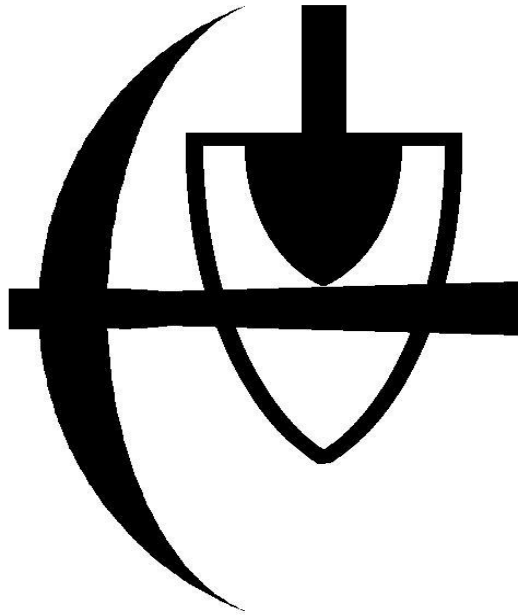


**LABORERS
HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA**

ACTIVE PLAN



Rules and Regulations
January 1, 2016

LABORERS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA

220 Campus Lane | Fairfield, California 94534-1498

TELEPHONE: 707-864-2800 • **TOLL-FREE NUMBER:** 800-244-4530

WEBSITE: www.norcalaborers.org

EMAIL: customerservice@norcalaborers.org

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Bullivant Houser Bailey PC

Weinberg, Roger & Rosenfeld

CONSULTANT AND ACTUARY

The Segal Company

ADMINISTRATIVE OFFICE

Laborers Funds Administrative Office of Northern California, Inc.

Mr. Edward J. Smith, Secretary

NOTICE OF GRANDFATHERED PLAN STATUS

This group health plan sponsored by Laborers Health and Welfare Trust Fund for Northern California believes that all of the plan options offered are considered to be “**grandfathered health plans**” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the above noted plan options may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. 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:

Laborers Health and Welfare Trust Fund for Northern California
220 Campus Lane
Fairfield, Ca 94534

You may also contact the Employee Benefits Security Administration,
U.S. Department of Labor at 1-866-444-3272 or
www.dol.gov/ebsa/healthreform/. This website has a table summarizing
which protections do and do not apply to grandfathered health plans.



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Laborers Health and Welfare Trust Fund for Northern California

Plan Rules and Regulations for Active Employees Amended and Restated January 1, 2016

Article I. Definitions

The following definitions will govern in the Plan:

- Section 1.00** The term “**Active Employee**” or “**Employee**” means a person who is working for an Individual Employer and for whom contributions are made to the Fund.
- Section 2.00** The term “**Active Participant**” or “**Participant**” means an Employee who has satisfied the eligibility requirements of Article II., Section 2.
- Section 3.00** The term “**Allowed Charge**”, “**Allowed Amount**” or “**Allowable Charge**” means the amount the Fund allows, subject to all Plan provisions, for eligible Medically Necessary services or supplies. The Allowed Charge amount is determined by the Plan Administrator or its designee to be the lowest of:
- a. For a **Participating Provider**, the negotiated contract rate shown in the agreement between the Participating Provider and Anthem Blue Cross.
 - b. For a **Non-Participating Provider**, the schedule of fees that lists the dollar amounts the Fund has determined it will allow for eligible Medically Necessary services or supplies. The Fund’s Allowed Charge amount list is not based on nor intended to reflect fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charges (UCR), prevailing or any similar term. The Fund reserves the right to have the billed amount reviewed by an independent medical review organization to assist in determining the amount the Fund will allow for the submitted claim; **or**
 - 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.

- Section 4.00** The term “**Ambulatory Surgical Center (ASC)**” means a free-standing surgical facility which is licensed under any applicable state statute or, in the absence of any state licensing statute, conforms with any other requirements imposed on free-standing surgical facilities within that jurisdiction.
- Section 5.00** The term “**BlueCard PPO**” means a national program that enables members of one Blue Cross and Blue Shield (BCBS) plan to obtain health care services while traveling or living in another BCBS plans’ service area. The program links participating health care providers with independent BCBS plans across the country through a single electronic network for claims processing.
- Section 6.00** The term “**Blue Distinction® Center**” is a designation awarded by the Blue Cross and Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality health care for specific services.
- Section 7.00** The term “**Board of Trustees**” or “**Board**” means the Board of Trustees established by the Trust Agreement.
- Section 8.00** The term “**Collective Bargaining Agreement**” means:
- a. the Laborers’ Master Agreement between Employers and the Union for the 46 Northern California Counties dated June 4, 1952, including any amendment, extension or renewal of that Agreement and the Tunnel Master Agreement between Employers and the Union dated June 18, 1952, including any amendment, extension or renewal of that Agreement, and
 - b. any other collective bargaining agreement between the Union or any of its affiliated local unions, and any employer organization or Individual Employer which provides for the making of Contributions to the Health and Welfare Fund.
- Section 9.00** The term “**Concurrent Utilization Review**” means the process through which the Professional Review Organization (PRO) determines the number of authorized days considered Medically Necessary. These authorized days are eligible for Hospital benefits according to the Plan provisions once an Eligible Individual has been confined in a Hospital on the recommendation of the Professional Review Organization (PRO).

- Section 10.00** The term **“Covered Charges”** as it relates to Article IV., Subsections 4.b. and 4.d., inpatient Hospital expense at a Non-Participating Hospital means: Room, board and routine nursing charges up to an amount equal to the Hospital’s lowest rate charged for semi-private or intensive care room accommodations, or 80% of the lowest rate charged for private room accommodations.
- Section 11.00** The term **“Covered Expense”** refers to the items of hospital and medical expense described in Article IV., Section 1 that may be payable under the Plan’s Comprehensive Hospital-Medical Benefits subject to all other Plan provisions.
- Section 12.00** The term **“Custodial Care”** means general assistance in performing the activities of daily living, which includes, but is not limited to, bathing, dressing, toileting, meal preparation, eating, housekeeping, board, room and other services provided on a long-term basis. This does not include medical care or treatment.
- Section 13.00** The term **“Dentist”** means:
- a. A legally qualified Dentist, **or**
 - b. A Physician authorized by his license to perform the particular dental procedure performed by him.
- Section 14.00** The term **“Dependent”** means:
- a. The Employee’s lawful spouse.
 - b. The Employee’s Domestic Partner but only if the Employee’s Individual Employer certifies in writing that it is doing business with a city, county or state that by law or regulation requires the Individual Employer to provide domestic partner coverage.
 - c. The Employee or Domestic Partner’s children include (for medical, prescription drug, dental, vision and dependents’ death benefits):
 - (1) Natural or adopted children or children acquired through legal guardianship, (adopted children and children acquired through legal guardianship are covered on the date the Employee becomes legally obligated to provide full or partial support), stepchildren or foster children younger than age 26. This Plan will provide coverage for the entire month during which the Dependent child attains age 26; **or**

- (2) Older than age 26 and prevented from earning a living because of a mental or physical handicap (provided the disabled child was handicapped and eligible as a Dependent prior to reaching the limiting age) and is primarily dependent upon the Employee for support. In order for coverage to be provided on a tax-free basis, the Dependent must be claimed on the Employee's tax return for the Plan Year for which coverage is provided.

In accordance with ERISA Section 609(a)(2)(A), this Plan will provide coverage for a Dependent child of an Employee if required by a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice.

- Section 15.00** The term **"Domestic Partner"** means an individual who is registered with the Employee as a domestic partner with any city, county or state agency provided the Employee's Individual Employer certifies in writing that it has entered into a job contract with the City or County of San Francisco, City of Oakland or the City of Sacramento; or an individual who is registered with the Employee as a domestic partner with the California Secretary of State provided the Employee's Individual Employer certifies in writing that it has entered into a job contract with the County of San Mateo or the State of California. A copy of the domestic partners certificate must be provided to the Trust Fund Office.
- Section 16.00** The term **"Drugs"** means any item which is lawfully dispensed under the Federal Food, Drug and Cosmetic Act, including any amendments and then only upon a written prescription from a Physician or Dentist licensed by law to prescribe it.
- Section 17.00** The term **"Durable Medical Equipment (DME)"** means medical equipment that can withstand repeated use, is not disposable, and is only related to care for a medical condition. Examples of DME include, but are not limited to, apnea monitors, wheelchairs, hospital beds and oxygen.
- Section 18.00** The term **"Eligible for Medicare"** means an Eligible Individual who is eligible for Part A of Medicare without payment of monthly premiums to the Social Security Administration and is eligible for Part B of Medicare whether or not the Eligible Individual has qualified for Part B Medicare benefits by enrollment or other procedures available to the Eligible Individual.
- Section 19.00** The term **"Eligible Individual"** means an Active Participant or an eligible Dependent.
- Section 20.00** The term **"Emergency Services"** means a medical screening examination within the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition, along with additional medical examination and treatment to the

extent they are within the capabilities of the staff and facilities available at the Hospital **“to stabilize”** the patient.

The term **“to stabilize”** means, to provide medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Section 21.00 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 Food and Drug Administration (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.

- Section 22.00** The term **“Federal Medicare”** or **“Medicare”** means benefits provided under Title XVIII of the Social Security Amendments of 1965.
- Section 23.00** The term **“Fund”** means the Laborers Health and Welfare Trust Fund for Northern California.
- Section 24.00** The term **“Future Moms’ Program”** means a voluntary program available to a female Active Participant, eligible Dependent spouse or Domestic Partner throughout the pregnancy. This includes the services of a nurse coach, screenings for risk of depression or early delivery and other useful tools.
- Section 25.00** The term **“Group Plan”** means any plan providing benefits of the type provided by this Plan supported wholly or in part by employer payments.
- Section 26.00** The term **“Home Health Care”** means skilled nursing care services provided by a Home Health Care Agency, which is an organization that provides a program of Home Health Care, approved by Medicare, or that is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.
- Section 27.00** The term **“Hospice”** means an organization that administers a program of palliative and supportive health care services for terminally ill individuals assessed to have a life expectancy of 6 months or less and is approved by Medicare or is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the jurisdiction in which it is located.
- Section 28.00** The term **“Hospital”** means any general acute care hospital licensed under any applicable state statute and must provide: (a) 24-hour inpatient care, and (b) the following basic services on the premises: medical, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services. The term **“Hospital”** also includes licensed free-standing psychiatric treatment facilities and licensed free-standing substance abuse facilities.
- Section 29.00** The term **“Licensed Pharmacist”** means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

Section 30.00 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 amounts that 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).

