b>Do you need to meet your calendar year Deductible before</b>
Well Child Benefit <i>(Eligible Dependents of Active Employees only)</i> <i>See Benefit Description for Specific Limitations</i>	100%	100%	No	Yes

A. Acupuncture Treatment Benefit

Benefits for acupuncture treatment will be paid according to the Schedule of Benefits if the treatment is performed by a professional who is licensed and certified in acupuncture.

Benefit Limitations

The Benefit will be limited to a maximum of 30 visits per Covered Person per Calendar Year.

B. Alcohol and Drug Treatment Benefit

Benefits for treatment of alcoholism, chemical dependency or substance use are payable according to the Schedule of Benefits for the Usual, Customary and Reasonable Charges for medical expenses for treatment, if such care and services are ordered and prescribed by a Legally Qualified Substance Use Professional. For the purposes of this benefit only, a “Legally Qualified Substance Use Professional” includes: psychiatrists, psychologists, certified mental health or substance use counselors, or a social worker who has a master’s degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of alcoholism and substance abuse under the laws of the state or jurisdiction where the services are rendered and who acts within the scope of his or her license.

Allowed charges are:

1. Charges by a Hospital for room and board charges (semi-private room only),
2. Charges for treatments by a Legally Qualified Substance Use Professional,
3. Charges for individual therapy by a Legally Qualified Substance Use Professional,
4. Administration of drugs or medicine if prescribed by a Legally Qualified Substance Use Professional legally authorized and licensed to prescribe drugs or medicine, and
5. Out-Patient charges for both Hospital and office visits (limited to one Hospital or office visit per day).

Benefits for treatment of alcohol or drug use are **NOT** payable for:

1. Service or treatment rendered by anyone other than a Legally Qualified Substance Use Professional, or
2. Any charges related to a period of confinement or frequency of treatment which is considered custodial or not reasonable for the diagnosed condition(s).

**BENEFITS FOR TREATMENT OF ALCOHOL OR DRUG USE ARE PAYABLE UNDER THE MAJOR MEDICAL BENEFIT PROVISION ONLY AND ARE SUBJECT TO THE SAME TERMS, CONDITIONS AND LIMITATIONS GOVERNING THE INDIVIDUAL BENEFITS FOR ANY OTHER SICKNESS OR INJURY UNDER THE PLAN.**

C. Chiropractic Expense Benefit

Benefits for Chiropractic Expense Benefit will be paid according to the Schedule of Benefits if the treatment is performed by a licensed chiropractor.

Chiropractic Expense Benefits are **NOT** payable for:

1. Any treatment by a chiropractor other than manual manipulation to correct subluxation, including (but not limited to) allergy therapy, diet or hair analysis,
2. Any diagnostic x-ray or laboratory procedure other than an x-ray to diagnose subluxation, including (but not limited to) urinalysis or blood chemistry,
3. Nutritional or food supplements and/or vitamins which may be legally obtained without a Physician's prescription,
4. Pillows, supports or similar devices,
5. More than one treatment per day, or
6. Booklets.

Benefit Limitations

Visits are limited to 30 manipulations per Covered Person per Calendar Year. Benefits for or related to treatment by a chiropractor are subject to the same terms, conditions and limitations governing individual Benefits for any other Sickness or injury.

D. Executive Physical Examination Benefit (Effective January 1, 2015, this benefit will be covered under the Preventive/Routine Care Benefit)

Benefits for Executive Physical Examination Benefit will be paid according to the Schedule of Benefits. The Benefit is provided through a contract with Concentra, which has agreed to provide physical examination services at a contracted fee.

The physical examinations provided are comprehensive and are provided without cost (no Employee Co-Payment) to eligible Employees and spouses. All eligible Retirees and their spouses are provided this benefit at a Co-Payment of \$50 per examination. Any benefit paid under this Benefit also applies to the Maximum Allowed Calendar Year Benefit allowed under the Routine Care Benefit.

Benefit Limitations

Only physical examination services provided by *Concentra* are provided under this Section. Physical examinations and services rendered by other providers will be covered as specified under the provisions of the Plan.

Frequency of Exam

Eligible Employee and Spouse under age 50.....1 exam every 2 years  
Eligible Employee and Spouse age 50 and over ..... 1 exam per year

E. Flu Shot Benefit (Effective January 1, 2015, this benefit will be covered under the Preventive/Routine Care Benefit)

Benefits for Flu Shot Benefit will be paid according to the Schedule of Benefits.

Flu shots are provided under this Benefit for In- and Out-of-Network providers without cost (no Employee Co-Payment) to all Covered Persons with a maximum of \$30 per injection. Any fee above this amount will be payable under the Major Medical Benefit, subject to the appropriate Deductible Amount and coinsurance.

F. Hearing Aid Benefit – Effective September 1, 2014

Benefits, on behalf of a Covered Person, for Covered Services for hearing aids, services or supplies will be paid according to the Schedule of Benefits, subject to a \$1,500 maximum each four calendar years.

G. Hospice Benefit

Benefits, on behalf of a Covered Person, for Covered Services for Hospice Care will be paid according to the Schedule of Benefits.

Hospice Benefits will only be paid if the patient’s attending Physician certifies, in writing, that the patient is terminally ill and that the patient is expected to die within six months or less.

Allowed charges are:

1. Room and board for confinement in a Hospice,
2. Services and supplies furnished by the Hospice while the patient is confined therein,
3. Part-time nursing care by or under the supervision of a Registered Nurse (RN),
4. Home Health Aide services,
5. Nutrition services,
6. Special meals,
7. Counseling services by a licensed social worker or a licensed pastoral counselor, and
8. Bereavement counseling by a licensed social worker or a licensed pastoral counselor for a patient's immediate family but limited to five visits during a six month period following the patient's death.

Hospice Benefits are **NOT** payable for:

1. Custodial Care or Services (i.e. room and board or other institutional or nursing services which are provided to or for a Covered Person due to the Covered Person's age, mental or physical condition) mainly to aid the person in daily living, or
2. Medical services to maintain the person's present state of health and which cannot reasonably be expected to improve the Covered Person's medical condition.

Benefit Limitations

Maximum Visits per Bereavement ..... 5 (in 6 months period) per person

H. Major Medical Benefit

Medical expenses included under the Major Medical Benefit will be payable based on the UCR Charge for Medically Necessary care and services that are ordered and prescribed by a Physician according to the Schedule of Benefits.

**CHRONIC CONDITION MANAGEMENT AND LIFESTYLE  
COACHING AVAILABLE FOR ALL COVERED PERSONS  
DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS:**

Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Depression, Diabetes, Heart Failure, Hypertension, Metabolic Syndrome and Cancer.

### Deductible Amount

The Deductible Amount is \$300 per person or \$600 per family for Expenses Incurred In-Network per calendar year; or \$500 per person or \$1,000 per family for Expenses Incurred Out-of-Network per calendar year. The Deductible Amount must be paid by the Employee before any Benefits under the base Plan of Benefits will be paid and will be applied only once per calendar year. The Deductible Amount does apply towards the annual Maximum Out-of-Pocket Limit.

#### **SMART HEALTHCARE CONSUMER TIP:**

##### *Use the Hospital Emergency Room for Real Emergencies*

Your doctor can give you the best care for illnesses and injuries that are not life threatening. Use emergency care clinics - they may be less expensive than the hospital emergency room and take less time to be treated.

### Allowed Charges

Medical expenses included under the Major Medical Benefit will be payable for the following Medically Necessary care and services which are ordered and prescribed by a Physician:

1. Hospital for room and board charges (semi-private room only).
2. Hospital emergency room charges. Emergency room co-payment will be waived if the Covered Person is admitted to the Hospital.
3. Private duty service of a registered graduate/licensed practical nurse, except when the nurse is related to the Covered Person.
4. X-ray and laboratory services for diagnostic purposes.
5. Anesthesia.
6. Administration and cost of blood or blood plasma.
7. Prescription drugs and medicine if prescribed by a Physician and dispensed by a licensed pharmacist for approved label purposes.
8. Surgery performed on an Out-Patient basis.
9. Surgical Procedures performed on a Covered Person for treatment of a non-occupational Sickness or accidental bodily injury. Charges made by an assistant surgeon will be considered under the Major Medical Benefit, provided such assistance is considered Medically Necessary.

### Definitions

“**Surgical Procedure**” means certain invasive procedures, as well as the reduction of fractures or dislocations, in addition to recognized cutting procedures. Surgical Procedures may be performed in a Hospital, Physician’s office or elsewhere.

“**Surgical Benefits**” include charges for necessary and related pre-operative and post-operative care (and any anesthetic customarily administered by the surgeon) as part of the Surgical Procedure.

10. Services of a licensed physiotherapist.

11. Durable Medical Equipment that meets each of the following criteria:

- a. Is certified, in writing, by the prescribing Physician as necessary in the treatment, habilitation or rehabilitation of a handicapped person,
- b. Is primarily and customarily used to serve a medical or rehabilitative purpose rather than primarily for transportation, comfort or convenience. The fact that the equipment or device is also useful for transportation, comfort or convenience will NOT serve as a disqualifying factor,
- c. Is not beyond the appropriate level of performance and quality required under the circumstances (i.e., non-luxury, non-deluxe),
- d. Would NOT be necessary in the absence of an Sickness or physical or mental disability, and
- e. Is appropriate for and intended for use in the home.

Examples of Durable Medical Equipment include equipment to assist mobility, such as a standard wheelchair, a standard Hospital type bed, oxygen concentrator units and the rental of equipment to administer oxygen, delivery pumps for tube feedings, braces that stabilize an injured body part, or mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions. Nondurable supplies (i.e. tubing, connectors and masks) are a Covered Expense when used with Covered Durable Medical Equipment. This Plan does not cover maintenance fees (i.e. batteries or warranties) related to Covered Durable Medical Equipment. Requests for Durable Medical Equipment must be accompanied by a Physician’s statement describing the Medical Necessity and length of use. The cost of these items will be limited to an amount determined by the Trustees. Rental of Durable Medical Equipment is covered up to the purchase price. **You should contact the Fund Office before purchasing or renting any of these items if you wish to know the cost that will be covered.**

12. Initial placement of contact lenses required due to cataract surgery.

13. Services for cosmetic and reconstructive surgery for injuries received: (a) as a result of a Surgical Procedure for which Benefits were paid under the Plan, or (b) for reconstruction of a breast on which a mastectomy has been performed, for surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, or for coverage for prostheses and physical complications of all states of mastectomy (including lymphedemas) in a manner determined in consultation with the attending Physician and the patient.
14. Human organ and tissue transplants (Contact the Fund Office for coverage details).
15. Prosthetic appliances (\$25,000 lifetime maximum).

I. Maternity Benefit

Maternity Benefits include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

**MATERNITY BENEFITS ARE PAYABLE UNDER THE MAJOR MEDICAL BENEFIT PROVISION ONLY AND ARE SUBJECT TO THE SAME TERMS, CONDITIONS AND LIMITATIONS GOVERNING THE INDIVIDUAL BENEFITS FOR ANY OTHER SICKNESS OR INJURY UNDER THE PLAN.**

Allowed charges are:

1. In-Patient stay of at least 48 hours for the mother and newborn child following a vaginal delivery.
2. In-Patient stay of at least 96 hours for the mother and newborn child following a cesarean section delivery.

**If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum time frames.**

Benefit Limitations

Maternity Benefits are **NOT** payable for pregnancy expenses or resulting complications of Eligible Dependent children.

