

**RULES AND REGULATIONS
PROVIDING HEALTH AND WELFARE
BENEFITS OF THE BRICK MASONS'
HEALTH AND WELFARE TRUST FUND
RESTATEMENT JUNE 12, 2007**

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BRICK MASONS' HEALTH AND WELFARE TRUST FUND ADOPTION RESOLUTION

WHEREAS, on August 1, 1982, the Trustees of the Brick Masons' Health and Welfare Trust Fund established the Health and Welfare Program as set forth in the "Rules and Regulations Providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust Fund," effective August 1, 1982; and

WHEREAS, from time to time the Trustees duly adopted various changes and amendments to the Rules and Regulations; and

WHEREAS, the Trustees desire to incorporate into one document the Rules and Regulations and subsequent amendments;

NOW, THEREFORE, it is hereby resolved that, effective June 12, 2007, the Trustees of the Brick Masons' Health and Welfare Trust Fund hereby restate and adopt the attached "Rules and Regulations Providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust Fund" upon the following understanding and conditions:

1. It is recognized that the benefits provided by the Rules and Regulations can be paid only to the extent that the Fund has available adequate resources for such payments. No contributing employer has any liability, directly or indirectly, to provide the benefits established hereunder beyond the obligation of the contributing Employer to make contributions as stipulated in its collective bargaining agreement. In the event that at any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in these Rules and Regulations shall be construed as obligating any contributing employer to make benefit payments or contributions (other than the contributions for which the contributing Employer may be obligated by his collective bargaining agreements) in order to provide for the benefits established hereunder. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, the Union, Associations or any other persons or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.
2. None of the benefits provided for in the Rules and Regulations, except benefits provided under Articles VII, IX, X, XVI, and XVII, are insured by any contract of insurance and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amount in the Trust Fund collected and available for such purposes.

IN WITNESS WHEREOF, the parties have adopted this Restatement of the Brick Masons' Health and Welfare Trust Fund at a meeting of Board of Trustees held on June 12, 2007.

Employer Trustees

/s/ Julie Salazar
/s/ Kenneth J. Tejeda
/s/ Jimmy Smith
/s/ Frank E. Smith

Union Trustees

/s/ Richard A. Whitney
/s/ Gary H. Anthony
/s/ Joseph C. Solis
/s/ Daniel Garcia

**RULES AND REGULATIONS PROVIDING
HEALTH AND WELFARE BENEFITS OF THE
BRICK MASONS' HEALTH AND WELFARE TRUST FUND
RESTATED JUNE 12, 2007**

(Including all changes made in the Plan effective on or before July 12, 2007)

ARTICLE I. DEFINITIONS

Section 1. Active Employee or Employee.

The term "Active Employee" or "Employee" means any person who by reason of his active employment, meets the eligibility requirements hereunder as established by the Fund and as amended from time to time, and such other person as the Employer Council and the Union may agree to designate as employees within the meaning and purpose of an applicable Collective Bargaining Agreement.

The term "Active Employee" shall also mean an individual who is employed by an Employer, such as a supervisor or estimator, or who is less than a 100% shareholder in an Employer which is incorporated, such as a Corporate Officer, provided that any such individual was a Covered Employee in the Fund as stated in Article I, Section 5 and provided further that contributions to the Pension, Health and Welfare, Vacation and Apprentice Funds on any such individual shall be made on all hours worked or paid for subject to a minimum of 160 hours per month. Initial eligibility for such individuals is established on the basis as it is for other Active Employees as detailed in Article II, Section 1(a)(1).

The term "Active Employee" does not include Helpers.

Section 2. Calendar Year.

The term "Calendar Year" means the year beginning January 1 and ending December 31.

Section 3. COBRA.

Consolidated Omnibus Budget Reconciliation Act of 1985.

Section 4. Collective Bargaining Agreement.

The term "Collective Bargaining Agreement" means any agreement between the Union and an Employer that provides for the making of uniform Employer contributions to this Fund, as well as any extensions, amendments, modifications or renewals of such agreement and any substitute, successor or predecessor agreement which provides for the making of Employer contributions to this Fund.

Section 5. Covered Employee.

The term "Covered Employee" means such Active Employee and Retired Employee.

Section 6. Dentist.

The term “Dentist” means a person licensed to practice dentistry in the state in which he renders treatment.

Section 7. Doctor, Physician, or Surgeon.

The term “Doctor,” “Physician” or “Surgeon” means a Doctor of Medicine or Doctor of Osteopathy. To the extent that benefits are provided while practicing within the scope of his license, Doctor will include a Dentist, podiatrist, chiropractor, optometrist, or psychologist. In no event will such term include the Eligible Individual or any person who is the spouse, domestic partner, parent, child, brother or sister of the Eligible Individual. The term will include a licensed clinical social worker who, upon referral by a Doctor of Medicine or Doctor of Osteopathy, is performing services covered under the terms of these Rules and Regulations.

Section 8. Dependent.

