

**AMENDMENT NO. 1
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations Providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) is amended as follows:

Effective May 1, 2007, Section 16 of Article I (Definitions) and Section 4 of Article II (Eligibility Rules) are restated to remove Helper and replace with Mason Finisher as follows:

ARTICLE I. DEFINITIONS

Section 16. Mason Finisher.

An individual classified as a "Mason Finisher", as defined under the Collective Bargaining Agreement, and who is eligible for limited coverage under the Plan.

ARTICLE II. ELIGIBILITY RULES

Section 4. Mason Finishers.

A Mason Finisher, as defined under the Collective Bargaining Agreement, will be covered when he or she meets the eligibility requirements set forth in Section 1 of this Article II, above. The Mason Finisher's coverage, however, will be limited as follows:

- (a) Unlike Active Employees, a Mason Finisher may only enroll in the Fee-For-Service Medical Plan (i.e., Articles III, IV, V and VI) and the Fee-For-Service Dental Plan (i.e., Article VIII); and
- (b) The Fund will not cover Dependents of Mason Finishers under any circumstances.

CERTIFICATE OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 1 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on September 11, 2007.

UNION TRUSTEES

Paul H. Hoberg

Gary H. Anthony

Joe C. Solis

Frank Cam

EMPLOYER TRUSTEES

J. C. Smith

Halcyon

Kenneth J. Zyde

Frank Edmund

**AMENDMENT NO. 2
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations Providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) is amended as follows:

Effective September 1, 2007, Section 8(e) of Article I (Definitions) is deleted in its entirety and Section 3(a) of Article III (Fee-For-Service Major Medical Benefit Plan) is deleted in its entirety and replaced with the following:

ARTICLE III. FEE-FOR-SERVICE MAJOR MEDICAL BENEFIT PLAN

Section 3. Benefits.

(a) Medically Necessary Covered Expenses: The Plan pays 80% of the Contracted Rate for Covered Expenses provided by a PPO Provider or 60% of the Non-PPO schedule for Covered Expenses provided by a Non-PPO Provider. Non-PPO Covered Expenses for anesthesiology claims are based on the 85th percentile of HIAA.

Effective November 1, 2007, Section 3(a) of Article II (Eligibility Rules) is deleted in its entirety and replaced with the following:

ARTICLE II. ELIGIBILITY RULES

Section 3. Retired Employees.

(a) An individual who retires on or after May 1, 1988, and was eligible for benefits during all of the six months prior to his retirement, and receives a Regular Pension or Disability Pension, as defined in the Rules and Regulations of the Brick Masons' Pension Trust, or who retires on or after November 1, 2007 and is eligible for benefits under any retirement plan sponsored by the Union, may continue health care benefits as described in Section 5 of this Article, provided he was covered under the Active Plan at retirement, or he may elect to be covered under the Retiree Benefit Plan as described in Section 3 (b) below. After the individual retires, upon the exhaustion of his reserve account, he will be asked to elect one of the aforementioned plans. Once he has made his selection, he may not change to the other plan.

CERTIFICATE OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 2 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on December 11, 2007.

UNION TRUSTEES

Gary R. Anthony

Joe Lohs

Paul A. Hickey

David Carr

EMPLOYER TRUSTEES

Kenneth J. Zepko

Salazar

Frank W. Smith

Jay Smith

**AMENDMENT NO. 3
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations Providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) is amended as follows:

Effective September 1, 2009, Section 5(h) of Article II (Eligibility Rules) is deleted in its entirety and replaced with the following:

ARTICLE II. ELIGIBILITY RULES

Section 5. COBRA Continuation Coverage.

(h) Employees who have residual hours left in their reserve account, but not enough for a full month of eligibility under the Active Plan, will be able to use these residual hours to subsidize their first month of COBRA self-payment premiums. The amount of the subsidy will be:

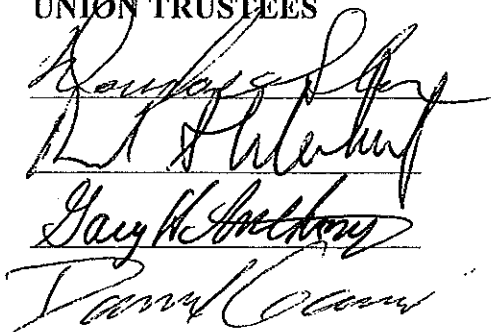
$$\frac{(\text{residual hours}) \times (\text{COBRA monthly self-payment premium rate})}{(\text{monthly reserve account deduction})}$$

In addition, life insurance benefits as outlined in Article XVI will continue for one month if the Employee loses eligibility and he or she has residual hours left in his or her reserve account, regardless of whether the Employee chooses to self-pay through COBRA.

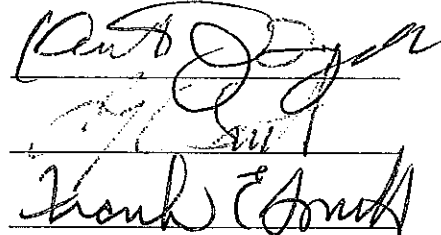
CERTIFICATE OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 3 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on March 8, 2010.

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**AMENDMENT NO. 4
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

Effective July 1, 2010, Section 1(c) of Article III (Fee-for Service Major Medical Benefit Plan) is deleted in its entirety and replaced with the following:

ARTICLE III. FEE-FOR-SERVICE MAJOR MEDICAL BENEFIT PLAN

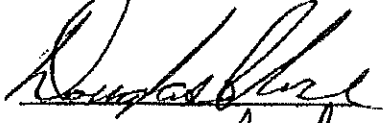
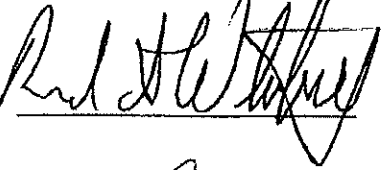
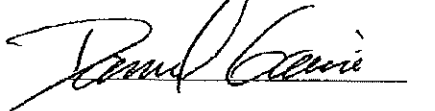
Section 1. Definitions

(c) Non-PPO Schedule – The term “Non-PPO Schedule” means a fixed schedule of allowances the Plan will pay for Medically Necessary Covered Expenses received from a Non-PPO Provider. This schedule is based on the 90th percentile of MDR for Non-PPO claims incurred prior to October 1, 2010 and the 90th percentile of Context for Non-PPO claims incurred on or after October 1, 2010, as updated from time to time.

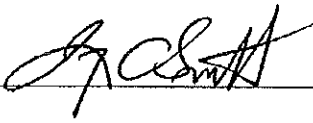
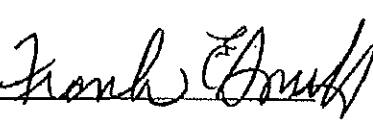
CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 4 to the Rule and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on June 8, 2010.

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**AMENDMENT NO. 5
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

Effective July 1, 2010, Sections 1, 2, and 3 of Article VII (Health Maintenance Organization (HMO) Benefits) is deleted in its entirety and replaced with the following:

ARTICLE VII. HEALTH MAINTENANCE ORGANIZATION (HMO) BENEFITS

Section 1. Kaiser Permanente.

Active and Retired Employees and their Dependents may enroll in the Kaiser Permanente HMO plan if they reside in the Kaiser service area. If a Covered Employee enrolls in the Kaiser Permanente plan, Kaiser Permanente will provide, subject to the terms and conditions of its agreement with the Fund, medical and prescription drug benefits and services as set forth in the aforementioned agreement. If a Covered Employee enrolls in the Kaiser Plan, benefit materials outlining the benefits and services, including the limitations and exclusions and claims and appeals procedures, will be furnished, free of charge, as a separate document. *After twelve (12) months of consecutive enrollment in the Kaiser Plan, you can change to another medical plan.*

Section 2. PacifiCare.

Active Employees and their Dependents may enroll in the PacifiCare HMO plan if they reside within 30 miles of the PacifiCare facility they wish to use (Retired Employees and their Dependents are not eligible for coverage in the PacifiCare plan). If a Covered Employee enrolls in the PacifiCare Plan, PacifiCare will provide, subject to the terms and conditions of its agreement with the Fund, medical and prescription drug benefits and services as set forth in the aforementioned agreement. If a Covered Employee enrolls in the PacifiCare plan, benefit materials outlining the benefits and services, including the limitations and exclusions and claims and appeals procedures, will be furnished, free of charge, as a separate document. *After twelve (12) months of consecutive enrollment in the PacifiCare Plan, you can change to another medical plan.*

Section 3. Default Enrollment in Fee-For-Service Plan.