Section 31.00 The term “**Medically Necessary**” applies to services and supplies received for the treatment of an illness or injury and for the purpose of determining eligibility for Plan benefits, and means those services and supplies that meet the following criteria:

- a. Appropriate and necessary for the symptoms, diagnosis or treatment of the illness or injury;
- b. Provided for the diagnosis or direct care and treatment of the illness or injury;
- c. Within the standards of good medical practice within the organized medical community;
- d. Not primarily for the personal comfort or convenience of the patient, the patient’s family, any person who cares for the patient, any Physician or other health care practitioner, or any Hospital or specialized health care facility. The fact that a Physician may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered Medically Necessary for coverage under the Plan;

- e. The most appropriate supply, level or service that can safely be provided. For Hospital confinement, this means that acute care as a bed patient is needed due to the kind of services the patient is receiving or the severity of the patient's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting; **and**
- f. The services or supplies provided must not be more costly than equally effective course of treatment, service or sequence of services.

Section 32.00 The term **"Non-Participating Hospital"** means a Hospital which is not part of the Fund's Preferred Provider Plan (PPO Plan) or the BlueCard PPO national program.

Section 33.00 The term **"Non-Participating Provider"** means a laboratory or radiology facility, Physician, Ambulatory Surgical Center (ASC) or licensed health care provider which is not part of the Fund's Preferred Provider Plan (PPO Plan) or the BlueCard PPO national program.

Section 34.00 The term **"Normal Retirement Age"** means age 65.

Section 35.00 The term **"Participating Hospital"** means a Hospital which is part of the Fund's Preferred Provider Plan (PPO Plan), or the BlueCard PPO national program.

Section 36.00 The term **"Participating Provider"** means a laboratory or radiology facility, Physician, Ambulatory Surgical Center (ASC), or licensed health care provider which **is** part of the Fund's Preferred Provider Plan (PPO Plan) or the BlueCard PPO national program.

Section 37.00 The term **"Physician"** means (a) physician or surgeon (MD/DO) licensed to practice medicine in the state in which he practices; **or** (b) any other practitioner of the healing arts who provides care or treatment within the limits set forth in the license issued to him by the applicable agency of the state in which he provides care or treatment.

Section 38.00 The term **"Plan Year"** means March 1st of any year through February 28th of the following year.

Section 39.00 The term **"Pre-Admission Utilization Review"** means the process through which the Professional Review Organization (PRO) determines the medical necessity of an Eligible Individual's elective confinement, as an inpatient, in a Hospital **prior** to the elective confinement occurring and, if Medically Necessary, the number of pre-authorized days eligible for unreduced benefits according to the Plan provisions.

- Section 40.00** The term “**Preferred Provider Organization (PPO)” means an organization that has contracted with medical providers, including Hospitals, laboratories, radiology facilities, Physicians, Ambulatory Surgical Centers (ASC) and other licensed medical practitioners, who provide medical services to Eligible Individuals based on negotiated contract rates.**
- Section 41.00** The term “**Preferred Provider Plan (PPO Plan)**” means a program or plan of benefits which uses the services of a PPO for the provisions of medical services to Eligible Individuals at the negotiated contract rate.
- Section 42.00** The term “**Preferred Provider Plan Service Area**” means the aggregate list of zip codes for all California Counties in which Eligible Individuals reside and are subject to the reimbursement provisions of the Preferred Provider Plan. The Preferred Provider Plan Service Area also includes the BlueCard PPO national program.
- Section 43.00** The term “**Professional Revue Organization (PRO)**” means an organization under contract with the Fund which is responsible for determining whether the confinement of an Eligible Individual in a Hospital is Medically Necessary. If Medically Necessary, the PRO also determines the number of Medically Necessary days for the confinement. For non-emergency outpatient services, the PRO determines whether the proposed services of an Eligible Individual are Medically Necessary.
- Section 44.00** The term “**Rehabilitation Therapy**” means physical, occupational or speech therapy that is prescribed by a Physician to improve or restore bodily function that has been restricted or diminished as a result of an illness, injury or surgery and that is performed by a licensed therapist acting within the scope of his license.
- Section 45.00** The term “**Retrospective Utilization Review**” means the process through which the Professional Revue Organization (PRO) determines the number of authorized days considered Medically Necessary and eligible for inpatient Hospital benefits. This review occurs after the Eligible Individual has been discharged from the Hospital.
- Section 46.00** The term “**Skilled Nursing Facility (SNF)**” means an institution which is primarily engaged in providing inpatient skilled nursing care and related services for patients who require rehabilitation services for recovery from an illness, injury or disability and which meets all of the following requirements:
- It is regularly engaged in providing skilled nursing care for sick and injured persons under 24-hour-a-day supervision of a Physician or a graduate Registered Nurse (RN);

- It has available at all times the services of a Physician who is a member of a general Hospital;
- It has on duty 24 hours a day, a graduate Registered Nurse (RN), Licensed Vocational Nurse (LVN), or a skilled practical nurse and it has a graduate Registered Nurse (RN) on duty at least 8 hours per day;
- It maintains a clinical record for each patient;
- It is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel or similar institution; **and**
- It complies with all licensing and other legal requirements and it is recognized as a “Skilled Nursing Facility (SNF)” by the Department of Health and Human Services (HHS) pursuant to Title XVIII of the Social Security Amendments of 1965.

Section 47.00 The term “**Trust Agreement**” means the Trust Agreement establishing the Laborers Health and Welfare Trust Fund for Northern California, including any amendment, extension or renewal.

Section 48.00 The term “**Utilization Review (UR) Program**” means a program that requires an Eligible Individual who is admitted or scheduled to be admitted to a Hospital to have his Physician obtain the opinion of the Professional Review Organization (PRO) as to the medical necessity of the confinement in order to receive the maximum benefits for confinement in a Hospital.

Section 49.00 The term “**Value-Based Site**” means a designated Participating Hospital or Ambulatory Surgical Center (ASC) that is a Participating Provider in the state of California whose agreed upon costs for services will not exceed the Maximum Plan Allowance (MPA) described in Article IV., Subsections 4.c.(1) and 4.f.(4)(e).

Article II. Eligibility for Benefits

Section 1. Definitions. The following definitions will apply to the provisions in this Article:

- a. The term “**Hour Bank**” means the account established for an Employee of an Individual Employer(s) and to which all hours are credited for contributions made to the Fund by Individual Employer(s) with respect to that Employee’s work.
- b. The term “**Individual Employer**” means any employer who is required by a collective bargaining agreement with the Union to make contributions to the Fund.
- c. The term “**Union**” means the Northern California District Council of Laborers of the Laborers’ International Union of North America (LIUNA), AFL-CIO and its affiliated local unions.

Section 2. Eligibility Rules

a. Establishment and Maintenance of Eligibility

- (1) A person who is an Employee of an Individual Employer on whose behalf contributions are made to the Fund will be eligible for Fund benefits on the first day of the second calendar month after the Employee works 440 hours for one or more Individual Employers. An Employee will continue to be eligible during any subsequent month for which the appropriate deduction has been made from his Hour Bank as described in Subsection 2.a.(2). The maximum hours in an Employee’s Hour Bank cannot exceed 990 hours after deducting the 110 hours for the current month’s eligibility specified in Subsection 2.a.(2).

Exception: In cases where a new Individual Employer had been providing health coverage to its employees immediately prior to signing a collective bargaining agreement, each employee who had coverage under the new Individual Employer’s prior plan, in the month immediately preceding transition to this Plan, will have coverage in this Plan beginning on the first day of the month immediately following the new Individual Employer’s transition to this Plan. The intention of this exception is to provide uninterrupted coverage for employees transitioning to this Plan as a result of their current employer signing a collective bargaining agreement requiring contributions to be paid to this Fund. This uninterrupted transition will only apply in cases where: (1) the new Individual Employer had provided coverage immediately prior to joining this Plan, and (2) the Employee had coverage under that plan during the month immediately preceding the first month of coverage under this Plan. Following this transition month, coverage will continue for each month in which he works a minimum of 160 hours for the new Individual Employer and for which contributions were made on his behalf. 110 hours are to be deducted for the current month’s eligibility and the remaining hours are to be placed in the Employee’s Hour

Bank. Once the Employee accumulates 440 hours in his Hour Bank, the appropriate deduction will be made from his Hour Bank as described in Subsection 2.a.(2).

- (2) **Hour Bank Deductions.** 110 hours will be deducted from the Employee's Hour Bank for each month of eligibility.
- (3) **Disability Hour Credit.** If an Employee has met the work-hour requirements of Subsections 2.a.(1) and (2) and becomes disabled and unable to perform any and every duty of his occupation, the Employee will receive Disability Hour Credit at the following maximum rate:
 - a. 8 hours per day (Disability Hour Credit is not given for Saturdays and Sundays)
 - b. 40 hours per week
 - c. 110 hours per month
 - d. 660 hours in any consecutive 12-month period

In order to obtain Disability Hour Credit, a Physician must certify the Employee's disability on a form approved by the Board and filed by the Employee within one year from the start of disability.

Disability Hour Credit will not be granted if the work-hour requirement of Subsections 2.a.(1) and (2) were met by hours credited in accordance with Subsection 2.a.(4) or the Employee is on a leave of absence covered by the terms of the Family Medical Leave Act (FMLA) of 1993.

- (4) **Reciprocity Credit.** Hours credited by another trust fund with which the Board has entered into a reciprocity agreement may be used to satisfy the requirements of Subsections 2.a.(1) and (2) if the Employee would otherwise be ineligible for benefits. However, an Employee may qualify for eligibility under this Subsection 2.a.(4) only for the month for which he timely files a request for credit with the Board.

In no event under this Subsection 2.a.(4) an Employee will have his Hour Bank credited for the same hours credited by the other trust fund.

- (5) **Transfer of Contributions.** If an Employee works outside the jurisdiction of the Fund for which contributions were made to another trust fund with which the Board has entered into a reciprocity money-follows-the-man agreement, the Employee may file a form, approved by the Board, authorizing the Fund to request that contributions made to the other trust fund be transferred to the Fund. However, contributions transferred to the Fund will be converted to hours and credited to the Employee's Hour Bank based on the contribution rate in effect at the time of work performed outside the jurisdiction of the Fund.

- (6) **Military Service.** An Active Participant's coverage under the Plan will terminate when he enters **active duty** in the uniformed services for 31 days or more. An Active Participant who enters military service for 31 days or more will be provided with health plan continuation and reemployment rights in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Temporary USERRA Continuation Coverage:

Period of Service Less than 31 days: If the Active Participant enters into a period of active duty military service for less than 31 days, his coverage will continue as if he had remained employed.

