Pursuant to the powers conferred upon them by Section 1(B) of Article V of the restated Agreement and Declaration of Trust (effective June 1, 2002) to adopt and from time to time amend, modify or otherwise change the Health and Welfare Plan, the Board of Trustees, meeting on the 25th day of August, 2020 amended the Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan as follows, to be effective as stated below, and authorized the Chairman and Secretary to authenticate the same by affixing their signatures hereto.

1. Effective July 1, 2020, amended Part 1, Section 5.01 in its entirety, to state as follows:

5.01 Eligibility

You will be eligible for retiree coverage if you meet the requirements of paragraphs (1) through (6) below:

(1) (a) you were an active Participant as an Employee for five of the eight years immediately preceding your retirement; or

(b) effective for retirements on and after February 1, 2013, you were an active Participant as an Employee for five of the twelve years immediately preceding your retirement, and you are able to demonstrate that you would have met the requirement in subparagraph (a), above, but for lack of work in the Industry; and

(2) you are receiving a pension from a pension plan administered and established under any trust to which either (a) the Union appoints trustees or (b) the Plan has sent reciprocity payments based on your employment within the geographic jurisdiction of the Union; and

(3) you apply for coverage within 60 days of your retirement;

(4) you make the required premium payment;

(5) if eligible for Medicare, you are enrolled in both Part A and Part B of Medicare; and

(6) if eligible for Medicare, you may elect Kaiser coverage only if enrolled in Kaiser Senior Advantage and residing in the Senior Advantage service area.

Retiree medical coverage options are Kaiser and UHC HMO only, for retirees residing within the service areas of Kaiser or UHC. Retirees may also apply for dental and vision coverage within 60 days of retirement for an additional premium. Premium payments are due to
the Trust Fund no later than the 20th of the month prior to the month of coverage. If you or your surviving Spouse or Domestic Partner fails to make premium payments in a timely manner, coverage will be terminated.

2. Effective July 1, 2020, amended Part 1, Section 7.06 in its entirety to state as follows:

7.06 Appeals to Medical Plan Carriers

If a claim for medical or vision benefits is denied on grounds other than eligibility under this Plan by Kaiser, UHC, another HMO, or other provider, the claimant's only appeal is under the appeals procedures provided by the HMO or other provider which rendered the decision to which the claimant objects.

3. Effective July 1, 2020, amended Part 2, Section 12.30 in its entirety to state as follows:

12.30 EMERGENCY SERVICES

The Plan will pay benefits for Emergency Services with respect to Emergency Medical Conditions. Emergency Services means, with respect to an Emergency Medical Condition, (A) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; (B) such further medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital and are required to stabilize the patient.

Emergency Medical Condition is acute symptoms that a prudent layperson with average knowledge of health and medicine would expect that the absence of medical attention would place the individual’s health in serious jeopardy, or seriously impair body functions, organs, or parts.

4. Effective July 1, 2020, amended Part 2, Section 13.02 in its entirety to state as follows:

13.02 EXCLUSIONS

No benefits will be paid for expenses or charges:

(1) for services or supplies for which a covered person is not required to pay or charges made only because coverage exists (subject to the right, if any, of the United States government to recover Reasonable and Customary Charges for care provided in a military or veterans’ Hospital but not in excess of the amount the Plan would pay on behalf of a similarly situated active or retired Participant who was not receiving care in a military or veterans’ facility). This will not apply if these charges are incurred in a non-governmental charitable research Hospital;
(2) for Sickness or Injury:
   (a) for which benefits are paid or payable under workers' compensation or any
       occupational disease or similar law whether such benefits are insured or self-insured; or
   (b) that is caused by, or connected in any way to, employment of the covered person.
       This includes self-employment or employment by others. It applies whether or not
       workers' compensation or any occupational disease or similar law covers the charges
       incurred. It applies whether the charges are covered on an insured or uninsured basis;

(3) for health exams that are not required for treatment of Sickness or Injury unless
    specifically provided under the Plan;

(4) for any act due to war, if declared or not, or arising out of service in the Armed Forces;
    or participation in a riot or insurrection; or participation in a felony, unless that Injury
    resulted from an act of domestic violence or a medical condition;

(5) for eye refractions, except as specifically provided under Covered Medical Charges;
    eyeglasses or the fitting of eyeglasses; radial keratotomy or other surgical procedure to
    correct myopia; visual training; and vision therapy;

(6) for speech therapy, unless Medically Necessary due to a covered Sickness or Injury
    incurred while covered under the Plan;

