Statement of Amendment No. 4
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 Active Plan were adopted (effective March 1, 2020):

1. **Article 1. Definitions, Section 1.00 subsection c. is amended by adding the texting in underlining below, as follows:**

   c. The provider's actual charge.

   The Plan will not always pay benefits equal to or based on the provider's actual charge for health care services or supplies, even if the Eligible Individual has paid the applicable Plan Year Deductible, Copayment and/or coinsurance. This is because the Plan covers only the "Allowed Charge" for health care services or supplies. Any amount in excess of the "Allowed Charge" does not count towards the Plan Year Out-of-Pocket Maximum. The Eligible Individual is responsible for amounts that exceed the "Allowed Charge" determined by the Plan.

2. **Article 1. Definitions, Section 26.00 is amended by adding the texting in underlining, as follows:**

Section 26.00 The term **"Maximum Plan Allowance (MPA)"** means the highest amount that the Fund will allow for hospital charges in connection with routine total hip or knee replacements, arthroscopic surgeries, cataract surgeries and colonoscopies in the state of California. The Eligible Individual is responsible for amountsthat exceed the MPA and those amounts will not accumulate to the Plan Year Out- of-Pocket Maximum. The MPA does not apply to covered outpatient surgeries performed at an outpatient surgical center.

Exceptions:

Inpatient and outpatient services furnished by a provider, hospital, or outpatient surgery center that has not agreed to accept the MPA may be treated as a MPA provider, hospital, or outpatient surgery center if:

(1) Access to a MPA provider, hospital, or outpatient surgery center is unavailable or the service cannot be obtained within a reasonable wait time or travel distance; and

(2) The quality of services for a covered Eligible Individual could be compromised with the MPA provider, hospital, or outpatient surgery center (e.g., if comorbidities present complications or patient safety issues).

3. **Article 1. Definitions, Sections 45.00 and 46.00 are renamed Sections 46.00 and 47.00, respectively. A new Section 45.00 is added, stating as follows:**

Section 45.00 The term "**Urgent Care Facility**" means a public or private Hospital-based or free-standing facility that is licensed or legally operating as an Urgent

Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

4. **Article IV. Comprehensive Hospital-Medical Benefits, Section 1. Covered Expense, a new subsection a.(6)(k) is added, stating as follows:**

(k) Tobacco cessation visits and interventions. Please see also subsection a.(6)(j), above, for available preventive care benefits, or Article V for available prescription drug benefits for tobacco cessation.

4. **Article IV. Comprehensive Hospital-Medical Benefits, Section 1. Covered Expense, subsection a. is amended by adding new subsections (19) and (20), stating as follows:**

(19) Procedures intended to reduce breast size performed to correct or improve a bodily function, except for cosmetic surgery which is not primarily for beautification as provided in Article VI Section 1.l.

(20) Nutritional counseling to assist individuals with their nutritional health and dietary needs. Benefits can be used for assistance with food choices when diagnosed with such diseases as, but not limited to, obesity, high blood pressure, cardiac disease, diabetes, high cholesterol, allergies, kidney disease, or an eating disorder.

5. **Article IV. Comprehensive Hospital-Medical Benefits, Section 2. Copayments, subsection a. is amended by deleting the text in strike through, and adding the text in underlining, as follows:**

a. Physician Office Visit. $~~20~~15 Copayment is required for each visit to a Physician's office except for the following:

(1) Visits to a chiropractor;
(2) Visits for Physician consultations; and
(3) Visits for Routine Physical Examinations; and
(4) Visits made by an Eligible Individual who is Eligible for Medicare.

6. **Article IV. Comprehensive Hospital-Medical Benefits, Section 2. Copayments, subsection b. is deleted in its entirety. Subsection c. is renamed subsection b.**

7. **Article IV. Comprehensive Hospital-Medical Benefits, Section 3. Deductible, subsection a. is amended by adding the text in underlining, as follows:**

a. **Amount**

Each Eligible Individual is responsible for the first $150 of Covered Expense. This Deductible is an out-of-pocket cost for Covered Expenses incurred during any one Plan Year before Comprehensive Hospital-Medical Benefits become payable. When a total of $450 in Deductible Covered Expenses has been satisfied by covered family members during any one Plan Year, the Plan will waive any further Deductible amount for that family for the remainder of the Plan Year.

Deductibles that would normally apply for Claims incurred in a month in which two Active Participants can claim each other as a Dependent will be waived while both Active

Participants remain eligible for benefits under the Plan. If either Active Participant subsequently loses eligibility under this Plan, the Deductible for the former Active Participant and any Dependent will be reinstated, less any Deductible amounts previously satisfied during the Plan Year.

The Deductible will not apply to the following charges:

(1) Confinement in a Hospital or **S**killed **N**ursing **F**acility (SNF) as described in Subsections 4.a. to 4.d.,

(2) Routine Physical Examinations as described in Subsection 4.f.(6)(d), and

(3) E-Visit through LiveHealth Online Services as described in Subsection 4.f.(3).