Periods of Service 31 days or more: If the Active Participant enters into a period of active duty military service for 31 days or more, the Active Participant and any eligible Dependents covered under the Plan on the day the leave started can continue health care coverage under this Plan **for up to 24 months under USERRA Continuation Coverage or he may elect COBRA Continuation Coverage for up to 18 months as described in Section 3 but he may not elect both. The Active Participant would be required to pay the appropriate monthly premium.**

Duty to Notify the Fund: The Fund will offer the Active Participant temporary USERRA Continuation Coverage only after the Board has been notified by the Active Participant **in writing** that he has been called to active duty in the uniformed services. The Active Participant must notify the Board as soon as possible **but no later than 60 days after the date on which the Active Participant will lose coverage due to the call to active duty of 31 days or more unless it is impossible or unreasonable to give such notice.**

Once the Board receives notice that the Active Participant has been called to active duty, the Fund will offer the right to elect temporary USERRA Continuation Coverage for the Active Participant and any eligible Dependent covered under the Plan on the day the leave started. The Active Participant and any eligible Dependents covered under the Plan on the day the leave started may also be eligible to elect COBRA Continuation Coverage as described in Section 3. Coverage elected under COBRA Continuation will run simultaneously with temporary USERRA Continuation Coverage.

Paying for Temporary USERRA Continuation Coverage. Paying for temporary USERRA Continuation Coverage works the same way as COBRA Continuation Coverage described in Subsection 3.i.. USERRA temporary Continuation Coverage premiums are determined by the Board in the same manner as they are determined for COBRA Continuation Coverage.

After Discharge from the Armed Forces. When the Active Participant is discharged from military service (not less than honorably), on the date he returns to work or makes himself available for work as a Laborer within the jurisdiction of the Fund for

an Individual Employer and within the period during which he has re-employment rights under USERRA, his Hour Bank and eligibility will be reinstated to the same level as on the date he entered military service **if** notice is filed on a form that has been approved by the Board and received within the following time frames:

For military service of less than 31 days: The Active Participant must file notice with the Board at the beginning of the next regularly scheduled work period on the day following discharge (plus travel time and an additional 8 hours).

For military service of 31 days but less than 181 days: The Active Participant must file the notice with the Board within 14 days from the date of discharge; **or**

For military service of 181 days or more: The Active Participant must file the notice with the Board within 90 days from the date of discharge.

If an Active Participant is hospitalized or is convalescing from an injury caused by his active duty, these time frames will be extended by two years.

- (7) A person who is a Dependent of an Employee will be eligible for benefits on the date the Employee becomes eligible or on the date the person becomes a Dependent, whichever is later, subject to the Fund's receipt of an enrollment form and required documents to validate the person's relationship with the Employee.

b. Termination of Eligibility

- (1) An Active Participant's eligibility will terminate on the earliest of the following dates:
 - (a) The last day of the month following the month in which his Hour Bank balance falls below 440 hours before the deduction is made for the current month's eligibility.

Exception: An Active Participant who retires and who has at least 440 hours in his Hour Bank on the date of his retirement will continue his eligibility under the Plan as an Active Participant for three additional months by using the remaining hours in his Hour Bank.
 - (b) The last day of the month following entry into military service (other than for a temporary tour of duty not exceeding 30 days).
 - (c) At the end of the calendar month in which he performs work of the type covered by the collective bargaining agreement, for an employer that is not an Individual Employer as defined in Subsection 1.b..

- (2) If an Active Participant dies, his eligibility will terminate on the last day of the month for which he qualified for coverage under Subsections 2.a.(1), (2) and (3). However, while eligible, his Dependents will have coverage, provided he had at least 440 hours in his Hour Bank on the date of his death. This will continue to maintain eligibility for three additional months by using the remaining hours in his Hour Bank.
- (3) The eligibility of a Dependent of an Active Participant will terminate on the earliest of the following dates:
 - (a) On the date the Active Participant's eligibility terminates. (Exception under Subsections b.(1)(a) and b.(2) above applies in this Subsection b.(3)(a)).
 - (b) On the date the Dependent no longer qualifies as a Dependent, as defined in Article I., Section 14.00.

c. **Reinstatement of Eligibility**

- (1) An Active Participant whose eligibility has terminated will be reinstated on the first day of the second month following the month in which the hours in his Hour Bank total a minimum of 440, provided eligibility is regained within 13 months of the loss of eligibility.
- (2) If a former Active Participant fails to regain his eligibility within 13 months, he will forfeit all hours in his Hour Bank and will only become eligible upon meeting the requirements of Subsection 2.a.(1).

Exception: If a former Active Participant fails to regain his eligibility within 13 months because he was disabled and unable to perform any and every duty of his occupation, he may petition the Board to reinstate any hours that were forfeited. The petition must include competent medical evidence that the former Active Participant was unable to engage in or perform work in the Building and Construction Industry. Evidence may include proof of continuous coverage under State Disability Insurance (SDI) or Workers' Compensation. The Board will not reinstate the Hour Bank of a former Active Participant whose disability was due to an illness or injury not covered by the Plan, or whose disability is due to non-physical causes. The Board may require that the former Active Participant sign a HIPAA compliant authorization for the release of medical records related to the disability.

Section 3. Continuation Coverage under COBRA

The health care continuation coverage provisions of the Employee Retirement Income Security Act (ERISA) §601 et seq., as amended, require that when coverage terminates under certain circumstances, health plan benefits must be made available to Eligible Individuals through self-payment. To the extent that COBRA applies to any Eligible Individual under this Plan, these benefits will be offered in accordance with this Section.

- a. **General.** Eligible Individuals who subsequently lose eligibility under the Plan may continue Plan coverage subject to the terms of this Section. For the purpose of COBRA continuation coverage, Eligible Individuals do not include the Domestic Partner of an Active Employee and the Dependent children of the Domestic Partner. This section is intended to comply with the health continuation provisions of COBRA, including any regulations which are incorporated by reference and will be controlling in the event of any conflict between those provisions and the terms of this Section.

Other Health Coverage Alternatives to COBRA. You may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. The purpose of the Marketplace is to help people without health coverage find and enroll in a health plan. (For California residents, see www.coveredca.com. For non-California residents, see your state Insurance Marketplace or www.healthcare.gov). Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan).

- b. **Continuation Coverage.** Eligible Individuals whose eligibility terminates may continue coverage (except Death and Accidental Death and Dismemberment Benefits), under COBRA upon the occurrence of a **"Qualifying Event"**.

A "Qualifying Event" is defined as any of the following:

- (1) The Active Participant's Employer(s) report less than the minimum required hours as shown in Subsection 2.a.(1);
- (2) The Active Participant's death;
- (3) Divorce or legal separation of the Active Participant from his Dependent spouse; or
- (4) Cessation of a child's Dependent status.

- c. **Qualified Beneficiary.** A Qualified Beneficiary is defined under COBRA as an individual who on the day before a Qualifying Event was covered under this Plan as an Eligible Individual.

- d. **Notice Requirements for Qualified Beneficiaries.**

- (1) The Qualified Beneficiary is responsible for providing the Trust Fund Office with timely written notice of any of the following events:
 - (a) The divorce or legal separation of an Active Participant from his Dependent spouse.
 - (b) Death of the Active Participant.
 - (c) A child losing Dependent status under the Plan.

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

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.

- (e) 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.
 - (f) 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.
- (2) 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.
 - (3) 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.
 - (4) 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.

e. Notice Requirements for Employers and the Plan.

- (1) 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.
- (2) 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.

- (3) 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, 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.

- f. **Types of Benefits Provided.** A Qualified Beneficiary will be provided health coverage under the Plan which is identical to the health coverage he had under the Plan on the day before the Qualifying Event and is identical to that being offered to other Active Participants or Eligible Individuals who have not experienced a Qualifying Event. A Qualified Beneficiary will have the option of taking "**Core Coverage**" or "**Core Plus Coverage**":

"**Core Coverage**" refers to the health benefits the Qualified Beneficiary was receiving immediately before the Qualifying Event and **does not** include dental and vision.

"**Core Plus Coverage**" refers to the health benefits the Qualified Beneficiary was receiving immediately before the Qualifying Event and **does** include dental and vision.

The Death Benefits described in Article III are not considered health coverage. Neither the **Core Coverage** nor **Core Plus Coverage** provide any death benefits.

- g. **Election Procedure.**

- (1) A Qualified Beneficiary must elect continuation coverage within 60 days after the later of:
 - (a) The date on which the Qualified Beneficiary loses coverage under the Plan as a result of a Qualifying Event; **or**
 - (b) The date on which the Qualified Beneficiary receives notice of COBRA Continuation Coverage from the Trust Fund Office.
- (2) 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 to elect or reject the coverage.

h. **Addition of New Dependents.**

- (1) 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 occurs within 30 days after acquiring that new Dependent. Adding a new Dependent may cause an increase in the amount that must be paid for COBRA Continuation Coverage.
- (2) 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.

- i. **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 and must include payment for all months of COBRA coverage to date. Thereafter, monthly premium payments are due on the first day of the month for which continuation coverage is elected. There will be a grace period of 30 days to pay the monthly premium. 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.

j. **Duration of Coverage.**

- (1) A Qualified Beneficiary whose coverage terminated because of a Qualifying Event as described in Subsection 3.b.(1) may elect continuation coverage for up to 18 months from the date of termination of eligibility. This 18-month period will expand to a maximum of 36 months from the date of the Qualifying Event if a second Qualifying Event (other than a Qualifying Event described in Subsection 3.b.(1)) occurs with respect to that Qualified Beneficiary during the original 18-month period and while the Qualified Beneficiary is covered under the Plan.
- (2) If coverage is terminated due to a Qualifying Event described in Subsection 3. b.(1), the 18-month period may be extended up to a total of 29 months for any Qualified Beneficiary who is determined by Social Security to be totally disabled any time before or during the first 60 days of COBRA Continuation Coverage. The disabled person and family may extend COBRA Continuation Coverage beyond the original 18 months up to 29 months. To qualify for the additional 11 months, a Qualified Beneficiary must report the Social Security disability determination to the Trust Fund Office in writing before the original 18-month period expires and within 60 days after the date of the determination. Premiums charged for the additional 11-month period will be approximately 50% higher than the premiums for the initial 18-month period.

