Statement of Amendment Number 6 to the
Laborers Health and Welfare Trust Fund for Northern California
Active Plan Rules and Regulations
Amended and Restated January 1, 2016

The undersigned Chairman and Co-Chairman of the Board of Trustees of the Laborers Health and Welfare Trust Fund for Northern California hereby certify that a meeting of said Board duly and regularly held on **June 17, 2020** the following temporary changes to the Laborers Health and Welfare Trust Fund for the Northern California Active Plan were adopted (effective March 1, 2020 through 60 days after the end of the National Emergency or other date determined by the Department of Labor and Treasury, hereinafter referred to as the "Outbreak Period"):

1. **Article I. Definitions, a new Section 34.01 is added, stating as follows:**

Section 34.01 The term "Outbreak Period" means, as defined in 85 Fed. Reg. 26351, the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency (the March 13, 2020, President Trump issued the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID–19) Outbreak, available at https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/) or other date announced by the Department of Treasury and Department of Labor in a future notification.

2. **Article II. Eligibility, a new Section 4 is added, stating as follows:**

Section 4. Temporary Changes: Effective March 1, 2020, through the end of the Outbreak Period, the following procedures apply to the Plan's Special Enrollment and COBRA procedures:

(1) Special Enrollment Provision

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions of Federal law that requires Group Plans to allow participants who previously declined enrollment in the plan for themselves or their dependents to enroll during a Special Enrollment period.

Participants are automatically enrolled in this Plan who have satisfied the eligibility requirements under the provisions of Subsection 2.a. in this Article II. This Plan does not allow Participants to decline coverage or defer enrollment at a later date.

Notwithstanding the provisions of Subsections 2.a., 2.b. and 2.c., a Dependent of an Employee may defer enrollment or re-establish eligibility in the Plan under any of the following circumstances:

(a) An Employee who acquires a new Dependent spouse or any Dependent child(ren) may enroll his newly acquired Dependents in the Plan, but no later than 60 days from the date he acquires the new Dependents, disregarding the Outbreak Period. For new dependents acquired during the Outbreak Period, the Employee must notify the Trust Fund Office no later than 60 days after the end of the Outbreak Period.

(b) If a Dependent spouse or any Dependent child(ren) of an Employee defers enrollment in this Plan because the Dependent has other health coverage

under any other health insurance or policy (including COBRA Continuation Coverage, individual insurance, Medicaid, Medicare or other public program), the Dependent may enroll in the Plan within 60 days, disregarding the Outbreak Period, after losing coverage from the other health insurance due to:

(i) Loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or, termination of the other coverage for cause, such as making a fraudulent claim or intentional misrepresentation of a material fact); or

(ii) The termination of employer contributions for the other health coverage; or

(iii) The exhaustion of COBRA Continuation Coverage. (COBRA is considered "exhausted" if it ceases for any reason other than nonpayment of the required premium in a timely manner); or

(iv) Moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or

(v) The other plan ceases to offer coverage to a group of similarly situated individuals; or

(vi) The loss of dependent status under the other plan's terms; or

(vii) The termination of a benefit package option under the other plan, unless substitute coverage is offered; or

(viii) The loss of eligibility due to reaching the lifetime benefit maximum for all benefits under the other plan (if that plan is able to maintain a lifetime limit and is not subject to ACA); or

(ix) The loss of coverage through Medicaid or a state **C**hildren's **H**ealth **I**nsurance **P**rogram (CHIP), the date the Dependent lose eligibility for that coverage; **or**

(x) The date the Dependent become eligible for a premium assistance program through Medicaid or CHIP.

For losses of health coverage occurring during the Outbreak Period, the Employee must notify the Trust Fund Office no later than 60 days after the end of the Outbreak Period

(c) If the Employee requests enrollment in the Plan of a Dependent who previously deferred enrollment **within the required 60 days** described in Subsections 2.d.(1) or 2.d.(2), disregarding the Outbreak Period, coverage for the Dependent will become effective on the first day of the following calendar month after the request for enrollment in the Plan is received. In the case of a newborn Dependent, coverage will become effective on the date of birth.

