AMENDMENT X TO THE PLAN DOCUMENT OF WELFARE FUND OF ENGINEERS LOCAL 513

Effective April 1, 2018, the Plan Document of Welfare Fund of Engineers Local 513 Rules and Regulations, Amended and restated as of May 1, 2014, is amended as follows:

Article V, Section 13 is hereby deleted in its entirety and replaced with the following:

SECTION 13. CLAIM DETERMINATIONS AND APPEAL PROCEDURES

No Participant, Dependent or beneficiary shall have any right or claim to benefits under the Plan or from the Board of Trustees, except as specified in the Plan. Any dispute as to rescissions of coverage, eligibility, Medical Necessity denials, Experimental/ Investigative denials, type, amount or duration of benefits under the Plan, or any amendment or modification thereof shall be resolved under the following Claim Determinations and Appeal Procedures. All benefit claim determinations will be made in accordance with governing Plan documents and, where appropriate, the Plan provisions will be applied consistently with respect to similarly situated claimants. No action may be brought for benefits provided under the Plan or any amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined under the following Claim Determinations and Appeal Procedures, unless otherwise permitted by law.

A. Initial Claim Determinations

1. General Provisions

   a. In the case of a failure by a claimant to follow the Plan's procedures for filing a Pre-Service Claim that: (1) is communicated by the claimant and received by a person or organizational unit customarily responsible for handling benefit matters, and (2) names the specific claimant, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested, the Fund will notify the claimant of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but in no event later than five days (or 24 hours in the case of a failure to file a claim involving urgent care) following the failure. The notification to claimant regarding the failure to follow the Plan's procedures for filing a Pre-Service Claim may be made orally, unless written notification is requested by the claimant.

   b. For all claims, the claimant will be afforded the opportunity to review the claim file and present evidence and testimony, including written comments, documents, records, and other information relating to the claim for benefits.

c. Claim decisions will be made impartially. The Board of Trustees will not base decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to individuals involved in the claims and appeals process, such as a claims adjudicator or medical expert, based upon the likelihood that the individual will support the denial of benefits.

d. If the Fund has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Fund of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Fund Office shall notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of the adverse benefit determination before the benefit is reduced or terminated.

   Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Fund Office shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Fund Office, provided that any such claim is made to the Fund Office at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

e. The Fund Office will provide diagnosis and treatment codes (and their meanings) upon request and will not consider a request for diagnosis and treatment codes in itself as a request for an internal appeal or external review.

2. Timelines

   a. *Urgent Care Claims* will be decided and notification provided to claimant as soon as possible, consistent with the medical exigencies involved but in no event later than 72 hours after the Fund Office receives the claim unless the claimant fails to provide sufficient information to determine whether or to what extent benefits are payable under the Plan. In the case of such a failure, the Fund Office shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Fund Office of the specific information necessary to complete the claim. The claimant will have a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to respond. The

Board of Trustee's designee will decide the claim and provide the required notification to the claimant as soon as possible after receiving the missing information, but no later than 48 hours after receipt of the missing information. If the designee does not receive the missing information, the designee will decide the claim and provide notice to the claimant as soon as possible, but no later than 48 hours after the time for providing the missing information has elapsed. The designee can notify the claimant orally of the benefit determination so long as a written notification is furnished to the claimant no later than three days after the oral notification.

b. *Pre-Service Claims* must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after the Fund Office has received the claim. The Board of Trustees' designee may extend the time period up to an additional 15 days if, for reasons beyond the designee's control, the decision cannot be made within the first 15 days. The designee must notify the claimant prior to the expiration of the first 15-day period, explaining the reason for the delay, requesting any additional information, and advising the claimant of when the designee expects to make the decision. If more information is requested, the claimant shall have at least 45 days to supply it. In the event a period of time is extended for deciding a claim due to the claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information or the time for responding to the request for additional information has elapsed. The designee must give the claimant written notice that his/her claim has been granted or denied before the end of the time allotted for the decision.

c. *Post-Service Claims* must be decided within a reasonable period of time, but not later than 30 days after the Fund Office has received the claim. If, because of reasons beyond the Board of Trustees' designee's control, more time is needed to review the claimant's request, the designee may extend the time period up to an additional 15 days. However, the designee has to let the claimant know before the end of the first 30-day period, explaining the reason for the delay, requesting any additional information needed, and advising the claimant when a final decision is expected. If more information is requested, the claimant shall have at least 45 days to supply it. In the event a period of time is extended for deciding a claim due to the claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the

date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information or the time for responding to the request for additional information has elapsed. The designee must give the claimant written notice that his/her claim has been denied in whole or in part (paying less than 100 percent of the claim) before the end of the time allotted for the decision.