(7) for educational testing or training; behavior modification programs; services primarily
    oriented toward treating a social, developmental or learning problem, except as specifically
    provided under the Plan;

(8) for Developmental Care or Custodial Care, except as part of approved Home Health
    Care;

(9) for sleep disorders, except when coordinated through the Utilization Review Program;

(10) which are incurred as a donor of an organ when the donee is not insured under the
    Plan;

(11) for drugs and medicines that may be obtained without a written prescription (this will
    not apply to insulin);

(12) which are more than the Reasonable and Customary Charges for the services and
    supplies furnished;

(13) for Hospital services and supplies when confinement is solely for diagnostic testing
    purposes;

(14) for comprehensive preventive child care except as specifically provided for;
(15) for sex change operations; or any expense incurred to change the physical characteristics of the covered person to those of the opposite sex; or any charge for treatment of sexual dysfunction;

(16) for "stand-by" services of a Physician or surgeon whether in the Physician's or surgeon's office or a Hospital;

(17) for transportation, except as specifically provided under the Plan; or

(18) for care, treatment, services or supplies:
   (a) not prescribed by a Physician;
   (b) not Medically Necessary;
   (c) which are experimental as recognized in the United States or provided mainly for the purpose of medical or other research;
   (d) received from a Nurse which do not require the skill and training of a Nurse;
   (e) to the extent that benefits are payable under other provisions of the Plan;
   (f) for which benefits are not paid due to the Deductible or Coinsurance provisions of the Plan;
   (g) received in a Hospital or Institution owned or operated by the United States government or any of its agencies (subject to the right, if any, of the United States government to recover Reasonable and Customary Charges for care provided in a military or veterans' Hospital); or
   (h) provided by or paid for by any governmental plan or law not restricted to the government's civilian employees and their dependents. (This will not apply to Medicaid or Medi-Cal.)

(19) which are incurred by a covered person while incarcerated in a jail, penitentiary, correctional facility or Hospital;

(20) for Cosmetic Surgery, unless specifically provided under the Plan;

(21) for appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria, and presents significant symptomatic medical problems) or any treatment of obesity (including surgery to treat morbid obesity, except as provided in Section 12.28);

(22) for sexual and gender identity disorders, including but not limited to sexual dysfunctions, paraphilias, or gender transformations;

(23) for services and supplies for the treatment of impotence/erectile dysfunction;

(24) for the diagnosis or treatment of the inability to conceive or become pregnant, or the promotion of fertility, including, but not limited to:
   (a) fertility tests and procedures;
   (b) reversal of surgical sterilization; or
(c) any similar method or treatment which attempts to cause conception or pregnancy by hormone therapy, artificial insemination, in vitro fertilization and/or embryo transfer; for medical procedures involving the in vitro fertilization process (unless otherwise specifically provided for in the Plan).

(25) for chelation therapy, except for acute arsenic, gold, mercury or lead poisoning;

(26) for services or supplies which are not provided in accordance with generally accepted professional standards and/or medical practice;

(27) for services or supplies which are primarily for the covered person's education, training or development of skills needed to cope with an Injury or Sickness;

(28) which are related to smoking cessation or treatment for nicotine addiction;

(29) for acupuncture treatment;

(30) which are primarily for the covered person's convenience or comfort or that of the covered person's family, caregiver, companion, sitter, Physician or other person;

(31) for bills for telephone calls, mailings, faxes, e-mails or any other communications to or from a Physician, Hospital or other medical provider;

(32) for breast augmentation or reduction, whether or not Medically Necessary, except for breast reconstruction following a mastectomy as required under state and federal laws and regulations;

(33) for developmental disorders or delays, or conduct disorder, except as specifically provided under the Plan or for medications for attention deficit disorder that are covered with prior authorization under the Prescription Drug Benefits program;

(34) for educational testing or educational remediation;

(35) for therapies designed to promote personal growth or enhancement;

(36) for exercise equipment;

(37) for services or supplies which are provided or paid for by the federal government or its agencies, except for:
   (a) the Veterans Administration, when services are provided to a veteran for a disability which is not service-connected;
   (b) a military Hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services;
   (c) a group health plan established by a government or its agencies for its own civilian employees and their dependents; or
(d) Medicaid, if required by a Medicaid assignment of benefits.

IN WITNESS of the adoption of this amendment, the Chairman and Secretary hereby subscribe their names, on the dates indicated.

Chairman

Date: AUGUST 28, 2020

Secretary

Date: Aug 28, 2020