- (3) If the Qualifying Event described in Subsection 3.b.(1) occurs less than 18 months after the date the Eligible Individual becomes Eligible for Medicare (Part A, Part B or both), the maximum period of continuation coverage for the Dependents of an Active Participant will be 36 months from the date of Medicare entitlement.
 - (4) Medicare entitlement is not a Qualifying Event under the Plan. Medicare entitlement following an Active Participant's termination of employment or reduction in hours will not extend a Dependent Qualified Beneficiary's COBRA coverage beyond the 18-month period allowed for the Qualifying Event described in Subsection 3.b.(1).
 - (5) A Qualified Beneficiary whose coverage would otherwise terminate because of a Qualifying Event other than one described in Subsection 3.b.(1), may elect continuation coverage for up to 36 months from the date of the Qualifying Event.
- k. **Termination of Continuation Coverage.** Notwithstanding the maximum duration of coverage described in the above paragraphs, a Qualified Beneficiary's continuation coverage will end on the **earlier** of the date on which:
- (1) The employer of the Qualified Beneficiary ceases to provide group health coverage to any employee;
 - (2) The premium described in Subsection 3.i. is not timely paid;
 - (3) The Qualified Beneficiary becomes covered under another Group Plan after electing COBRA Continuation Coverage (as an Active Participant or otherwise);
 - (4) The Qualified Beneficiary (after the Qualifying Event), enrolls in either Part A or Part B of Medicare; **or**
 - (5) The Qualified Beneficiary has continued coverage for additional months due to a disability and there has been a final determination by Social Security that the individual is no longer disabled.

Article III. Death Benefits

Section 1. Regular Death Benefit for Active Participants

If an Active Participant dies while eligible or within 31 days following the termination of his eligibility, the Fund will, subject to all other Plan provisions, pay a Regular Death Benefit of \$15,000.

Section 2. Accidental Death Benefit for Active Participants

If an Active Participant sustains bodily injuries solely through external, violent and accidental means, and dies as a result of those injuries within one year following the accident in which the injuries were sustained, the Fund will, subject to all other Plan provisions, pay an Accidental Death Benefit of \$15,000 in addition to the \$15,000 Regular Death Benefit described in Section 1.

Section 3. Dismemberment Benefit for Active Participants

If an Active Participant sustains bodily injuries solely through external, violent and accidental means, and suffers one of the losses listed below, the Fund will, subject to all other Plan provisions, pay to the Active Participant a Dismemberment Benefit in the following amount:

- a. \$7,500 for (a) loss of a hand by severance at or above the wrist, (b) the loss of a foot by severance at or above the ankle, or (c) the irrecoverable loss of sight of an eye.
- b. \$15,000 for the loss of more than one of the members identified in Subsection 3.a. above.

Section 4. Limitations

- a. The total amount payable under Sections 2 and 3 as a result of any one accident may not exceed \$15,000.
- b. No benefits are payable for any loss resulting from bodily injuries sustained as a result of:
 - (1) Disease, bodily or mental infirmity, medical or surgical treatment, ptomaine or bacterial infections (except infections occurring through an accidental cut or wound);
 - (2) Suicide, attempted suicide or self-inflicted injury (not applicable if suicide or attempted suicide is due to a physical or mental health condition or as a result of domestic violence);
 - (3) War or an act of war, or service in any military, naval or air force of any country engaged in war, or police duty as a member of any military, naval or air organization;

- (4) Participation in, or as the consequence of having participated in, the commission of a felony, unless such loss resulting from bodily injuries is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor;
- (5) Intake of any drug, medication or sedative unless prescribed by a doctor, or the intake of any alcohol in combination with any drug, medication or sedative; **or**
- (6) Use of alcohol, non-prescription drugs or controlled substance, such as PCP (also known as angel dust), LSD or any other hallucinogen, cocaine, heroin or any other narcotics, amphetamines or other stimulants, barbiturates or other sedative or tranquilizers or any combination of one or more of these substances.

Section 5. Payment of Regular Death Benefit of Totally Disabled Former Active Participant

The Regular Death Benefit that would have been payable under Section 1 on the date eligibility terminated will be payable to the beneficiary of a totally disabled former Active Participant under the following circumstances:

- a. He must, while eligible and prior to age 60, have become totally disabled so as not to have been able to engage in any occupation for compensation or profit; **and**
- b. If he dies within one year following the date his eligibility would have otherwise terminated under Article II., Subsection 2.b., and proof of continuous total disability was furnished to the Board within one year following his death; **or**
- c. If he dies one year or more following the date his eligibility would have otherwise terminated under Article II., Subsection 2.b., and proof of uninterrupted total disability was submitted to the Board within one year after that date and annually thereafter; **and**
- d. If he was totally disabled for 2 full years, he submitted to a medical examination by a Physician, but not more often than once a year if he was required to do so by the Board.
- e. For former Active Participants who become totally disabled on or after June 1, 1994, a Regular Death Benefit will not be payable under any circumstances once he reaches Normal Retirement Age (65).
- f. For former Active Participants who become totally disabled on or after September 1, 2015, a Regular Death Benefit will not be payable under any circumstances.

Section 6. Dependents' Death Benefit

Upon the death of a Dependent of an Active Participant, the Fund will, subject to all other Plan provisions, pay the Dependents' Death Benefit to the Active Participant or the beneficiary, whichever is applicable, in the following amount:

Spouse: \$7,500

Children (to the age of 26): \$1,000

The Dependents' Death Benefit will be paid to the Active Participant, if living. Otherwise, the Dependents' Death Benefit will be paid in accordance with Subsection 8.b..

Section 7. Payments

- a. If the beneficiary is a minor, legally incompetent or incapable of handling his own affairs, the Fund reserves the right to make payment in monthly installments not to exceed \$100 to the person or persons, or institution, who is caring for or supporting the beneficiary, until a claim is made for the remainder by a duly appointed guardian, conservator or other legal representative of the beneficiary.
- b. The Fund may, at its option, pay an amount not to exceed \$250 of the Regular Death Benefit to any person who has incurred expenses in connection with the burial of the deceased Active Participant.
- c. Any payment made under Subsection 7.a. or 7.b. will discharge the obligation of the Fund to the extent of that payment.

Section 8. Beneficiaries

a. Designation of Beneficiary

A Participant may designate a beneficiary or beneficiaries to receive the death benefits payable under this Article by forwarding to the Trust Fund Office a beneficiary designation on a form acceptable to the Board. The Participant has the right to change his beneficiary designation without consent of the beneficiary. No beneficiary change will be effective or binding on the Fund until the Trust Fund Office receives a new or subsequent beneficiary designation form. All payments will be made to the beneficiary whose designation is on file with the Trust Fund Office at the time of the Participant's death. If more than one beneficiary is designated, and their respective interests are not specified, they will share equally.

If a designated beneficiary is found guilty of feloniously and intentionally causing the death of the Participant, that beneficiary will be disqualified from receiving payment of death benefits payable under this Article. If no other beneficiary has been designated, then any death benefits payable will be paid in accordance with Subsection 8.b..

b. Lack of Beneficiary Designation

If no beneficiary has been designated by the Participant, or the designated beneficiary is otherwise ineligible or dies before the Regular Death Benefit or Accidental Death Benefit is paid, the benefit will be paid to the lawful spouse of the Participant, if living. If there is no lawful spouse at the time of payment, payment may be made to one or more of the following surviving relatives of the Participant: (1) child or children, (2) mother or father, (3) brothers or sisters, or (4) to the Participant's estate as the Board, in its sole discretion, may designate.

Article IV. Comprehensive Hospital-Medical Benefits

Section 1. Covered Expense

The term “**Covered Expense**” refers to the hospital and medical expenses described in this Section that may be payable under the Plan’s Comprehensive Hospital-Medical Benefit subject to all other Plan provisions.

a. Covered Expenses include the following:

- (1) Charges for medical or surgical services by a Physician.
- (2) Charges made by an Ambulatory Surgical Center (ASC).
- (3) Charges made by a Hospital or Skilled Nursing Facility (SNF) for covered inpatient services.
- (4) Charges made by a Hospital for covered outpatient services.
- (5) Charges made by the emergency room of a Hospital.
- (6) Charges for the following medical services and supplies:
 - (a) Anesthesia and its administration;
 - (b) Blood and blood products;
 - (c) Surgical dressings, splints, casts and other devices for the treatment of burns and reduction of fractures and dislocations;
 - (d) Diagnostic tests, x-rays and laboratory examinations prescribed by a Physician for diagnostic purposes or in connection with the therapeutic treatment of an Eligible Individual;
 - (e) Radiation therapy and chemotherapy;
 - (f) Durable Medical Equipment (DME) prescribed by a physician. Rental charges are covered if they do not exceed the reasonable purchase price of the equipment;
 - (g) Professional ambulance services when used to transport the Eligible Individual in need of paramedic transport assistance:
 - (i) Directly from the place where he is injured by accident or stricken by an illness to a Physician’s office;

- (ii) To or from a Hospital; **or**
 - (iii) By licensed air ambulance if the charges do not exceed the Allowed Charge and if the Fund determines that the location and nature of the illness or injury made air transportation cost effective or Medically Necessary to avoid the possibility of serious complications or the loss of life.
- (h) Immunizations and Inoculations;
- (i) Outpatient intravenous therapy when authorized by and under the supervision of a Physician for treatment of an illness that would otherwise require hospitalization. Therapy includes any Drug that requires administration under the supervision of a Physician; **and**
 - (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.
- (7) Charges for nursing services provided by a nurse practitioner, registered nurse or vocational nurse 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 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.
- (9) Charges made by a Hospice, upon the referral by the Plan's case management program.
- (10) Charges made for Home Health Care, upon the referral by the Plan's case management program.
- (11) Charges made by a Physician for services and supplies related to administering contraceptive implants, injections, devices, or surgical procedure resulting in voluntary infertility.

- (12) Charges in connection with mastectomy, including reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.
- (13) Charges in connection with Medically Necessary surgical treatment of morbid obesity when the Eligible Individual's **B**ody **M**ass **I**ndex (BMI) is greater than 35 and complicated by any of the following:
- (a) Life-threatening cardiopulmonary conditions;
 - (b) Difficulty controlling diabetes mellitus or hypertension;
 - (c) End stage renal disease with difficulty dialyzing;
 - (d) Severe sleep apnea documented by a sleep study performed by a certified sleep clinic;
 - (e) Severe lower extremity edema with ulcerations;
 - (f) Symptomatic degenerative joint disease resulting in ambulatory difficulties (cane, walker, wheelchair); **or**
 - (g) Stress incontinence and gynecological abnormalities.

