Statement of Amendment Number 3 to the
Laborers Health and Welfare Trust Fund for Northern California
Retired Plan Rules and Regulations
Amended and Restated March 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 December 3, 2019 the following changes to the Laborers Health and Welfare Trust Fund for the Northern California Retiree Plan were adopted (effective March 1, 2020):

1. Article I. Definitions, Section 18.00, is amended by adding the text in underlining, as follows:

The term **"Experimental or Investigative Procedures"** means a drug, device or medical treatment or procedure if:

a. The drug or device cannot be lawfully marketed without the approval of the **F**ood and **D**rug **A**dministration (FDA); **and**

(1) Approval for marketing has not been given at the time the drug or device is prescribed or provided; **or**

(2) Approval has not been given by the FDA for the specific diagnosis, illness or condition for which the drug or device is prescribed or provided; **or**

b. The drug, device, medical treatment or procedure, or the patient's informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires a review or approval; **or**

c. **"Reliable Evidence"** shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment or diagnosis; **or**

d. **"Reliable Evidence"** shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

e. Note that under this medical plan, experimental, investigational or unproven does not include **routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.** The routine costs that are covered by this Plan are discussed below:

(1) "**Routine costs**" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

(2) An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control & Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(3) A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating health care provider in the Plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the Plan with medical and scientific information establishing that participation in the trial would be medically appropriate.

(4) The Plan may require that an eligible individual use a Network provider as long as the provider will accept the patient. This Plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

(5) The Plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process.

2. **Article IV. Comprehensive Hospital-Medical Benefits, Section 1. Covered Expense, subsection a.(6)(j) is amended by adding the text in underlining and deleting the text in strikethrough, as follows:**

(j) ~~Newborn and well child visits, including routine immunizations from birth through 24 months of age, in accordance with the recommended schedule of the American Pediatrics.~~ This Plan voluntarily provides coverage for certain Preventive Services required by the Patient Protection and Affordable Care Act of 2010 even though it is not required to do so as a retiree-only plan. Coverage is voluntarily provided for the following Preventive Services when received from a Participating Provider:

(i) Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,

(ii) Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and

(iii) Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines relating to services for infants, children, and adolescents and HRSA guidelines relating to services for women.

3. **Article IV. Comprehensive Hospital-Medical Benefits, Section 1. Covered Expense, subsections a.(7), a.(8), a.(11), and a.(18) are amended by adding the text in underlining and deleting the text in strikethrough, as follows:**

(7) Charges for nursing services provided by a nurse practitioner, registered nurse, ~~or~~ vocational nurse, or other licensed provider licensed under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license and is performing services under the supervision of a Physician if supervision is required.

(8) Charges made for rehabilitation therapy performed by a licensed therapist or other licensed provider ~~not related to the Eligible Individual by blood or marriage~~ who is acting within the scope of his license. Covered services include short-term active, progressive occupational or physical therapy. Speech therapy is covered if it is to restore normal speech or correct dysphasic swallowing defects due to an illness, injury or surgical procedure.

Habilitative/Habilitation services provided to Eligible Individuals with developmental delays who have never acquired normal functional abilities are not covered under Article VI., Subsection 1.~~v~~u.

(11) Charges made by a Physician, Pharmacist, or other licensed provider acting within the scope of his license for services and supplies related to administrating contraceptive implants, injections, devices, or surgical procedure resulting in voluntary infertility.

(18) Charges of a Dentist or other licensed provider acting within the scope of his license for the following:

(a) Treatment necessary to alleviate the damage to broken or injured teeth as a result of accidental bodily injury. No payment is made under this Subsection for replacement of teeth in whole or in part; and
(b) Medically Necessary surgery not covered under the Fund's Dental Benefits.

4. **Article IV. Comprehensive Hospital-Medical Benefits, Section 2. Copayments, subsection c. is amended by adding the text in underlining and deleting the text in strikethrough, as follows:**

c. Hospital Emergency Room. If an Eligible Individual incurs expenses in the emergency room of a Hospital, a

~~(1)~~ $25 Copayment for each of the first three visits per calendar year, and $50 Copayment each visit thereafter for visits to a Participating Hospital and/~~;~~ or

(~~2) $50 Copayment for each visit~~ to a Non-Participating Hospital combined is required.

The Copayment will be waived under the following circumstances:

(1) The emergency room visit results in the overnight Hospital confinement of the Eligible Individual.
(2) The Eligible Individual is transported to the emergency room by ambulance.
(3) The Eligible Individual is dead upon arrival at the emergency room or dies while receiving services in the emergency room.