J. Mental Health Benefit

Benefits for Expenses Incurred by a Covered Person for treatment prescribed by a Legally Qualified Substance Use Professional for mental or nervous Sickness will be paid according to the Schedule of Benefits for Medically Necessary care and services.

Allowed charges are:

1. Mental health evaluations and assessment,
2. Diagnosis,
3. Treatment planning,
4. Referral services,
5. Medication management,
6. Short-term individual, family and group therapeutic services (including intensive Out-Patient therapy),
7. Crisis intervention,
8. Psychological testing.

Mental Health Benefits are **NOT** payable for:

1. Service or treatment rendered by anyone other than a Legally Qualified Substance Use Professional,
2. Any charges related to a period of confinement or frequency of treatment which is considered custodial or not reasonable for the diagnosed condition(s), or
3. Behavior disorders.

**MENTAL HEALTH BENEFITS ARE PAYABLE UNDER THE MAJOR MEDICAL BENEFIT PROVISION ONLY AND ARE SUBJECT TO THE SAME TERMS, CONDITIONS AND LIMITATIONS GOVERNING THE INDIVIDUAL BENEFITS FOR ANY OTHER SICKNESS OR INJURY UNDER THE PLAN.**

K. Rehabilitative Therapy Benefit

Rehabilitative Therapy for an injury or Sickness shall be **considered** under the Plan according to the Schedule of Benefits, provided the Fund Office receives a complete plan of treatment from a referring Physician. The plan of treatment must include:

1. Diagnosis,
2. Type of treatment, and
3. Anticipated length of treatment.

Benefit Limitations

Payment for rehabilitative therapy is dependent upon approval by the Plan. Your Physician should submit the plan of treatment to the Fund Office **before** beginning any rehabilitative therapy.

<p><b>SMART HEALTHCARE CONSUMER TIP:</b></p> <p><i>Be Prepared when you go to your Doctor's Office</i></p> <p>Keep your scheduled appointments, especially if you are being treated for a chronic illness. Write down your symptoms and changes in your health since your last visit and keep a log of the prescription and over-the-counter medications you are taking and how often you take them. This way, you won't forget to ask important questions and give your doctor pertinent health information during your appointment.</p>
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L. Routine Care Benefit (effective January 1, 2015, this benefit is covered under the Preventive/Routine Services Benefit)

Benefits are payable for preventative services and supplies in a calendar year for the Usual, Customary and Reasonable Charges according to the Schedule of Benefits.

Routine Care is provided without cost (no Employee Co-Payment) to eligible Employees and spouses. All eligible Retirees and their spouses are provided this benefit at a Co-Payment of \$50 per examination.

Allowed charges are:

1. Lab and x-ray test, including Pap smears and mammograms for females,
2. Immunizations and inoculations, except for flu vaccines and injections, and
3. Other preventative diagnostic tests or procedures ordered by the examining Physician.

Benefit Limitations

Maximum Covered Routine Physical Exams

Covered Person Under Age 50 .....	1 every other year per person
Covered Person Age 50 and Over.....	1 per year per person

Benefits under the Routine Care Benefit are **NOT** payable for:

1. Any examination or service provided for non-routine purposes, or
2. Any treatment of a condition diagnosed as a result of a routine examination.

M. Surgery – Second Surgical Opinion (Third if Necessary)

When a Covered Person wishes to secure a second or third opinion regarding the Medical Necessity for an In-Patient Surgical Procedure of a non-emergency nature, Benefits will be paid according to the Schedule of Benefits for the second or third opinion provided:

1. The Covered Person is examined in person by a board certified specialist; and the specialist Physician submits a written report of findings and recommendation, and
2. The specialist Physician who renders the second or third opinion does not also perform or assist in performing the recommended Surgical Procedure, and
3. The specialist Physician has no relationship with the Physician(s) who rendered prior opinions or who performs or assists in the Surgical Procedure.

If surgery is performed after the second or third surgical opinion, the Fund will pay the surgical fees under the Major Medical Benefit.

N. Well Child Benefit (dependents of Active Employees only) (effective January 1, 2015, this benefit is covered under the Preventive/Routine Services Benefit)

In addition to other Benefits available to Eligible Dependents of Active Employees, an Eligible Dependent child shall be entitled to coverage of UCR Charges, according to the Schedule of Benefits, for Child Health Supervision Services from birth through age 17.

Definition

“**Child Health Supervision Services**” means Physician-delivered or Physician-supervised services including routine well-baby care, pediatric preventative services, developmental assessment and appropriate immunizations and laboratory tests which are delivered as stated in the Schedule of Benefits.

Allowed Charges

The Plan will provide full coverage for routine exams, as described below and most routine immunizations required for the placement of dependent children in a child care facility, school or similar programs.

Maximum Well Child Benefit (birth through age 17)

Eligible Dependent children birth 0 up to age 1 year ..... All visits per year  
Eligible Dependent children age 1 year up to age 3 years ..... 5 visits per year  
Eligible Dependent children age 3 years through age 17 years ..... 1 visit per year  
Eligible Dependent children age 18 years and over ..... 0 visits per year

O. Preventive/Routine Services Benefit (effective January 1, 2015)

This benefit covers certain Preventive Care benefits, including immunizations for routine use in children, adolescents, and adults, certain preventive health screenings and additional preventive services for women without the imposition of a deductible, co-payment or co-insurance if the preventive service is provided In Network. A list of the covered preventive care benefits is available through the Fund Office. Please contact the Fund Office or go to the website, <http://www.bac15benefits.org>, for a current list of covered preventive routine care benefits generally described in this Section O.

## **Section Five – Prescription Drug Benefit**

### **SMART HEALTHCARE CONSUMER TIP:**

#### *Follow the Directions on the Label*

Take your medications as your doctor has prescribed them, especially antibiotics. Don't take other people's medications. If you are taking prescriptions medications, check with your doctor before taking over-the-counter remedies. They may interact with medications your doctor has prescribed for you or be inappropriate for your illness.

With the Prescription Drug Benefit, eligible Employees and Retirees will receive two prescription drug cards. A card should be presented at a participating pharmacy with each prescription drug purchase. The cards will permit eligible Employees and Retirees and their Eligible Dependents to purchase prescription drugs at a discounted price. You will only pay the required Co-Payment when you make a purchase with the card. The Fund will pay the remaining cost.

#### A. Retail and Mail Order

This Benefit includes both retail pharmacies and a mail order service. A prescription for a generic drug filled at a retail pharmacy can provide medication for up to 34 days or up to 90 days per Co-Payment. A prescription for a brand name drug filled at a retail pharmacy can provide medication for no more than 34 days per Co-Payment. A prescription filled through the mail order service can provide your medication for 90 days per Co-Payment.

### **SMART HEALTHCARE CONSUMER TIP:**

#### *Use Generic / Brand Formulary Drugs*

Generic and brand formulary drugs are less expensive than brand name medications and can save you and the Plan money.

#### B. First Dollar Coverage

You do not have to satisfy the annual individual or family deductibles in order to have a prescription covered by the Fund. As long as you are eligible, the prescription drug that you are purchasing is covered by the Fund and you are making your purchase at a participating pharmacy, then your purchase will be covered.

C. Co-Payments

There will be three levels of Co-Payments. What you pay will depend upon the type of prescription drug you are purchasing and where it is being purchased (retail or mail order). The Co-Payment levels are:

<b>Formulary Level - Drug Type</b>	<b>Retail (up to 34-day supply)</b>	<b>Retail (up to 90-day supply)</b>	<b>Mail Order (up to 90-day supply)</b>
Level 1 – Generic	<u>Lesser</u> of \$10 or 100% of cost of drug	<u>Lesser</u> of \$20 or 100% of cost of drug	<u>Lesser</u> of \$20 or 100% of cost of drug
Level 2 – Preferred Brand Name	<u>Greater</u> of \$25 or 25% of cost of drug	N/A	<u>Greater</u> of \$50 or 20% of cost of drug
Level 3 – Non-Preferred Brand Name	<u>Greater</u> of \$40 or 25% of cost of drug	N/A	<u>Greater</u> of \$80 or 20% of cost of drug

D. Formulary Choice Guide

Some brand name drugs are very expensive and are no more effective than other medications that have a lower price. Generic drugs are often available that are chemically equal to a brand name drug. In other situations, two brand name drugs are available that treat the same condition. One may be significantly more expensive than the other. The prescription drug benefit will not tell you which medication you should purchase. That is left to you and your Physician. The benefit will hopefully encourage you to make the most cost effective purchase that is consistent with your medical needs.

You will receive a listing of the Preferred brand name drugs called a Formulary Choice Guide. You will find that most drugs require the Level 2 Co-Payment. If a brand name drug is not part of the formulary it will be considered a non-preferred brand name drug and will require a Level 3 Co-Payment.

If you have any questions regarding the Prescription Drug Benefit or have any problems with a purchase at a participating pharmacy, please contact Sav-Rx 24 hour Customer Service at (866) 912-7425.

E. Flu Shot Benefit *Effective January 1, 2015, flu shots will be covered under the Preventive/Routine Services Benefit.*

Benefits for Flu Shot Benefit will be paid according to the Schedule of Benefits.

Flu shots are provided under the Prescription Drug Benefit for In- and Out-of-Network providers without cost (no Employee Co-Payment) to all Covered Persons with a maximum of \$30 per injection. Any fee above this amount will be payable under the Major Medical Benefit, subject to the Appropriate Deductible Amount and coinsurance.

F. Medicare Part D Coverage

Any Medicare-eligible Participant or Eligible Dependent covered by this Plan who also enrolls in the Medicare Part D coverage will lose their prescription drug coverage under this Plan (but not their medical coverage). The Fund Office will be reporting to Medicare the names of the individuals that are covered by this Plan. The Fund Office, in turn, will be advised by Medicare if duplication of coverage occurs.

If your prescription drug coverage under this Plan is terminated because you enroll in the Medicare Part D coverage, you will only have an opportunity to have your prescription drug coverage reinstated under this Plan one time each year – effective the following January 1. Between October 15 and December 7 of each year, you will have an opportunity to enroll (or re-enroll) in the Medicare Part D coverage for the upcoming calendar year. For example: If you decided to enroll in the Medicare Part D coverage for 2012, you must keep your Part D prescription coverage for one year. Between October 15 and December 7 of 2014, you will have an opportunity to decide on your coverage for 2015. You can re-enroll in the Medicare Part D coverage or you can return to this Plan for coverage (provided that you have continued your medical coverage under this Plan and that you continue to pay all of your monthly self-pay premiums on a timely basis).

G. Contact Information

If you have questions or need help determining if a pharmacy is an in-network provider for Sav-Rx or if you have questions regarding drug formulary, you will need to contact Sav-Rx. Their contact information can be found on your drug card and is as follows:

**Call:** 24-hour Customer Service Phone No.: (866) 912-7425

**Write:**

**General Information:**

Sav-Rx  
224 N. Park Avenue  
Fremont, NE 68025

**Mail Order:**

Sav-Rx Pharmacy  
P.O. Box 8  
Fremont, NE 68026

**Website:** [www.savrx.com](http://www.savrx.com)

H. Prescription Claim Appeals

For information on the appeals process, refer to Section Ten - Claims and Appeal of Denied Claims Procedures on page 57. Further questions should be directed to the Fund Office at (913) 236-5490 or toll-free at (800) 542-4482.

I. Exclusions and Limitations

Certain classes of prescription drugs are excluded from coverage under the Plan. Please refer to Section Nine – Benefit Exclusions and Limitations beginning on page 53 for information on exclusions for prescription drugs.

From time to time the Trustees may implement special programs to control plan costs. An example of such a program is Step Therapy, as explained in subsection J, below.

