Amendment No 1 to the January 1, 2014 Restatement

Effective July 1, 2014:

1. Pages 8 and 9, “Schedule of Benefits”, is replaced in its entirety with the attached Exhibit A.

2. On the introductory page at the beginning of the booklet, the following paragraph has been deleted in its entirety.

The Bricklayers and Allied Craftworkers Health and Welfare Fund of Indiana believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. Being a grandfathered health plan means that the Plan does not include certain consumer protections of the Affordable Care Act. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the office of the Third Party Administrator (TPA). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at www.healthreform.gov.

3. On page 8, the “Definitions” section has been amended to include the following:

Approved Clinical Trial shall mean a phase I, II, III or IV trial if it is:
1. Conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, and;
2. Is one of the following:
   a. Approved and funded by one or more of the following:
      i. National Institutes of Health (NIH);
      ii. Centers for Disease Control and Prevention (CDC);
      iii. Agency for Health Care Research and Quality (AHRQ);
      iv. Centers for Medicare and Medicaid Services (CMS);
      v. A non-governmental research entity identified in the NIH guidelines for center support grants;
      vi. Department of Defense, Department of Veterans’ Affairs or Department of Energy (if the trial has undergone unbiased, scientific peer review by experts without conflict and the Department of Health and Human Services Secretary deems the review to be comparable to the NIH peer review system);
      vii. Cooperative group or center for any of the above agencies, other than Department of Energy; or
   b. Is either:
      i. Conducted under an investigational new drug application (IND) reviewed by the Food and Drug Administration; or
      ii. A drug trial that is exempt from the IND application requirements.

Routine Patient Costs shall mean all items and services that the Plan would otherwise cover if the Covered Person were not enrolled in a clinical trial.

Qualified Individual shall mean a Covered Person who is eligible, according to the trial protocol, to participate in an Approved Clinical Trial and either:
1. The referring health care professional is a participating provider and has concluded that the Covered Person’s participation in the clinical trial would be appropriate; or
2. The Covered Person provides medical and scientific information establishing that the individual’s participation in the clinical trial would be appropriate.

4. **On page 46, the following item “39” is being added as follows to the “Covered Charges” section:**

39. **Clinical Trial Routine Patient Costs.** Routine Patient Costs for a Qualified Individual in an Approved Clinical Trial. This benefit does not include: the investigational item, device or service itself; items and services solely for data collection and analysis purposes and not for direct clinical management of the Participant; or any service inconsistent with the established standard of care for the Participant’s diagnosis. Routine Patient Costs services, treatment or items provided by an Out-of-Network provider are covered only if the Approved Clinical Trial is only offered outside the Covered Person’s state of residence.

5. **On page 51, “Wellness Benefits”, the 2nd to last paragraph titled “IN-NETWORK or OUT-OF NETWORK” is deleted and replaced with the following:**

**IN-NETWORK ONLY**
As required by the Affordable Care Act (Healthcare Reform), the Plan covers recommended In-Network preventative care, screenings, and immunizations at 100%, with no deductible or coinsurance.

6. **On page 12, “Definitions”, the definition for “Dependent” is deleted and replaced with the following:**

- The spouse you are legally married to, as determined under applicable State law at the time and location the marriage was entered into; or
- Your child under 19 years of age; or
- Your child who is adopted or placed for adoption prior to the age of 18 and who otherwise meets the eligibility criteria for a child as described herein; or
- Your child who is 19 years old until his or her 26th birthday; or
- Your child who reached his or her 26th birthday while a Covered Person, but who is incapable of earning his or her own living due to mental or physical handicap, which occurred prior to the child’s 19th birthday. In this circumstance, the child must permanently reside in your household and be financially dependent on the Covered Member for at least 50% of his or her support. The Plan will require proof of incapacity, residency and financial dependency. Such proof may be given at any time within 120 days after the date the limiting age is reached, and will not be required earlier than sixty days (60) before the limiting age is reached. The Plan may also require proof of continuing incapacity, residency and financial dependency. It may require such proof no more than once each year after initial proof is given. If proof is not given within sixty days of a request, coverage for the dependent will end sixty days (60) after the request is made.