If no medical plan selection is made at the time of initial eligibility or reinstatement of eligibility, Covered Employees and their Dependents, if any, will be enrolled in the Fee-For-Service Medical Plan. *After twelve (12) months of consecutive enrollment in the Fee-For-Service Plan, you can change to another medical plan.*

Effective July 1, 2010, the following section (Sections 8. Enrollment) is added to Article VIII (Fee-For-Service Dental Benefit):

Section 8. Enrollment

If no dental plan selection is made at the time of initial eligibility or reinstatement of eligibility, Covered Employees and their Dependents, if any, will be enrolled in the Fee-For-Service Dental Plan. *After twelve (12) months of consecutive enrollment in the Fee-For-Service Plan, you can change to another dental plan.*

Effective July 1, 2010, Section 1 of Article IX (Prepaid Dental Benefits) is deleted in its entirety and replaced with the following:

ARTICLE IX. PREPAID DENTAL BENEFITS

Section 1. United Concordia.

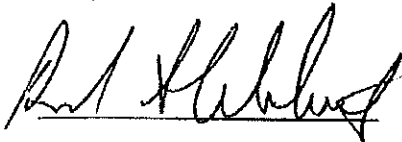
Active Employees and their Dependents may enroll in the United Concordia dental plan if they reside in the United Concordia service area. If a Covered Employee enrolls in the United Concordia plan, United Concordia will provide, subject to the terms and conditions of its agreement with the Fund, dental and orthodontic benefits and services as set forth in the aforementioned agreement. If a Covered Employee enrolls in the United Concordia plan, documents outlining the benefits and services, including the limitations and exclusions and claims and appeals procedures, will be furnished, free of charge, as a separate document. *After twelve (12) months of consecutive enrollment in the United Concordia Plan, you can change to another dental plan.*

CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 5 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on July 20, 2010.

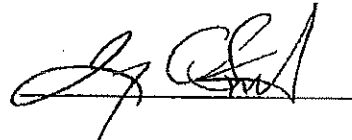
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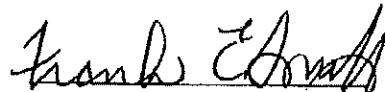






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**AMENDMENT NO. 6
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

Effective November 1, 2010, the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

Sections 3 of Article II (Eligibility Rules) is deleted in its entirety and replaced with the following:

ARTICLE II. ELIGIBILITY RULES

Section 3. Medicare and Non-Medicare Retired Employees.

- (a) A Medicare or Non-Medicare individual who retires on or after May 1, 1988, and was eligible for benefits during all of the six months prior to his retirement, and receives a Regular Pension or Disability Pension, as defined in the Rules and Regulations of the Brick Masons' Pension Trust, or who retires on or after November 1, 2007 and is eligible for benefits under any retirement plan sponsored by the Union, may continue health care benefits as described in Section 5 of this Article, provided he was covered under the Active Plan as described in Section 3 (b) below. After the individual retires, upon the exhaustion of his reserve account, he will be asked to elect one of the aforementioned plans, once he has made his selection, he may not change to the other plan.
- (b) The Retiree Plan consists of medical benefits provided by an HMO described in Article VII, Sections 1 and 2, prescription drug benefits described in Article VI, Section 1, and hearing aid benefits described in Article XI only. It does not include life insurance, accidental death and dismemberment, loss of time, dental or vision benefits. If the individual selects the Retiree Plan, coverage will start as of the date pension benefits start, or after the number of hours in his reserve account falls below 100, whichever is later. The Retired Employee will maintain coverage under the Retiree Plan by remitting self-payment premiums by the 15th day of the month before the month for which coverage is desired. Individuals who select the Retiree Plan and have residual hours left in their reserve account, but not enough for a full month of eligibility under the Active Plan, will be able to use these residual hours to subsidize their first month of retiree self-payment premiums. The amount of the subsidy will be:

$$\frac{(\text{residual hours}) \times (\text{retiree monthly self-payment premium rate})}{(\text{monthly reserve account deduction})}$$

- (c) Coverage under the Retiree Plan will cease on the earliest of the following dates:
 - (1) The date the Retired Employee ceases to be eligible for pension benefits;
 - (2) The date the Fund ceases to provide such coverage;
 - (3) The date the Retired Employee ceases to pay premiums;
 - (4) The date the Retired Employee becomes covered under another group health plan;
- (d) The Retired Employee may also continue his Dependents' benefits, if they are eligible under the Retiree Plan, or they may elect the special continuation coverage. Dependent benefits will terminate on the earliest of the following dates:
 - (1) The date the Fund ceases to provide such coverage.
 - (2) The date the Dependent becomes covered under another group health plan.
 - (3) The date the Dependent ceases to qualify as a Dependent.
 - (4) The date the Retired Employee's coverage terminates.
- (e) If the benefits of a Dependent covered under the Retiree Plan terminate due to one of the qualifying events listed in Section 5(a) of this Article, that Dependent will then be eligible to continue Retiree Plan Benefits under the Special Continuation Coverage as described in Section 5.

Sections 5 of Article II (Eligibility Rules) is deleted in its entirety and replaced with the following:

ARTICLE II. ELIGIBILITY RULES

Section 5. COBRA Continuation Coverage.

- (a) Under federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if a Covered Employee or his Dependent ceases to be eligible due to one of the following "Qualifying Events," he may continue certain health care benefits through self-payment.
 - (1) Termination of employment (except for gross misconduct) or loss of eligibility due to reduced hours;
 - (2) The death of the Covered Employee;

- (3) Divorce or legal separation;
- (4) A dependent child loses Dependent status

The Covered Employee or Dependent may continue medical and prescription drug benefits, or medical, prescription drug, dental and vision care benefit, if he was covered under the Plan for Active Employees. HMO coverage may also be continued. Life insurance and accidental death and dismemberment insurance benefits may not be continued.

- (b) If the Qualifying Event is that one described in Section 5(a)(1), coverage may be continued for 18 months. If a second Qualifying Event occurs, the continuation period for Dependents may be extended, but not beyond a total of 36 months.
- (c) If the Qualifying Event is that one described in Section 5(a)(2), (3), (4) or (5), coverage may be continued for 36 months.
- (d) If the Qualifying Event is the termination of employment, the reduction of work hours, or the death of an Employee, the Employer must advise the Plan Administrator of the event within 60 days.
- (e) If the Qualifying Event is a divorce, legal separation, or a dependent child's loss of Dependent status, the Employee or family member must advise the Plan Administrator of the event within 60 days.
- (f) The Plan Administrator must provide the Employee with additional information about the continuation coverage. Election of continuation coverage must take place within 60 days after such information is sent. All premiums must be paid within 45 days of the election. Subsequent payments must be received by the 15th day of the month before the month for which coverage is desired. No premium statements will be issued by the Fund.
- (g) The continuation coverage will cease on the earliest of the following dates:
 - (1) The date the maximum extension period has been reached;
 - (2) The date the Fund ceases to provide health care coverage;
 - (3) The date the individual ceases to pay premiums when due;
 - (4) The date the individual becomes covered under another health care plan.
- (h) Employees who have residual hours left in their reserve account, but not enough for a full month of eligibility under the Active Plan, will be able to use these residual hours to subsidize their first month of COBRA self-payment premiums. The amount of the subsidy will be:

$$\frac{(\text{residual hours}) \times (\text{COBRA monthly self-payment premium rate})}{(\text{monthly reserve account deduction})}$$

- (i) If an Eligible Individual is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage as outlined in Section 5(b), the Eligible Individual and all Eligible Individuals in the family may be entitled to receive up to an additional 11 months of COBRA coverage. Eligible Individuals who become totally disabled, as determined by the Social Security Administration, while covered by the Plan and prior to the end of the first 60 days of eligibility for this continuation of coverage, and who provide a copy of the Social Security award before the end of the first eligibility period of 18 months, are entitled to extend this coverage for a total of 29 months, although the cost of the coverage may be greater in months 19 through 29.
- (j) If an Eligible Individual is enrolled in a Health Maintenance Organization plan and is receiving COBRA coverage, the Eligible Individual may be entitled to an 18-month extension of coverage under California law (Cal-COBRA), up to a total of 36 months from the date Plan coverage was lost as outlined in Section 5(a)(1). Premium payments for extended coverage (months 19 through 36) will be higher than standard COBRA coverage.
- (k) If while receiving COBRA coverage, a Covered Employee acquires a new Dependent through marriage, birth, adoption or placement for adoption, the Dependent(s) may be enrolled for the remainder of the Covered Employee's COBRA coverage period provided that notice is given to the Trust Fund Office within 30 days of acquiring the new Dependent.
- (l) If a Covered Employee becomes eligible for Trade Adjustment Assistance (TAA) pursuant to the Trade Adjustment Assistance Reform Act of 2002 or is an eligible alternative TAA recipient under the Act, and did not elect COBRA continuation coverage during the 60-day election period that was a direct consequence of the TAA-related loss of coverage, the Covered Employee may elect COBRA coverage (for him/herself and any eligible dependents) during a 60-day period that begins on the first day of the month in which the Covered Employee is determined to be a TAA-eligible individual. The election must be made no later than six months after the date of the TAA-related original loss of coverage. However, the maximum COBRA period is measured from the initial loss of coverage. TAA-eligible individuals can elect coverage for themselves and eligible family members may also elect COBRA continuation coverage.