The term “Dependent” means:

- (a) The Covered Employee’s lawful spouse; or registered same sex domestic partner in accordance with AB 2208 (opposite sex at age 62 or older), except for those benefits set forth in Articles III, IV, V VI, VIII, XI, XVI, and XVII. The Covered Employee must register the domestic partnership with the Secretary of State in accordance with Section 298 of the Family Code, and a copy of a valid Declaration of Domestic Partnership must be submitted to the Fund. Domestic partners will be deemed a Dependent for benefits in the HMO medical and prescription drug plans, prepaid dental plan, and vision benefit plan only. Both the Covered Employee and his or her domestic partner must be enrolled in the same medical and dental plan.
- (b) The Covered Employee’s unmarried children, from birth to age 19, including step-children, adopted children and foster children who are primarily dependent upon the Covered Employee for support and maintenance.
- (c) The Covered Employee’s unmarried children between the ages of 19 and 23 who are full-time students and dependent upon the Covered Employee for support and maintenance (a full-time student shall mean a dependent child enrolled as a full-time student for any term and during a summer break, provided the dependent child was enrolled as a full-time student in the term immediately preceding the summer break).
- (d) The Covered Employee’s unmarried children older than 19 years of age who are prevented from earning a living because of mental and physical handicap, provided such disabled children were so handicapped and eligible as a Dependent prior to age 19 and remain primarily dependent upon the Covered Employee for support.

In no event shall a lawful spouse, domestic partner, child, mother, father, mother-in-law or father-in-law be eligible under the Plan both as an eligible Dependent and as a Covered Employee, nor shall a child be considered an eligible Dependent of more than one Covered Employee.

In no event shall a child of a domestic partner be considered an eligible Dependent.

Section 9. Eligible Individual.

The term “Eligible Individual” means a Covered Employee and each of his/her Dependents, if any.

Section 10. Employer.

The term “Employer” means any association, individual, partnership, joint venture or corporation which has agreed to be bound by the terms and provisions of the Trust Agreement and is obligated to make employer contributions to the Trust Fund in accordance with a Collective Bargaining Agreement. “Employer” may also mean any Local Union, signatory hereto, and the Trust Funds which make contributions hereto and behalf of its employees, provided the inclusion of said Local Union or Trust Funds as an Employer is not a violation of any applicable law or state. An employer shall not be deemed an Employer simply because he is part of a controlled group of corporations or of a trade or business under common control, some part of which is a contributing Employer.

Section 11. Extended Care Facility.

The term “Extended Care Facility” means an institution which (1) provides skilled nursing care under 24 hours a day supervision of a Doctor or Registered Nurse, (2) has available at all times the services of a Doctor who is a staff member of a Hospital, (3) provides 24 hours a day nursing service by a Registered Nurse, Licensed Vocational Nurse or skilled practical nurse and has a Registered Nurse on duty at least 8 hours per day, (4) maintains a daily medical record for each patient, and (5) is not a place of rest, custodial care, for the aged, for treatment of chemical dependency, nor is a hotel or similar institution.

Section 12. Experimental.

The term “Experimental” means those treatments, procedures, methods, or services that: (1) lack endorsement by appropriate authorities, e.g. Food and Drug Administration (FDA), medical or dental societies, or specialties; (2) are uncertain in terms or efficacy, safety, or reliability as reported in current medical literature; or (3) are undergoing or have yet to begin clinical trials.

Section 13. Fund.

The term “Fund” means the Brick Masons’ Health and Welfare Trust Fund; the “Fund” also means the Board of Trustees established by the Trust Agreement where applicable.

Section 14. Injury

Bodily Injury caused by an accident. The accident must occur while coverage is in force. It must also result directly and independently of all other causes of a loss covered by the Plan

Section 15. Hospital.

The term “Hospital” means an establishment which:

- (a) Holds a license as a hospital (if required in the state);

- (b) Operates primarily for the reception, care and treatment of sick or injured persons as inpatients;
- (c) Provides around the clock nursing service;
- (d) Has a staff of one or more physicians available at all times;
- (e) Provides organized facilities for diagnosis and surgery;
- (f) Is not primarily a clinic, nursing, rest or convalescent home or a skilled nursing facility or a similar establishment; and
- (g) Is not, other than incidentally, a place for treatment of drug addiction.

The nursing service must be by registered or graduate nurses on duty or call. The surgical facilities may be either at the hospital or at a facility with which it has a formal arrangement.

Confinement in a special unit of a hospital used primarily as a nursing, rest or convalescent home or skilled nursing facility will not be deemed confinement in a hospital.

A Hospital also includes:

- (a) A Psychiatric Health Facility as defined in Section 1250.2 of the California Health and Safety Code, when service is rendered there for psychiatric or mental conditions; and
- (b) A licensed ambulatory surgical center. The center must have permanent facilities and be equipped and operated primarily for the purpose of performing surgical procedures. The type of procedures performed must permit discharge from the center in the same "working day." The center will not qualify as a hospital if:
 - (1) it is maintained as an office by a physician for the practice of medicine;
 - (2) its primary purpose is performing abortions; or
 - (3) it is maintained as an office for the practice of dentistry.