7. **On page 52, the following is added to the “Covered Charges” section of the Prescription Drug Benefit:**

7. Prescriptions for Women’s Health and Preventative Care as mandated by the Affordable Care Act (Healthcare Reform).

8. **On page 64, the sections entitled “Appeal of Denied Claim” and “Review of Denied Claim” are deleted in their entirety and replaced with the following:**

**Appeal Process**
In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The Participant has one hundred eighty (180) days following an initial Adverse Benefit Determination to file an appeal of that determination. To initiate the appeal process, the Fund Administrator must receive a written request from the Participant, or an Authorized Representative of the Participant, with the proper form for review of an Adverse Benefit Determination.

**Full and Fair Review of All Claims**
The appeal process of this Plan provides a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

- Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
- Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Participants the opportunity to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

- For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

- That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant’s claim in possession of the Plan Administrator or Fund Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant’s right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant’s medical circumstances;

- That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale; and

- The first level of appeal will be the responsibility of the Fund Administrator and will be decided within thirty (30) days of the Fund Administrator's receipt of the request. The second level of appeal will be decided within thirty (30) days of the Plan’s receipt of the request.

**APPEAL**

**Requirements for Appeal**

The Participant must file the appeal, in writing, within 180 days following receipt of the notice of an Adverse Benefit Determination.

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed to HealthSCOPE Benefits (please refer to page 3 for contact information).

It shall be the responsibility of the Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the employee/Participant;

- The employee/Participant’s social security number;
• The group name or identification number;

• All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;

• A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

• Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

The Trustees or its authorized Committee will meet quarterly to render a determination on appeals received since the prior meeting, provided any appeal filed within the 30 day period preceding a meeting will be decided at the next following meeting. If special circumstances require a delay in the decision, the decision will be rendered no later than the third meeting following receipt of the appeal, and the Fund Administrator will notify the Participant of the delay prior to any extension. The Participant will be informed of the decision within five days of the date the decision is made.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Appeal
The Plan Administrator shall provide a Participant with notification, in writing or electronically, of a Plan’s Adverse Benefit Determination on review, setting forth:

• Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

• A reference to the specific portion(s) of the plan provisions upon which a denial is based;

• Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan’s standard, if any, that was used in denying the claim, and a discussion of the decision;

• A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

• A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

• A description of the Plan’s review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant’s right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

• A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant’s claim for benefits;
The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request; and

In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant’s medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request.

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to “Manner and Content of Notification of Adverse Benefit Determination on Review” as appropriate.

Decision on Review
If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

External Review Process
A. Scope

1. The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

2. The Federal external review process applies only to:
   (a) An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan’s or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and
   (b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard external review
Standard external review is external review (as described in paragraph B of this section).

1. Request for external review. If a Participant receives an Adverse Benefit Determination as the result of an initial appeal to the Plan Administrator (see “Timing of Notification of Benefit Determination on Review” section above), the Plan will allow a claimant to file a request for an external review with the Plan, if the request is filed within four (4) months after the date of receipt of the notice of Adverse Benefit Determination, that was the result of an initial appeal. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. **Preliminary review.** Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   (a) The Participant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   (b) The Adverse Benefit Determination does not relate to the Participant’s failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   (c) The Participant has exhausted the Plan’s internal appeal process unless the Participant is not required to exhaust the internal appeals process under the interim final regulations; and
   (d) The Participant has provided all the information and forms required to process an external review.

   Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the Participant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Participant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization.** The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. **Reversal of Plan’s decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.
Exhibit A – Effective July 1, 2014
Schedule of Benefits - Active and Early Retirees

<table>
<thead>
<tr>
<th>Active Employees Only</th>
<th>Benefit Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Amount (disabled other than on your job)</td>
<td>$200.00 per week</td>
</tr>
<tr>
<td>Maximum Number of Weeks</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Benefits Begin</td>
<td>1st day of Accident, 8th Day for Sickness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Active Employees and Early Retirees Only</th>
<th>Benefit Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death Benefit Amount</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>Accidental Death Benefit (Active Employees Only)</td>
<td>$5,000.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Active Participants and Early Retirees</th>
<th>Comprehensive Major Medical Expense Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVERED SERVICE OR PLAN CATEGORY</td>
<td>IN NETWORK</td>
</tr>
<tr>
<td>Maximum Annual Benefit</td>
<td>No Limit for all Essential Benefits</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>Individual Deductible: $500</td>
</tr>
<tr>
<td>Out of Pocket Maximum (excluding co-payments)</td>
<td>Individual: $3,500 per calendar year</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>80% of Covered Charges</td>
</tr>
<tr>
<td>Non-Emergency Use of Emergency Room</td>
<td>$200 Co-pay, then 80% of covered charges after Deductible</td>
</tr>
<tr>
<td>Manual Manipulations and Treatment</td>
<td>Plan pays 80% of covered charges after Deductible.</td>
</tr>
<tr>
<td></td>
<td>$750 maximum per calendar year</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Plan pays 80% of covered charges after Deductible.</td>
</tr>
<tr>
<td></td>
<td>Limited to 60 days per calendar year</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Plan pays 80% of covered charges after deductible</td>
</tr>
<tr>
<td></td>
<td>Limited to 50 Visits per calendar year</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Plan pays 80% of covered charges after deductible</td>
</tr>
<tr>
<td></td>
<td>Limited to a Lifetime Maximum of $10,000 per person</td>
</tr>
<tr>
<td>COVERED SERVICE OR PLAN CATEGORY</td>
<td>IN NETWORK</td>
</tr>
<tr>
<td>---------------------------------</td>
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</tr>
<tr>
<td>Orthotics</td>
<td>Plan pays 80% of covered charges after deductible</td>
</tr>
<tr>
<td></td>
<td>Limited to $250 per calendar year</td>
</tr>
<tr>
<td>Preventive Care Wellness Benefit</td>
<td>100% of Covered charges for preventative care, screenings and immunizations, as recommended and required by the Affordable Care Act.</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>Plan pays 80% of covered charges after Deductible</td>
</tr>
<tr>
<td>Mental &amp; Nervous Conditions</td>
<td>Plan pays 80% of covered charges after Deductible</td>
</tr>
</tbody>
</table>

**Prescription Benefit**

**Coverage**

Prescription Drug Card Benefit

- 25% co-payment, with a $200 maximum per prescription (30 days supply)\(^{(1)}\). Maximum out of pocket $2,850 Individual/$5,700 Family per calendar year. *(If a generic drug is available, the Plan will only pay up to the cost of the generic, less the co-payment, for Brand name drugs.)*

If a Non-Network pharmacy is used, the Covered Person will pay 100% of the drug cost, and must file the claim with SAVRX for reimbursement. *(Refer to Prescription Drug Benefit Section.)*

**Vision Benefit**

**Coverage**

- Vision Benefit Maximum: $200 per person per Calendar Year
- Benefit Percentage: 80% - all providers
- Services Covered:
  - Complete Vision Exam
  - Frames
  - Lenses per pair
  - Conventional Contacts
  - Disposable Contacts
  - One per calendar year – Includes Refraction
  - One Frame per 2 consecutive calendar years
  - One set per calendar year
  - One set per calendar year
  - Subject to the calendar year maximum

**Dental Benefit**

- Effective January 1, 2005, the Trustees contracted with Delta Dental Company for dental coverage under Policy No. 5022-001. **This is for the Active Participants Only.** Dental cards and certificates of coverage will be provided to you when you become eligible. **ALL DENTAL CLAIMS MUST BE FILED WITH DELTA DENTAL, P.O. BOX 9085, FARMINGTON HILLS, MI 48333-9085.**

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\(^{(1)}\) Co-payments for prescriptions covered under the Women’s Health and Preventative Care requirements of the Affordable Care Act (Healthcare Reform), will be determined based on the mandated provisions of the Affordable Care Act.