J. Step Therapy

Participants seeking treatment with certain types of medications will be required to try less expensive but clinically appropriate medications, commonly referred to as ‘first line drugs,’ before a prescription will be covered under the Plan for what is considered a ‘second line drug.’ First line drugs include over-the-counter products, generic drugs and some brand name drugs. The types of medications listed below are considered ‘second line drugs’ and will be covered by the Plan only after first line drugs have been tried and demonstrated to be ineffective for treating the problem.

- Angiotensin II Receptor Antagonists (high blood pressure)
- BPH – Avodart
- Enhanced Bisphosphonates
- Preferred PPIs
- Fenofibrate
- Hypnotics
- Leukotriene Pathway Inhibitors
- Lyrica
- Nasal Steroid
- Non-Sedating Antihistamines
- Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and COX-2s
- Other Antidepressants (depression)
- Preferred Overactive Bladder
- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Tekturna
- Tetracyclines - Oral
- Topical Acne
- Topical Corticosteroids
- Topical Immunomodulators

The pharmacist will advise you if you are presenting a prescription for a medication that is covered by the Step Therapy program. Sav-Rx will work with your pharmacist and doctor to implement the program but still provide you with suitable medication on a timely basis.

## **Section Six – Vision Benefit**

If a Covered Person incurs expenses for vision care services at any vision provider, the Fund will pay Benefits according to the Schedule of Benefits.

### **Definitions**

The following definitions apply to the Vision Benefit:

**“Allowed Charges”** are:

1. Vision Screening (eye examination),
2. Visual Analysis,
3. Lenses when provided by an optometrist, Physician or optician,
4. Frames when provided by an optometrist, Physician or optician,
5. Contact Lenses when provided by an optometrist, Physician or optician, and
6. One pair of prescription or non-prescription safety glasses per calendar year.

**“Vision Screening”** (eye examination) means a survey of the principal visual functions in order to determine the condition of the vision. If the Vision Screening indicates a need for further work, a Visual Analysis may be necessary.

**“Visual Analysis”** means and includes, but is not limited to, the following:

1. Case history,
2. Examination for pathology or anomalies,
3. Refraction,
4. Visual field charting, and
5. Prescription for proper lenses.

### **Benefit Limitations**

Vision Benefits for dependents age 19 and over, on or after September 1, 2014, will be limited to a \$250 per person per Calendar Year maximum. Vision Benefits for dependents age 19 and over, prior to September 1, 2014, will be limited to a \$200 per person per Calendar Year maximum. Vision Benefit limits for Eligible Dependents under age 19 do not apply to reasonable expenses for pediatric services as required by law. Please contact the Fund Office for a list of covered pediatric services.

## **Section Seven – Dental Benefit**

When a Covered Person incurs a covered Dental Expense prior to September 1, 2014, the Plan will pay 80% of all reasonable dental charges subject to the \$1,500 calendar year Maximum Benefit per person as set forth in the Schedule of Benefits. When a Covered Person incurs a covered Dental Expense on or after September 1, 2014, the Plan will pay 80% of all reasonable dental charges subject to the \$1,750 calendar year Maximum Benefit per person as set forth in the Schedule of Benefits. Covered Persons may use any Dentist that they choose. However, using a Dentist in the Connection Dental Network through PHP, may result in a lower out-of-pocket expense for the Covered Person. See page 7 for information on how to find a Connection Dental Network provider.

If a Covered Person has a life threatening illness that causes the Covered Person to incur reasonable dental charges greater than the maximum allowed, the Covered Person could receive an additional \$3,500 of dental benefits for the Calendar Year. Examples of life threatening illness for the additional Dental Benefits include, but are not limited to, cancer, HIV/AIDS and lupus. The additional Dental Benefits are provided if the Covered Person receives pre-authorization from the Board of Trustees, submits a dental treatment plan indicating the requested treatment and a signed Physician's statement describing the life threatening illness that makes the additional requested treatment necessary and such documentation is submitted to the Fund Office.

The Dental Benefit is also subject to a separate lifetime maximum of \$1,000 per Covered Person through age 18 for Orthodontia charges. The Orthodontia Benefit under the Plan is a stand-alone benefit irrespective of any other dental Benefits used during a Plan Year. Benefits will be paid in the same manner and with the same Co-Payments as all other dental Benefits until the treatment is completed or the lifetime benefit maximum is met.

### **Definitions**

The following definitions apply to the Dental Benefit:

**“Calendar Year”** means January 1 through December 31 of each year.

**“Dental Expense”** means the part of a charge for dental services which meets **all** of the following:

1. Is covered under the Dental Benefit, and
2. Does not exceed the Prevailing Fee for the service.

**“Dental Hygienist”** means a duly licensed dental hygienist who works under the supervision of a Dentist.

**“Dentist”** means a duly licensed dentist or Physician who is operating within the scope of a dentist's or Physician's license.

**“Prevailing Fee”** means a charge for Dental Expense which does not exceed the 90<sup>th</sup> percentile of the Plan’s prevailing health care data.

Benefit Limitations

Benefits will **NOT** be paid for more than two Prophylactic Dental Examinations per calendar year, per person. Dental Benefit limits for Eligible Dependents under age 19 do not apply to reasonable expenses for pediatric services as required by law.

## Section Eight – Death and Dismemberment Benefits

Active Eligible Employees Only

A. Death Benefit

Upon the death of an active eligible Employee, the Plan will pay the Benefit stated in the Schedule of Benefits to the designated Beneficiary.

B. Accidental Death and Dismemberment Benefit

When bodily injury to an Active Employee caused solely by an Accident shall result in any of the following losses within 90 days after the date of the Accident, the Plan will pay the benefit stated in the Schedule of Benefits and in the table below.

<u>Loss</u>	<u>Amount</u>
Life.....	\$10,000
Both Hands or Both Feet.....	\$10,000
Entire Sight of Both Eyes .....	\$10,000
One Hand <b>and</b> One Foot.....	\$10,000
One Hand <b>or</b> One Foot <b>and</b> Entire Sight of One Eye.....	\$10,000
One Hand <b>or</b> One Foot .....	\$ 5,000
Entire Sight of One Eye .....	\$ 5,000

Definition

The following definition applies to the Accidental Death and Dismemberment Benefit:

“**Loss**” with reference to the hand or foot means complete severance through or above wrist or ankle joint, and with reference to the eye means the irrevocable loss of the entire sight thereof. In the event of multiple losses, Benefits will be paid for the greatest loss sustained as a result of any one Accident.

Benefit Limitations

Benefits will **NOT** be paid for any loss caused by:

1. Injuries suffered during combat, war or act of war,
2. Injuries which were intentionally self-inflicted unless the injury is in connection with a medical condition, and

3. Aircraft, except when the eligible Employee is a passenger in a licensed aircraft (other than chartered aircraft) operated by a licensed pilot on a regularly scheduled passenger flight offered between specified airports by a licensed passenger carrier.

## **Section Nine – Benefit Exclusions and Limitations**

The Plan provides Benefits only for those Medically Necessary covered services and charges expressly described in the Plan. **Any omission of service or charge shall be presumed to be an exclusion even though not expressly stated as such.**

**IF YOU ARE UNSURE WHETHER A MEDICAL SERVICE OR PROCEDURE IS COVERED, PLEASE CONTACT THE FUND OFFICE FOR CLARIFICATION. FAILURE TO DO SO COULD RESULT IN YOU BEING RESPONSIBLE FOR ANY NON-COVERED OR EXCLUDED CHARGES YOU INCUR.**

Benefits **WILL NOT** be paid for or shall be limited as follows:

1. Loss caused by accidental bodily injury, disease or Sickness which arises out of or occurs in the course of any occupation or employment for wage or profit; loss caused by any accidental bodily injury, disease or Sickness for which the Covered Employee claims to be, or may claim to be, or is entitled to any benefits under any Worker's Compensation or occupational disease law. The Fund retains the option to withhold payment of Benefits for treatment of any injury, disease or Sickness which may be compensable under a Worker's Compensation or occupational disease law.
2. Hospital, medical or surgical treatment provided because of loss suffered in war or while in Military Service.
3. Any service furnished by an institution which is primarily a place of rest, a place for the aged, a nursing home, a convalescent home or any institution of like character or for convalescent or custodial services.
4. Routine foot care procedures such as the trimming of nails, corns or calluses, fallen arches or other symptomatic complaints of the feet, impression casts for prosthetics and appliances, including prescriptions for orthotics.
5. Services, supplies, procedures and drugs which are not customary and generally accepted by the medical profession and services, supplies, procedures and drugs which are experimental or for the purpose of research.
6. Services or supplies related to sex transformations or sexual dysfunction.
7. Visual analysis, eye examination or the correction of vision, eyeglasses, therapy or training for muscular imbalance of the eye, or fitting of glasses or orthotics, except as stated under the Vision Benefit.

8. Services provided by an audiologist when not performed in connection with a Sickness, devices to improve hearing and their related fittings, except as stated under the Hearing Aid Benefit.
9. Expenses related to treatment or services for Accident or Sickness rendered prior to the Covered Person's becoming eligible for Benefits or after losing eligibility for Benefits, except as stated under the Dental Benefit provisions.
10. Rehabilitation therapy for an injury, unless performed by a licensed physiotherapist, subject to pre-authorization by the Board of Trustees and a complete treatment plan is submitted to the Fund Office by the referring Physician.
11. Loss suffered for which a contributing cause was the Covered Person's commission of or attempt to commit a felony or the Covered Person's engaging in an illegal occupation.
12. Any Expense Incurred for obesity or morbid obesity such as weight reduction programs, drugs, surgical and non-surgical treatments and procedures and reversion of such procedures, including bariatric surgery, gastric bypass, gastric banding, open or laparoscopic vertical banded gastroplasty, laparoscopic adjustable gastric banding (Lap-Band system), lipotomy, or any other such procedure, as well as cosmetic or other surgery for removal of excess fat or skin following weight loss, pregnancy or surgery, regardless of Medical Necessity or supervision by a Physician. Complications from any excluded expenses are also excluded.
13. Treatment or services in connection with an elective abortion.
14. Tooth extractions or other dental work or surgery that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease or disease of the gingival tissue except as otherwise provided under the Dental Benefit, or when treatment is provided within 120 days following an accidental injury to the jaw, sound natural teeth, mouth or face.
15. The maximum payable for either the initial purchase and/or replacement of prosthetic appliances shall be limited to the UCR Charge with a lifetime maximum of \$25,000 per Covered Person.
16. Alternative Treatments as defined by the Office of Alternative Medicine of the National Institutes of Health except for as provided for in the Acupuncture Treatment Benefit. Examples of some treatments not covered are aromatherapy, hypnotism, massage therapy and rolfing.
17. Treatment for behavioral, conduct and impulse control disorders.