(4) an urgent care facility visit.

5. Article IV. Comprehensive Hospital-Medical Benefits, Section 4. Benefits and Payment, subsections a., b., c., and e.(1)(c)(1) are amended by deleting the text in strike-through and adding the text in underlining, as follows:

a. Confinement in a Participating Hospital

If an Eligible Individual is confined in a Participating Hospital with the approval of the **P**rofessional **R**eview **O**rganization (PRO), the Fund will, subject to all other Plan provisions, pay the Participating Hospital ~~85~~90% of the first $10,000 of the negotiated contract rate and 100% of that negotiated contract rate thereafter for all Medically Necessary services, including, but not limited to, room, board and routine nursing care.

b. Confinement in a Non-Participating Hospital

If an Eligible Individual is confined on an **elective or non-emergency basis** in a Non-Participating Hospital with the approval of the PRO, the Fund will, subject to all other Plan provisions, pay the Retired Employee ~~65~~70% of the first $10,000 of **Covered Charges**, as defined in Article I., Section 8.00, and 100% thereafter for all Medically Necessary services including, but not limited to, room, board and routine nursing care.

Exceptions:

(1) If an Eligible Individual **does not reside** within the Fund's Preferred Provider Plan Service Area and is confined in a Non-Participating Hospital with the approval of the PRO, the Fund will pay the Retired Employee ~~85~~90% of the first $10,000 of **Covered Charges** and 100% thereafter for all Medically Necessary services.

(2) If an Eligible Individual **resides within** the Fund's Preferred Provider Plan Service Area and is confined in a Non-Participating Hospital due to a **serious or life- threatening emergency basis**, the Fund will pay the Retired Employee ~~85~~90% of the first $10,000 of **Covered Charges** and 100% thereafter for all Medically Necessary services. The Fund may require the transfer of the Eligible Individual to a Participating Hospital upon the advice of a Physician that it is medically safe to make the transfer.

c. Maximum Plan Allowance (MPA) for Routine Total Hip or Knee Replacement Surgery

(1) If an Eligible Individual is confined in a Hospital for routine total hip or knee replacement surgery with the approval of the PRO, the Fund will, subject to all other Plan provisions, pay the benefits described in Subsection 4.a. or 4.b. but not to exceed the **M**aximum **P**lan **A**llowance (MPA) of $30,000. Any amount over the MPA will be

the responsibility of the Eligible Individual and will not count toward the Plan Year Out-of-Pocket Maximum described in Subsection 4.g..

(2) If an Eligible Individual uses a Value-Based Site Hospital described in Article I, Section ~~46~~47.00, for routine total hip or knee replacement surgery and that facility is over 50 miles from the Eligible Individual's home, he may request reimbursement for up to $750 for travel expenses, including mileage, hotel expense and meals. This reimbursement by the Fund may be considered taxable income by the IRS.

e.(1)(c)(1) If an Eligible Individual is admitted to a Non-Participating Hospital and a Pre-Admission Review is not obtained, the Retired Employee will, subject to all other Plan provisions, be responsible for an additional coinsurance of 20% of the first $10,000 of Covered Charges whether or not the PRO has conducted a Retrospective Review and determined that the confinement was Medically Necessary. This additional coinsurance is over-and-above the usual coinsurance described in Subsections 4.b. to 4.d. and does not count toward the Plan Year Out-of-Pocket Maximum described in Subsection 4.g..

6. Article IV. Comprehensive Hospital-Medical Benefits, Section 4. Benefits and Payment, subsection f., as amended, is further amended by adding the text in underlining and deleting the text in strikethrough, as follows:

f. Other Covered Expenses

(1) For Covered Expenses incurred at ~~an emergency room~~ a Participating Provider or the outpatient department of a **Participating Hospital, ~~Home Health Care, Hospice or Ambulatory Surgical Center,~~** the Fund will, subject to all other Plan provisions, pay 90% of the negotiated contract rate, except for office visits, the Fund will, subject to all other Plan provisions, pay 100% of the negotiated rate after a $15 Physician Office Visit Copayment.

(2) For Covered Expenses incurred at ~~an emergency room~~ a Non-Participating Provider or the outpatient department of a **Non-Participating Hospital,** the Fund will, subject to all other Plan provisions, pay the lesser of the amount of the actual charge or 70% of the Allowed charge except ~~90% of the Allowed Charge.~~

(a) **Emergency Room Services:** If an Eligible Individual receives treatment at an 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 Charge.

~~(3)~~(b) **Professional Ambulance Services:** If an Eligible Individual requires ambulance transport for Emergency Services, ~~For Covered Expenses incurred at a **Participating Provider,** the Fund will, subject to all other Plan provisions, pay 75% of the negotiated rate. For Covered Expenses incurred at a **Non-Participating Provider**~~, the Fund will, subject to all other Plan provisions, pay ~~75%~~ the lesser of the amount charged or 90% of the Allowed Charge.