(d) If the Employee requests enrollment in the Plan of a Dependent who previously deferred enrollment **beyond the required 60 days**, disregarding the Outbreak Period, described in Subsections 2.d.(1) or 2.d.(2), coverage for the Dependent

will become effective on the **first day of the second calendar month** after the request for enrollment in the Plan is received.

In order for any Dependent to enroll in the Plan, the Employee must be enrolled in the Plan except in case of a surviving spouse enrolled in COBRA coverage.

(2) Notice Requirements for Qualified Beneficiaries.

(a) The Qualified Beneficiary is responsible for providing the Trust Fund Office with timely written notice of any of the following events:

i The divorce or legal separation of an Active Participant from his Dependent spouse.

ii Death of the Active Participant.

iii A child losing Dependent status under the Plan.

iv If a second Qualifying Event occurs after a Qualified Beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months.

v In the case of the events described in Subsections (a), (b), (c) and (d) above, the Qualified Beneficiary must notify the Trust Fund Office in writing no later than 60 days after the date of the Qualifying Event, disregarding the Outbreak Period. For Qualifying Events occurring during the Outbreak Period, the Qualified Beneficiary must notify the Trust Fund Office no later than 60 days after the end of the Outbreak Period.

vi When a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled, the Qualified Beneficiary must provide written notice to the Trust Fund Office of the disability determination before the end of the 18-month continuation coverage period and within 60 days after the date of the determination, disregarding the Outbreak Period. For Social Security Administration determinations of disability occurring during the Outbreak Period, the Qualified Beneficiary must notify the Trust Fund Office no later than 60 days after the end of the Outbreak Period.

vii When the Social Security Administration determines that the Qualified Beneficiary is no longer disabled, written notice must be provided to the Trust Fund Office no later than 30 days after the date of the determination by the Social Security Administration that the person is no longer disabled, disregarding the Outbreak Period. For Social Security Administration determinations of disability occurring during the Outbreak Period, the Qualified Beneficiary must notify the Trust Fund Office no later than 60 days after the end of the Outbreak Period.

(b) The written notice must contain the following information: name of Qualified Beneficiary, the Active Participant's name and Health Plan ID or social security number, the Qualifying Event for which the notice is being given, the date of the Qualifying Event, copy of the final marital dissolution if the event is a divorce or if the event is a legal separation, a copy of the court order of legal separation.

(c) Notice may be provided by the Active Participant, Qualified Beneficiary with respect to the Qualifying Event or any representative acting on behalf of the Active Participant or Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all Qualified Beneficiaries affected by the same Qualifying Event.

(d) Failure to provide the Trust Fund Office with written notice of the occurrences described in Subsection 3.d.(1) and within the required time frames will prevent the individual from obtaining or extending COBRA Continuation Coverage.

(3) Notice Requirements for Employers and the Plan.

(a) If the Qualifying Event is the death of the Active Participant, the Employer must notify the Trust Fund Office in writing of the Qualifying Event within 30 days after the Qualifying Event, disregarding the Outbreak Period. For Qualifying Events occurring during the Outbreak Period, the Employer must notify the Trust Fund Office no later than 30 days after the end of the Outbreak Period.

(b) If the Qualifying Event is a reduction in hours, the determination that the Active Participant's Employer(s) has reported less than the minimum required hours referenced in Subsection 2.a.(1) on the Active Participant's behalf will be made by the Trust Fund Office.

(c) No later than 14 days after the date on which the Trust Fund Office receives written notification from the Qualified Beneficiary or Employer, or after the Trust Fund Office has determined that less than the minimum required hours have been reported by the Employer, disregarding the Outbreak Period but as soon as practicable, the Trust Fund Office will send a written notice to the Qualified Beneficiary affected by the Qualifying Event of his rights to continuation coverage.

Notwithstanding the immediately preceding paragraph, the Trust Fund Office's written notification to a Qualified Beneficiary who is a Dependent spouse will be treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.

(4) Election Procedure.

(a) A Qualified Beneficiary must elect continuation coverage within 60 days, disregarding the Outbreak Period, after the later of:

i The date on which the Qualified Beneficiary loses coverage under the Plan as a result of a Qualifying Event; **or**

ii The date on which the Qualified Beneficiary receives notice of COBRA Continuation Coverage from the Trust Fund Office.