d. *Disability Claims* must be decided within a reasonable period of time, but not later than 45 days after the Fund Office has received the claim. If, because of reasons beyond the Board of Trustees' designee's control, more time is needed to review the claimant's request, the designee can extend the timeframe up to 30 days by notifying the claimant prior to the end of the first 45-day period that additional time is needed, the circumstances requiring the extension of time and the date by which the designee expects to render a decision. If prior to the end of the first 30-day extension period, the designee determines that, due to matters beyond its control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the designee notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the designee expects to render a decision. In the case of any extension the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information. In the event a period of time is extended for deciding a claim due to the claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information or the time for responding has elapsed. The designee must give the claimant notice of whether the claimant's claim has been denied before the end of the time allotted for the decision.

3. Notice of Claim Denial

The Board of Trustees' designee shall provide a claimant with written or electronic notification in a culturally and linguistically appropriate manner of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall be

set forth, in a manner calculated to be understood by the claimant and shall include the following:

a. The specific reason for an adverse benefit determination;

b. Reference to the specific Plan provision(s) on which the denial was based;

c. A description of any additional material or information necessary to perfect the claim and an explanation of why such material is necessary;

d. An explanation of the Plan's appeal procedures, including applicable time limits, how to initiate an appeal, and a statement of the claimant's right to bring civil action following an adverse benefit determination on review;

e. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request to the Fund Office;

f. If the adverse benefit determination was based on a Medical Necessity or Experimental or Investigative treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request to the Fund Office;

g. In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

h. In the case of an adverse benefit determination with respect to disability benefits;

    i. A discussion of the decision, including an explanation of the basis for disagreeing with or not following to the extent applicable: (i) the views presented by the claimant to the Fund of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advise was obtained on behalf of the Fund in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination, and (iii) a disability determination

regarding the claimant presented by the claimant to the Fund made by the Social Security Administration;

ii. If the adverse benefit determination is based on a Medical Necessity or Experimental or Investigative treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgement for the determination will be provided free of charge upon claimant's request to the Fund Office;

iii. The specific internal rules, guidelines, protocols, standards or other similar criteria of the Fund relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Fund do not exist; and

iv. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits. A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information: (i) was relied upon in making the benefit determination; (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (iii) demonstrates compliance with the administrative process and safeguards required by 29 C.F.R. 2560.503-1 in making the benefit determination; or (iv) constitutes a statement of policy or guidance with respect to the Fund concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In the case of an adverse benefit determination with respect to disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner;

i. The date of service;

j. The health care provider;

k. The claim amount (where applicable);

l. A statement describing the availability upon request, or the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;

m. Denial code and its corresponding meaning as well as a description of the Fund's standard, if any, that was used in denying the claim; and

n. Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793 to assist individuals with the internal claims and appeal and external review process.

B. Internal Appeals

1. General Provisions

a. If the claimant's claim for benefits under the Plan is denied in whole or in part, the Board of Trustee's designee will notify the claimant of such in writing as set out above. The claimant shall have the right to appeal a denied claim to the Board of Trustees, and to request a personal appearance before the Board of Trustees if he/she so desires.

b. To file an appeal of an adverse benefit determination, the claimant must file a request for review of the adverse benefit determination within 180 days of the claimant's receipt of the adverse benefit determination notice. Failure to file a request within the 180-day period will constitute a waiver of the claimant's right to appeal the adverse benefit determination or to take any other action with respect to it. An appeal shall be in writing, shall state in clear and concise terms the reason(s) for disputing the denial, and shall be accompanied by any pertinent documentary material not already furnished to the Board of Trustees that the claimant wishes to submit.

c. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with these procedures without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted due to the claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of extension is sent to the claimant until the date on which the claimant responds to the request for additional information

d. When deciding appeals, the Board of Trustees will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim,

without regard to whether such information was submitted or considered in the initial benefit determination. The review on appeal will not afford deference to the initial adverse benefit determination and will be conducted by the Board of Trustees, which does not make initial adverse benefit determinations.

e. The Fund Office will provide diagnosis and treatment codes (and their meanings) upon request and will not consider a request for diagnosis and treatment codes in itself as a request for an internal appeal or external review.

f. For all appeals, the claimant will be afforded the opportunity to review the claim file and present evidence and testimony, including written comments, documents, records, and other information relating to the claim for benefits.