Only one of the following bariatric surgical procedures will be covered in a lifetime:

- Roux-en Y gastric bypass,
- Gastric stapling, or
- Biliopancreatic bypass.

Prior approval by Anthem Blue Cross is required and the Eligible Individual must use only a Blue Distinction® Center for the surgery.

Surgery performed at any facility other than a Blue Distinction® Center will not be covered regardless of the medical necessity.

- (14) Charges in connection with the treatment of substance abuse, mental health or psychiatric disorders.
- (15) Expenses incurred for a hearing aid device prescribed by a Physician. Repairs to or replacement of a hearing aid device that is lost, broken or stolen are not covered. Hearing tests are covered as Physician's Office Visit, subject to all other Plan provisions.

- (16) Charges in connection with Medically Necessary treatment of gender identity disorder or gender dysphoria including, but not limited to, gender reassignment surgery. An Eligible Individual must undergo medical and psychological evaluations, medical therapies and behavioral trials to confirm that surgery is the most appropriate treatment choice for the Eligible Individual. The Fund's Professional Review Organization (PRO) must approve the gender reassignment surgery as Medically Necessary in order for the Fund to allow benefits.
- (17) Routine Physical Examinations.
- (18) Charges of a Dentist 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.

Section 2. Copayments

The term "**Copayment**" means the amount the Eligible Individual is required to pay before Comprehensive Hospital-Medical Benefits become payable. A Copayment will apply as follows:

- a. **Physician Office Visit.** \$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.
- b. **E-Visit (Electronic or Online Medical Evaluation).** \$10 Copayment is required for each E-Visit with a Physician through LiveHealth Online Services.
- c. **Hospital Emergency Room.** If an Eligible Individual incurs expenses in the emergency room of a Hospital:
 - (1) \$25 Copayment for each visit to a Participating Hospital; **or**
 - (2) \$50 Copayment for each visit to a Non-Participating Hospital.

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.

Section 3. Deductible

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 Skilled Nursing Facility (SNF) as described in Subsections 4.a. to 4.d.,
- (2) Routine Physical Examinations as described in Subsection 4.f.(4)(d), and
- (3) E-Visit through LiveHealth Online Services as described in Subsection 4.f.(3).

b. Carryover

If Covered Expense is incurred during the last 3 months of the Plan Year (December, January or February) and is applied against the Deductible for that Plan Year, the expense will be credited toward the Deductible amount for the following Plan Year.

Section 4. Benefits and Payment

If an Eligible Individual receives therapeutic treatment for an illness or injury or receives treatment in connection with a pregnancy, the Fund will, subject to all other Plan provisions, pay for Covered Expenses as indicated below:

a. **Confinement in a Participating Hospital**

If an Eligible Individual is confined in a Participating Hospital with the approval of the Professional Review Organization (PRO), the Fund will, subject to all other Plan provisions, pay the Participating Hospital 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 Active Participant 70% of the first \$10,000 of **Covered Charges**, as defined in Article I, Section 10.00, 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 Active Participant 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 Active Participant 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 **Maximum Plan Allowance** (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 49.00, 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.

d. **Confinement in a Skilled Nursing Facility (SNF)**

If an Eligible Individual is confined in a Skilled Nursing Facility (SNF) 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..

e. **Utilization Review**

(1) **Elective Admission.** If an Eligible individual is to be admitted to a Hospital on an elective, non-emergency basis, the admitting Physician must obtain, through the Professional Review Organization (PRO), the following:

(a) **Pre-Admission Review.** The purpose is to have the PRO, **prior to the admission**, determine the medical necessity of the Hospital confinement and the number of Hospital days that are Medically Necessary for the confinement, **and**

(b) **Concurrent Review.** In addition to the Pre-Admission Review, a Concurrent Review must be obtained so the PRO can determine, once the Eligible Individual has been admitted to the Hospital, the number of days authorized that are Medically Necessary, or any change in the number of days authorized as Medically Necessary if Pre-Admission Review has previously taken place, **or**

(c) **Retrospective Review.** In the absence of a Pre-Admission Review and/or Concurrent Review, the Hospital or the Fund may require that the PRO conduct a Retrospective Review after the Eligible Individual has been discharged from the Hospital to determine the number of days authorized as Medically Necessary.

(1) If an Eligible Individual is admitted to a Non-Participating Hospital and a Pre-Admission Review is not obtained, the Active Participant 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..

(2) **Emergency Admission.** If an Eligible Individual is admitted to a Hospital on an emergency basis, the admitting Physician must contact the PRO to obtain the following:

(a) **Concurrent Review.** To determine once the Eligible Individual has been admitted to the Hospital, the number of days authorized as Medically Necessary; **or**

- (b) **Retrospective Review.** In the absence of a Concurrent Review, the Hospital or the Fund may request that the PRO conduct a Retrospective Review after the Eligible Individual has been discharged from the Hospital to determine the number of days authorized as Medically Necessary.
- (3) **Exception:** In accordance with the Newborns' and Mothers' Health Protection Act (NMHPA), if a Pre-Admission Review is not obtained, the additional coinsurance of 20% will not be imposed for a Hospital admission that does not exceed 48 hours for a normal vaginal delivery and 96 hours for a C-Section. However, for a Hospital stays that exceed the NMHPA allowed days, a Concurrent or Retrospective Review should be obtained in accordance with Subsection 4.e.(2)(a) or (b).
- (4) **Limitation.** If an Eligible Individual is admitted to a Hospital, the Fund will only be obligated to cover the cost of services that are determined by the PRO to be Medically Necessary. Any days of confinement that exceed the number authorized by the PRO will not be the responsibility of the Fund.

f. **Other Covered Expenses**

- (1) For Covered Expenses incurred at a **Participating Provider or the outpatient department of a Participating Hospital**, the Fund will, subject to all other Plan provisions, pay 90% of the negotiated contract rate, except:
- (a) 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 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 amount of the actual charged or 70% of the Allowed Charge, **except:**
- (a) **Emergency Room Services:** If an Eligible Individual receives treatment at a 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.
- (b) **Professional Ambulance Services:** If an Eligible Individual requires ambulance transport for Emergency Services, the Fund will, subject to all other Plan provisions, pay the lesser of the amount charged or 90% of the Allowed Amount.
- (3) For E-Visits described in Subsection 2.b., the Fund will pay 100% of the Allowed Charge after payment of the \$10 E-Visit Copayment.

- (4) The Fund will, subject to all other Plan provisions, pay the following Covered Expenses, but not to exceed the Plan's Maximum Plan Allowance (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:
 - (1) \$300 per examination for the Active Participant.
 - (2) \$300 per examination for a Dependent spouse or Domestic Partner.
 - (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) 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 Maximum Plan Allowance (MPA) will be the Eligible Individual's responsibility and will not count toward the Plan Year Out-of-Pocket Maximum.

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 Maximum Plan Allowance (MPA).

Article V. Prescription Drug Benefits

Section 1. Definitions. The following definitions will apply to the provisions in this Article:

- a. The term “**Contracting Pharmacy**” means a pharmacy which has a contract to provide prescription Drug services to Eligible Individuals.
- b. The term “**Formulary**” means a preferred list of quality, cost effective medications established by the Pharmacy Benefit Manager. When an Eligible Individual uses a Formulary Drug, it results in a lower copayment.
- c. The term “**Non-Contracting Pharmacy**” means a pharmacy which has no contract to provide prescription Drug services to Eligible Individuals.
- d. The term “**Pharmacy Benefit Manager (PBM)**” means an organization under contract with the Fund to administer Drug benefits for Eligible Individuals.
- e. The term “**Specialty Pharmacy**” means a pharmacy that provides medication that may be self-administered or medications administered at a Physician’s office to treat chronic or acute illnesses. A Specialty Pharmacy offers services to manage specialty medications, including training by pharmacists and nurses on proper use of the medications. Specialty medications often require special storage and handling that may not be available at a retail pharmacy.

Section 2. Covered Charges

Included in Covered Charges are charges made by a Licensed Pharmacist, pharmacy, Physician or Hospital for:

- a. Drugs prescribed by a Physician 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.

- e. Therapeutic vitamins, cough mixtures, antacids, eye and ear medications prescribed by a Physician 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®.

Section 3. Benefits and Copayment

If an Eligible Individual obtains any of the items listed under Covered Charges in Section 2 above, the Fund will, subject to all other Plan provisions, pay the amount described below less the Eligible Individual's share of cost that is payable to the Pharmacy by the Eligible Individual.

- a. **Contracting Pharmacy.** If the prescription Drug is obtained in accordance with established procedures at a retail Contracting Pharmacy, the Fund will pay the Contracting Pharmacy as follows for up to a 30-day supply per prescription Drug:
 - (1) For generic Drugs, the cost of the prescription less a copayment of \$10 **for the initial fill plus the first 2 refills.**
 - (2) For Formulary brand-name Drugs, **if a generic Drug is available**, the cost of the prescription less (a) a copayment of \$20 **plus** (b) the difference in price between the generic and the Formulary brand-name Drug **for the initial fill plus the first 2 refills.**
 - (3) For Formulary brand-name Drugs, **if a generic Drug is not available**, the cost of the prescription less a copayment of \$20 **for the initial fill plus the first 2 refills.**
 - (4) For non-Formulary brand-name Drugs, **if a generic Drug is available**, the cost of the prescription less (a) a copayment of \$30 **plus** (b) the difference in price between the generic and the non-Formulary brand-name Drug **for the initial fill plus the first 2 refills.**
 - (5) For non-Formulary brand-name Drugs, **if a generic Drug is not available**, the cost of the prescription less a copayment of \$30 **for the initial fill plus the first 2 refills.**
 - (6) If the Eligible Individual continues to have the prescription Drug filled at a retail contracting Pharmacy after **the initial fill plus the first 2 refills**, the copayment amounts described in Subsections 3.a.(1) to (5) will be double.

- b. **Non-Contracting Pharmacy.** If the prescription Drug is obtained at a retail Non-Contracting Pharmacy, the Eligible Individual will be responsible for payment of the full cost of the prescription Drug to the Non-Contracting Pharmacy. The Eligible Individual will be reimbursed in accordance with the payable amounts described in Subsections 3.a.(1) to (6).
- c. **Mail Service Pharmacy.** If the prescription Drug is obtained in accordance with the Fund's established procedures through mail service Contracting Pharmacy, the Fund will pay the Contracting Pharmacy as follows for up to a 90-day supply per prescription Drug:
 - (1) For generic Drugs, the cost of the prescription less a copayment of \$20.
 - (2) For Formulary brand-name Drugs, **if a generic Drug is available**, the cost of the prescription less (a) a copayment of \$40 **plus** (b) the difference in price between the generic and the Formulary brand-name Drug.
 - (3) For Formulary brand-name Drugs, **if a generic Drug is not available**, the cost of the prescription less a copayment of \$40.
 - (4) For non-Formulary brand-name Drugs, **if a generic Drug is available**, the cost of the prescription less (a) a copayment of \$60 **plus** (b) the difference in price between the generic and the non-Formulary brand-name Drug.
 - (5) For non-Formulary brand-name Drugs, **if a generic Drug is not available**, the cost of the prescription less a copayment of \$60.