18. Charges for personal care items that are primarily for personal comfort or convenience, including, but not limited to, diapers, bathtub grabbers, handrails, lift chairs, over-bed tables, incontinence pads, ramps, snug seats, recreational items, home improvements and home appliances, spas, wigs and braces for sports.
19. Charges for motor driven wheelchairs or scooters, implantable spinal column stimulator unless such stimulator is pre-authorized by the Board of Trustees and a signed Physician's statement is submitted to the Fund Office describing Medical Necessity, ThAIRapy vests or non-standard equipment of any type. Any equipment that does not meet the covered Durable Medical Equipment criteria on page 38, is NOT a covered Benefit. Any nondurable supplies related to equipment that is not covered will also not be a covered Benefit.
20. Services for cosmetic and reconstructive surgery except: (a) as a result of a surgical procedure for which Benefits were paid under the Plan, (b) for reconstruction of a breast on which a mastectomy has been performed, for surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, or for coverage for prostheses and physical complications of all states of mastectomy (including lymphedemas) in a manner determined in consultation with the attending Physician and the patient.
21. Fertility treatments, artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, penile prosthesis and any related prescription medication treatment.
22. Genetic or chromosomal testing, counseling or therapy.
23. Treatment of hair loss including wigs, toupees, hairpieces, hair implants or transplants and drugs to treat hair loss.
24. Home Health Care except as provided for under the Hospice Benefit. The following are examples of excluded services:
  - a. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional occupational and social activities,
  - b. Services rendered by registered or licensed practical nurses, other health professionals and other allied health workers who are not employed by or functioning pursuant to a contractual arrangement with a Community or Hospital Home Health Care Agency, and
  - c. Services provided to persons who are not essentially homebound for medical reasons.
25. Expenses Incurred for contraceptives and related supplies except as provided under the Preventive/Routine Care Benefit.

26. Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism.
27. Physical conditioning programs such as athletic training, bodybuilding, exercise fitness, flexibility and diversion or general motivation.
28. Biopharmaceutical medications.
29. Services and supplies for which the individual is not legally required to pay for or which no charge would be made if this coverage did not exist.
30. Maternity or obstetrical services for a dependent child in connection with pregnancy or resulting complications, except as provided under the Preventive/Routine Care Benefit.
31. Treatment pertaining to the periodontium, except as covered under the Dental Benefit.
32. Any dental treatment, except as covered under the Dental Benefit.
33. Any treatment not considered Medically Necessary.
34. Any expenses not actually incurred by a Covered Person.
35. Any expenses for treatment of temporomandibular joint (TMJ) syndrome.
36. Any expenses for dental x-rays except as covered under the Dental Benefit.
37. Any expenses for eye examination or the fitting of eyeglasses except as covered under the Vision Benefit.
38. Charges made by an assistant surgeon unless assistance is considered Medically Necessary.
39. Prescription or non-prescription safety glasses, except for the one pair covered under the Vision Benefit each calendar year.
40. Prophylactic dental examinations, except for the two covered under the Dental Benefit each calendar year.

## **Section Ten – Claims and Appeal of Denied Claims Procedures**

The following procedure to process claims and appeals will apply to any claim filed with the BAC Local Union 15 Welfare Plan (Fund). These procedures have been adopted to comply with regulations issued by the U.S. Department of Labor, at 29 CFR 2560.503.1. For all claims filed prior to the date this Restated Plan Document and Summary Plan Description, procedures are on file with the Fund Office.

The Board of Trustees (Board) is both the Plan Administrator and the fiduciary responsible for all benefit determinations on appeal. The Board may delegate all fiduciary responsibility for claims determination to an Appeal Committee (Committee). Such Committee shall meet once each calendar quarter at regularly scheduled times.

The Board or Committee shall have the authority to interpret, construe and apply all terms of the Restated Plan Document and Summary Plan Description, the Trust Agreement 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 making an initial benefit determination and a determination on appeal.

Under Federal law, a Covered Person or Beneficiary has the right to bring a civil action under ERISA Section 502(a), if dissatisfied with an adverse benefit determination. Before bringing such an action, the Covered Person or Beneficiary must exhaust the Plan's Claims and Appeal of Denied Claims Procedures. Any such legal action against the Plan under ERISA must be filed within two years of the date of the decision of the Trustees on appeal.

### A. Definitions

#### 1. Medical Claim

A “**Medical Claim**” is a written or Health Insurance Portability and Accountability Act (HIPAA) compliant electronic post-service request for payment of Benefits from the Fund:

- a. Made by a Claimant,
- b. Received by the Fund Office or applicable PPO within one year of the date of service, and
- c. Includes all of the following:
  - i. Participant's Name,
  - ii. ID Number,

- iii. Address,
- iv. Patient Name/Date of Birth/Relationship to Participant,
- v. Claimant authorization to pay/or not,
- vi. ICD-9 diagnosis code,
- vii. Date of Service,
- viii. Place of Service,
- ix. CPT procedure codes,
- x. Charges,
- xi. Provider Federal ID Number, Name and Address, and
- xii. Patient account number.

d. A claim is **NOT**:

- i. A verbal inquiry about whether a specific service is a covered benefit.
- ii. A voluntary pre-service determination of whether a treatment, service or product is covered.
- iii. An inquiry regarding eligibility to receive a treatment, service or product. However, after service is incurred, a determination of eligibility will be made by the Fund.
- iv. An attempt to purchase or receive a prescription drug at the counter. However, any denial of such purchase or receipt entitles the Claimant to file a claim after the denial.

2. Disability Claim

A **“Disability Claim”** is a claim for benefit for the active disabled Employee’s hours credit of 30 hours worked per week for a maximum of 13 weeks as described in the Section Two “Eligibility Rules” at Subsection G., Eligibility for Active Disabled Employees; or a claim for Accidental Death & Dismemberment Benefits.

3. Claimant  
A **“Claimant”** is:
  - a. An eligible Participant in the Fund,
  - b. An Eligible Dependent, or
  - c. The duly appointed Authorized Representative of an eligible Participant or Eligible Dependent, as described below.
  
4. Authorized Representative  
An **“Authorized Representative”** is a person who is specially designated by a Claimant to represent the Claimant in respect to a claim for Benefits or an appeal of a denied claim. In order to designate an Authorized Representative, the Claimant must present to the Fund Office a written statement designating an Authorized Representative. For your convenience, a “Designation of Authorized Representative” form is available at the Fund Office. The statement must include:
  - a. The name, telephone number and mailing address of the Authorized Representative,
  - b. The name, mailing address, date of birth and Social Security number of the Claimant, and
  - c. The signature of the eligible Participant or, in the case of an Eligible Dependent, the individual or a minor child’s parent or legal guardian.

You may assign your Claim for Payment purposes only to a PPO in-network provider, without designating such provider as an Authorized Representative for all other purposes under the Plan. You may not assign to a non-PPO provider the right to receive payment directly from the Plan.

The Board of Trustees has the sole discretion to determine whether a Claimant has properly designated an Authorized Representative.

Assigning a health care provider the right to receive Benefits does not make the provider an Authorized Representative. Any individual wishing to designate a health care provider as an Authorized Representative must provide the Fund Office with a separate written statement designating the provider as such. For your convenience, a “Designation of Authorized Representative” form is available at the Fund Office.

If a Claimant has designated an Authorized Representative, the Authorized Representative will receive all information and notifications, and will be authorized to act on behalf of the Claimant, with respect to all aspects of the

claim. This includes, but is not limited to, the initial determination, requests for documents, appeals, and any other communication regarding the claim. The authorization will remain in effect unless or until the Claimant provides the Fund Office with written notification that restricts or cancels the authorization.

5. Days  
“Days,” for purposes of computing any time period under this Section, shall mean calendar days.

B. Filing Medical Claims

When you receive medical services at a PPO provider, you should present your medical benefits identification card (ID card) at the time of service. Generally, if you use a PPO provider, the provider will submit a Medical Claim directly to the Fund Office or the entity responsible for processing Medical Claims.

Most health care providers will file Medical Claims for you. Be sure to show your ID card so your provider knows where to submit your claim. If your provider does not submit a claim for you, you or your Authorized Representative should file a claim as soon as possible after you receive medical services, but in no event should a claim be filed later than one year from the date you receive medical services or your Medical Claim will be denied.

If you are a Grandfathered Covered Person in the Springfield area and need to submit a **Medical Claim** for medical services, submit an itemized statement or bill that details the charges to:

Preferred Health Professionals  
PO Box 25938  
Shawnee Mission, KS 66225-5938

All other members who need to submit a **Medical Claim** for medical services should submit an itemized statement, or bill that details the charges, to:

Blue Cross Blue Shield of Kansas City  
PO Box 419169  
Kansas City, MO 64141-6169

If you need to submit a **Dental Claim** for dental services, submit an itemized statement or bill that details the charges to:

Preferred Health Professionals  
PO Box 25938  
Shawnee Mission, KS 66225-5938

If you need to submit a **Vision Claim** for vision services, submit an itemized statement or bill that details the charges to:

BAC Local Union 15 Welfare Fund  
6405 Metcalf, Suite 200  
Cloverleaf Building 3  
Overland Park, KS 66202  
Fax: (913) 236-5499

When filing a claim:

1. If your claim is for healthcare that is also covered by Medicare, attach a copy of the itemized bill relating to the health service provided and a copy of Medicare's explanation of benefits. Both the bill and Medicare's explanation of benefits should be submitted.
2. If a claim is for an Eligible Dependent, provide the name of the Eligible Dependent.
3. If you or an Eligible Dependent has coverage under more than one plan, be sure to include the name of the other plan(s).

C. Time Periods for Initial Determination

1. Medical Claims

The Fund will make its initial benefit determination within 30 Days of receipt of the claim. The Fund may extend this initial benefit determination period 15 additional Days. The Fund will notify the Claimant within the first 30 Days, if an extension will apply. If additional information is needed to process the claim, the Fund will give the Claimant 45 Days to provide this additional information. The request for additional information may include a notice to the Claimant that the claim is denied, in whole or in part, if the requested information is not provided within the 45 day period.

2. Disability Claims

The Fund will make its initial determination within 45 Days. The Fund may extend this initial benefit determination up to two times of 30 additional Days each. The Fund will notify the Claimant if an extension will apply before the end of each previous determination deadline. If additional information is needed to process the claim, the Fund will give the Claimant 45 Days to provide this additional information. The request for additional information may include a notice to the Claimant that the claim is denied, in whole or in part, if the requested information is not provided within the 45 day period.

**SMART HEALTHCARE CONSUMER TIP:**

*Review Your Explanation of Benefits Forms*

Make sure that the services your Plan has paid for were actually provided. If you do not recognize the name of the Provider, or did not go to the doctor on the date of service shown on the form, call the contract claims administrator.

D. Notice of Initial Determination

The Fund will issue a written or HIPAA compliant electronic notice of benefit determination, which may be a denial of Benefits, also known as an adverse benefit determination. This notice is also called an “Explanation of Benefits,” or EOB. This notice will contain:

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific benefit provisions on which the determination is based.
3. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Fund’s review procedures and the time limits applicable to such procedures, including a statement of the Claimant’s right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion shall be provided to the Claimant; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the Claimant upon request.
6. If the adverse benefit determination is based on a Medically Necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the benefit Plan to the Claimant’s medical circumstances shall be provided to the Claimant, or a statement that such explanation will be provided free of charge upon request.

E. Time Periods for Appeals – Medical and Disability Claims

A request for review (an appeal) must be submitted in writing to the Fund Office no later than 180 Days after the Claimant’s receipt of the notice of adverse benefits determination. The Board of Trustees may delegate to an Appeal Committee the authority to make all benefit determinations on appeal. The Fund shall issue a benefit determination on appeal no later than the next regularly scheduled quarterly meeting of the Appeal Committee of the Board of Trustees. Except that if the appeal is received by the Fund less than 30 Days before the next quarterly Appeal Committee meeting, a benefit determination on appeal shall be made no later than the second quarterly committee meeting after the receipt of the appeal. In addition, if, due to circumstances beyond the control of the Fund, a decision still cannot be made by that time, the Fund may extend the period to make a determination until the next quarterly meeting. If the Claimant requests a hearing, a benefit determination shall be made no later than the third Appeal Committee meeting after receipt of the appeal.