The Copayment described in Subsections 2.a. and 2.c., are in addition to the annual Deductible.

5. **Article IV. Comprehensive Hospital-Medical Benefits, Section 4. Benefits and Payment, subsection f.(2)(a) is amended by adding the text in underlining and deleting the text in strikethrough, as follows:**

(a) Emergency Room Services: If an Eligible Individual receives treatment at an ~~Participating Hospital's~~ emergency room from an attending Physician that is not a Participating Provider, the Fund will, subject to all other Plan Provisions, pay the lesser of the amount charged or 90% of the Allowed Amount.

6. **Article IV. Comprehensive Hospital-Medical Benefits, Section 4. Benefits and Payment, subsection f. is amended by renaming subsection (6) to subsection (7), and then adding a new subsection (6), stating as follows:**

(6) This Fund voluntarily provides coverage for certain Preventive Services required by the Patient Protection and Affordable Care Act of 2010 even though it is not required to do so as a retiree-only plan. Preventive services that are identified by the Plan under subsection 1.a.(6)(j) of this Article IV will be covered with no cost-sharing by the Participant or Dependent when received from a Participating Provider. This means that the service will be covered at 100% of the Plan's Allowed Charge, with no coinsurance, copayment, or deductible.

If preventive services are received from a Non-Participating Provider, they will not be eligible for coverage under this Preventive Services benefit unless there is no provider in the Plan's network who can provide the particular service. In some cases, federal guidelines are unclear about which preventive benefits must be covered under the

ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

7. Article V. Prescription Drug Benefits, Section 2. Covered Charges, is amended by adding the text in underlining and deleting the text in strikethrough, as follows:

Section 2. Covered Charges
Included in Covered Charges are charges made by a Licensed Pharmacist, pharmacy, Physician, ~~or~~ Hospital, or other licensed provider for:

a. Drugs prescribed by a Physician or other provider licensed by law to administer or prescribe Drugs.
b. Drugs or insulin or insulin injection kits:
   (1) Which are supplied to the patient in the Physician's office, **and**
   (2) For which a charge is made separately from the charge for any other item or expense, **or**
   (3) Which are for use outside of the Hospital in connection with treatment received in the Hospital, provided the Drugs are prescribed by a Physician licensed by law to administer or prescribe Drugs.
c. Compounding dermatological preparation s prescribed by a Physician.
d. Contraceptives which have been prescribed by a Physician or other licensed provider.
e. Therapeutic vitamins, cough mixtures, antacids, eye and ear medications prescribed by a Physician or other licensed provider for the treatment of a specific illness or complaint.
f. Self-administered oral or injectable Drugs to treat a chronic or an acute condition and which can safely be administered in the patient's home. If the medication is included on the Plan's list of specialty medications that require ongoing clinical supervision, the medications must be obtained from and distributed under a program managed by the Plan's Specialty Pharmacy. Self-administered injectables, such as insulin and Imitrex® are not specialty medications, requiring distribution from the Fund's Specialty Pharmacy; these can be obtained from a retail Contracting Pharmacy.
g. Injectable medications such as: Ana-Kits, Epi-Pens, Glucagon and Imitrex®.
h. Certain preventive care drugs mandated by the Affordable Care Act (as described in Article IV, Subsection 1.a.(6)(j)) will be voluntarily covered by this Retiree-only plan at no charge when received from a Contracting Pharmacy. When a generic is available, only the generic will be covered at no charge, unless the generic is medically inappropriate.

8. Article V. Prescription Drug Benefits, Section 4. Exclusions, subsection d. is amended by adding the text in underlining, as follows:

d. Multiple and non-therapeutic vitamins, cosmetics, dietary supplements (except as specifically covered under Subsection 2(h) of this Article V), health and beauty aids

9. Article VI. Exclusions, Limitations and Reductions, Section 1. Exclusions, subsections m. and n. are amended by adding the text in underlining, as follows:

m. Pregnancy of a Dependent child, except that certain preventive screenings mandated by the Affordable Care Act will be voluntarily covered by this Retiree-only plan when received from a Participating Provider, in accordance with Article IV Section 4.f.(6).

n. Pregnancy of an Eligible Individual functioning as a surrogate (except that certain preventive screenings mandated by the Affordable Care Act will be voluntarily covered by this Retiree-only

plan when received from a Participating Provider, in accordance with Article IV Section 4.f.(6)), or any person functioning as a surrogate to an Eligible Individual. This includes, but not limited to, prenatal care, labor/delivery and postnatal services of the surrogate.