Section 4. Exclusions. No Benefits are payable for:

- a. Drugs taken or administered while a patient is in the Hospital.
- b. Patent or proprietary medicines not requiring a prescription, except insulin.
- c. Appliances, devices, bandages, heat lamps, braces, or splints.
- d. Multiple and non-therapeutic vitamins, cosmetics, dietary supplements, health and beauty aids.
- e. Injectable Drugs (except insulin and injection kits, or as provided in connection with outpatient intravenous therapy as described in Article IV, Subsection 1.a.(6)(i) or as provided in this Article V., Subsections 2.f. and 2.g.) and blood and blood products.
- f. Drugs for which reimbursement is provided by any federal, state, local governmental agency or programs.
- g. Charges for prescription Drugs in excess of a 30-day supply if obtained through a retail Contracting or Non-Contracting Pharmacy or a 90-day supply if obtained through the mail-service Contracting Pharmacy.

Article VI. Exclusions, Limitations and Reductions

This Article does not apply to the benefits described in Article III. Death Benefits.

Section 1. Exclusions

The Fund will not provide benefits for services, expenses, charges, treatment and/or supplies related to or in connection with:

- a. Any accidental bodily injury arising out of, or in the course of, the Eligible Individual's employment or in connection with an illness for which the Eligible Individual is entitled to indemnity under the provisions of any Workers' Compensation or similar law.
- b. Any confinement or treatment in a Veterans Administration Hospital or for care or treatment obtained from any federal, state or local governmental agency or program where the care or treatment is available without cost to the Eligible Individual, except to the extent the law requires benefits to be paid by the Fund.
- c. Confinement or care obtained in a Hospital owned or operated by any federal, state or local governmental agency or program, unless there is an unconditional requirement that the Eligible Individual pay for the confinement or care, without regard to any rights against others, contractual or otherwise.
- d. Conditions caused by or arising out of an act of war, armed invasion or aggression.
- e. Conditions for which the Eligible Individual is not under the care of a Physician, or for a period of confinement beyond that authorized by the Professional Review Organization (PRO).
- f. Eye refractions or eyeglasses.
- g. Callus or corn paring; toenail trimming; treatment of chronic conditions of the foot such as weak or fallen arches, flat or pronated foot metatarsalgia, or foot strain.
- h. Medical services or supplies received outside of the United States, its Territories, and Possessions, except for treatment of a life-threatening emergency which, without immediate intervention, would result in placing the Eligible Individual's health in serious jeopardy or serious impairment to bodily functions or serious dysfunction of any body part. Some examples of life threatening conditions requiring emergency care include, but are not limited to, heart attacks, strokes, poisoning and appendicitis.
- i. Hospital or medical services or supplies in connection with the treatment of obesity or weight control, except as provided in Article IV., Subsection 1.a.(13).
- j. Experimental or Investigative Procedures except as provided in Article I., Section 21.00.

- k. Intentionally self-inflicted injury, or injury or illness resulting from participating in, or the consequence of having participated in, the commission or attempted commission of an assault or felony, unless the injury or illness is the result of domestic violence or is the direct result of an underlying health factor.
- 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).
- m. Pregnancy of a Dependent child.
- n. Pregnancy of an Eligible Individual functioning as a surrogate, 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.
- o. Infertility as defined by the American College of Obstetrics and Gynecology including, but not limited to, in vitro fertilization, artificial insemination, surgery, including treatment to alleviate pelvic adhesions (unless determined to be Medically Necessary) and other infertility related services, **including charges to reverse voluntary or surgically induced infertility.**
- p. Dental appliances, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth of gums except as provided in Article IV., Subsection 1.a.(18).
- q. Travel or transportation expenses except as provided in Article IV., Subsections 1.a.(6)(g) and 4.c.(2).
- r. An institution that is primarily a rest home, home for the aged, a nursing home, a convalescent home or any institution of similar character providing Custodial Care.
- s. Ambulance transportation that is primarily for the convenience of the Eligible Individual or ambulance transportation by railroad.
- t. For which an Eligible Individual is not required to pay or which are obtained without cost or for which there would be no charge if the Eligible Individual receiving the treatment were not covered by the Plan.
- u. Habilitative/Habilitation services provided to Eligible Individuals with developmental delays who have never acquired normal functional abilities.

Section 2. Limitations

The Fund does not provide benefits for medical services or supplies that are not Medically Necessary as determined by the Plan. Furthermore, the Fund will not provide benefits for medical services or supplies that are in excess of the Allowed Charge or Maximum Plan Allowance (MPA) as determined by the Plan.

Section 3. Coordination of Benefits with another Group Plan

If an Eligible Individual is entitled to benefits from another Group Plan, for hospital, medical, dental or health care expenses for which benefits are also due from this Plan, then the benefits provided by this Plan will be paid according to the following provisions, not to exceed 100% of the Allowed Charge actually incurred by the Eligible Individual.

- a. If the Eligible Individual is the Active Participant, Plan benefits will be provided without reduction.
- b. The benefits of a Group Plan which covers the Eligible Individual other than as a Dependent will be determined before the benefits of a Group Plan which covers that person as a Dependent.
- c. If the Eligible Individual for whom a claim is made is a Dependent child whose parents are not separated or divorced, the benefits of the Group Plan which covers the Eligible Individual as a Dependent of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year, will be determined before the benefits of a Group Plan which covers that Eligible Individual as a Dependent of the parent whose date of birth, excluding year of birth, occurs later in a calendar year. If either Group Plan does not have the provisions of this Subsection c. regarding Dependents, which results either in each Group Plan determining its benefits before the other or in each Group Plan determining its benefits after the other, the provisions of this Subsection will not apply, and the rule set forth in the Group Plan which does not have the provisions of this Subsection will determine the order of benefits.
- d. In the case of an Eligible Individual for whom a claim is made as a Dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Group Plan which covers the child as a Dependent of the parent with custody of the child will be determined before the benefits of a Group Plan which covers the child as a Dependent of the parent without custody.
- e. In the case of an Eligible Individual for whom a claim is made as a Dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Group Plan which covers the child as a Dependent of the parent with custody will be determined before the benefits of the Group Plan which covers that child as a Dependent of the stepparent, and the benefits of a Group Plan which covers that child as a Dependent of the stepparent will be determined before the benefits of a Group Plan which covers that child as a Dependent of the parent without custody.

- f. In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding Subsections d. and e. above, the benefits of a Group Plan which covers the child as a Dependent of the parent with financial responsibility will be determined before the benefits of any other Group Plan which covers the child as a Dependent child.
- g. In the case of a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the benefits of the Group Plan which has covered the person for the longer period of time will be determined before the benefits of the Group Plan which has covered the Eligible Individual for the shorter period of time. If the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the Dependent or the employee-spouse covering the Dependent.
- h. When any of Subsections 3.a. to 3.f. do not establish an order of benefit determination, the benefits of a Group Plan which has covered the person for the longer period of time will be determined before the benefits of the Group Plan which has covered the Eligible Individual for the shorter period of time, provided that:
 - (1) The benefits of a Group Plan covering the Eligible Individual as a laid-off or retired employee or Dependent of the person, will be determined after the benefits of any other Group Plan covering the person as an employee, other than as a laid-off or retired employee, or Dependent of the Retired Participant; **and**
 - (2) If either Group Plan does not have a provision regarding laid-off or retired employees, which result in each Group Plan determining its benefits after the other, then the provisions of Subsection 3.h.(1) will not apply.

For the purposes of this Section only, the term “laid-off” or “retired employee” will also include employees covered by COBRA.

Section 4. Coordination of Benefits with Medicare and a Group Plan

If an Eligible Individual who is Eligible for Medicare is entitled to benefits from another Group Plan as an employee or as a dependent of an employee, the benefits of the Group Plan which covers the Eligible Individual as an employee or as a dependent of the employee will be determined before Medicare and this Fund. In other words, the employer Group Plan becomes the primary payer, Medicare the secondary payer and the Fund the last payer.

Section 5. Coordination with Medicaid

Payments by this Plan for benefits with respect to an Eligible Individual will be made in compliance with any assignment of rights made by or on behalf of the Eligible Individual as required by California's plan for medical assistance approved under Title XIX, §1912 (a)(1)(A) of the Social Security Act (Medicaid).

Where payment has been made by the State under Medicaid for medical assistance in any case where this Plan has the legal liability to make payment for that assistance, payment for the benefits will be made in accordance with State law which provides that the State has acquired the rights with respect to an Eligible Individual to payment for that assistance, but in no event, will exceed the time frame allowed by regulation or law. Reimbursement to the State, like any other entity which has made payment for medical assistance where this Plan has a legal liability to make payment, will be equal to Plan benefits or the amount actually paid, whichever is less.

Article VII. General Provisions

Section 1. Payment of Benefits

Except as described in Article IV., Subsection 4.a., all benefits will be paid by the Fund to the Active Participant as they accrue upon receipt of written proof, satisfactory to the Board, covering the occurrence, character and extent of the event for which the claim is paid.

Section 2. Benefits May Not Be Alienated

The benefits payable by the Fund may not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person. However, an Active Participant may assign his rights to those benefits and request that payment be made to the Hospital in which he or his Dependent is hospitalized, to any provider of medical or dental services or supplies for those services or supplies or to any other person or agency that may have provided or paid for or agreed to provide or pay for any benefits.

Section 3. Notice of Claim Required

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.

Section 4. Offset and Recoupment

In the event it is determined that due to either a mistake of fact or law or to any other circumstance, the Active Participant or his Dependent or beneficiary has been paid more than he is entitled to under the terms of the Plan or under the law, the Board may offset, recoup and recover the amount of the overpayment from payments due or becoming due to the Active Participant or his beneficiary in installments and to the extent the Board determines.