COBRA continuation coverage elected during the second election period will begin on the first day of the second election period, and not on the date on which coverage originally lapsed. The time between the loss of coverage and the start of the second election period will not be counted for purposes of determining whether the individual has had a 63-day break in coverage (see Section 8 below).

Sections 2 of Article VII (Health Maintenance Organization (HMO) Benefits) is deleted in its entirety and replaced with the following:

ARTICLE VII. HEALTH MAINTENANCE ORGANIZATION (HMO) BENEFITS

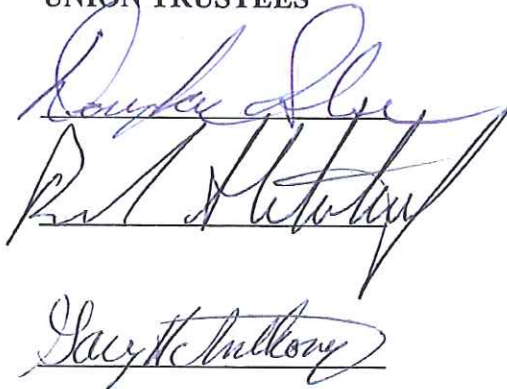
Section 2. PacifiCare.

Active and Retired Employees and their Dependents may enroll in the PacifiCare HMO plan if they reside within 30 miles of the PacifiCare facility they wish to use. If a Covered Employee enrolls in the PacifiCare Plan, PacifiCare will provide, subject to the terms and conditions of its agreement with the Fund, medical and prescription drug benefits and services as set forth in the aforementioned agreement. If a Covered Employee enrolls in the PacifiCare plan, benefit materials outlining the benefits and services, including the limitations and exclusions and claims and appeals procedures, will be furnished, free of charge, as a separate document.

CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 6 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on September 28, 2010.

UNION TRUSTEES



EMPLOYER TRUSTEES



**AMENDMENT NO. 7
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

Effective **May 1, 2011**, Section 8 of Article I (Definitions) is deleted in its entirety and replaced with the following:

ARTICLE I. DEFINITIONS

Section 8. Dependent.

The term "Dependent" means:

- (a) The Covered Employee's lawful spouse; or registered same sex domestic partner in accordance with AB 2208 (opposite sex at age 62 or older), except for those benefits set forth in Articles III, IV, V VI, VIII, XI, XVI, and XVII. The Covered Employee must register the domestic partnership with the Secretary of State in accordance with Section 298 of the Family Code, and a copy of a valid Declaration of Domestic Partnership must be submitted to the Fund. Domestic partners will be deemed a Dependent for benefits in the HMO medical and prescription drug plans, prepaid dental plan, and vision benefit plan only. Both the Covered Employee and his or her domestic partner must be enrolled in the same medical and dental plan.
- (b) The Covered Employee's children, from birth to age 26, including step-children, adopted children and foster children. Adult children who are eligible to enroll in an employer-based group health plan provided by their employer or the employer of their spouse are not eligible for coverage.

(c)

In no event shall a lawful spouse, domestic partner, child, mother, father, mother-in-law or father-in-law be eligible under the Plan both as an eligible Dependent and as a Covered Employee, nor shall a child be considered an eligible Dependent of more than one Covered Employee.

In no event shall a child of a domestic partner be considered an eligible Dependent.

Effective **May 1, 2011**, Section 1 of Article V (Physical Examination Benefit) is deleted in its entirety and replaced with the following:

ARTICLE V. PHYSICAL EXAMINATION BENEFIT

Section 1. Benefits.

The Plan will pay benefits for routine physical examinations for an Active Employee and Dependent spouse performed by a licensed Physician as follows:

- (a) Once per Calendar Year for a Covered Employee or spouse of a Covered Employee once every two years under the age of 35; and
- (b) Once per Calendar Year for a Covered Employee or spouse of a Covered Employee age 35 and over.
- (c) If any abnormality is discovered as a result of a physical examination, the benefits outlined in Article III will be paid on the same basis as any illness.
- (d) The benefits covered under routine physical examinations are limited to those generally considered medically appropriate based on the age and gender of the person being examined.

Effective **July 1, 2011**, Section 3 of Article III (Fee-For-Service Major Medical Benefit Plan) is deleted in its entirety and replaced with the following:

ARTICLE III. FEE-FOR-SERVICE MAJOR MEDICAL BENEFIT PLAN

Section 3. Benefits.

If an Eligible Individual receives therapeutic treatment of an Injury or Sickness, the Plan will, subject to the terms and conditions hereafter stated, pay the following benefits:

- (a) Medically Necessary Covered Expenses: The Plan pays 80% of the Contracted Rate for Covered Expenses provided by a PPO Provider or 60% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider. Non-PPO Covered Expenses for anesthesiology claims are based on 85th percentile of HIAA.
- (b) Physical Therapy, Acupuncture, and Chiropractic Care: The Plan pays 80% of the Contracted Rate for Covered Expenses for physical therapy, acupuncture, and chiropractic care provided by a PPO Provider or 60% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider up to a maximum payable amount of \$35. Benefits are limited to 20 combined visits per year.
- (c) Outpatient Psychiatric Services: The Plan pays 50% of Covered Expenses for psychometric testing and psychotherapy when not confined in a Hospital as a registered bed patient. Covered Expenses for psychometric testing and

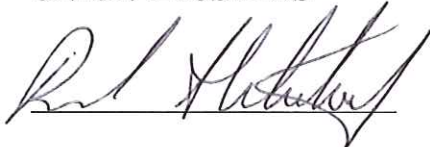


psychotherapy when not confined in a Hospital as a registered bed patient will not exceed a daily amount of 50% of covered charges up to a maximum of 50 visits per Calendar Year.

- (d) Immunizations: The Plan will cover adult and children immunizations recommended by the US Preventative Care Task Force Guidelines. The Plan pays 80% of the Contracted Rate for Covered Expenses provided by a PPO Provider or 60% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider.

CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 7 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on March 14, 2011.

UNION TRUSTEES

EMPLOYER TRUSTEES





**AMENDMENT NO. 8
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

Effective **May 1, 2012**, Section 1 of Article II (Eligibility Rules) is deleted in its entirety and replaced with the following:

ARTICLE II. ELIGIBILITY RULES

Section 1. Active Employees.

(a) Establishment and Maintenance of Eligibility:

- (1) Any Active Employee working for Employers who contribute to the Brick Masons' Health and Welfare Trust Fund shall be eligible for Plan benefits:
 - (i) on January 1, 1989, if he was eligible for Plan benefit on December 31, 1988;
 - (ii) after January 1, 1989, on the first day of the second calendar month next following any consecutive period of four calendar months or less during which the number of hours for which contributions are made on his behalf by an Employer total at least 400 hours.
- (2) A reserve account has been established by the Fund for each Active Employee and is comprised of hours in excess of 100 hours worked by the Active Employee, while in an eligible class, with one or more contributing Employers during a month.

Such hours credited to the reserve account of the Active Employee under the Fund shall be carried over to his credit for continued eligibility for benefits. The maximum number of hours credited to the Active Employee's reserve account at any time shall in no event exceed 600 hour after the deduction has been made for the current month's coverage.

All hours credited to an Active Employee's reserve account shall be cancelled if the Active Employee does not satisfy the requirements for becoming eligible for benefits under the Fund for four consecutive calendar months.

If when an Active Employee loses eligibility he or she has hours remaining in his or her reserve account and elects to self-pay for coverage through COBRA, the first month's self-pay amount will be prorated (reduced) by the hours remaining in the reserve account as outlined in Article II, Section 5(h).

- (3) If an Active Employee has at least one hour in his or her Hour Bank, he or she may purchase additional hours, up to 100 hours, at a rate per hour as determined by the Trustees to maintain coverage. He or she will be allowed to purchase additional hours twice per fiscal plan year for maintaining eligibility, so long as there is at least one hour in his or her hour bank.
 - (34) An Active Employee's Dependent becomes eligible on the date the Active Employee's eligibility is effective, or on the date the Active Employee acquires the Dependent, whichever is later.
 - (45) Individuals who are employed by an Employer as a supervisor or estimator, as well as shareholders or Corporate Officers who hold less than 100% of the shares in an incorporated Employer, may participate in the Fund, provided that their Employers pay current contributions to the Health and Welfare, Pension, Vacation and Apprentice Funds on their behalf on the greater of 160 hours or actual hours worked per month. The Employer(s) must notify the Fund of the individual's participation and sign a participation agreement with each of the above-listed Funds. The individuals are subject to the same initial eligibility rules that apply to Active Employees as set forth in Article I, Section 1, Subsections (a)(1), (a)(2) and (a)(3). Sole proprietors are not eligible to participate in the Fund.
- (b) Termination of Eligibility. An Active Employee's eligibility will terminate on whichever of the following dates is applicable:
- (1) on the last day of the calendar month for which he does not qualify under Section 1 of this Article II, except as provided in Sections 3, 5, or 6 of this Article;
 - (2) on the date an Active Employee starts performing work that is not pursuant to a recognized Collective Bargaining Agreement in the area covered by the Plan. All contributions credited to the Employee's reserve account will be forfeited if eligibility is lost under this provision;
 - (3) on the date of entrance into full-time active duty with the Armed Forces of the United States;
 - (4) on the date the Plan is terminated by the Board of Trustees.