The Fund shall issue its decision no later than five Days following the benefit determination.

F. Claimant's Rights on Appeal

The following rules govern the Claimant's rights on appeal:

1. As stated in Subsection D above, a Claimant shall have at least 180 Days following receipt of a notification of an adverse benefit determination within which to appeal the determination.
2. The review on appeal shall not give deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Fund who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.
3. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
4. The Plan shall provide to Claimant the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.
5. The appeal review process shall provide that the health care professional engaged for purposes of a consultation under Paragraph 3 of this Subsection E shall be an individual who 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.
6. The written decision of the Appeal Committee shall be final, binding and conclusive upon the Claimant.
7. All review procedures described above must be followed and exhausted before a Claimant may institute any legal action including an action or proceeding before any court, administrative agency or arbitrator (legal body). Generally, such legal bodies require a Claimant to follow and exhaust the Fund's review procedures before allowing a Claimant's legal action to proceed. If a Claimant files a legal action before following and exhausting the Fund's review procedures, this may result in a negative ruling by the relevant legal body and impair or cause the loss of the right to bring any further legal action.

G. Content of Notice of Benefit Determination on Appeal

The Plan Administrator will provide a Claimant with written or electronic notification of the Fund's benefit determination on review. Any electronic notification shall comply with the standards imposed by law. In the case of an adverse benefit determination, the notification will include the following, in a manner that is understood by the Claimant:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific benefit provisions on which the determination is based;
3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for Benefits.
4. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion shall be provided to the Claimant; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the Claimant upon request; or
5. If the adverse benefit determination is based on a Medically Necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the benefit Plan to the Claimant's medical circumstances shall be provided to the Claimant, or a statement that such explanation will be provided free of charge upon request.
6. A statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA.

H. Hearing Procedure

The Board of Trustees establishes the following procedures for hearings:

1. The Claimant and/or duly Authorized Representative shall be afforded an opportunity to appear before the Appeal Committee and shall have the right and opportunity to examine witnesses, produce documents and other evidence material to the claim.
2. The proceeding of the hearing shall be preserved by means of meeting minutes or as authorized by the Trustees.

3. In conducting the hearing, the Appeal Committee shall not be bound by the usual common law or statutory rules of evidence.
4. The Claimant or Authorized Representative shall have the right to review the minutes of the hearing, obtain a reproduced copy thereof and obtain a copy of all documents and records introduced or referred to. The cost of copies or documents shall be 25¢ per page.
5. There shall be copies made of all documents and records introduced at the hearing, and the copies shall be attached to the record of the hearing and made a part thereof and shall be retained in the Claimant's file.
6. All information upon which the Appeal Committee bases its decision shall be disclosed to the Claimant or Authorized Representative at the hearing or in a written decision.

I. Fraudulent Claim Warning

Any person who knowingly and with intent to defraud files a statement of claim or assists anyone else in filing such a statement of claim which contains any material with false information, or conceals for the purpose of misleading information concerning any fact material hereto, commits a fraudulent act which is a crime. In the event that such a claim is submitted by a Participant or anyone else, the claim would be denied and the full sanctions under the law would be followed. In the event any claim is paid as the result of such a fraudulent statement or submission, which is determined to be fraudulent, the full penalty of the law will be applied and the amount of the claim paid will be recovered with interest.

For example, if you are married and become divorced, you must notify the Fund Office immediately. If you fail to do so and your former spouse incurs medical expenses which are covered by the Plan, you may be held liable for those expenses as outlined above. If you let any individual who is not eligible under the Plan as a member of your immediate family use your Plan identification card to obtain medical care, you may be held liable for the Plan's attorney's fees.

As noted, participating in allowing others who are not eligible for Benefits under the Plan, as in the aforementioned examples, is considered fraud and could also possibly subject you and the ineligible individuals who incur such expenses to criminal prosecution. Further in the event such expenses are incurred by ineligible individuals due to your active or passive participation (i.e. failing to report to the Fund Office a divorce or the use of your Plan identification card by an ineligible individual) the Plan may offset any such expenses against any expenses you, your Eligible Dependents or new spouse, if you remarry, may incur. In other words, the Plan may not pay such expenses until the amount of expenses that were improperly paid have been offset in full against any expenses that Plan would otherwise have paid.

J. Limitation on when a Lawsuit May be Filed to Obtain Benefits

A Claimant may not start a lawsuit to obtain benefits until after:

1. The Claimant has requested an appeal and a final decision has been reached on appeal; or
2. until the appropriate timeframe described in the claim and appeal section of the Plan has elapsed since you filed a request for appeal and you have not received a final decision or notice from the Board that an extension will be necessary to reach a final decision.

For claims incurred on or after April 1, 2015, any lawsuit brought against the Plan must be initiated no more than two years after the date of:

1. a determination denying the claim for benefits; or
2. the time for a decision on an appeal has expired.

## **Section Eleven – Use and Disclosure of Protected Health Information**

- A. This Section of the Plan is effective April 14, 2003, is adopted to effect compliance with the Health Insurance Portability and Accountability Act of 1996 and the Regulations issued thereunder by the Secretary of Health & Human Services concerning the privacy of protected health information (together referred to herein as The Privacy Rule). The Privacy Rule is incorporated herein by reference.
- B. All capitalized terms have the meaning as stated in this Restated Plan Document and Summary Plan Description or The Privacy Rule.
- C. This Section establishes the required and permitted uses and disclosures of Protected Health Information (PHI) by the Plan Sponsor, which is the Board of Trustees. The Board of Trustees is also the Plan Administrator under the Employee Retirement Income Security Act of 1974 (ERISA).
- D. PHI may be used by and disclosed to the Board of Trustees or individual Trustees for purposes of general administration of the Plan, as follows:
  - 1. Underwriting and budgeting;
  - 2. Claims review and processing;
  - 3. Amending or modifying the Plan of benefits (plan design);
  - 4. Claims assistance;
  - 5. Eligibility review;
  - 6. Any and all general administration of the Plan.
- E. PHI may be disclosed to the Board of Trustees, or individual Trustees as authorized by an individual.
- F. The BAC Local Union 15 Welfare Fund shall make reasonable efforts to limit disclosure and use of PHI to the Board of Trustees to the minimum necessary to accomplish the intended use or disclosure.
- G. The Board of Trustees:
  - 1. Shall not use or further disclose PHI other than as permitted or required by this Restated Plan Document and Summary Plan Description or as required by law.
  - 2. Shall comply with verification procedures of the group health plan.

3. Shall ensure adequate separation between the group health plan and the Plan Sponsor as follows:
  - a. Describe those employees or classes of employees or other persons under the control of the plan Sponsor to be given access to the PHI to be disclosed, provided that any employee or person who receives PHI relating to treatment, payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business must be included in such description;
  - b. Restrict the access to and use by such employees and other persons described in paragraph (G)(3)(a) of this Section to the Plan administration functions that the Plan Sponsor performs for the group health plan; and
  - c. Provide an effective mechanism for resolving any issues of noncompliance by persons described in paragraph (G)(3)(a) of this Section with the Plan Document provisions required by this paragraph.
4. Shall not use or disclose PHI for employment related decisions.
5. Shall ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.
6. Shall not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual or pursuant to a Business Associate contract.
7. Shall report to the Plan any use or disclosure of the information that is inconsistent with the allowed uses or disclosures of which it becomes aware.
8. Shall make PHI available to the Plan when the Plan is requested by an individual to gain access to PHI in accordance with the access requirements of HIPAA.
9. Shall make PHI available to the Plan when the Plan is requested by an individual for amendment and incorporate any amendments to PHI in accordance with HIPAA.
10. Shall make available to the Plan the information required to provide an accounting of disclosures.

11. Shall make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA, and
  12. Shall return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
- H. Each Trustee shall certify compliance with the Privacy Rule and the Privacy Policy of the BAC Local Union 15 Welfare Fund.
- I. This provision of Section Eleven of the Plan concerning security of electronic PHI is effective April 20, 2005 and is adopted to further comply with The Security Rule, which is incorporated herein by reference. The Board of Trustees shall:
1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
  2. Ensure that the adequate separation discussed above in Paragraph G, subparagraph 3, specific to electronic PHI, is supported by reasonable and appropriate security measures;
  3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
  4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

The terms electronic protected health information, electronic PHI and e-PHI, as used in the Plan, mean protected health information that is transmitted by or that is maintained in an electronic media, including but not limited to: magnetic tape, computer hard drive, computer disks, CDs, CD-ROM, flash memory devices, backup tapes or disks, etc.

## Section Twelve – Administrative Information

The following topics are discussed under this Section on Administrative Information:

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|-------------------------------------|--|
| A. Coordination of Benefits         | G. Reciprocity and Portability             |
| B. Determination of Benefits        | H. Termination of Plan                     |
| C. Medical Examination              | I. Right to Release or Request Information |
| D. Employer Rights to Contributions | J. Subrogation of Benefits                 |
| E. Encumbrance of Benefits          |  |
| F. Facility of Payment              |  |
- 

### A. Coordination of Benefits

The following rules govern the Coordination of Benefits:

#### 1. Applicability

This Coordination of Benefits (COB) provision applies to This Plan when a Participant or a Participant's Eligible Dependent has health care coverage under more than one plan. "This Plan" and "Another Plan" are defined below.

If this COB provision applies, the Order of Benefit Determination Rules in Subsection 3 below should be looked at first. Those rules determine whether the Benefits of This Plan are determined before or after those of Another Plan. The Benefits of This Plan:

- a. Will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its Benefits before Another Plan (This Plan pays first); but
- b. May be reduced when, under the Order of Benefits Determination Rules, Another Plan determines its benefits first (This Plan pays second). The above reduction is described in Subsection 4, "Effect of the Benefits of This Plan".

#### 2. Definitions

- a. **"Allowable Expense"** means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private Hospital room will not be considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in This Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When Benefits are reduced under a Primary Plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services and preferred provider arrangements.

- b. **“Another Plan”** is any of the following which provides benefits or services for, or because of, medical or dental care or treatment that is not BAC Local Union 15 Welfare Fund:
  - i. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
  - ii. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time, including Medicare Part D).

Each contract or other arrangement for coverage under i. or ii. above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

- c. **“Claim Determination Period”** means a calendar year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
- d. **“Primary Plan/Secondary Plan”** is determined using The Order of Benefit Determination Rules.

When This Plan is a Primary Plan, its Benefits will be determined before those of Another Plan and without considering Another Plan’s benefits.

When This Plan is a Secondary Plan, its Benefits will be determined after those of Another Plan and may be reduced because of Another Plan’s benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

e. **“This Plan”** is BAC Local Union 15 Welfare Fund.