Section 5. Payment in Event of Incompetency or Lack of Address

In the event the Fund determines that the Active Participant is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Active Participant has not provided the Fund with an address at which he can be located to receive payment, the Fund may, during the lifetime of the Active Participant, pay any amount otherwise payable to the Active Participant to the spouse or relative by blood of the Active Participant or to any other person or institution determined by the Fund to be equitably entitled. In the case of the death of the Active Participant and before all amounts payable under Articles III, IV and V, have been paid, the Fund may pay any amount due to any person or institution determined by the Fund to be equitably entitled to that payment. The remainder of the amount will be paid to one or more of the following surviving relatives of the Active Participant:

- (a) lawful spouse,
- (b) child or children,
- (c) mother or father,
- (d) brothers or sisters, or
- (e) to the Active Participant's estate, as the Board, in its sole discretion, may designate.

Any payment made under this provision will discharge the obligation of the Fund to the extent of that payment.

Section 6. Physical Examination or Autopsy

The Fund, at its own expense, has the right to examine an Eligible Individual when and as often as it may reasonably require during the pendency of any Claim. The Fund also has the right to request an autopsy where it is not forbidden by law.

Section 7. Benefits Not in Lieu of Workers' Compensation

The benefits provided by this Fund are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

Section 8. Rights Against Third Parties

- a. If an Eligible Individual has an illness, injury, disease or other condition for which a third party may be liable or legally responsible by reason of an act or omission, or insurance coverage of that third party, the Fund will provide coverage for Hospital, medical or other related expenses, provided the Eligible Individual satisfies the following requirements of the Plan:
 - (1) An Eligible Individual must agree to reimburse the Fund for payment of Hospital, medical or other related expenses made on behalf of the Eligible Individual by signing the Plan's "Reimbursement Agreement" prior to payment of any claims by the Fund, which are related to the illness, injury, disease or other condition.
 - (2) An Eligible Individual must also agree to diligently prosecute any claims for damages against the third party, his insurance carrier, guarantor or other indemnitor or by reason of uninsured or underinsured motorist coverage or any other source of third party recovery.

- b. The Fund will have an automatic priority lien against the proceeds the Eligible Individual receives by way of judgment, arbitration, award, settlement or otherwise in connection with or arising out of any claim for or any right to any damages by the Eligible Individual against the third party or any other source of third party recovery for the full amount of the benefits paid by the Fund. The Eligible Individual and legal representative agree to:
 - (1) Take no action that would waive, impair or interfere with the Fund's right to reimbursement;
 - (2) Consent to an equitable lien/constructive trust which exists in favor of the Fund;
 - (3) Hold any recovery or settlement in trust for the benefit of the Fund; **and**
 - (4) Execute any documents necessary to secure reimbursement to the Fund and provide any documents requested.
- c. The Fund's lien is limited to the Eligible Individual's recovery from the third party, regardless of how that recovery is classified, allocated or held. The Fund's right to reimbursement will not be affected, reduced or eliminated by the make whole doctrine, comparative fault, common fund doctrine nor that the recovery does not specifically include medical expenses.
- d. If the Eligible Individual fails to reimburse the Fund as required by the Reimbursement Agreement or manifests an intent to breach the Reimbursement Agreement, the Board, in its sole discretion, may take any action necessary to recover the amounts paid on behalf of the Eligible Individual including, but not limited to, taking legal action, offsetting current payments against future benefits, ceasing payments of benefits and any other actions reasonably required to secure reimbursement.

Section 9. Gender

Wherever any words are used in this Plan in the masculine gender, they should be construed as though they were also used in the feminine gender in all situations where they would apply. Whenever any words are used in this Plan in the singular form, they should be construed as though they were also in the plural form in all situations where they would apply and vice versa.

Section 10. Trust Agreement Governs

The provisions of these Rules and Regulations are subject to and controlled by the provisions of the Trust Agreement. In the event of any conflict between the provisions of these Rules and Regulations and the provisions of the Trust Agreement, the provisions of the Trust Agreement will prevail.

Article VIII. Claims and Appeals Procedures

Section 1. Definitions. The following definitions will apply to the provisions of this Article:

- a. An **“Adverse Benefit Determination”** is any denial, reduction or termination of a benefit or failure to provide or make payment for a benefit, in whole or in part, under the terms of the Plan. Each of the following is an example of an Adverse Benefit Determination:
- (1) A payment of less than 100% of a Claim for benefits (including coinsurance or Copayment amounts of less than 100% and amounts applied to the Deductible);
 - (2) A denial, reduction, termination of a benefit or failure to provide or make payment for a benefit, in whole or in part, resulting from any **Utilization Review** (UR) or Pre-Authorization Review decision, source of injury, exclusion, network exclusion or other limitation on an otherwise covered benefit;
 - (3) Failure to cover an item or service because the Fund considers it to be an Experimental or Investigative Procedure, not Medically Necessary or not medically appropriate;
 - (4) A decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan; **or**
 - (5) A rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An Adverse Benefit Determination does not include:

- (1) A pharmacy’s refusal to fill a prescription because the item is not covered by the Plan, **or**
 - (2) A Physician or Hospital refusal to provide service because the service is not covered by the Plan.
- b. A **“Claim”** is a request for a benefit made by a claimant in accordance with the Plan’s reasonable procedures.

Casual inquiries concerning benefits or under which circumstances benefits might be paid are **not** considered Claims. A request for a determination as to whether an individual is eligible for benefits under the Plan is **not** considered to be a Claim. However, if a claimant files a Claim for specific benefits and the Claim is denied because the individual is not eligible for benefits under the Plan, the coverage determination **is** considered a Claim.

The presentation of a prescription order at a pharmacy does not constitute a Claim if the pharmacy follows rules established by the Plan and has no discretion to act on behalf of the Fund. Similarly, interactions between a claimant and Participating Providers (Physicians and Hospitals) do not constitute Claims in cases where the providers exercise no discretion on behalf of the Fund. If a Physician, Hospital or pharmacy declines to provide services or refuses to fill a prescription order unless the claimant pays the entire cost, the claimant may submit a Post-Service Claim for the services or prescription, as described in Section 2. Claims Procedures.

A request for pre-certification or prior authorization of a benefit that does **not** require pre-certification or prior authorization by the Plan is **not** considered a Claim. However, requests for pre-certification or prior authorization of a benefit where the Plan **does** require pre-certification or prior authorization are considered Claims and should be submitted as Pre-Service Claims (or Urgent Care Claims, if applicable), as described in Section 2. Claims Procedures.

- c. A **“Concurrent Claim”** is a Claim that is reconsidered after an initial approval has been made and results in a reduction, termination or extension of a benefit.
- d. An **“Independent Review Organization (IRO)”**, means an entity that conducts independent external reviews of Adverse Benefit Determinations in accordance with the Plan’s external review provisions and current federal external review regulations.
- e. A **“Post-Service Claim”** is a Claim for benefits that is not a Pre-Service, Urgent Care or Concurrent Claim. A Claim regarding rescission of coverage will be treated as a Post-Service Claim.
- f. 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.
- g. **“Rescission”** means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions. The Fund is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of this Plan.
- h. **“Relevant Documents”** includes documents pertaining to a Claim if those documents were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the regulations or constitute the Plan’s policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could also include Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that demonstrate that the Plan’s rules were appropriately applied to a Claim.

- i. An **“Urgent Care Claim”** is a Claim for medical care or treatment that, 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.

Section 2. Claims Procedures

a. 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**evue **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**evue **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. If the information is not provided within 45 days, 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). 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.

b. 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. If the information is not provided within 48 hours, 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. 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.

c. **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 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.

d. **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. 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:

- The patient's name and Health Plan ID or social security number;
- The date of service;
- 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);
- 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);
- The billed charge(s);
- The number of units (for anesthesia and certain other claims);
- The provider's federal taxpayer identification number (TIN); **and**
- 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. If the information is not provided within that period, the Claim will be denied. During the 45-day 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 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. 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. 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.

e. **Authorized Representatives**

A claimant may designate a person as his authorized representative, such as a spouse or an adult child, to submit an appeal on his behalf. The claimant must sign and submit an authorization form in writing and on a form prescribed by the Board. The Laborers Health and Welfare Trust Fund may request additional information to verify that the designated person is authorized to act on the claimant's behalf.

A health care professional (including a Hospital or other facility) with knowledge of the claimant's medical condition may act as an authorized representative in connection with a Claim without the claimant having to designate the health care professional to act.

f. **Notice of Initial Benefit Decision**

- (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;
 - 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).
- (2) 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.

Section 3. The Fund's Internal Appeals Procedure

a. 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.

(1) 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.

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.

(2) 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.

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.

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

(3) 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.

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.

(4) **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.

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

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.

A person different from 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.

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) 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.

c. **The Time Frames for Sending a Notice of an Appeal Decision**

(1) **Pre-Service Claims**

Written notice of the appeal decision for a Pre-Service Claim will be sent by the Fund on behalf of the Board within 30 days of receipt of the appeal by the Fund.

(2) **Urgent Care Claims**

Written notice of the appeal decision for Urgent Care Claims will be sent by the Fund on behalf of the Board within 72 hours of receipt of the appeal by the Fund.

(3) **Concurrent Claims**

Written notice of the appeal decision for Concurrent Claims that involves a termination or reduction of previously approved care will be sent by the Fund on behalf of the Board before the care is terminated or reduced.

Written notice of the appeal decision for a Concurrent Claim that involves an extension of care will be sent by the Fund on behalf of the Board based on the time frames for an Urgent, Pre-Service or Post-Service Claim, whichever type Claim applies to the appeal.

(4) **Post-Service Claims**

A decision on an Internal Appeal involving Post-Service Claims will be made by the Board no later than the date of the quarterly meeting of the Board that immediately follows receipt of the request for reconsideration, unless the request is filed within 30 days preceding the date of the meeting. In that case, a decision will be made no later than the date of the second meeting following receipt of the request for reconsideration. If special circumstances require a further extension of time for processing, a decision will be made no later than the third meeting following receipt of the request for reconsideration. The Board will provide the claimant with a written notice of the extension, describing the special circumstances and the date by which the benefit determination will be made prior to the commencement of the extension. The Fund on behalf of the Board will notify the claimant of the benefit decision as soon as possible, but not later than 5 days after the decision is made regarding the claimant's appeal.

d. **Content of an Appeal Decision Notice**

The decision on an Internal Appeal will be provided to the claimant in writing.

- (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.

- (2) 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.

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.

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 does not 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 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 Employee Benefits Security Administration (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 Independent Review Organization (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.
- (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 Affordable Care Act (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 Independent Review Organization (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.

Section 5. When a Lawsuit May Be Started

The claimant may not start a lawsuit to obtain benefits until after the claimant has requested an appeal and a final decision has been reached. A claimant may also file a lawsuit if the time frames described above have lapsed based on the date the claimant requested a review but did not receive a final decision from the reviewing entity. If the claimant is not satisfied with the final decision, he has the right to bring a civil action to obtain benefits under ERISA §502(a).