(c) Reinstatement of Eligibility

- (1) An Active Employee's eligibility will be reinstated if his reserved account reflects a total of at least 400 hours within the four month period following the termination of his previous eligibility. Such reinstatement will be effective on the first day of the second calendar month which follows the month in which this requirement is met.

If the Active Employee is not reinstated within a four month period, any hours remaining in his reserve account at the time of termination of his eligibility will be cancelled, and his eligibility can only be reinstated by satisfying the eligibility requirements as outlined in Section 1(a)(1)(ii) of this Article.

- (2) If an Active Employee enters full-time active duty with the Armed Forces of the United States, and subsequently returns to work for an Employer within 90 days from his discharge date, he will be eligible on the first day of such re-employment, and he is to be credited with any hours held in his reserve account at the time of entrance to active duty.

If work is not commenced for an Employer within 90 days after his discharge date, his eligibility can only be reinstated by satisfying the eligibility requirements as outlined in Section 1(a)(1)(ii) of this Article.

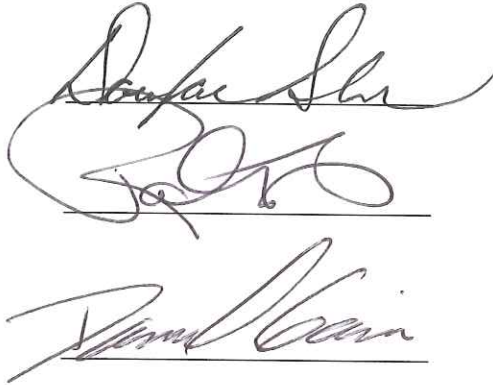
- (d) Reciprocity. The Trust Fund is a party to the International Reciprocal Agreement. Under this agreement, if an Active Employee is working temporarily under the jurisdiction of another union local that is a party to the reciprocity agreement, any contributions made on the Active Employee's behalf to the Trust Fund covering that local will be transferred to the Active Employee's Home Trust Fund in order to maintain eligibility of benefits.

- (1) In order to participate in the reciprocity program, the Active Employee must, before he begins working in the jurisdiction of another union local, obtain a health and welfare transfer authorization.
- (2) The health and welfare transfer authorization must be submitted to the union local in whose jurisdiction the Active Employee is now working within thirty-five (35) days of the date he began work in that jurisdiction.
- (3) If an Active Employee has already established eligibility and incurred claims under this Trust Fund, he may not designate another Trust Fund as his Home Fund unless he transfers his union membership to a local not covered by the Home Fund.

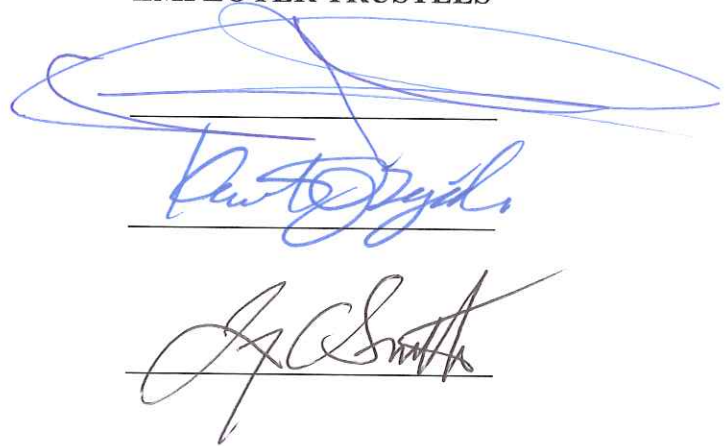
CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 8 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on June 12, 2012.

UNION TRUSTEES



EMPLOYER TRUSTEES



**AMENDMENT NO. 9
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

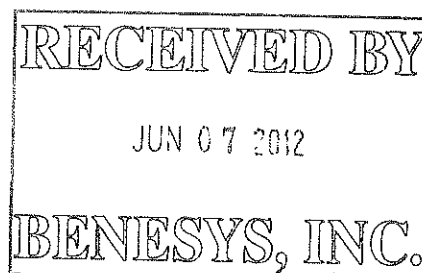
Effective **July 1, 2012**, Section 4 of Article II (Eligibility Rules) is deleted in its entirety and replaced with the following:

ARTICLE II. ELIGIBILITY RULES

Section 4. Mason Finisher.

A Mason Finisher, as defined under the Collective Bargaining Agreement, will be covered when he or she meets the eligibility requirements set forth in Section 1 of this Article II, above. The Mason Finisher's coverage, however, will be limited as follows:

- (a) Unlike Active Employees, a Mason Finisher may only enroll in the Fee-For-Service Medical Plan (i.e., Articles III, IV, V, VI) and Fee-For-Service Dental Plan (i.e., Article VIII); and
- (b) The Fund will not cover Dependents of a Mason Finisher under any circumstances.
- (c) Upon completion of the Mason Finisher Apprenticeship program (or the transitioning into the Bricklayer Apprenticeship program) a Mason Finisher will be entitled to the same benefits as Active Employees and any remaining hours earned as a Mason Finisher will be fully credited into his or her reserve account as an Active Employee. The Mason Finisher will be eligible as an Active Employee the month following the 1st contributions received at the Active Employee rate.



CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 9 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on June 12, 2012.

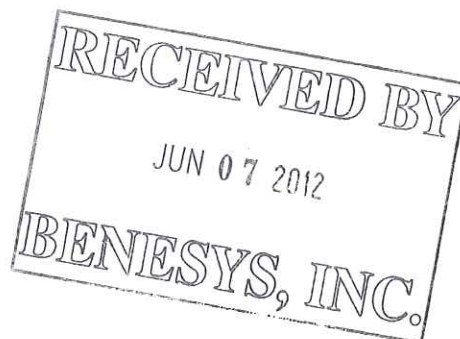
UNION TRUSTEES

Gayle Anthony
David Lee
David Lee

EMPLOYER TRUSTEES

[Signature]
Paul D. Doyle
[Signature]

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**AMENDMENT NO. 10
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

Effective **January 1, 2013**, Section 3 of Article III (Fee-For-Service Major Medical Benefit Plan) is deleted in its entirety and replaced with the following:

ARTICLE III. FEE-FOR-SERVICE MAJOR MEDICAL BENEFIT PLAN

Section 3. Benefits.

If an Eligible Individual receives therapeutic treatment of an Injury or Sickness, the Plan will, subject to the terms and conditions hereafter stated, pay the following benefits:


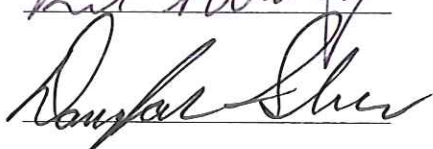

- (a) Medically Necessary Covered Expenses: The Plan pays 80% of the Contracted Rate for Covered Expenses provided by a PPO Provider or 60% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider. Non-PPO Covered Expenses for anesthesiology claims are based on 85th percentile of HIAA.
- (b) Physical Therapy, Acupuncture, and Chiropractic Care: The Plan pays 80% of the Contracted Rate for Covered Expenses for physical therapy, acupuncture, and chiropractic care provided by a PPO Provider or 60% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider up to a maximum payable amount of \$35. Benefits are limited to 20 combined visits per year.
- (c) Outpatient Psychiatric Services: The Plan pays 50% of Covered Expenses for psychometric testing and psychotherapy when not confined in a Hospital as a registered bed patient. Covered Expenses for psychometric testing and psychotherapy when not confined in a Hospital as a registered bed patient will not exceed a daily amount of 50% of covered charges up to a maximum of 50 visits per Calendar Year.
- (d) Immunizations: The Plan will cover adult and children immunizations recommended by the US Preventative Care Task Force Guidelines. The Plan pays 80% of the Contracted Rate for Covered Expenses provided by a PPO Provider or 60% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider.

- (e) Emergency Services: The Plan pays 80% of the Contracted Rate for Covered Expenses provided by a PPO Provider or 80% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider.

CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 10 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on December 11, 2012.