10. Article VIII. Claims and Appeals, Section 1. Definitions, subsection i. is amended by adding the text in underlining and deleting the text in strikethrough, as follows:

i. An "Urgent Care Claim" is a Claim for medical care or treatment that, in the opinion of a Physician with knowledge of the claimant's medical condition, if Pre-Service Claim standards were applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or ~~in the opinion of a Physician with knowledge of the claimant's medical condition,~~ would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

11. Article VIII. Claims and Appeals, Section 2. Claims Procedures, subsection f.(1) is amended by adding the text in underlining and deleting the text in strikethrough, as follows:

(1) The claimant will be provided with written notice of the initial benefit decision on his Claim. If the decision is an Adverse Benefit Determination, the notice will include:

- The identity of the Claim involved (date of service, health care provider, Claim amount), if applicable;
- A statement, that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an Internal Appeal or an External Review;
- The specific reason(s) for the determination including the denial code and its corresponding meaning as well as any Plan standards used in denying the Claim;
- Reference to specific Plan provision(s) on which the decision is based;
- Contain a statement that you are entitled to receive, upon request, free access to and copies of documents relevant to your claim;
- A description of any additional material or information necessary to complete the Claim and an explanation of why the material or information is necessary;
- A description of the Fund's Internal Appeals Procedure and External Review Process including applicable time limits and information regarding how to initiate an appeal or review;
- A statement of the claimant's right to bring a civil action under ERISA §502(a) following the appeal of an Adverse Benefit Determination;
- If an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon written request at no charge;
- If the initial benefit decision was based on the absence of medical necessity or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon written request at no charge;
- Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with the Fund's Internal Claims and Appeals Procedures and External Review Process; **and**

- For Urgent Care Claims, a description of the expedited review process applicable to Urgent Care Claims (for Urgent Care Claims, the notice may be provided orally and followed with written notification).

12. Article VIII. Claims and Appeals, Section 3. The Fund's Internal Appeals Procedure, subsection b. is amended by adding the text in underlining and deleting the text in strikethrough, as follows:

b. The Internal Appeal Procedure

(1) In connection with the claimant's request for an Internal Appeal to the Board, the claimant has the opportunity to submit written comments, documents and other information for consideration during the Internal Appeal, even if the information was submitted or considered as part of the initial benefit decision. The claimant will be provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his Claim.

(2) The claimant will be provided automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

(3) A person different from the person who originally made the initial Adverse Benefit Determination on the Claim, and who is not the subordinate of the person who originally made the initial Adverse Benefit Determination on the Claim, will review the appeal. The reviewer will not consider the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including any additional documents and comments submitted by the claimant, without regard to whether such information was submitted or considered in the initial benefit determination.

(4) If the Claim was denied on the basis of a medical judgment (such as a decision that the treatment was not Medically Necessary or was an Experimental or Investigative Procedure), a health care professional who has the appropriate training and experience in a relevant field of medicine will be consulted. Upon request, the claimant will be provided with the identification of medical consultant or adviser, if any, that gave advice on the Claim, without regard to whether the advice was relied upon in deciding the Claim.

(~~2~~5) If a claimant does not understand English and has questions about a Notice of Initial Benefit Decision, he should contact the Fund to find out if assistance is available in Spanish. Para obtener asistencia en Espanol, llame al Fund.

13. Article VIII. Claims and Appeals, Section 3. The Fund's Internal Appeals Procedure, subsection d.(1) is amended by adding the text in underlining and deleting the text in strikethrough, as follows:

(1) If the decision is an Adverse Benefit Determination on the Internal Appeal, the notice will include:

- Information that is sufficient to identify the Claim involved (the date of service, name of the health care provider, Claim amount, if applicable);
- A statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for External Review;
- The specific reason(s) for the decision including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the Claim;
- Reference to the specific Plan provision(s) on which the decision is based;
- ~~A statement that the claimant is entitled to receive the diagnosis and corresponding treatment codes relevant to the Claim upon written request and free of charge;~~
- A statement that the claimant is entitled to receive reasonable access to and copies of all documents relative to the Claim upon written request and free of charge;
- A statement of the claimant's right to bring a civil action under ERISA §502(a) following an Adverse Benefit Determination on an Internal Appeal;
- An explanation of the External Review Process along with any time limits and information regarding how to initiate the next level of review;
- If an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon written request and free of charge;
- If the decision was based on medical necessity, or because the treatment was an Experimental or Investigative Procedure or other similar exclusion, a statement that an explanation of the specific or clinical judgment for the decision is available upon written request and free of charge;
- The statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office"; **and**
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with Internal Claims and Appeals and External Review Process.