(4) ~~For Covered Expenses incurred at a **Non-Participating Provider**, the Fund will, subject to all other Plan provisions, pay 75% of the Allowed Charge.~~

(3)~~(5)~~ For E-Visits ~~described in Subsection 2.b.~~(Electronic or Online medical, mental health or substance abuse services), the Fund will pay 100% of the Allowed Charge ~~after payment of the $10 E-Visit Copayment~~.

(4)~~(6)~~ The Fund will, subject to all other Plan provisions, pay the following Covered Expenses, but not to exceed the Plan's **M**aximum **P**lan **A**llowance (MPA):

(a) $500 per day for charges made by a licensed free-standing **Non-Participating** Ambulatory Surgical Center.

(b) $1,200 for hearing aid device for each ear once every 36 months.

(c) For charges made by a chiropractor~~,~~:

~~(1) $40 per visit~~ up to 20 visits per Plan Year~~, and~~

~~(2) $100 for x-rays each Plan Year~~.

(d) For Routine Physical Examinations, if an Eligible Individual undergoes a Routine Physical Examination by a Physician, the Fund will pay the amount actually charged for the examination and any x-rays and laboratory services performed in conjunction with the physical examination but not to exceed ~~the amount shown below per Plan Year~~:

(1) $300 per examination for the Retired Employee.

(2) $300 per examination for a Dependent spouse.

(3) $200 per examination for a Dependent child who is over 24 months of age.

(e) For charges incurred in the outpatient surgical department of a Hospital, the Fund will pay the benefits described in Subsection 4.f.(1) or (2) but not to exceed:

(1) $6,000 for arthroscopy surgery.

(2) $2,000 for cataract surgery.

(3) $1,500 for colonoscopy procedure.

Any amount over the **M**aximum **P**lan **A**llowance (MPA) ~~listed above~~ will be the Eligible Individual's responsibility and will not count toward the Plan Year Out-of-Pocket Maximum.

7. Article IV. Comprehensive Hospital-Medical Benefits, Section 4. Benefits and Payment, a new subsection g. is added, stating as follows:

g. Plan Year Out-of-Pocket Maximum

The maximum out-of-pocket expense for Active Participants and their eligible Dependents will be $3,000 per Eligible Individual, up to $6,000 per family. The following charges incurred by the Eligible Individual will not be applied to the Out-of-Pocket Maximum:

(1) Physician Office Visit Copayment;
(2) Hospital Emergency Room Copayment;
(3) Coinsurance payment for Hospital confinements when the Eligible Individual resides within the Fund's Preferred Provider Service Area and uses the services of a Non-Participating Hospital, except in cases of serious of life-threatening emergencies;
(4) Coinsurance payment to a Non-Participating Provider;
(5) Charges for any medical services or supplies excluded by the Plan;
(6) Penalties for non-compliance with the Plan's Utilization Review Program;
(7) Charges that exceed the **M**aximum **P**lan **A**llowance (MPA).

8. **Article V. Prescription Drug Benefits, Section 2. Covered Charges, is amended by adding a new subsection i., stating as follows:**

i. Tobacco cessation drugs. Tobacco cessation drugs and supplies available over-the-counter will be covered with a Provider's prescription. Please see also subsection h., above, for available preventive care drugs, or Article IV for available medical benefits for tobacco cessation.

8. **Article V. Prescription Drug Benefits, Section 3. Benefits and Payment, subsections a. through c. are renamed b. through d., respectively. A new subsection a. is added, stating as follows:**

a. Prescription Drug Out-of-Pocket Maximum

The maximum prescription drug out-of-pocket expense for services received from a Contracting Pharmacy for Active Participants and their eligible Dependents will be $3,000 per Eligible Individual, up to $6,000 per family. The following charges incurred by the Eligible Individual will not be applied to the Prescription Drug Out-of-Pocket Maximum:

(1) Charges for prescription drugs filled by a Non-Contract Pharmacy;
(2) Charges for any prescription drugs excluded by the Plan;
(3) Penalties for non-compliance with the Plan's Utilization Review Program;

9. **Article VI. Exclusions & Limitations, Section 1. Exclusions, subsections l. and m. are amended by adding the text in underlining and deleting the text in strikethrough, as follows:**

l. Cosmetic surgery~~, including procedures intended to reduce breast size except cosmetic~~ surgery which is not primarily for beautification, but is performed to correct or improve a bodily function ~~or as provided in Article IV., Subsection 1.a.(12)~~ or treatment includes surgery or medical treatment to improve or preserve physical appearance or self-esteem or to treat psychosocial complaints related to one's appearance, but not to treat physical function.

m. Pregnancy of a Dependent child~~.~~ except that certain preventive services, as provided in Article IV. Section 1.a.(6)(j) will be covered.

June 17, 2020
Date

June 17, 2020
Date

/s/ Bill Koponen
Mr. Bill Koponen – Chairman

/s/ Oscar De La Torre
Mr. Oscar De La Torre – Co-Chairman