g. The claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. A document, record or other information shall be considered "relevant" to a claimant's claim if such document, record or other information: (i) was relied upon in making the claim determination; (ii) was submitted, considered, or generated in the course of making the claim determination, without regard to whether such document, record, or other information was relied upon in making the claim determination; (iii) demonstrates compliance with the administrative processes and safeguards required by 29 C.F.R 2560.503-1 in making the benefit determination; or (iv) constitutes a statement of policy or guidance with respect to the Fund concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the claim determination.

h. The Board of Trustees will provide that, in deciding an appeal of any initial adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigative, or not Medically Necessary or appropriate, the Board of Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

i. The Board of Trustees will provide for the identification of medical or vocational experts whose advise was obtained on behalf of the Fund in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

j. If the Board of Trustees considers, relies upon or generates new or additional evidence in connection with an appealed claim other than the evidence furnished by the claimant, the Board of Trustees will afford the claimant a reasonable opportunity to respond to the new or additional evidence. The Board of Trustees will provide the claimant with a copy of the new or additional evidence free of charge, within a sufficient amount of time to respond to the evidence prior to the date on which the Board of Trustees is required to provide a final determination on the claim. If the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond. After the claimant responds, or has a reasonable opportunity to respond but fails to do so, the Fund Office shall notify the claimant of the Fund's benefit determination as soon as a fund acting in a reasonable and prompt fashion can provide the notice, taking into account medical exigencies.

k. If the Board of Trustees denies a claim on appeal based on a rationale different from the rationale for the original claim denial, the Board of Trustees will afford the claimant a reasonable opportunity to respond to the new rationale. The Board of Trustees will provide the claimant with the rationale free of charge, within a sufficient amount of time to respond to the new rationale prior to the date on which the Board of Trustees is required to provide a final determination on the claim. If the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond. After the claimant responds or has a reasonable opportunity to respond but fails to do so, the Fund Office shall notify the claimant of the Fund's benefit determination as soon as a fund acting in a reasonable and prompt fashion can provide the notice, taking into account medical exigencies.

l. If 10 percent or more of the population residing in the claimant's county are literate in the same non-English

language, as determined based on American Community Survey data published by the United States Census Bureau, then upon request, the Board of Trustees will provide notices to a claimant in that non-English language.

m. Appeal decisions will be made impartially. The Board of Trustees will not base decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to individuals involved in the claims and appeals process, such as a claims adjudicator or medical expert, based upon the likelihood that the individual will support the denial of benefits.

n. The Board of Trustees will provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary for the Fund who is neither the individual who made the adverse benefit determination that is the subject of appeal, nor the subordinate of such individual.

2. Timelines

a. *Urgent Care Claims*: Appeals related to Urgent Care Claims will be decided and notice provided to the claimant as soon as possible consistent with the medical exigencies involved but in no event later than 72 hours after the Fund Office receives the appeal. In the case of an Urgent Care Claim, the request for an expedited appeal may be submitted orally or in writing by the claimant and all necessary information, including the Board of Trustees' benefit determination on review will be transmitted between the Board of Trustees and the claimant by telephone, facsimile, or other available similarly expeditious method.

b. *Pre-Service Claims*: Appeals related to Pre-Service Claims must be decided and notice provided to the claimant within a reasonable period of time consistent with the medical exigencies involved but in no event later than 30 days after the Fund Office receives the appeal.

c. *Post-Service Claims*: Appeals related to Post-Service Claims must be decided by the Board of Trustees no later than the date of the meeting of the Board of Trustees that immediately follows the Fund Office's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination will be made by no later than the date of the second Board of Trustees' meeting following the Fund Office's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not

later than the third Board of Trustees' meeting following the Fund Office's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Fund Office shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Fund Office shall notify the claimant of the Board of Trustees' benefit determination as soon as possible, but not later than five days after the benefit determination on appeal is made.

d. *Disability Claims*: Appeals related to Disability Claims must be decided by the Board of Trustees no later than the date of the meeting of the Board of Trustees that immediately follows the Fund Office's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination will be made by no later than the date of the second Board of Trustees' meeting following the Fund Office's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third Board of Trustees' meeting following the Fund Office's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Fund Office shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Fund Office shall notify the claimant of the Board of Trustees' benefit determination as soon as possible, but not later than five days after the benefit determination on appeal is made.