14. Article VIII. Claims & Appeals, Section 4. External Review of Claims, is amended by adding the text in underlining and deleting the text in strikethrough, as follows:

Section 4. External Review of Claims

The External Review Process is intended to comply with the Affordable Care Act (ACA). For purposes of this section, references to "you" or "your" include you, your covered Dependent(s), and you and your covered Dependent(s)' Authorized Representatives; and references to "Plan" include the Plan and its designee(s).

You may seek further review through the External Review Process by an Independent Review Organization (IRO), if your Internal Appeal of a health care Claim, whether Urgent, Concurrent, Pre-Service or Post-Service Claim is denied and it fits within the following guidelines:

(1) The denial involves medical judgment including, but not limited to, those based on the Plan's requirement for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit or a determination that a treatment is an Experimental or Investigative Procedure. The IRO will determine whether a denial involves a medical judgment; and/or

(2) The denial is due to a Rescission of coverage (retroactive elimination of coverage) regardless of whether the Rescission has any effect on any particular benefit at that time.

The External Review Process is not available for any other types of denials, including if your Claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, the External Review Process does not pertain to Claims for Death, and Accidental Death and Dismemberment (AD&D), dental or vision benefits.

Generally, you may only request an External Review after you have exhausted the Internal Appeal Procedures described above. This means that, in the normal course, you may only seek an External Review after a final decision has been made on an Internal Appeal. See also Section 6 on Deemed Exhaustion of the Plan's Internal Claims and Appeals Procedures.

There are two types of Claims, outlined below, that are eligible for the External Review Process: Standard (non-Urgent) Claims and Expedited Urgent Claims.

(1) External Review of Standard (non-urgent) Claims. Your request for an External Review of a Standard (non-urgent) Claim must be made in writing within four (4) months of the date that you receive notice of an Initial Claim Benefit Determination or Adverse Benefit Determination on an Internal Appeal. For convenience, these decisions are referred to below as an "Adverse Benefit Determination," unless it is necessary to address them separately.

~~Generally, the Fund's Internal Appeal Procedure must be exhausted before an External Review is available. An External Review of a Standard (non-urgent) Claim will only be available after an Adverse Benefit Determination is issued on an Internal Appeal.~~

(A) Preliminary Review of Standard (non-urgent) Claims.

(1) Within five (5) business days of the Fund's receipt of your request for an External Review of a Standard (non-urgent) Claim, the Fund will complete a preliminary review of the request to determine whether:

(a) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a Retrospective Review, were covered under the Plan at the time the health care item or service was provided;

(b) The Adverse Benefit Determination on an Internal Appeal satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation;

(c) You have exhausted the Fund's Internal Appeal Procedures (except in limited, exceptional circumstances when under the regulations the claimant is not required to do so); **and**

(d) You have provided all of the information and forms required to process an External Review.

(2) Within 1 business day of completing its preliminary review, the Fund will notify you in writing as to whether your request for an External Review meets the above requirements. The notification will inform you:

(a) If your request is complete and eligible for an External Review; or

(b) If your request is complete but not eligible for an External Review, in which case the notice will include the reasons for its ineligibility, and contact information for the **E**mployee **B**enefits **S**ecurity **A**dministration (EBSA) (toll-free telephone number 1 866 444 EBSA (3272)); **or**

(c) If your request is incomplete, the notice will describe the information or materials needed to complete the request and allow you to complete your request for External Review within the 4 month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

(B) External Review of Standard (non-urgent) Claims by an **I**ndependent **R**eview **O**rganization (IRO)

(1) If the request is complete and eligible for an External Review, the Fund will assign the request to an IRO (Note: The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Fund may rotate assignments among IROs with which it contracts.) Once the Claim is assigned to an IRO, the following procedure will apply:

(a) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for External Review, including directions about how you may submit additional information regarding your Claim (generally, you are to submit this information within 10 business days).

(b) Within 5 business days after the Claim is assigned to an IRO for an External Review, the Fund will provide the IRO with the documents and information the Fund considered in making its Adverse Benefit Determination.

(c) If you submit additional information related to your Claim to the IRO, the assigned IRO must, within 1 business day, forward that information to the Fund. Upon receipt of any additional information, the Fund may reconsider its Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Fund will not delay the External Review. However, if upon reconsideration, the Fund reverses its Adverse Benefit Determination, the Fund will provide written notice of its decision to you and the IRO

within 1 business day after making that decision. Upon receipt of the notice, the IRO will terminate its External Review.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Fund's Internal Appeals Procedures. However, the IRO will be required to follow the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms of the Plan are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Fund, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

(e) The assigned IRO will provide written notice of its final External Review decision to you and the Fund within 45 days after the IRO receives the request for the External Review.