If the later of (a) or (b) occurs during the Outbreak Period, the Qualified Beneficiary must elect continuation coverage no later than 60 days after the end of the Outbreak Period.

(b) Any election made by a Qualified Beneficiary who is an Active Participant or Dependent spouse on behalf of any other Qualified Beneficiary will apply to all Qualified Beneficiaries. However, each individual who is a Qualified Beneficiary with respect to the Qualifying Event has an independent right to elect COBRA coverage. The failure to elect COBRA by an Active Participant or Dependent

spouse will not prevent any other Qualified Beneficiary from being given the same 60-day period, disregarding the Outbreak Period, to elect or reject the coverage.

(5) Addition of New Dependents.

(a) If, while enrolled for COBRA Continuation Coverage, a Qualified Beneficiary acquires a new Dependent, he may enroll that new Dependent for the balance of the period of COBRA Continuation Coverage if enrollment is requested within 30 days, disregarding the Outbreak Period, after acquiring that new Dependent. For new Dependents acquired during the Outbreak Period, the Qualified Beneficiary must request enrollment no later than 30 days after the end of the Outbreak Period. Adding a new Dependent may cause an increase in the amount that must be paid for COBRA Continuation Coverage.

(b) Any Qualified Beneficiary may add a new Dependent to his COBRA Continuation Coverage. However, only the newly added Dependents of **the former Active Participant** will have the rights of a Qualified Beneficiary, including the opportunity to stay on COBRA Continuation Coverage longer in the event of a second Qualifying Event.

(6) **Premiums.** A premium for COBRA Continuation Coverage will be charged to Qualified Beneficiaries in amounts established by the Board. The premium will be payable in monthly installments. The first premium payment is due within 45 days of the date the Qualified Beneficiary elects continuation coverage, disregarding the Outbreak Period, and must include payment for all months of COBRA coverage to date. For COBRA Elections made during the Outbreak Period, the Qualified Beneficiary must make the first premium payment no later than 45 days after the end of the Outbreak Period. Thereafter, monthly premium payments are due on the first day of the month for which continuation coverage is elected, disregarding the Outbreak Period. There will be a grace period of 30 days, disregarding the Outbreak Period, to pay the monthly premium. For monthly premium payments due during the Outbreak Period, the Qualified Beneficiary must make the payment no later than 30 days after the end of the Outbreak Period. If payment of the amount due is not made by the end of the applicable grace period, COBRA Continuation Coverage will terminate. The Board may, upon good cause shown, extend the premium payment due date.

3. Article VII. General Provisions, Section 3. Notice of Claim Required, is restated as follows:

Section 3. Notice of Claim Required

(1) Benefits will be paid by the Fund only if notice of Claim is made as soon as practicable but not later than one year from the date on which the expenses were incurred. Proof of claim forms, as well as other forms, and methods of administration and procedure will be solely determined by the Board.

(2) **Temporary Changes to Claims Procedures:** Effective March 1, 2020, through the end of the Outbreak Period, the following procedures apply to the Plan's Claims procedures: Benefits will be paid by the Fund only if notice of Claim is made as soon as practicable but not later than one year from the date on which the expenses were incurred, disregarding the Outbreak Period. For expenses incurred during the Outbreak Period, the claimant must provide notice of Claim no later than one year after the end

of the Outbreak Period. Proof of claim forms, as well as other forms, and methods of administration and procedure will be solely determined by the Board.

4. Article VIII. Claims & Appeals, Section 2. Claims Procedures, a new subsection g. is added, stating as follows:

g. Temporary Changes to Claims Procedures: Effective March 1, 2020, through the end of the Outbreak Period, the following procedures apply to the Plan's Claims procedures:

(1) Pre-Service Claims

A Pre-Service Claim is a Claim for a benefit that requires pre-certification or prior authorization by the Plan before medical care is obtained. All elective, non-emergency Hospital admissions require pre-certification (Pre-Admission Review). Therefore, pre-certification of an elective, non-emergency Hospital admission is treated as a Pre-Service Claim. Pre-Service Claims for the pre-certification of Hospital admissions must be arranged by calling the appropriate **P**rofessional **R**eview **O**rganization (PRO).