UNION TRUSTEES

EMPLOYER TRUSTEES





**AMENDMENT NO. 11
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

Effective May 1, 2014, Section 4 of Article II (Eligibility Rules) is deleted in its entirety and replaced with the following:

ARTICLE II. ELIGIBILITY RULES

Section 4. Mason Finisher Apprentice.

A Mason Finisher Apprentice, as defined under the Collective Bargaining Agreement, will be covered when he or she meets the eligibility requirements set forth in Section 1 of this Article II, above. The Mason Finisher Apprentice's coverage, however, will be limited as follows:

- (a) Unlike Active Employees, a Mason Finisher Apprentice may only enroll in the Fee-For-Service Medical Plan (i.e., Articles III, IV, V, VI) and Fee-For-Service Dental Plan (i.e., Article VIII); and
- (b) If a Mason Finisher Apprentice wishes to cover their dependent child(ren), they must elect this coverage by contacting the Trust Administrative Office. The Fund will not cover spouses of a Mason Finisher Apprentice under any circumstances.
- (c) Upon completion of the Mason Finisher Apprenticeship program (or the transitioning into the Bricklayer Apprenticeship program) a Mason Finisher Apprentice will be entitled to the same benefits as Active Employees and any remaining hours earned as a Mason Finisher Apprentice will be fully credited into his or her reserve account as an Active Employee. The Mason Finisher Apprentice will be eligible as an Active Employee the month following the 1st contributions received at the Active Employee rate.

Effective May 1, 2014, Section 5 of Article III (Fee-For-Service Major Medical Benefit Plan) is deleted in its entirety and all subsequent sections are renumbered accordingly.

ARTICLE III. FEE-FOR-SERVICE MAJOR MEDICAL BENEFIT PLAN

~~Section 5. Annual and Lifetime Maximum Benefits.~~

- ~~(a) Annual Maximum. The annual maximum amount payable for each Eligible Individual for benefits under the Fee-For-Service Medical Plan is \$100,000.~~
- ~~(b) Lifetime Maximum. The lifetime maximum amount payable for each Eligible Individual for benefits under the Fee-For-Service Medical Plan is \$500,000.~~

Effective May 1, 2014, Section 2 of Article VIII (Fee-For-Service Dental Benefit) is deleted in its entirety and replaced with the following:

ARTICLE VIII. FEE-FOR-SERVICE DENTAL BENEFIT

If an Active Employee or his Dependent incurs Covered Dental Expense, the Plan will pay for the treatment, examination or procedure, but not more than 80% of the Covered Dental Expense or the Dentist's Reasonable Charge, whichever is less.

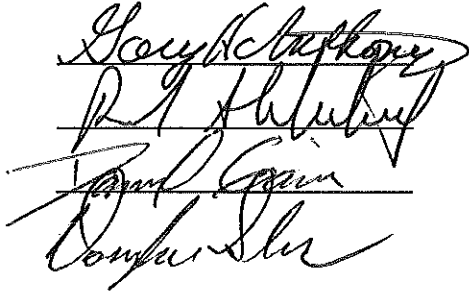
The maximum amount payable hereunder for Covered Dental Expense incurred by each Active Employee or Dependent in any Calendar Year shall be \$1,000. This Calendar Year maximum does not apply to children under the age of 19.

If benefits are payable under this benefit and the Fee-For-Service Medical Plan, payment will be made only under the plan which allows the greater payment.

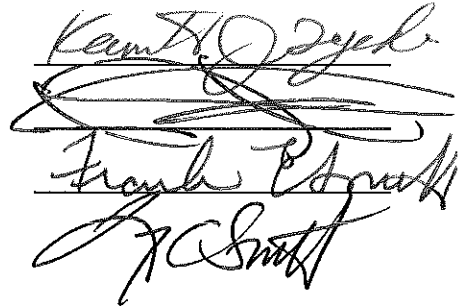
CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 11 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on June 10, 2014.

UNION TRUSTEES

Four handwritten signatures of Union Trustees, each written over a horizontal line.

EMPLOYER TRUSTEES

Three handwritten signatures of Employer Trustees, each written over a horizontal line.

**AMENDMENT NO. 12
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

Effective May 1, 2014, Article XX is deleted in its entirety and replaced with the following:

ARTICLE XX. PROTECTED HEALTH INFORMATION

Section 1. The Board of Trustees shall use and/or disclose Protected Health Information only to the extent necessary to perform the following administrative functions:

- (a) The Plan may use or disclose health information to make payment to or collect payment from third parties, such as other health plans or providers;
- (b) The Plan may disclose information to facilitate treatment which involves the providing, coordinating or managing of health care or related services;
- (c) The Plan may use or disclose health information for its own operations, to facilitate the administration of the Plan and as necessary to provide coverage and services to all of the Trust's participants. Health care operations include: making eligibility determinations; contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management, medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Plan (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities);
- (d) The Plan may disclose health information to the Board of Trustees and to necessary advisors which assist the Board of Trustees in performing plan administration functions, such as handling claim appeals. The Plan also may provide health information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans. Summary Health Information is information which summarizes participants' claims information but from which names and other identifying information have been removed. The Plan may also disclose information about whether an individual is participating in the Plan or one of its available options;
- (e) In addition, the Plan will disclose health information where applicable law requires. This includes:

- (1) The Plan will in response to an order from a court or administrative tribunal disclose protected health information in accordance with the express terms of such an order. The Plan may also disclose protected health information in response to a subpoena or other lawful process if the Plan receives satisfactory documentation that the affected individual has received notice of the subpoena or legal process, the notice provided sufficient information to allow the individual to raise an objection and the time for raising an objection has passed and either no objections were filed or were resolved by the court or administrative tribunal. Alternatively, the party requesting disclosure may provide satisfactory documentation that the affected individual has agreed to the disclosure or that it has obtained a qualified protective order which meets the requirements of the Privacy Rules and which allows for disclosure;
- (2) The Plan will disclose protected health information when it is required to do so for law enforcement purposes. This may include compliance with laws which require reporting certain types of injuries; pursuant to court issued legal process; or a grand jury subpoena or other administrative requests if satisfactory documentation is provided that the request is relevant to a legitimate law enforcement purpose, the request is reasonably tailored to meet this legitimate law enforcement purpose and de-identified information cannot be reasonably provided as an alternative. Additionally, limited disclosure may be made for purposes of identifying or locating a suspect, fugitive, material witness or missing person, identifying a victim of a crime or in connection with a criminal investigation that occurred on Plan premises;
- (3) The Plan may disclose health information to a health oversight agency for authorized activities (including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Plan, however, may not disclose health information if the individual is the subject of an investigation and the investigation does not arise out of or is not directly related to the individual's receipt of health care or public benefits;
- (4) The Plan may, consistent with applicable law and ethical standards of conduct, disclose health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to health or safety of an individual or to the health and safety of the public;
- (5) In certain circumstances, federal regulations require the Plan to use or disclose health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates;
- (6) The Plan may release health information to the extent necessary to comply with laws related to workers compensation or similar programs; and,
- (7) The Plan may disclose health information to an individual who is authorized by the effected individual or applicable law to serve as a personal representative.

Section 2. The Plan shall disclose Protected Health Information to the Board of Trustees only to the extent necessary to perform the following administrative functions for the Trust:

- (a) Plan administration purposes performed by the Board of Trustees on behalf of the Plan;
- (b) Enrollment and eligibility purposes;
- (c) Summary Health Information provided for purposes of obtaining premium bids or setting or evaluating plan rates;
- (d) Summary Health Information provided for purposes of evaluating benefits provided by the Plan; and,
- (e) Protected Health Information which an Individual authorizes the Board of Trustees to use or disclose.

Section 3. The Plan shall disclose Protected Health Information to the Board of Trustees only to the extent necessary to perform the following administrative functions for the Trust:

- (a) The Board of Trustees shall ensure the confidentiality, integrity and availability of all Electronic Protected Health Information the Plan creates, receives, maintains or transmits;
- (b) The Board of Trustees will protect against any reasonably anticipated threats or hazards to the security or integrity of Electronic Protected Health Information;
- (c) The Board of Trustees shall protect against any reasonably anticipated uses or disclosures of Electronic Protected Health Information that are not permitted or required under applicable law;
- (d) The Board of Trustees shall require each of its Business Associates which may create, receive, maintain or transmit Electronic Protected Health Information to agree to written contractual provisions which impose at least the same obligations in regards to Electronic Protected Health Information as apply to the Board of Trustees and to otherwise meet the requirements established by 45 CFR 164.314(a);
- (e) The Board of Trustees collectively, and each Trustee individually, shall report any security incident of which it or the individual Trustee becomes aware;
- (f) The Board of Trustees shall maintain its policies and procedures and documentation of any action or assessment undertaken to comply with the security regulations or other applicable law for six (6) years from the later of the date of the documents creation or its last effective date; and,
- (g) The Privacy Official appointed by the Plan shall also serve as Security Official.