3. Notice of Benefit Determination on Appeal

The Fund Office shall provide claimant with written or electronic notification of the Board of Trustees' notice of benefit determination following an internal appeal in a culturally and linguistically appropriate manner. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall be set forth, in a manner calculated to be understood by the claimant and shall include the following:

a. The specific reason for an adverse benefit determination;

b. Reference to the specific Plan provision(s) on which the benefit determination was based;

c. A statement that the claimant is entitled to receive, upon request and free of charge reasonable access to, and copies of all documents, records and other information relevant to the claimant's claim for benefits. A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information: (i) was relied upon in making the benefit determination; (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (iii) demonstrates compliance with the administrative process and safeguards required by 29 C.F.R. 2560.503-1 in making the benefit determination; or (iv) constitutes a statement of policy or guidance with respect to the Fund concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination;

d. An explanation of the Plan's external review procedures, including applicable time limits, how to initiate an external review and a statement of the claimant's right to bring civil action following the final external review decision. The explanation shall include a description of any applicable contractual limitations period that applies to the claimant's right to bring a civil action under Section 502(a) of the Act, including the calendar date on which the contractual limitations period expires for the claim;

e. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination on appeal, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination on appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request to the Fund Office;

f. If the adverse benefit determination on appeal was based on a Medical Necessity or Experimental or Investigative treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request to the Fund Office;

g. The following statement: "You and your plan may have other voluntary alternative 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 your State insurance regulatory agency."

h. In the case of an adverse benefit determination on appeal with respect to disability benefits,

i. A discussion of the decision, including an explanation of the basis for disagreeing with or not following to the extent applicable: (i) the views presented by the claimant to the Fund of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advise was obtained on behalf of the Fund in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination, and (iii) a disability determination regarding the claimant presented by the claimant to the Fund made by the Social Security Administration;

ii. If the adverse benefit determination on appeal is based on a Medical Necessity or Experimental or Investigative treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided free of charge upon claimant's request to the Fund Office;

iii. The specific internal rules, guidelines, protocols, standards or other similar criteria of the Fund relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Fund do not exist; and

In the case of an adverse benefit determination on appeal with respect to disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner;

i. In the case of an adverse benefit determination on appeal concerning a claim involving urgent care, the notification of adverse benefit determination may be provided to the claimant orally within the time lines set out above for responding to claims involving urgent care, provided that a written or electronic notification of adverse benefit determination is provided to the claimant not later than 3 days after the oral notification;

j. The date of service;

k. The health care provider;

l. The claim amount (where applicable);

m. A statement describing the availability upon request, or the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;

n. Denial code and its corresponding meaning as well as a description of the Plan's standard, if any, that was used in denying the claim; and

o. Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793 to assist individuals with the internal claims and appeal and external review process.

C. External Review Procedure

If a claim or internal appeal involving: (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, or (2) a rescission of coverage, is denied by the Board of Trustees, the claimant will have the opportunity to request external review of the Board of Trustees' decision according to the following procedure.

1. Standard External Review Process:

This Section sets forth procedures for standard external review. Standard external review is external review that is not considered expedited (as described in paragraph C(2) below).

a. A claimant may file a request for external review within four months after receipt of a notice that a claim or internal appeal was denied. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

b. Within five business days after receipt of a request for external review, the Board of Trustees will complete a preliminary review to verify: (1) that the claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided; (2) that the claim or appeal denial was not based on ineligibility for coverage; (3) that the claimant has exhausted the Plan's internal claims and appeals processes (or is deemed under applicable regulations to have done so), and that the claim or appeal denial is otherwise eligible for external review; and (4) that the claimant has furnished all information required to process an external review.

c. The Board of Trustees will notify the claimant in writing of whether the request is complete and the request is eligible for external review within one business day after completion of the preliminary review. If the request is not eligible for external review, the notice will explain why, and provide contact information (including phone number) for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information needed, and the Board of Trustees will allow the claimant to perfect the request within the four-month filing period or, if longer, within 48 hours after receipt of the notice.

d. The Fund will ensure that the Independent Review Organization ("IRO") process is not biased and ensures independence. Any IRO used by the Fund will be accredited by URAC or by a similar nationally-recognized accrediting organization. The IRO is not eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits and the IRO process may not impose any costs, including filing fees on the claimant requesting the external review.

e. The Fund will ensure that the contract between the IRO and the Fund complies with 45 CFR 147.136(d)(2)(iii)(B).

f. The Fund will contract with at least three accredited IROs, and will assign eligible requests for external review to them in rotating order.

g. Within five business days after assignment of a request to an IRO, the Fund Office will provide to the IRO the documents and information considered by the Board of Trustees or its designee in denying the claim or appeal. Regulations provide that if the Fund fails to timely provide the documents and information, the external review cannot be delayed and the IRO may terminate the external review and make a decision to reverse the adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Fund.