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)	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	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)	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
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 Time Frames Chart (continued)

Steps In The External Review Process	Time Frame For Standard Claims (Non-Urgent)	Time Frame For Expedited Claims Urgent Care
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 external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to claimant and Fund)
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

Article IX. Health Insurance Portability and Accountability Act (HIPAA) Protected Health Information

Section 1. Definitions. The following definitions will apply to the provisions this Article:

- a. The term “**Covered Entity**” means (1) a Health Plan; (2) a health care clearinghouse; or (3) a health care provider that transmits Health Information in electronic form in connection with a Transaction.
- b. The term “**Health Information**” means any information, whether oral or recorded in any form or medium that: (1) is created or received by a health care provider, Health Plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.
- c. The term “**Health Plan**” means any individual or group plan that provides or pays the cost of medical care (as defined in §28/79 (1) (2) of the PHS Act, 42 U.S.C. §300gg-91(a) (2)).
- d. The term “**Individually Identifiable Health Information**” means a subset of Health Information, including demographic information collected from an individual, and (1) is created or received by a health care provider, Health Plan, employer or health care clearinghouse; and (2) relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (i) that identifies the individual; or (ii) there exists a reasonable basis to believe the information can be used to identify the individual.
- e. The term “**Plan Administration Function**” means administration functions performed by the Plan Sponsor on behalf of the Plan, excluding functions performed by the Plan Sponsor in connection with any other benefit or benefit payment of the Plan Sponsor.
- f. The term “**Protected Health Information (PHI)**” means Individually Identifiable Health Information that is transmitted by electronic media; maintained in any form described in the definition of electronic media at 42 CFR §16.103; or transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information in (i) Education records covered by the Family Education Rights and Privacy Act, as amended, 20 U.S.C. §1232g; (ii) records described at 20 U.S.C. §1232g(a)(4)(B)(iv); and (iii) employment records held by a Covered Entity in its role as employer.
- g. The term “**Summary Health Information**” means information that (1) summarizes the claims history, claims expenses or types of claims of individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information at 42 CFR §164.514(b)(2)(i) has been removed.

- h. The term “**Transaction**” means the transmission of information between two parties to carry out financial or administrative activities related to health care.

Section 2. Use and Disclosure of Protected Health Information: Payment and Plan Operations

- a. The Plan will use **P**rotected **H**ealth **I**nformation (PHI) to the extent and in accordance with the uses and disclosures permitted by the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996 (HIPAA) as amended by the **H**ealth **I**nformation **T**echnology for **E**conomic and **C**linical **H**ealth Act (HITECH). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment of health care and health care operations. Except as permitted by HIPAA, the Plan will only use or disclosed your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment) with your written authorization.

“**Payment**” includes activities undertaken by the Plan to obtain premiums, to determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual being provided health care. Activities include, but are not limited to the following:

- (1) Determine eligibility, coverage and cost sharing amounts (cost of a benefit, Plan maximums and Copayments for an individual’s claim),
- (2) Coordinate benefits,
- (3) Adjudicate health benefit claims (including appeals and payment disputes),
- (4) Subrogate health benefit claims,
- (5) Establish employee contributions,
- (6) Calculate risk adjustment amounts based on enrollee health status and demographic characteristics,
- (7) Billing, collection and related health care data processing,
- (8) Handle claims management and related health care data processing, includes payment audits, investigation and resolution of payment disputes and responses to Active Participant inquiries concerning payments,
- (9) Obtain payment under a reinsurance contract (including stop-loss and excess loss insurance),
- (10) Review claims for medical necessity, appropriateness of care or justification of charges,

- (11) Conduct Ut lization Review (UR), including pre-certification, Pre-Authorization, Concurrent and Retrospective Reviews,
 - (12) Disclose to consumer reporting agencies information related to the collection of premiums or reimbursement (for payment purposes, the following PHI can be disclosed: name and address, date of birth, social security number, payment history, account number, and name and address of provider or Health Plan), **and**
 - (13) Reimburse the Plan.
- b. **“Health Care Operations”** include, but are not limited to, the following activities:
- (1) Performing quality assessment,
 - (2) Conducting population-based activities related to improving health or reducing health care costs, developing protocol, case management and care coordination, disease management, contacting health care providers and patients with information concerning treatment alternatives and related functions,
 - (3) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities,
 - (4) Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 1670.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), premium rating and other activities relating to the creation, renewal or replacement of a contract for health insurance or health benefits, and securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance),
 - (5) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
 - (6) Business planning and development, such as conducting cost-management and planning analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies,
 - (7) Managing and administering the activities of the entity including, but not limited to:
 - a. Implementation of and compliance with the requirements of HIPAA Administrative Simplification,
 - b. Customer service, including the provision of data analyses for policyholders, Plan sponsors or other customers,

- c. Resolution of internal grievances, **and**
 - d. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if that successor is a Covered Entity or, following completion of the sale or transfer, will become a Covered Entity.
- (8) Compliance with and preparation of all documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500, Summary Annual Report (SAR) and other documents.

Section 3. Use and Disclosure of PHI: Required by law or Permitted by Authorization

The Plan will only use and disclose PHI for Treatment, Payment and Operations (TPO) purposes; or as required by law and as permitted by authorization of the Active Participant or beneficiary. The Plan will disclose PHI to the individuals or organizations identified under the Plan Administration Team Members Roster, as amended and updated from time to time, for purposes related to the administration of the Plan.

Section 4. Use and Disclosure of PHI: To the Plan Sponsor

For purposes of this Article, the Board of Trustees of the Laborers Health and Welfare Trust Fund for Northern California is the "Plan Sponsor." The Plan will disclose PHI to the Plan Sponsor, only upon receipt of a certification from the Plan Sponsor, that the Plan Rules and Regulations have been amended to incorporate the following provisions. With respect to Protected Health Information (PHI), the Plan Sponsor agrees to:

- (1) Not use or further disclose the information other than as permitted or required by the Plan Rules and Regulations or as required by law;
- (2) Insure that any agents, including their subcontractors to whom the Plan Sponsor provides PHI it receives from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- (3) Not use or disclose the information for employment related actions and decision, unless authorized by the individual;
- (4) Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual;
- (5) Report to the Plan, as it becomes known, any use or disclosure of PHI that is not consistent with the uses or disclosures provided for by HIPAA;
- (6) Make PHI available to the individual in accordance with the access requirements of HIPAA;

- (7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- (8) Make available the information required to provide an accounting of disclosures;
- (9) Make internal practices, books and records relating to the use and disclosure of PHI received from the group Health Plan available to the Secretary of Health and Human Services (HHS) for the purposes of determining compliance by the Plan with HIPAA;
- (10) Return or destroy (if feasible) all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of that information when no longer required for the purpose for which the disclosure was made. If the return or destruction is not feasible, limit further uses and disclosures only to those purposes that make the return or destruction not feasible, **and**
- (11) Notify affected individuals in the event of breach of their unsecured Protected Health Information (PHI).

Section 5. Fund Staff Access to PHI

- a. Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:
 - (1) The Plan Administrator,
 - (2) Staff designated by the Plan Administrator, as identified under the Plan Administration Team Members Roster,
 - (3) The person described in this Section may only have access to use and disclosure of PHI for Plan Administration Functions that the Plan Sponsor performs for the Plan.
- b. If the persons described in this Section do not comply with the provisions of this Article, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.
- c. For purposes of complying with HIPAA privacy rules, this Plan is a “Hybrid Entity” because it has both Health Plan and non-Health Plan functions. Non-Health Plan functions include administration of a Death and Dismemberment Benefit for Active Participants and eligible Dependents. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other Plan functions or benefits.

Section 6. Plan Sponsor Protection of Electronic PHI

The Board of Trustees of the Laborers Health and Welfare Trust Fund for Northern California, who is the Plan Sponsor:

- (1) Implements administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Health Plan;
- (2) Ensures that the adequate separation discussed in Section 5., specific to electronic PHI, is supported by reasonable and appropriate security measures;
- (3) Ensures that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; **and**
- (4) Reports to the Plan any security incident of which it becomes aware concerning electronic PHI.

Section 7. Changes to Privacy Notice

The Fund has the right to change the Privacy Notice. Any changes made to the notice will be provided to Plan Participants and beneficiaries.

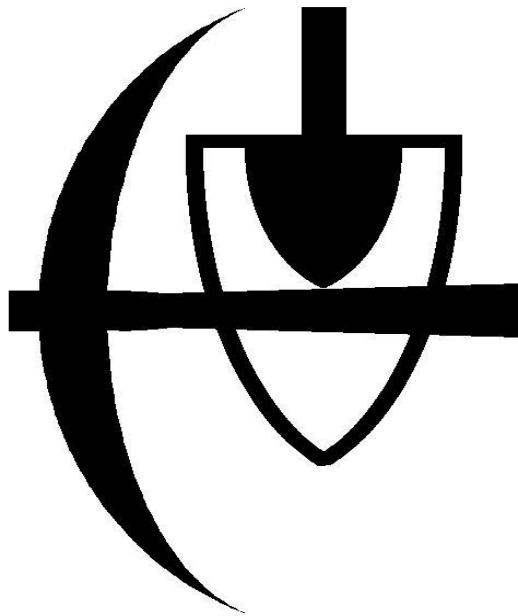
Article X. Amendment and Termination

In order that the Fund may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Plan Participants, the Board of Trustees expressly reserves the right, in its sole discretion at any time on a non-discriminatory basis:

- a. To terminate or amend either the amount or condition with respect to any benefit even though a termination or an amendment affects claims which have already accrued;
- b. To alter or postpone the method of payment of any benefit; **and**
- c. To amend or rescind any other provision of these Rules and Regulations.

Article XI. Disclaimer

None of the benefits provided in these Rules and Regulations is insured by any contract of insurance. There is no liability on the part of the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Trust Fund collected and available for that purpose.



Adoption Resolution

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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 at a meeting of the Board of Trustees held on December 8, 2015, the Health and Welfare Plan of the Active Laborers Health and Welfare Trust Fund Restated Effective January 1, 2016 was adopted pursuant to the authority given to the Board by the Health and Welfare Trust Agreement entered into on April 7, 1953.

Executed this 8th day of December 2015 Executed this 8th day of December 2015

/s/ _____
Oscar De La Torre, Chairman

/s/ _____
Byron C. Loney, Co-Chairman