3. Order of Benefit Determination Rules

a. General

When there is a basis for a claim under This Plan and Another Plan, This Plan shall be Secondary Plan which has its benefit determined after those of Another Plan, unless:

- i. The other Plan has rules coordinating its benefits with those of This Plan; and
- ii. Both those rules and This Plan’s rules, in Subsection b. below, require that This Plan’s Benefits be determined before those of the other plan.

b. Rules

This Plan shall determine its order of Benefits using the **first** of the following rules that apply:

i. Non-Dependent/Dependent

The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) shall be determined before those of the plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVII of the Social Security Act and implementing regulations, Medicare is Secondary to the plan covering the person as a dependent and Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent. This Plan will not coordinate with Medicare Part D.

ii. Dependent Child/Parents not Separated or Divorced

Except as stated in Paragraph iii. below, when This Plan and Another Plan cover the same child as a dependent of different persons, called “parents,” the benefits of the plan of the parent whose birthday (month and day) falls earlier in a year shall be determined before those of the plan of the parent whose birthday (month and day) falls later in that year. But if both parents have the same birthday (month and day), the benefits of the plan which covered one parent longer will be determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in this Paragraph ii., but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

iii. Dependent Child/Separated or Divorced

If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child shall be determined in this order:

- (a) First, the plan of the parent with custody of the child;
- (b) Then, the plan of the spouse of the parent with the custody of the child; and
- (c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan shall be determined first. The plan of the other parent shall be the Secondary Plan. This Paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

iv. Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph ii., above.

v. Active/Inactive Employee

The benefits of a plan which covers a person as an employee who is neither laid off nor retired shall be determined before those of a plan which covers that person as a laid off or retired employee. The same is true if a person is a dependent of a person covered as a Retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

vi. Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under Another Plan, the following will be the order of benefit determination:

- (a) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);
- (b) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

vii. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan which covered the employee, member or subscriber longer will be determined before those of the Plan which covered that person for the shorter term.

4. Effect on the Benefits of this Plan

The following rules govern the effect on the benefits of these COB rules:

a. When this Section Applies

This Subsection 4 applies when, in accordance with Subsection 3 "Order of Benefits Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event, the Benefits of This Plan may be reduced under this Section. Such other plan or plans are referred to as "Another Plan" in Subsection b. ii., below.

b. Reduction in This Plan's Benefits

The Benefits of This Plan will be reduced when the sum of:

- i. The Benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision, and
- ii. The benefits that would be payable for the Allowable Expenses under Another Plan, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period.

In that case, the Benefits of This Plan will be reduced so that they and the benefits payable under Another Plan do not total more than those Allowable Expenses.

When the Benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

c. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. This Plan has the right to decide which facts it needs. To the extent allowed under law, This Plan may get needed facts from or give them to any other organization or person. This Plan need not inform or get the consent of any person to do this, unless required to do so by law. Each person claiming Benefits under This Plan must give any facts This Plan needs to pay the claim.

d. Facility of Payment

A payment made under Another Plan may include an amount which should have been paid under This Plan. If it does, This Plan may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term “payment made” includes providing Benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

e. Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB provision, This Plan may recover the excess from one or more of:

- i. The persons it has paid or for whom it had paid,
- ii. Insurance companies, or
- iii. Other organizations.

The “amount of the payments made” includes the reasonable cash value of any Benefits provided in the form of services.

B. Determination of Benefits

The Trustees have full authority and sole discretion to make determinations of entitlements to and amounts of Benefits. Subject to the right of appeal, the determination shall be final and binding upon all parties claiming Benefits under the Plan.

C. Medical Examination

No medical examination shall be required to obtain coverage for benefits initially. However, the Trustees have the right, through a medical examiner of their choosing, to examine a Covered Person as often as they may reasonably require during the pendency of a claim and the right and opportunity to request an autopsy in case of death where it is not forbidden by law.

D. Employer Rights to Contributions

Except in the case of mistaken contributions, the Employers shall have no right, title or interest in the contributions made by them to the Fund and no part of the Fund shall revert to the Employers in the event of a termination of the Fund.

E. Encumbrance of Benefits

No monies, property or equity of any nature whatsoever in the Fund, policies, Benefits or monies payable therefrom, shall be subject in any manner by a Covered Person or person claiming through a Covered Person, to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, garnishment, mortgage, lien or charge and any attempt to cause any benefit to be subject thereto shall be null and void; provided however, that Benefits may be assigned by the Covered Person or Beneficiary to the health care provider who furnished the services or supplies for which a benefit is payable.

F. Facility of Payment

Whenever payments which should have been made under this Plan in accordance herewith have been made under any other plans, the Trustees have the right, exercisable alone and in their sole discretion, to pay to the other organization making such payments any amounts which they determine to be warranted in order to satisfy the intent of this provision. Any amounts paid shall be deemed to be Benefits paid under this Plan and the Trustees shall be fully discharged from any future liability.

G. Reciprocity and Portability

The Trustees may enter into or amend portability or reciprocity agreements with other welfare funds.

H. Termination of Plan

The Benefits provided under this Plan are NOT vested benefits and the Trustees have the authority to terminate any benefit, including Retiree Benefits, or the entire Plan, at any time.

In the event of termination of the Plan, the Trustees shall apply the Fund to pay or provide the payment of any and all obligations of the Fund and shall distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Fund. No part of the corpus or income of the Fund will be used for or diverted to purposes other than for the expenses of the Fund or for other payments in accordance with the provisions of the Fund. Under no circumstances will any portion of the corpus or income of the Fund, directly or indirectly, revert to or accrue to the benefit of the Employers, the Association or the Union.

I. Right to Release or Request Information

For the purpose of determining the applicability and implementing the Coordination of Benefits and/or Subrogation provisions or any similar provisions in other plans,

to the extent allowed by law, the Trustees may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person, any information with respect to any person which the Trustees deem necessary for such purposes. In so acting, the Trustees shall be free from any liability that may arise in relation to such action. Any person claiming Benefits under this Plan must furnish such information as the Trustees may reasonably deem necessary in order to implement this provision.

**THE TRUSTEES WILL HAVE NO OBLIGATION TO FURNISH ANY BENEFIT UNDER THE PLAN UNTIL ALL ADDITIONAL INFORMATION REQUESTED HAS BEEN RECEIVED.**

J. Subrogation of Benefits

In the event the Plan provides benefits for injury, Sickness or other loss (hereinafter the "Injury") to any Covered Person, the Plan is automatically subrogated to all rights of recovery to any funds or monies that person, his spouse, dependents, parents, heirs, guardians, conservators, next friend, executors, assigns, personal representative or other representatives (individually and collectively called the "Subrogation Covered Person") may have arising out of said injury, Sickness or other loss. Said recovery shall not be limited by characterization of loss and shall include recovery for personal injury, lost wages, loss of service, disability and claims for wrongful death, survivor or other claims under any state or federal law. The Plan is not limited or bound by any judgment or settlement that apportions recovery among the various elements of damage. The Plan shall automatically have a first priority lien and shall be entitled to first dollar reimbursement from any recovery regardless of whether the Subrogation Covered Person is made whole by said recovery. The Plan shall be entitled to assert a lien against third parties, insurers, attorneys and other appropriate person or entities admitted, determined and/or alleged to be liable to the Subrogation Covered Person in order to protect its right of subrogation.

This right of subrogation is specifically and unequivocally pro tanto subrogation; that is subrogation from the first dollar received by the Subrogation Covered Person, and this pro tanto is specifically and unequivocally to take effect before the whole debt is paid to the Subrogation Covered Person. The Plan's subrogation rights include, without limitation, an automatic first priority lien upon the first dollar recovery from any judgment, settlement or payment of any kind to the Subrogation Covered Person by any party admitted, determined, and/or alleged to be liable to the Subrogation Covered Person as well as all rights of recovery of a Subrogation Covered Person to any payments made by or on behalf of an admitted, determined and/or alleged to be liable party including, but not limited to, a recovery:

1. Against any person, insurer or other entity that is in any way responsible for providing compensation, indemnification or benefits for the injury;
2. From any fund, or policy of insurance or accident benefit plan providing No Fault, Personal Injury Protection (PIP) or financial responsibility insurance or coverage;
3. Under uninsured or underinsured motorist insurance;
4. Under motor vehicle medical payment insurance and;
5. Under specific risk accident and health coverage or insurance, including without limitation premises or homeowners medical payments insurance or athletic or sports "school" or "team" coverages or insurance.

These rights of reimbursement and subrogation are reserved whether the admitted, determined and/or alleged liability of a third party arises in tort, contract or otherwise. Regardless of how proceeds are designated, the Plan's rights shall attach to any full or partial judgment, settlement or other recovery.

The Subrogation Covered Person, or if a minor, the Subrogation Covered Person's parent or legal guardian, conservator or next friend shall execute and deliver such documents and papers (including, but not limited to a benefits Questionnaire, Subrogation Agreement and Authorization to Release Medical Information) to the Fund Office as the Plan may require to protect its rights of reimbursement and subrogation. The Subrogation Covered Person shall do whatever else is necessary to protect the rights of the Plan, including allowing the intervention by the Trustees or Plan in any claim or action against the admitted, determined and/or alleged to be liable party or parties.

The Trustees are vested with full discretionary authority to determine eligibility for Benefits, to construe subrogation and other Plan provisions and to reduce or compromise the amount of the Plan's recoverable interest where, in the sole discretion of the Trustees, circumstances warrant such action. No settlement, however, shall be binding on the Plan without the Plan's written approval thereof, and the Plan expressly reserves the right to collect the entire amount of its subrogation interest in all cases. The amount of the Plan's subrogation interest shall be deducted first from any recovery from any entity or source by or on behalf of the Subrogation Covered Person regardless of any common fund or make-whole doctrines. The amount payable to the Plan, pursuant to the subrogation right, shall not be reduced pursuant to the application of any common fund doctrine, any make-whole doctrine and/or any other common law/state law doctrine purporting to reduce the amount of the Plan's recovery.

The Plan reserves the right to initiate an action in the name of the Subrogation Covered Person or his guardian, conservator or next friend to recover its

subrogation interest, and the Subrogation Covered Person or his guardian, conservator or next friend will cooperate fully with the Plan in such instances.

In the event of any failure or refusal by the Subrogation Covered Person (1) to execute the Subrogation Agreement or any other document requested by the Fund Office, or (2) to take any other action requested by the Fund Office to protect the interest of the Plan, the Plan may withhold payment of Benefits or deduct the amount of any payments made from future claims of the Subrogation Covered Person.

The Subrogation Covered Person shall not do any act or engage in any negotiations that would reduce, compromise or prejudice the Plan's rights to first recovery from any third party. In the event the Subrogation Covered Person recovers any amount by settlement or judgment from any person, party, corporation, insurance carrier, governmental agency or other party which is admitted, determined and/or alleged to be liable to the Subrogation Covered Person, (1) the Plan shall be repaid in an amount equal to the full amount of Benefits paid by the Plan and (2) no further Benefits for treatment or services related to the injury leading to the settlement or recovery will be paid by the Plan. If the Subrogation Covered Person refuses or fails to repay such amount, or otherwise interferes with the Plan's right to subrogation, the amount of the Plan's claim shall be deemed to be held in constructive trust, and the Plan shall be entitled to seek restitution, impose a constructive trust or seek any other equitable or legal action against the Subrogation Covered Person or other party. In addition, the Plan reserves the right to offset and/or deduct any amounts paid as Benefits against future claims submitted by the Participant and his Eligible Dependents.

The Plan shall not pay or be held responsible for any portion of the Subrogation Covered Person's legal fees or expenses related to any recovery whether by settlement or judgment. The Plan reserves the right to first dollar from any recovery to the full amount of Benefits paid by the Plan and hereby claims a first lien against the proceeds of any settlement or judgment and priority over any claim or lien of legal counsel, insurers or any other third party. The Subrogation Covered Person shall provide all of the above referenced parties with notice of the Plan's first right of subrogation. However, the Trustees may, in their discretion, agree to share legal fees and expenses with the Subrogation Covered Person or his guardian, conservator or next friend, provided any such agreement is established in writing.

The "make whole" rule, any similar state law doctrine or the "common fund" doctrine is specifically and unequivocally rejected. The Plan's right of first dollar subrogation or reimbursement applies regardless of whether the Subrogation Covered Person is made whole or receives a partial recovery and regardless of the characterization or application of any recovery. The subrogation and reimbursement provisions of the Plan will apply even in the absence of a written agreement. Any person who is represented by counsel will give notice of the written agreement, and a copy thereof, to their counsel.