The Plan requires prior authorization for various services and prescription drugs, as described in this booklet. Pre-Service Claims for services requiring prior authorization and prescription drugs must be submitted by calling the appropriate **P**rofessional **R**eview **O**rganization (PRO).

If a Pre-Service Claim is properly filed, the claimant will be notified of a decision within 15 days from receipt of the Claim. If additional time is needed, the time for response may be extended up to 15 days due to matters that are beyond the control of the Fund. The claimant will be notified of the circumstances requiring the extension of time and the date by which the Fund expects a decision to be made available.

If an extension of time is necessary because the Fund requires additional information from the claimant, the claimant will be notified, in writing, before the end of the initial 15-day period, of the information required. The claimant will have 45 days from receipt of the notification to provide the additional information, disregarding the Outbreak Period. If the information is not provided within 45 days, disregarding the Outbreak Period, the Claim will be denied. During the period that the claimant is allowed to provide additional information, the normal deadline for making a decision on the Claim will be suspended from the date of the extension notice until either 45 days or the date the claimant responds to the request (whichever is sooner), both timeframes disregarding the Outbreak Period. The Fund then has 15 days to make a decision on the Claim and notify the claimant of the determination.

If a claimant improperly files a Pre-Service Claim with the Laborers Health and Welfare Trust Fund, the Fund or the appropriate PRO will notify the claimant as soon as possible but not later than 5 days after receipt of the Claim of the proper procedures to be followed in filing a Claim. The claimant will only receive notice of an improperly filed Pre-Service claim if the claim includes (1) the patient's name, (2) the patient's specific medical condition or symptom, and (3) the specific treatment, service or product for which approval is requested. Unless the claim is properly re-filed, it will not constitute a Claim.

(2) Urgent Care Claims

An Urgent Care Claim is a Claim for a benefit for which the Plan requires pre-certification or prior authorization before medical care is obtained and, where if normal Pre-Service Claim standards applied, the life or the health of the Eligible Individual would be seriously jeopardized.

The Fund will determine whether a Claim is an Urgent Care Claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Alternatively, if a Physician with knowledge of the patient's medical condition determines that the Claim is an Urgent Care Claim and notifies the Fund the Claim will be treated as an Urgent Care Claim.

Urgent Care Claims, which may include pre-certifications (Pre-Admission Review) of Hospital admissions and prior authorizations of various services and prescription drugs, must be submitted in the same manner as Pre-Service Claims by calling the appropriate PRO.

For a properly filed Urgent Care Claim, the Fund will respond to the claimant with a determination by telephone as soon as possible, taking into account the medical circumstances and condition, but not later than 72 hours after receipt of the Claim. The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Fund will notify the claimant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The claimant must provide the specific information within 48 hours, disregarding the Outbreak Period. If the information is not provided within 48 hours, disregarding the Outbreak Period, the Claim will be denied.

During the period that the claimant is allowed to provide additional information, the normal deadline for making a decision on the Claim will be suspended from the date of the extension notice until either 48 hours or the date the claimant responds to the request, whichever occurs first and both timeframes disregarding the Outbreak Period. Notice of the decision will be provided no later than 48 hours after receipt of the specified information or the end of the 48-hour period allowed for the claimant to provide this information, whichever is sooner.

If a claimant improperly files an Urgent Care Claim with the Laborers Health and Welfare Trust Fund, the Fund or the appropriate PRO will notify the claimant as soon as possible but not later than 24 hours after receipt of the Claim, of the proper procedures to be followed in filing an Urgent Care Claim. The claimant will only receive notice of an improperly filed Urgent Care Claim if the Claim includes (1) the patient's name, (2) the patient's specific medical condition or symptom, and (3) the specific treatment, service or product for which approval is requested. Unless the claim is properly re-filed, it will not constitute a Claim.

(3) Concurrent Claims

A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by plan amendment or termination) will be made by the Fund as soon as possible. In any event, the claimant will be given enough time to request an appeal, disregarding the Outbreak Period, and to have the appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend an approved Urgent Care Claim will be acted upon by the Fund within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Care Claim. A request to extend approved treatment that does not involve an Urgent Care Claim will be decided according to the guidelines for Pre-Service or Post-Service Claims, as applicable.