Section 4. The Plan acknowledges that disclosure of Protected Health Information to the Board of Trustees collectively or individually has been conditioned upon the Board of Trustees' certification that this Amendment has been adopted and that the Board of Trustees, as plan sponsor, has agreed to abide by the following conditions:

- (a) The Board of Trustees, as plan sponsor, and each Trustee individually, agree to not use or disclose any Protected Health Information received from the Trust, except as permitted in this Amendment or required by law;
- (b) The Board of Trustees will require each of its Business Associates to whom it may provide Protected Health Information to agree to written contractual provisions that impose at least the same obligations to protect the use and disclosure of Protected Health Information as are imposed on the Board of Trustees and to require reasonable and appropriate provisions concerning the maintenance or transmittal of electronic protected health information;
- (c) The Board of Trustees, collectively and each Trustee as an individual, will not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any unrelated benefit or other employee benefit plan;
- (d) The Board of Trustees, collectively and each Trustee as an individual, will report to the Plan and its Privacy Officer any security incident or any known impermissible or improper use or disclosure of Protected Health Information not authorized by this Amendment or applicable law;
- (e) The Board of Trustees will make the Plan's internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Department of Health and Human Services ("DHHS") or its designee for the purpose of determining the Plan's compliance with HIPAA;
- (f) When the Protected Health Information is no longer needed for the purpose for which disclosure was made, the Board of Trustees will, if feasible, return to the Plan or destroy all Protected Health Information that the Board of Trustees, collectively or individually, received from or on behalf of the Trust. This includes all copies in any form, including any compilations derived from the Protected Health Information. If return or destruction is not feasible, the Board of Trustees, individually and collectively, agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible. This provision shall be interpreted in accordance with Section 45 CFR 164.530(j)(2) of the Privacy Rules;
- (g) The Board of Trustees will use its best efforts to request only the minimum necessary type and amount of Protected Health Information to carry out the functions for which the information is requested; and,
- (h) The Board of Trustees certifies that its individual Trustees have been educated about the HIPAA Privacy Rule and their obligations under it and that future Trustees will be similarly trained. Individual Trustees will not be provided Protected Health Information or allowed to participate in discussions where Protected Health Information is discussed if they have not received training.

Section 5. The Board of Trustees has also certified it will observe the following in regards to plan participants and their Protected Health Information:

- (a) The Board of Trustees will allow participants to inspect and copy their Protected Health Information contained in a designated record set pursuant to § 164.524;
- (b) The Board of Trustees will allow participants to amend or correct Protected Health Information contained in a designated record set that is inaccurate or incomplete and incorporate amendments as provided by § 164.526; and,
- (c) The Board of Trustees will make available the information necessary for an accounting of disclosures pursuant to § 164.528.

Section 6. The Board of Trustees represent that adequate separation exists between the health plans the Plan sponsors and the Board of Trustees and that reasonable and appropriate security measures have been taken to ensure this separation so that Protected Health Information will be used only for necessary Plan administration purposes. The Plan does not have any employees to which protected health information will be disclosed.

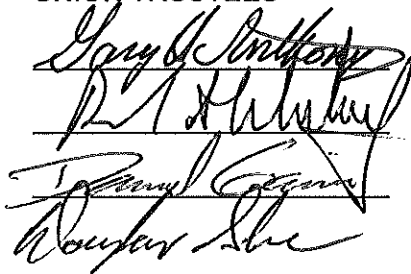
Section 7. The Board of Trustees certify that any Trustee or any person under the control of the Board of Trustees has been informed that complaints about the improper use or disclosure of Protected Health Information or the occurrence of any security incident in regards to the creation, receipt, maintenance or transmittal of Electronic Protected Health Information should be reported to the Trust's Privacy Official at the following address:

Barry Osharow
BeneSys Administrators
1050 Lakes Drive, Suite 120
West Covina, CA 91790
Phone: (626) 646-1090
E-mail: barry.osharow@benesysinc.com

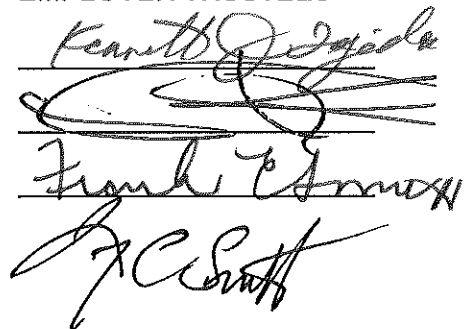
CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 12 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on June 10, 2014.

UNION TRUSTEES



EMPLOYER TRUSTEES



**AMENDMENT NO. 13
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

Effective **May 1, 2013**, Section 3(c) of Article III (Fee-For-Service Major Medical Benefit Plan) is deleted in its entirety and replaced with the following.

ARTICLE III. FEE-FOR-SERVICE MAJOR MEDICAL BENEFIT PLAN

- (c) Inpatient and Outpatient Mental Health and Substance Use Disorder Services: Covered as any other Injury or Sickness.

Effective **May 1, 2013**, Sections 6(l) and 6(m) of Article III (Fee-For-Service Major Medical Benefit Plan) is deleted in its entirety and replaced with the following.

ARTICLE III. FEE-FOR-SERVICE MAJOR MEDICAL BENEFIT PLAN

- (l) Mental Health and Substance Use Disorder Services: Covered as any other Injury or Sickness.
- (m) Residential Mental Health/Substance Abuse Facilities. Residential Mental Health/Substance Abuse facilities room, board, and general nursing care which commences within seven days after a period of at least five days confinement in a Hospital, excluding that part of the Residential Mental Health/Substance Abuse Facility's daily charge in excess of the charge for its most prevalent semi-private room rate and any charges incurred after the 60th day of confinement during any disability.

Effective **May 1, 2013**, Section 7 of Article III (Fee-For-Service Major Medical Benefit Plan) is deleted in its entirety and replaced with the following. All subsequent sections are renumbered accordingly.

ARTICLE III. FEE-FOR-SERVICE MAJOR MEDICAL BENEFIT PLAN

Section 7. Limitations.

Major Medical Benefits are subject to the following limitations:

- (a) Coverage for physical therapy, acupuncture, and chiropractic care are paid at 80% of the Contracted Rate for PPO Providers and 60% of the Non-PPO Schedule for Non-PPO Providers up to a maximum of 20 combined visits per year.
- (b) Medical care by a Doctor, Dentist or oral Surgeon for a fractured jaw or an Injury to natural teeth (including replacement of such teeth) will be covered if the treatment occurs within six months after the date of the accident and the Eligible Individual was covered at the time of the accident.

- (c) Charges for the services of an assistant surgeon (Doctor) shall be limited to a maximum payment equal to 20% of the amount payable to the primary Surgeon (Doctor) performing the surgical procedure.
- (d) Charges in connection with pregnancy for Dependent children are limited to complications of pregnancy. Complications of pregnancy is defined as:
 - (1) Conditions, requiring Hospital confinements (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. Examples are acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. False labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy are not considered "complications";
 - (2) Non-elective caesarian section;
 - (3) Ectopic pregnancy which is terminated; or
 - (4) Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.
- (e) Treatment of Temporomandibular Joint Dysfunction (TMJ) shall be limited to that which is Medically Necessary, according to accepted medical practices, to alleviate discomfort and/or restore function.

Effective May 1, 2013, Section 8(k) of Article III (Fee-For-Service Major Medical Benefit Plan) is deleted in its entirety and all subsequent sections are renumbered accordingly.

ARTICLE III. FEE-FOR-SERVICE MAJOR MEDICAL BENEFIT PLAN

- (k) — Treatment of drug addiction;

Effective May 1, 2013, Section 1(g) of Article XIII (General Exclusions and Limitations) is deleted in its entirety and replaced with the following:

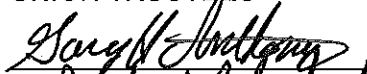
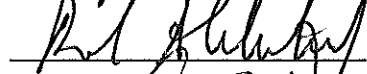
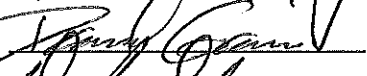

ARTICLE XIII. GENERAL EXCLUSIONS AND LIMITATIONS

- (g) care of treatment of a sex offender or deviant in any Hospital or facility of any state or political subdivision;



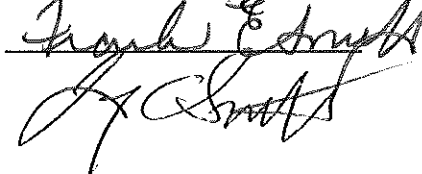
CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 13 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on June 10, 2014.

UNION TRUSTEES

EMPLOYER TRUSTEES

**AMENDMENT NO. 14
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

Effective **January 1, 2015**, Section 7(a) of Article III (Fee-For-Service Major Medical Benefit Plan) is deleted in its entirety and replaced with the following. All subsequent sections are renumbered accordingly.