The Plan has the right to offset any pending or future claims against any recovery by the eligible individual or Eligible Dependent to the extent the recovery exceeds the unreimbursed Benefits paid by the Plan, even if no Benefits have been paid by the Plan. The Plan will also have a lien to the extent of the Benefits paid, which may be filed with any party alleged, determined, and/or alleged to be liable to the Subrogation Covered Person on account of the loss incurred.

If the Subrogation Covered Person, or his guardian, conservator or next friend does not attempt a recovery of the Benefits paid by the Plan or for which the Plan may be obligated, the Plan shall be entitled to institute legal action against the party or parties alleged, determined, and/or alleged to be liable to the Subrogation Covered Person in the name of the Plan or Trustees in order that the Plan may recover all amounts paid to or on behalf of the Subrogation Covered Person.

In an action brought by the Plan, the reasonable cost of recovery, including the Plan's attorneys' fees, shall first be deducted from any recovery by judgment or settlement against the party or parties deemed liable by admission, judicial and/or administrative determination, or allegedly liable to the Subrogation Covered Person. The Plan's subrogation interest, to the full extent of Benefits paid or due as a result of the occurrence causing the injury or Sickness, shall next be deducted with the balance paid to the Subrogation Covered Person.

## **Section Thirteen – Your Rights Under Federal Law**

**READ THIS SECTION CAREFULLY.** This is the only way to ensure that you have the information you need to protect your rights and your best interests under this Plan.

### **Your ERISA Rights as a Participant**

In 1974, Congress passed and the President signed the Employee Retirement Income Security Act, commonly referred to as ERISA. As a Participant of the BAC Local Union 15 Welfare 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:

#### **A. 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 Benefit 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.

Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new employer if the new employer maintains a group health care Plan. The new employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

Be informed that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish eligibility rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of domestic violence); or (8) disability.

Be informed that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict Benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48 hour or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours, as applicable. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan administrator.

Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical Benefits with respect to mastectomies shall include medical and surgical Benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery Benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such Benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and coinsurance.

**B. Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Restated Plan Document and Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Exclusionary periods of coverage for pre-existing conditions under the Plan may be reduced or eliminated if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from this Plan (any other group health plan), or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

C. Prudent Actions by Plan Fiduciaries

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

D. Enforce Your Rights

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

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

However, all review and appeal procedures described in the Plan usually must be followed and exhausted before a Claimant may institute any legal action including any action or proceedings before any court, administrative agency or arbitrator (“legal bodies”). Generally, such legal bodies require a Claimant to follow and exhaust the Fund’s review procedures before allowing a Claimant’s legal action to proceed. If a Claimant files a legal action before following and exhausting the Fund’s review procedures, this may result in a negative ruling by the relevant legal body and impair or cause the loss of the right to bring any further legal action.

E. 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 Benefit

Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

## **Section Fourteen – Other Important Information**

One of the main goals of the Employee Retirement Income Security Act of 1974 (ERISA) is expanded reporting and disclosure of benefit plan operations and provisions, that is, reporting to the Department of Labor, Internal Revenue Service and to the Plan Participants and Beneficiaries.

It is the intention of the Trustees to comply with all aspects of ERISA. Thus the required information in this Section has been reported to the appropriate federal agencies and is hereby “disclosed” to you.

A. Administration of Plan

The Plan is administered by a joint Board of Trustees, one-half of whom are appointed by the Union and one-half of whom are appointed by the Association. 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:

TIC International Corporation  
6405 Metcalf, Suite 200  
Overland Park, Kansas 66202  
(913) 236-5490 or (800) 542-4482

B. Employer Identification Number

The Employer Identification Number assigned to the Plan by the Internal Revenue Service is 23-7386028.

C. Funding Medium for the Accumulation of Plan Assets

All contributions and investment earnings of the Plan are accumulated in a Trust Fund which is utilized to pay Benefits to eligible individuals and to defray reasonable costs of administration.

D. Name of Plan

The full legal name of the Plan is the BAC Local Union 15 Welfare Plan.

E. Plan Advisors

*Fund Attorney (Person to Receive Service of Legal Process)*

Linda N. Winter, Esq.  
Arnold, Newbold, Winter & Jackson, P.C.  
1100 Main Street, Suite 2001  
Kansas City, Missouri 64105-5178

Service may also be made on any Plan Trustee or Plan Administrator.

*Plan Consultant and Plan Actuary*  
United Actuarial Services, Inc.  
11590 North Meridian Street, Suite 610  
Carmel, Indiana 46032-4529

- F. Plan Fiscal Year  
April 1 of each year and ends on March 31 of the following year.
- G. Plan Number  
The Plan Number is 501.
- H. Plan Year  
April 1 of each year and ends on March 31 of the following year.
- I. Sources of Contributions  
This Plan is funded through contributions by the Employers on behalf of their Employees, under the terms of a Collective Bargaining Agreement, and by investment income earned on a portion of the Fund's assets. In some cases, a Covered Person will be entitled to make self-payments in order to maintain eligibility for Benefits.
- J. Type of Plan  
This Plan provides hospitalization, medical, death, accidental death and dismemberment, maternity, dental and other related health care benefits. It is maintained pursuant to a Collective Bargaining Agreement between the Union and the Association which is available for examination at the Fund Office. A copy of the agreement may be obtained upon written request to the Fund Office. Upon request, the Fund Office will also inform you if a particular employer or union participates in the Plan and, if so, the address of that employer or union.
- K. Amendment  
The Trustees reserve the right to amend, modify or terminate this Plan, or any Benefits, as circumstances dictate.
- L. Grandfathered Health Plan  
This Plan believes this health 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 that law was enacted. Being a grandfathered health plan means that your Plan 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 administrative manager at the Fund Office.

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

## Section Fifteen – Definitions

**THE FOLLOWING WORDS HAVE SPECIFIC MEANINGS WHEN USED IN THE PLAN. IT IS IMPORTANT TO UNDERSTAND THE MEANINGS OF THESE DEFINED TERMS WHILE USING THIS BOOKLET.**

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A. Accident	R. In-Patient
B. Association	S. Medically Necessary
C. Beneficiary	T. Out-Patient
D. Benefits	U. Participant
E. COBRA Continuation Coverage	V. Physician
F. Collective Bargaining Agreement	W. Plan
G. Contributions	X. Retiree
H. Covered Employee	Y. Sickness
I. Covered Person	Z. Subrogation Covered Person
J. Eligible Dependent	AA. Totally Disabled
K. Eligibility Rules	BB. Trust Agreement
L. Employee	CC. Trust Fund
M. Employer	DD. Trustees
N. ERISA	EE. Union
O. Expense Incurred	FF. Usual, Customary and Reasonable Charge (UCR Charge)
P. Hospice	
Q. Hospital	

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A. Accident

The term “**Accident**” means a physical injury, such as a cut, break, sprain or bruise, occurring from an unexpected, undesirable and unavoidable act. This does NOT include overuse of muscles resulting in strains or aching arms and legs. **Intentionally inflicted injuries are excluded.**

B. Association

The term “**Association**” means The Builders’ Association.

C. Beneficiary

The term “**Beneficiary**” means a person designated by an Employee or by the terms of the Plan of Benefits established pursuant to the Trust Agreement who is, or who may become, entitled to receive any type of benefit from the Fund. When a benefit is payable to a Beneficiary, it will be paid to the Employee-designated Beneficiary on file at the Fund Office. In the event the Employee fails to designate a Beneficiary or if the designated Beneficiary dies before the Employee, the benefit shall be payable to the first of the following, if living:

1. To the legal spouse, or
2. If no legal spouse is living, to the living children in equal shares, or
3. If no legal spouse or children are living, to the living parents in equal shares, or
4. If no legal spouse, children or parents are living, to the living brothers and sisters in equal shares, or
5. If none of the above are living, to the Employee's estate.

The Employee may designate a new Beneficiary at any time by filing a written request with the Fund Office.

D. Benefits

The term "**Benefits**" means the Health and Welfare benefits to be provided pursuant to the Plan together with any amendments, modifications or interpretations adopted by the Board of Trustees.

E. COBRA Continuation Coverage

The term "**COBRA Continuation Coverage**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, and any amendments thereto and any governmental regulations, guidance or interpretations issued thereto, requiring that health and welfare plans offer employees and their families the opportunity for a temporary extension of health coverage.

F. Collective Bargaining Agreement

The term "**Collective Bargaining Agreement**" means the labor agreement between the Union and the Association and any other employer, group of employers or association of employers.

G. Contributions

The term "**Contributions**" means the money paid to the Fund by Employers in accordance with the provisions of the Collective Bargaining Agreement(s).

H. Covered Employee

The term "**Covered Employee**" means an employee for whom Contributions are made to the Fund as provided by a Collective Bargaining Agreement or other written agreement approved by the Trustees and who is covered according to the provisions set forth under the Eligibility Rules.

I. Covered Person

The term “**Covered Person**” means either the Covered Employee or Retiree and their Eligible Dependents.

J. Eligible Dependent

The term “**Eligible Dependent**” means any of the following:

1. The lawful spouse of the Covered Employee or Retiree (not legally separated or divorced).
2. The natural or adopted children (or placed for adoption) or stepchildren of the Covered Employee or Retiree, as defined below:
  - a. who are:
    - i. under the age of 26; or
    - ii. Totally Disabled; and
  - b. Other unmarried minor children, for whom the Covered Employee or Retiree has been appointed by the court as legal guardian as well as been required to provide medical coverage for the children, who are:
    - i. under the age of 19; or
    - ii. under the age of 24, if full-time student; or
    - iii. Totally Disabled.
  - c. The term “placed for adoption” means the assumption and retention by a Covered Employee or Retiree of a legal obligation of a child in anticipation of the adoption of the child prior to that child’s 18<sup>th</sup> birthday. The child’s placement with the Covered Employee or Retiree ends upon the termination of such legal obligation.
  - d. Full-time students are any other unmarried minor children as described above, who are at least age 19 who have not attained age 24, who have not graduated and are full-time students in high school or are enrolled as full-time students at an accredited junior college, college, university, nurses training center or a vocational or trade school approved by the Department of Labor, and who are reported to the Administration Office with this proof prior to submitting a claim, whether or not the student has health coverage available through an employer or through their spouse’s employer, if married.

In the case of an unmarried child under age 24 who is covered under the Plan due to full-time attendance at an accredited institution of learning (“attending school”) immediately before the first day of a “Medically Necessary Leave of Absence,” the Plan shall not terminate coverage of such child under the Plan due to such Medically Necessary Leave of Absence before the date that is the earlier of:

- i. The date that is one year after the first day of the Medically Necessary Leave of Absence; or
- ii. The date on which such coverage would otherwise terminate under the terms of the Plan.

This provision is subject to the Plan being in force at the time of the leave of absence and the receipt by the Plan of written certification by a treating physician of the child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is Medically Necessary.

As used in this Section, the term “Medically Necessary Leave of Absence” means a leave of absence of a child attending school, or any other change in enrollment of such child at the school, that:

- i. Commences while such child is suffering from a serious illness or injury;
  - ii. Is Medically Necessary; and
  - iii. Causes such child to lose full-time student status for purposes of coverage under the terms of the Plan.
- e. Totally Disabled children who are disabled because of a qualifying physical or mental handicap under this definition. In order to qualify, the physical or mental handicap must:
- i. occur before the child reaches age 19;
  - ii. be certified by a Physician; and
  - iii. render the child incapable of self-sustaining employment so as to make the child dependent upon the parents for financial support and maintenance. Initial proof of such disability and financial dependence must be furnished to the Board of Trustees within 31 days of the child’s reaching 19 years of age. Subsequent proofs may be required by the Board of Trustees after the child reaches age 21, but not more frequently than annually.