h. Regulations provide that the IRO will: (1) utilize legal experts where appropriate to make coverage determinations under the Plan; (2) timely notify the claimant of the request's eligibility and acceptance for review and allow the claimant ten days to submit additional information for consideration; (3) forward any additional information submitted by the claimant to the Board of Trustees within one business day so the Fund can reconsider its adverse benefit determination as provided in (i) below; (4) review all of the information and documents timely received and review the claim without consideration for the previous decisions made by the Board of Trustees or its designee; and (5) provide written notice to the Board of Trustees and the

claimant of the IRO's final decision within 45 days after receiving the request for external review.

i. Where additional information is submitted by the claimant during the external review and that information is then forwarded to the Fund as provided in (h) above, 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 and the external review may only be terminated as a result of the reconsideration if the Fund decides, upon completion of its reconsideration to reverse its adverse benefit determination and provide coverage or payment. Within one business day after making such decision, the Fund must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Fund.

j. In conducting its review, the IRO will consider the following documents in reaching a decision to the extent they are available and the IRO considers them appropriate:

    i. The claimant's medical records;

    ii. The attending health care professional's recommendation;

    iii. Reports from appropriate health care professionals and other documents submitted by the Fund, claimant or the claimant's treating provider;

    iv. The terms of the claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

    v. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

    vi. Any applicable clinical review criteria developed and used by the Fund unless the criteria are inconsistent with the terms of the Plan or applicable law; and

    vii. To the extent the final IRO decision maker is different from the IRO's clinical reviewer, the option of such clinical reviewer, after considering information described in the notice, to the extent the information or documents are available and the clinical reviewer or

reviewers consider such information or documents appropriate.

k. The decision notice from the IRO will contain the following:

   i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the Fund's denial);

   ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

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

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

   v. A statement that the IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either the Fund or the claimant, or to the extent the Fund voluntarily makes payment on the claim or otherwise provides benefits at any time, including after a final external revision decision that denies the claim or otherwise fails to require such payment or benefits;

   vi. A statement that judicial review may be available to the claimant; and

   vii. Current contact information, including phone number for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

l. After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six years. The IRO will make such records available for examination by the claimant, Fund or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

m. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or adverse benefit determination on appeal, the Fund will immediately provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

2. Expedited External Review

A claimant may make a request for an expedited external review with the Fund Office at the time the claimant receives: (1) an adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or (2) an adverse benefit determination on appeal, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the adverse benefit determination on appeal concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from the facility. Where a claimant has requested an expedited external review, the expedited external review will be processed as follows:

a. The Board of Trustees or its designee will conduct the preliminary review immediately upon receipt of the request for expedited external review, to determine whether the request meets the reviewability requirements for standard external review, and then immediately send notification in writing to the claimant of its determination. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and current contact information, including the phone number, for the EBSA. If the request is not complete, such notification must describe the information or materials needed to make the request complete and the Fund must allow the claimant to perfect the request for external review within the four-month period or within the 48 hour period following receipt of the notification, whichever is later.

b. Upon determining that the request is eligible for external review, the Board of Trustees or its designee will assign the request to an IRO pursuant to the requirements set out above in Standard External Review Process. The Fund will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination

to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

c. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the Standard External Review Process. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Fund's internal claims and appeals process.

The Board of Trustees contract will require the IRO to provide notice of its decision to the Board of Trustees and the claimant as expeditiously as possible given the claimant's medical condition and circumstances, but no later than 72 hours after receiving the request for expedited external review. The notice will be consistent with the notice provided under the Standard External Review Process set out in Section C(1)(k) above. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Fund.

D. Authorized Representatives

A claimant has the right to designate an authorized representative to represent him/her under these Claim Determinations and Appeal Procedures, including the external review process set out below. Claimant must designate his/her authorized representative to the Board of Trustees in writing, except in the case of an Urgent Care Claim, in which case, a health care professional with knowledge of the claimant's medical condition shall be permitted to act as the authorized representative of the claimant.

E. Culturally and Linguistically Appropriate Notices

To ensure the Fund is providing notifications in a culturally and linguistically appropriate manner when required to do so by law, the Fund will:

1. Provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English Language;

2. Provide, upon request, a notice in any applicable non-English language; and

3. Include, in the English versions of all notices, a statement prominently displayed in any applicable non-English language

clearly indicating how to access the language services provided by the Fund.

With respect to an address in any Untied States county to which a notice is sent, a non-English language is an "applicable non-English language" if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of the Department of Labor.

F. Providing continued coverage pending the outcome of an appeal

The Fund will provide continued coverage pending the outcome of an appeal where the Fund has approved an ongoing course of treatment. The Fund will provide an opportunity for appeal or review before reducing/terminating coverage (except where reduction or termination is due to a Plan amendment or termination).

Executed by authority of the Board of Trustees on this 28th day of February, 2018:

Chairman

Secretary