ARTICLE III. FEE-FOR-SERVICE MAJOR MEDICAL BENEFIT PLAN

- (a) Physical Therapy, Acupuncture, and Chiropractic Care: The Plan pays 80% of the Contracted Rate for Covered Expenses for physical therapy, acupuncture, and chiropractic care provided by a PPO Provider or 60% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider up to a maximum payable amount of \$35 per visit. Benefits are limited to 20 combined visits per year.

Effective **January 1, 2015**, Sections 1, 2, and 3 of Article VII (Health Maintenance Organization (HMO) Benefits) are deleted in their entirety and replaced with the following:

ARTICLE VII. HEALTH MAINTENANCE ORGANIZATION (HMO) BENEFITS

Section 1. Kaiser Permanente.

Active and Retired Employees and their Dependents may enroll in the Kaiser Permanente HMO plan if they reside in the Kaiser service area. If a Covered Employee enrolls in the Kaiser Permanente plan, Kaiser Permanente will provide, subject to the terms and conditions of its agreement with the Fund, medical and prescription drug benefits and services as set forth in the aforementioned agreement. If a Covered Employee enrolls in the Kaiser Plan, benefit materials outlining the benefits and services, including the limitations and exclusions and claims and appeals procedures, will be furnished, free of charge, as a separate document. *Active and Retired Employees and their Dependents may change to another medical plan at the earlier of twelve (12) months of consecutive enrollment in the Kaiser Plan or at the next open enrollment period (May 1 of each year). If the member changes plans through self-directed enrollment, the change will go into effect on the first day of the following month.*

Section 2. PacifiCare.

Active Employees and their Dependents may enroll in the PacifiCare HMO plan if they reside within 30 miles of the PacifiCare facility they wish to use (Retired Employees and their Dependents are not eligible for coverage in the PacifiCare plan). If a Covered Employee enrolls in the PacifiCare Plan, PacifiCare will provide, subject to the terms and conditions of its agreement with the Fund, medical and prescription drug benefits and services as set forth in the aforementioned agreement. If a Covered Employee enrolls in the PacifiCare plan, benefit materials outlining the benefits and services, including the limitations and exclusions and claims and appeals procedures, will be furnished, free of charge, as a separate document. *Active and Retired Employees and their Dependents may change to another medical plan at the earlier of twelve (12) months of consecutive enrollment in the PacifiCare Plan or at the next open enrollment period (May 1 of each year). If the member changes plans through self-directed enrollment, the change will go into effect on the first day of the following month.*

Section 3. Default Enrollment in Fee-For-Service Plan.

If no medical plan selection is made at the time of initial eligibility or reinstatement of eligibility, Covered Employees and their Dependents, if any, will be enrolled in the Fee-For-Service Medical Plan. *Active and Retired Employees and their Dependents may change to another medical plan at the earlier of twelve (12) months of consecutive enrollment in the Fee-For-Service Plan or at the next open enrollment period (May 1 of each year). If the member changes plans through self-directed enrollment, the change will go into effect on the first day of the following month.*

Effective January 1, 2015, Section 8 of Article VIII (Fee-For-Service Dental Benefit) is deleted in its entirety and replaced with the following:

Section 8. Enrollment

If no dental plan selection is made at the time of initial eligibility or reinstatement of eligibility, Covered Employees and their Dependents, if any, will be enrolled in the Fee-For-Service Dental Plan. *Active and Retired Employees and their Dependents may change to another dental plan at the earlier of twelve (12) months of consecutive enrollment in the Fee-For-Service Plan or at the next open enrollment period (May 1 of each year). If the member changes plans through self-directed enrollment, the change will go into effect on the first day of the following month..*

Effective January 1, 2015, Section 1 of Article IX (Prepaid Dental Benefits) is deleted in its entirety and replaced with the following:

ARTICLE IX. PREPAID DENTAL BENEFITS




Section 1. United Concordia.

Active Employees and their Dependents may enroll in the United Concordia dental plan if they reside in the United Concordia service area. If a Covered Employee enrolls in the United Concordia plan, United Concordia will provide, subject to the terms and conditions of its agreement with the Fund, dental and orthodontic benefits and services as set forth in the aforementioned agreement. If a Covered Employee enrolls in the United Concordia plan, documents outlining the benefits and services, including the limitations and exclusions and claims and appeals procedures, will be furnished, free of charge, as a separate document. *Active and Retired Employees and their Dependents may change to another dental plan at the earlier of twelve (12) months of consecutive enrollment in the United Concordia Plan or at the next open enrollment period (May 1 of each year). If the member changes plans through self-directed enrollment, the change will go into effect on the first day of the following month.*




CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 14 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on December 16, 2014.

UNION TRUSTEES

EMPLOYER TRUSTEES

**AMENDMENT NO. 15
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

Effective **September 1, 2015**, Section 1(a) of Article II (Eligibility Rules) is deleted in its entirety and replaced with the following. All subsequent sections are renumbered accordingly.

ARTICLE II. Eligibility Rules

Section 1. Active Employees

(a) Establishment and Maintenance of Eligibility:

- (1) Any Active Employee working for Employers who contribute to the Brick Masons' Health and Welfare Trust Fund shall be eligible for Plan benefits:
 - (i) on January 1, 1989, if he was eligible for Plan benefit on December 31, 1988;
 - (ii) after January 1, 1989, on the first day of the second calendar month next following any consecutive period of four calendar months or less during which the number of hours for which contributions are made on his behalf by an Employer total at least 400 hours.
- (2) A reserve account has been established by the Fund for each Active Employee and is comprised of hours in excess of 120 hours worked by the Active Employee, while in an eligible class, with one or more contributing Employers during a month.

Such hours credited to the reserve account of the Active Employee under the Fund shall be carried over to his credit for continued eligibility for benefits. The maximum number of hours credited to the Active Employee's reserve account at any time shall in no event exceed 600 hour after the deduction has been made for the current month's coverage.

All hours credited to an Active Employee's reserve account shall be cancelled if the Active Employee does not satisfy the requirements for becoming eligible for benefits under the Fund for four consecutive calendar months.

If when an Active Employee loses eligibility he or she has hours remaining in his or her reserve account and elects to self-pay for coverage through COBRA, the first month's self-pay amount will be prorated (reduced) by the hours remaining in the reserve account as outlined in Article II, Section 5(h).

- (3) If an Active Employee has at least one hour in his or her Hour Bank, he or she may purchase additional hours, up to 120 hours, at a rate per hour as

determined by the Trustees to maintain coverage. He or she will be allowed to purchase additional hours twice per fiscal plan year for maintaining eligibility, so long as there is at least one hour in his or her hour bank.

- (4) An Active Employee's Dependent becomes eligible on the date the Active Employee's eligibility is effective, or on the date the Active Employee acquires the Dependent, whichever is later.
- (5) Individuals who are employed by an Employer as a supervisor or estimator, as well as shareholders or Corporate Officers who hold less than 100% of the shares in an incorporated Employer, may participate in the Fund, provided that their Employers pay current contributions to the Health and Welfare, Pension, Vacation and Apprentice Funds on their behalf on the greater of 160 hours or actual hours worked per month. The Employer(s) must notify the Fund of the individual's participation and sign a participation agreement with each of the above-listed Funds. The individuals are subject to the same initial eligibility rules that apply to Active Employees as set forth in Article I, Section 1, Subsections (a)(1), (a)(2) and (a)(3). Sole proprietors are not eligible to participate in the Fund.

Effective **September 1, 2015**, a new Section 5 of Article III (Fee-For-Service Major Medical Benefit Plan) is added after Section 4 and all subsequent sections are renumbered accordingly:

ARTICLE III. FEE-FOR-SERVICE MAJOR MEDICAL BENEFIT PLAN

Section 5. Out-of-Pocket Maximum.

Once an Eligible Individual satisfies their calendar year out-of-pocket maximum, the Plan will pay 100% of Covered Expenses for the remainder of the calendar year. The calendar year out-of-pocket maximum does not apply to premiums, balance billing, or services that are not covered under the Plan.

The calendar year out-of-pocket maximums are as follows:

- (a) Individual: \$2,000
- (b) Family: \$6,000

Effective **September 1, 2015**, Section 3 of Article VII (Health Maintenance Organization (HMO) Benefits) is deleted in their entirety and replaced with the following:

ARTICLE VII. HEALTH MAINTENANCE ORGANIZATION (HMO) BENEFITS

Section 3. Required Enrollment in Fee-For-Service Plan.

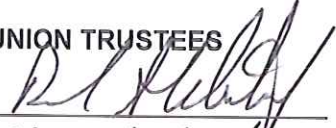



Upon initial eligibility, the Covered Employee and his Dependents, if any, are required to enroll in the Fee-For-Service Medical Plan for the first twelve (12) months of coverage. Once satisfied, the Covered Employee and his Dependents, if any, may change to another medical plan at the earlier of the next open enrollment period (May 1 of each year) or through self-directed enrollment. If the Covered Employee changes plans through self-directed enrollment, the change will go into effect on the first day of the following month.