3. Children for whom coverage must be provided because of a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order, administrative order pursuant to state law or court decree relating to child support under the Plan. The Fund Office shall be delegated the authority to determine if a National Medical Support Notice, issued by a state agency pursuant to ERISA Section 609, 20 USC Section 1169 and the regulations promulgated therefrom, constitutes a QMCSO. QMCSOs other than National Medical Support Notices must be approved by the Board of Trustees to be qualified. A copy of the Plan's QMCSO qualification procedures is available from the Fund Office upon request.
4. For dependents working full-time under the age of 26 and having their own health care coverage, this Plan will coordinate and be the secondary payer. In the event that two Employees are married to each other, Benefits will be paid at the rate of 80% as an Employee and an additional 20% as an Eligible Dependent.

K. Eligibility Rules

The term “**Eligibility Rules**” applies to active Employees and their Eligible Dependents, retired Employees and their Eligible Dependents, total and permanently disabled Employees and their Eligible Dependents, and Employees and Eligible Dependents under COBRA Continuation Coverage.

L. Employee

The term “**Employee**” means:

1. Any person who is employed by an Employer, as that term is defined in the Plan, and for whom the Employer is required to make contributions into the Trust Fund;
2. Any full time employee of the Union or of a participating union;
3. Any full time employee of the Association;
4. Any full time employee of the Board of Trustees; and
5. Any other employee of any Employer who has been accepted as such by the parties to the Trust Agreement.

M. Employer

The term “**Employer**” means:

1. Any member of the Association who is a party to, or otherwise bound by a Collective Bargaining Agreement with the Union requiring Contributions to the Trust Fund with respect to employees represented by the Union.

2. Any employer who has signed a Stipulation in accordance with Annex “A” of the Trust Agreement or in a form otherwise approved by the Board of Trustees.
3. Any other employer, association of employers or group of employers who have been accepted and approved by the Board of Trustees.
4. The Trustees as to its Employees, the participating unions as to Employees of participating unions, the Association as to Employees of the Association, and related funds as to the Employees of the related funds. Such status of the Union, participating unions, the Trustees and related funds shall be solely for the purpose of making the required contributions to the Trust Fund.

N. ERISA

The term “**ERISA**” means the Employee Retirement Income Security Act of 1974, any amendments as may from time to time be made, and any regulations promulgated pursuant to the provisions of said Act.

O. Expense Incurred

The term “**Expense Incurred**” includes only those charges made for services and supplies which are reasonably priced and are appropriate and consistent with the diagnosis according to accepted standards of community practice, and could not have been omitted without adversely affecting the person’s condition or the quality of medical care. All Expenses Incurred will be considered on a Usual, Customary and Reasonable Charge basis in the given geographical area which shall be no higher than the 90<sup>th</sup> percentile of prevailing health care charges data.

P. Hospice

The term “**Hospice**” means a licensed agency that provides counseling and medical services to the terminally ill and which meets **all** of the following tests:

1. Has obtained any required state or governmental Certificate of Need approval,
2. Provides services on a 24 hour, seven day a week basis,
3. Is under the direct supervision of a Physician,
4. Has a nurse coordinator who is a Registered Nurse (R.N.),
5. Has a social service coordinator who is licensed,
6. Is an agency that has as its primary purpose the provision of Hospice services,
7. Has a full time administrator,

8. Maintains written records of services provided to the patients, and
9. Is licensed in the jurisdiction in which it is located, if licensing is required.

Q. Hospital

The term “**Hospital**” means only a facility which meets **all** of the following criteria:

1. Is licensed as a hospital by the state, county or municipality where it is located,
2. Operates primarily for the active care of the sick and injured and not for custodial care or educational service,
3. Provides 24 hour a day, on the premises, nursing services by registered nurses (R.N.),
4. Has a staff of one or more Physicians available at all times,
5. Provides organized facilities for diagnosis and surgery on its premises,
6. Is not primarily a clinic, nursing, rest or convalescent home or extended care facility, and is not a place for substance abuse treatment including but not limited to drug addiction, alcoholism, etc.,
7. Maintains permanent and full time facilities for bed care of 50 or more resident patients.
8. For purposes of Alcohol and Drug Treatment Benefits and Mental Health Benefits, Hospital means, (a) facilities or institutions as defined in Subsection 1, above; or (b) a facility licensed by the appropriate state governmental authority and certified under Medicare as a participating hospital for the treatment of mental and nervous disorders or alcohol or substance use disorders. The facility described in (b) shall be located within the States of Kansas or Missouri if a duly accredited facility exists therein, or otherwise shall be approved as a qualified facility by the Trustees prior to treatment.

R. In-Patient

The term “**In-Patient**” means a person who is a resident patient using and being charged for the room and board facilities of a Hospital.

S. Medically Necessary

The term “**Medically Necessary**” means only those services, treatments or supplies provided by a Hospital, a Physician, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees based upon the opinion of a qualified medical professional, to identify or treat a Covered Person’s Accident or Sickness and which are:

1. Appropriate and necessary for the symptoms, diagnosis and treatment of the Covered Person’s condition, disease, ailment or injury,
2. Consistent with acceptable medical practice according to the medical policy established by the national Blue Cross and Blue Shield Association (the right to review this medical policy is available upon review of a denied claim in accordance with terms of Section X,
3. Not primarily for the convenience of the Covered Person, his family, Physician or other provider,
4. Consistent with attaining reasonably achievable outcomes,
5. Not deemed to be Experimental, Investigative or Inappropriate, and
6. Reasonably calculated to result in the improvement of the Covered Person’s physiological and psychological functioning.

The fact that a Physician prescribes services or supplies does not automatically mean the services or supplies are Medically Necessary and covered by the Plan.

For purposes of this Plan, the use of any treatment (which includes use of any treatment, procedure, facility, drug equipment, device, or supply) is considered to be “Experimental,” “Investigative” or “Inappropriate” if:

1. It is a service or treatment on which the consensus of expert medical opinion, based on Reliable Evidence (i.e., published reports and/or articles), indicates that further trials or studies are needed to determine the safety, efficiency and outcomes of such treatment or services compared to standard treatment. Experimental, Investigative or Inappropriate also means such services or treatment not yet official and not yet recognized as having proven beneficial outcomes, those still primarily confined to a research setting and those that are not appropriate based on medical circumstances and/or given the advanced stage of a Covered Person’s Sickness or the likelihood that the service or treatment will measurably improve the Covered Person’s Sickness or the likelihood that the service or treatment will measurably improve the Covered Person’s Sickness or medical condition,

2. The drug or device cannot be lawfully marketed without the US Food and Drug Administration approval and that no approval for marketing has been given at the time the drug or device is furnished,
3. Reliable Evidence shows the drug, device, treatment or procedure is:
  - a. The subject of ongoing Phase I or Phase II clinical trial, the experimental or research arm of a Phase III clinical trial, or in any other manner with the objective of evaluating the maximum tolerated dosage, toxicity, safety or efficacy,
  - b. Provided following a written protocol or other document with the objective of evaluating the toxicity, safety or efficacy, or
  - c. Experimental or Investigative based on the patient's informed consent document used with the drug, device or medical treatment,
4. The uniform medical policy of the national Blue Cross and Blue Shield Associate (as amended from time to time) has determined that the device or medical treatment/procedure is investigational based on:
  - a. Not receiving final approval from the appropriate governmental regulatory bodies,
  - b. Scientific evidence does not permit conclusions about the effect of the device of medical treatment/procedure on health outcomes,
  - c. The device or medical treatment/procedure does not improve the overall health outcome,
  - d. The device or medical treatment/procedure is not as beneficial as established alternatives, or
  - e. The improvement is not attainable outside the investigational settings.

Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocol used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.

The Trustees will have the sole authority to determine, in their discretion, whether a service, procedure, drug, device or treatment modality is Experimental, Investigative or Inappropriate. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, drug, device or treatment does not, in itself, make it eligible for payment.

T. Out-Patient

The term “**Out-Patient**” means a person who receives services and treatments in a Hospital (provided that there is no charge for room and board), ambulatory clinic, free-standing surgical unit, or Physician’s office.

U. Participant

The term “**Participant**” means an Employee or former Employee of an Employer who is eligible to receive any type of Benefit from this Fund.

V. Physician

The term “**Physician**” means medical doctors, osteopaths, surgeons, dentists, podiatrists, chiropractors and psychologists with a Ph.D., when practicing within the scope of their license.

W. Plan

The term “**Plan**” means the Schedule of Benefits and the rules and regulations of the BAC Local Union 15 Welfare Fund and the Trust Fund as established heretofore, or as shall be established from time to time by amendments, modifications or interpretations by the Trustees for the administration of the Trust Fund and Plan.

The Plan was established as of April 5, 1973, in accordance with the provisions of the Trust Agreement.

X. Retiree

The term “**Retiree**” means a Covered Employee who has retired from active employment and who meets the eligibility requirements for Retirees as explained in Section 2E.

Y. Sickness

The term “**Sickness**” includes physical illness, pain or a fever not caused by an Accident. Sicknesses resulting from intentional use, such as overdose of drugs, are excluded.

Z. Subrogation Covered Person

For the purpose of Section Twelve J, the term “**Subrogation Covered Person**” means a Covered Person, his spouse, dependents, parents, heirs, guardians, conservators, next friend, executors, assigns, personal representative or other representative.

AA. Totally Disabled

The term “**Totally Disabled**” unless otherwise specifically defined, refers to a disability resulting solely from a Sickness or Accident which prevents the Covered Employee from performing Bricklayer and Allied Crafts work as defined in the work jurisdiction definition of the Collective Bargaining Agreement or prevents the Covered Employee’s dependent(s) from engaging in substantially all of the normal activities of a person of like age and sex in good health. Both the Covered Employee and the Covered Employee’s Eligible Dependent(s) must be under the regular care and actual attendance of a Physician.

BB. Trust Agreement

The term “**Trust Agreement**” means the amended Agreement and Declaration of Trust effective January 1, 1976, including the original Trust Agreement.

CC. Trust Fund

The term “**Trust Fund**” means the Trust Fund created pursuant to the Trust Agreement and generally the monies or other things of value which comprise the corpus and additions to the Trust Fund.

DD. Trustees

The term “**Trustees**” (or “**Board**” or “**Board of Trustees**”) means the persons designated in the Trust Agreement, their predecessors or their successors designated and appointed in accordance with the terms of the Trust Agreement. The Trustees shall constitute the “Administrator,” the “Plan Sponsor” and the “Named Fiduciaries” of the Trust Fund and of the Plan established and maintained under the authority of the Trust Agreement.

EE. Union

The term “**Union**” means Local 15 of the International Union of Bricklayers and Allied Craftworkers, AFL-CIO, and other BAC Unions which may become parties to the Trust.

FF. Usual, Customary and Reasonable Charge (UCR Charge)

The term “**Usual, Customary and Reasonable Charge (UCR Charge)**” means that the charge by any provider for a service must be similar to all other like providers of the same service in that geographical area and which is no higher than the 90<sup>th</sup> percentile of prevailing health care data on such charges. The “geographical area” reference is the zip code for the general level of charges being made by a Physician of similar training and experience. For In-Network providers, the allowed charge is the UCR Charge.