(4) Post Service Claims

A Post-Service Claim must be submitted to the Laborers Health and Welfare Trust Fund, in writing, using the appropriate claim form, as soon as practicable but in no event later than

one year after the expenses were incurred, disregarding the Outbreak Period. A claim form may be obtained by contacting the Trust Fund Office.

The claim form must be completed in full and an itemized bill(s) attached to the claim form in order for the request for benefits to be considered a Claim. The claim form and/or itemized bill(s) must include the following information for the request to be considered a Claim:

(a) The patient's name and Health Plan ID or social security number;

(b) The date of service;

(c) The type of service or CPT code (the code for physician services and other health care services found in the Current Procedural Terminology, as maintained and distributed by the American Medical Association);

(d) The diagnosis or ICD code (the diagnosis code found in the International Classification of Diseases, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);

(e) The billed charge(s);

(f) The number of units (for anesthesia and certain other claims);

(g) The provider's federal taxpayer identification number (TIN); and

(h) The provider's billing name and address.

A Post-Service Claim is considered filed upon receipt of the Claim by the Fund. Ordinarily, claimants are notified of decisions on Post-Service Claims within 30 days from receipt of the Claim by the Fund. The Fund may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the claimant will be notified before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Fund expects a decision to be made available.

If an extension is required because the Fund needs additional information from the claimant, the Fund will issue a Request for Additional Information that specifies the information needed. The claimant will have 45 days from receipt of the notification to supply the additional information, disregarding the Outbreak Period. If the information is not provided within that period which also disregards the Outbreak Period, the Claim will be denied. During the period in which the claimant is allowed to provide additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the Request for Additional Information until either 45 days disregarding the Outbreak Period or until the date the claimant responds to the request, whichever is sooner. The Fund then has 15 days to make a decision on the Claim and notify the claimant of the determination.

If the Fund determines that additional information is required from the claimant, it may issue a combined Request for Additional Information and Notice of Adverse Benefit Determination. The Notice of Adverse Benefit Determination would only be applicable if the claimant fails to provide any information within 45 days, disregarding the Outbreak Period. In this case, the Fund would not issue a separate Notice of Adverse Benefit Determination if the claimant failed to submit any information within 45 days, disregarding the Outbreak Period. The combined notice will clearly state that the Claim will be denied if the claimant fails to submit any information in response to the Fund's request, and will satisfy the content

requirements of both the Request for Additional Information and the Notice of Adverse Benefit Determination. When the combined notice is used, the time frame for appealing the Adverse Benefit Determination begins to run at the end of the 45-day period prescribed in the combined notice for submitting the requested information, disregarding the Outbreak Period.

5. Article VIII. Claims & Appeals, Section 3. The Fund's Internal Appeals Procedure, a new subsection e. is added, stating as follows:

e. Temporary Changes to Appeals Procedures: Effective March 1, 2020, through the end of the Outbreak Period, the following procedures apply to the Plan's Appeals Procedures:

(1) Appealing an Adverse Benefit Determination

If a Claim is denied in whole or in part, or if the claimant disagrees with the decision made on a Claim, the claimant may appeal the decision first through the Internal Appeals Procedure with the Board of Trustees for the Laborers Health and Welfare Trust Fund.

(a) Pre-Service Claims

An appeal of an Adverse Benefit Determination issued by the PRO regarding Pre-Service Claims must be made by phoning the PRO.

An appeal of an Adverse Benefit Determination issued by the Fund regarding a Pre-Service Claim should be submitted in writing to the Board within 180 days from receipt of the notice of Adverse Benefit Determination, disregarding the Outbreak Period.

The request to the Board for an Internal Appeal must include:

- The patient's name, address and Health Plan ID number or social security number;
- The claimant's full name and address (if the address is different from that of the Active Participant);
- A statement that this is an appeal request of a decision by the Board;
- The date of the Adverse Benefit Determination; **and**
- The basis for the appeal, specifically, the reason(s) why the Claim should not be denied.

(b) Urgent Care Claims

An appeal of an Adverse Benefit Determination issued by the PRO regarding an Urgent Care Claim must be made by phoning the PRO within 180 days after receipt of the Notice of Adverse Benefit Determination, disregarding the Outbreak Period.