However, if the eligibility of the Covered Employee and his Dependents are terminated, but he otherwise re-enrolls in the Medical Plan within twelve (12) months of being so terminated, he and his Dependents can enroll in the Medical Plan they were in immediately before his eligibility was terminated.

CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 15 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on June 9, 2015.


UNION TRUSTEES

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EMPLOYER TRUSTEES







AMENDMENT NO. 16
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS' HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended as follows:

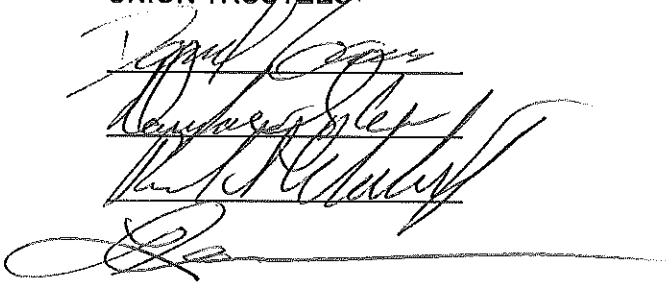
Effective October 1, 2017, the first part of Section 1 of Article V (Physical Examination Benefit) is amended in its entirety as follows:

"The Plan will pay benefits for routine physical examinations for an Active Employee, Dependent spouse, and Dependent child performed by a licensed Physician as follows:"

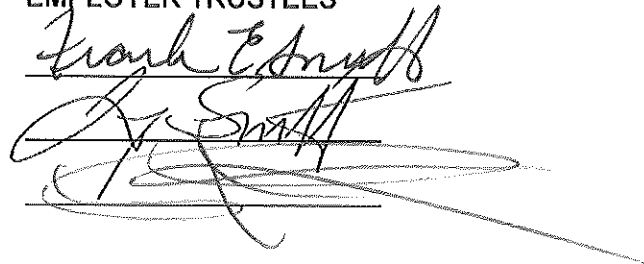
CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons' Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 16 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust Fund (Restated June 12, 2008) was duly adopted on December 4, 2017.

UNION TRUSTEES

Four handwritten signatures of Union Trustees, each written over a horizontal line.

EMPLOYER TRUSTEES

Two handwritten signatures of Employer Trustees, each written over a horizontal line.

**AMENDMENT NO. 16 A
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended, as follows:

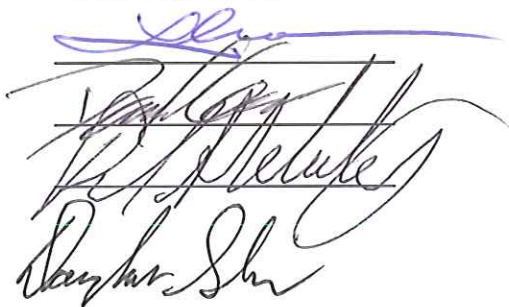
Effective April 1, 2018, section 9 of Article III (Extended Benefits During Total Disability) and section 1 of Article XII are amended by adding the following sentence to the end of said sections.

"An Eligible Individual will be deemed to be Totally Disabled for purposes of this section if a Physician (M.D.) certifies that the Eligible Individual meets the definition of Total Disability as defined in Article I, Section 26."

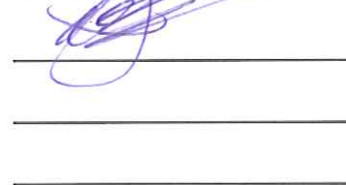
CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 16 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on June 14, 2018.

UNION TRUSTEES



EMPLOYER TRUSTEES



**AMENDMENT NO. 17
TO THE
RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) is amended, as follows:

Effective August 1, 2019, section 1(b)(2) of Article II (Termination of Eligibility) is amended by revising and replacing this section, as follows:

"Termination of Eligibility. An Active Employee's eligibility will terminate on whichever of the following dates is applicable:

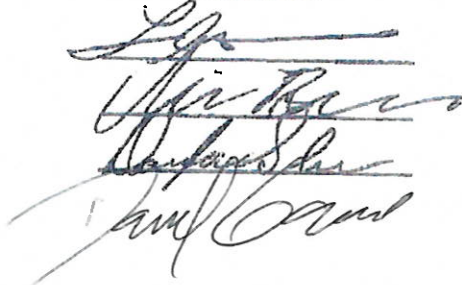
...

- (2) on the last day of the month in which an Active Employee receives notice (from the Fund) that he has been performing work that is not pursuant to a recognized Collective Bargaining Agreement in the area covered by the Plan. In addition to losing eligibility upon the last day of the month in which such notice was received, all contributions credited to the Employee's reserve account will also be forfeited on such date if eligibility is lost under this provision.

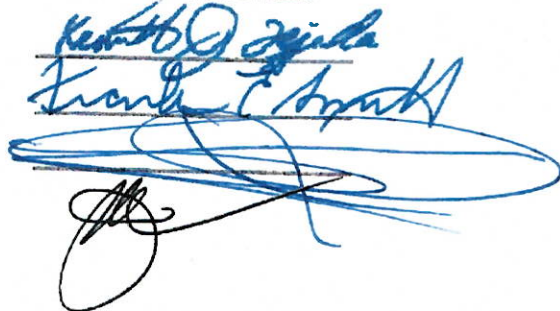
CERTIFICATION OF ADOPTION

The undersigned Trustees of the Brick Masons Health and Welfare Trust Fund do hereby certify that the foregoing Amendment No. 17 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons Health and Welfare Trust Fund (Restated June 12, 2007) was duly adopted at a meeting held on June 11, 2019.

UNION TRUSTEES



EMPLOYER TRUSTEES



**Amendment No. 18
to the
Rules and Regulations Providing Health and Welfare Benefits of the
Brick Masons' Health and Welfare Trust**

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) are amended, as follows:

Effective January 15, 2022, a new section 6.A is inserted after section 6 in Article III. Section 6.A shall be entitled "COVID-19 Over the Counter (OTC) Tests" on page 22, as follows:

Section 6.A. COVID-19 Over the Counter (OTC) Tests.

Beginning on January 15, 2022 and effective until either: (i) the Secretary of the Department of Health and Human Services declares that a 2019 novel coronavirus ("COVID-19") related public health emergency is no longer in effect; or (ii) applicable regulatory guidance is issued which states that providing coverage for OTC COVID-19 tests is no longer required by the Plan, the Plan shall provide coverage for OTC COVID-19 tests, as follows:

The Plan shall only cover OTC COVID-19 tests that are authorized, cleared or approved by the Food and Drug Administration ("FDA"). Only OTC COVID-19 tests that are self-administered and self-read are eligible for reimbursement. (Tests that require the assistance of a lab or other third party provider are not covered unless ordered by a physician.)

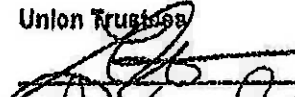
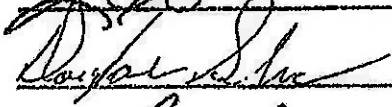
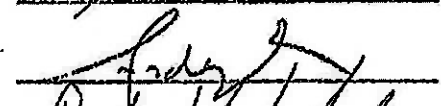
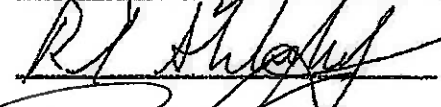

The Plan shall not provide coverage for more than eight (8) individual tests per calendar month per participant or dependent. Such tests (up to the 8-test limit) shall be reimbursed in full without participant cost sharing. No medical management such as an order from a physician or health care provider shall be required.

The Plan may require the participant or dependent to attest that the test was purchased for personal use, not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale. The Plan may also require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of a test, such as but not limited to the UPC code for the test.

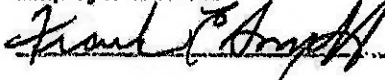
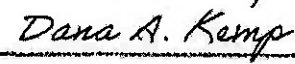

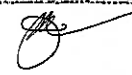
Certification of Adoption

The undersigned Trustees of the Brick Masons' Health and Welfare Trust do hereby certify that the foregoing Amendment No. 18 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) was duly adopted at a meeting held on February 1, 2022.

Union Trustees

Employer Trustees




Kenneth J. Tejada

Digitally signed by Kenneth J. Tejada
DN: cn=Kenneth J. Tejada, o=Brick Masons,
ou=Trust, email=ktejada@brickmasons.org, c=US
Date: 2022.02.18 17:53:22 -0500
Digitally signed by John Chrysler
DN: cn=John Chrysler, o=Brick Masons,
ou=Trust, email=jchrysler@brickmasons.org, c=US
Date: 2022.02.21 15:50:03 -0500

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