(1) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(2) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

(f) The assigned IRO's decision notice will contain:

(1) Information sufficient to identify the Claim including the date or dates of service, health care provider, Claim amount (if applicable), diagnosis code and its corresponding meaning, treatment code and its corresponding meaning and the reason for the previous denial;

(2) The date that the IRO received the request to conduct the External Review and the date of the IRO's decision;

(3) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

(4) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

(5) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

(6) A statement that judicial review may be available to you; **and**

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the **A**ffordable **C**are **A**ct (ACA) to assist with External Review Processes.

(8) If the IRO's final External Review reverses the Fund's Adverse Benefit Determination, upon the Fund's receipt of the notice of such reversal, the Fund will immediately provide coverage or payment for the reviewed Claim. However, even after providing coverage or payment for the Claim, the Fund may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(9) If the final External Review upholds the Fund's Adverse Benefit Determination, the Fund will continue to deny coverage or payment for the reviewed Claim. If you are dissatisfied with the External Review decision, you may seek judicial review as permitted under ERISA §502(a).

(2) **External Review of Expedited Urgent Care Claims**

(A) You may request an expedited External Review if:

(1) You receive an adverse initial Claim Benefit Determination that involves a medical condition for which the time frame for completion of an expedited Internal Appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited Internal Appeal; **or**

(2) You receive an Adverse Benefit Determination on an Internal Appeal that involves a medical condition for which the time frame for completion of a Standard (non-urgent) Claim for an External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or you receive an Adverse Benefit Determination of an Internal Appeal that concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services but you have not yet been discharged from a facility.

(B) Preliminary Review for an External Review of an Expedited Urgent Care Claim:

Immediately upon receipt of the request for expedited External Review, the Fund will complete a preliminary review of the request to determine whether the requirements for a preliminary review are met (as described under Standard (non-urgent) Claims above). The Fund will immediately notify you (by telephone or by fax) as to whether your request for an External Review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard (non-urgent) Claims above).

(C) External Review of Expedited Urgent Care Claim by an **I**ndependent **R**eview **O**rganization (IRO):

Following the preliminary review that a request is eligible for an expedited External Review, the Fund will assign an IRO (following the process described under Standard (non-urgent) External Review above). The Fund will expeditiously (meaning by telephone, fax, courier, overnight delivery,

etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Benefit Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for a standard External Review (described above under Standard Claims). In reaching a decision, the assigned IRO must review the Claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Fund's Internal Appeals Procedures. However, the IRO will be required to follow the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited External Review decision, in accordance with the requirements, set forth above under Standard (non-urgent) Claims, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice of the IRO's decision is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Fund.

(1) If the IRO's final External Review reverses the Fund's Adverse Benefit Determination, upon the Fund's receipt of the notice of such reversal, the Fund will immediately provide coverage or payment for the reviewed Claim. However, even after providing coverage or payment of the Claim, the Fund may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(2) If the final External Review upholds the Fund's Adverse Benefit Determination, the Fund will continue to deny coverage or payment for the reviewed Claim. If you are dissatisfied with the External Review decision, you may seek judicial review as permitted under ERISA §502(a).

(3) For an overview of the time frames during the federal External Review Process, see the chart on the next page.

15. Article VIII. Claims & Appeals is amended by adding a new Section 6, stating as follows:

Section 6. Deemed Exhaustion of the Plan's Internal Claims and Appeals Procedures
If the Plan fails to strictly adhere to all rules for processing disability claims, a claimant will be deemed to have exhausted the Plan's administrative procedures for internal claim appeal and will be entitled to take legal action, unless there was only a minor error violation of the required claims procedures, with minor being: (1) de minimis, (2) non-prejudicial, (3) attributable to good cause or matters beyond the plan's control, (4) in the context of an on-going good faith exchange of information, and (5) not reflective of a pattern or practice of noncompliance. A claimant is entitled, upon request, to an explanation of the minor error violation from the Plan, and the Plan has 10 days to respond. A claimant who is not satisfied with the Plan's explanation, or who does not even request an explanation, may take legal action.

December 3, 2019

Date

/s/ Bill Koponen

Mr. Bill Koponen – Chairman

December 3, 2019

Date

/s/ Oscar De La Torre

Mr. Oscar De La Torre – Co-Chairman