You may also submit an appeal to the Board of Trustees by writing to the Board within 180 days after receipt of the notice of Adverse Benefit Determination from the Fund, disregarding the Outbreak Period.

If an appeal is made within 72 hours of receipt of the Notice of Adverse Benefit Determination from the Fund, disregarding the Outbreak Period, the appeal may be made orally by phoning the Trust Fund Office.

(c) Concurrent Claims

An appeal of an Adverse Benefit Determination regarding a Concurrent Claim must be made by phoning the PRO if the Adverse Benefit Determination was made by the PRO.

An appeal of an Adverse Benefit Determination regarding a Concurrent Claim must be made by writing to the Board if the Adverse Benefit Determination was issued by the Fund.

For a Concurrent Claim that involves a termination or reduction of previously approved care, there is no set time frame for appeal; however, the appeal must be completed before the care is terminated or reduced, disregarding the Outbreak Period.

For a Concurrent Claim regarding an extension of care, the appeal time frame will be the time frame for an Urgent, Pre-Service or Post-Service Claim, whichever category applies to the appeal.

(d) Post-Service Claims

An appeal of a Post-Service Claim must be made, in writing, to the Board of Trustees within 180 days after receipt of the notice of Adverse Benefit Determination, disregarding the Outbreak Period.

The request for an Internal Appeal must include:

- The patient's name, address and Health Plan ID number or social security number;
- The claimant's name and address (if the address is different from that of the Active Participant);
- A statement that this is an appeal of a decision made by the Board;
- The date of the Adverse Benefit Determination; **and**
- The basis of the appeal, specifically, the reason(s) why the Claim should not be denied.

All requests for an Internal Appeal for a Pre-Service, Urgent Care, Concurrent or Post-Service Claims should be sent to:

The Board of Trustees
Laborers Health and Welfare Trust Fund for Northern
California 220 Campus Lane
Fairfield, CA 94534-1498

6. Article VIII. Claims & Appeals, a new Section 6. is added, stating as follows:

Section 6. Temporary Changes to External Review Time Frames: Effective March 1, 2020, through the end of the Outbreak Period, the following timeframes apply to the Plan's External Review procedures:

Temporary External Review Time Frames Chart

Steps In The External Review Process	Time Frame For Standard Claims (Non-Urgent)	Time Frame For Expedited Claims Urgent Care
Claimant requests an External Review (generally after Internal Claims Appeals Procedures have been exhausted)	Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice), disregarding the Outbreak Period	After receipt of an Adverse Claim Benefit Determination (benefits denial notice)
Fund performs preliminary review	Within 5 business days following the Fund's receipt of an external review request	Immediately
Fund's notice to claimant regarding the results of the preliminary review	Within 1 business day after Fund's completion of the preliminary review	Immediately
When appropriate, claimant's timeframe for perfecting an incomplete External Review request	Remainder of the 4 month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete, both timeframes disregarding the Outbreak Period	Expeditiously
Fund assigns case to IRO	In a timely manner	Expeditiously
Notice by IRO to claimant that case has been accepted for review along with the time frame for submission of any additional information	In a timely manner	Expeditiously
Claimant's submission of additional information to the IRO	Within 10 business days following the claimant's receipt of a notice from the IRO that additional information is needed (IRO may accept information after 10 business days), disregarding the Outbreak Period	Expeditiously
IRO forwards to the Fund any additional information submitted by the claimant	Within 1 business day of the IRO's receipt of the information	Expeditiously

Steps In The External Review Process	Time Frame For Standard Claims (Non-Urgent)	Time Frame For Expedited Claims Urgent Care
If (on account of the new information) the Fund reverses its denial and provides coverage, a Notice is provided to claimant and IRO	Within 1 business day of the Fund's decision	Expeditiously
External Review decision by IRO to claimant and Fund	Within 45 calendar days of the IRO's receipt of the request for external review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited
Upon Notice from the IRO that it has reversed the Fund's Adverse Benefit Determination	Fund must immediately provide coverage or payment for the Claim	Fund must immediately provide coverage or payment for the Claim

June 17, 2020

Date

/s/ Bill Koponen

Mr. Bill Koponen – Chairman

June 17, 2020

Date

/s/ Oscar De La Torre

Mr. Oscar De La Torre – Co-Chairman