Section 16. Mason Finisher.

An individual classified as a "Mason Finisher," as defined under a Collective Bargaining Agreement, and who is eligible for limited coverage under the Plan.

Section 17. Medical Necessity or Medically Necessary.

The terms "Medical Necessity" or "Medically Necessary" means a service or supply that is therapeutic for a diagnosed Sickness or Injury that (a) is appropriate and consistent with the diagnosis and in accordance with accepted standards of community practice, and (b) could not have been omitted without adversely affecting the patients' condition or the quality of medical care. The fact that a Physician orders a service or supply does not, in itself, determine Medical

Necessity. Medical Necessity shall be determined by the Trustees in their discretion, who may rely upon the advice of medical professionals of their choice.

Section 18. Medicare.

The term “Medicare” as used herein, means the program established under Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

Section 19. Mental and Nervous Disorder.

The conditions listed in the Mental Disorders section of the current edition of the World Health Organization's International Classification of Diseases, as published by the Commission of Professional and Hospital Activities.

Section 20. Plan.

The term “Plan” means these Rules and Regulations as adopted and thereafter amended by the Board of Trustees.

Section 21. PPO.

Preferred Provider Organization.

Section 22. Registered Nurse.

The term “Registered Nurse” means a registered graduate nurse who does not ordinarily reside in the Eligible Individual's home and is not the spouse, domestic partner, child, brother, sister or parent of the Eligible Individual or of the Eligible Individual's spouse.

Section 23. Retired Employee.

The term “Retired Employee” means any person who has qualified for a Regular Pension or Disability Pension under the Brick Masons' Pension Trust.

Section 24. Reasonable Charges.

The term “Reasonable Charges” means the customary charges, in the area in which they are incurred, but not exceeding such charges as would have been made in the absence of the benefits provided under these Rules and Regulations. A “customary charge” as used herein means the usual charge made by a Hospital, Extended Care Facility, Physician, Dentist, or other professional provider, or other person or firm having rendered or furnished the services, treatments or supplies which do not exceed the general level of charges made by others rendering or furnishing such services, treatments or supplies within the area in which the charge is incurred, for bodily Injuries or Sickesses comparable in severity and nature to the bodily Injuries or Sickness treated or being treated. The term “area,” as it would apply to any particular item for which a covered charge may be incurred, means a county or such greater area as is necessary to obtain a representative cross-section of entities furnishing such items. A charge is considered to have been incurred as of the date on which the service or supply for which the charge is made is rendered or obtained. The Board of Trustees may, at its discretion, utilize the services of an independent source in determining Reasonable Charges as necessary.

Section 25. Sickness.

An illness or disease which causes loss covered by the Plan. The loss must commence while the Employee is insured under the Fund. For Fee-For-Service Medical Plan benefits, pregnancy is considered a Sickness with respect to female Covered Employees and the spouses of male Covered Employees only. Pregnancy for dependent children is not covered except for complications of pregnancy.

Section 26. Total Disability.

The term “Total Disability” shall mean, with respect to an Active Employee, that as a result of bodily Injury or Sickness, the Active Employee is completely unable to engage in any gainful occupation for which he is reasonably qualified by reason of education, training or experience and that he is not engaged in any gainful occupation.

The term “Total Disability” shall mean, with respect to any other Eligible Individual, that as a result of bodily Injury or Sickness, the Eligible Individual is unable to engage in his or her regular and customary activities and is not, in fact, engaged in any employment occupation for wage or profit.

Section 27. Trust Agreement.

The term “Trust Agreement” means the Agreement and Declaration of Trust establishing the Brick Masons’ Health and Welfare Trust Fund dated May 26, 1960 and any modification, amendment, extension or renewal thereof.

Section 28. Trustees.

The term “Trustees” shall mean any persons designated as Trustees pursuant to the terms of the Trust Agreement, and the successor of such persons from time to time in office. The term “Board of Trustees” and “Board” means the Board of Trustees established by the Trust Agreement.

Section 29. Union.

The term “Union” means Local No. 4 of the International Union of Bricklayers and Allied Craftsmen and any other Local Unions which have a Collective Bargaining Agreement in effect with an Employer and agree to be bound by the terms and provisions of the Trust Agreement.

ARTICLE II. ELIGIBILITY RULES

Section 1. Active Employees.

- (a) Establishment and Maintenance of Eligibility:
- (1) Any Active Employee working for Employers who contribute to the Brick Masons' Health and Welfare Trust Fund shall be eligible for Plan benefits:
- (i) on January 1, 1989, if he was eligible for Plan benefit on December 31, 1988;
- (ii) after January 1, 1989, on the first day of the second calendar month next following any consecutive period of four calendar months or less during which the number of hours for which contributions are made on his behalf by an Employer total at least 400 hours.
- (2) A reserve account has been established by the Fund for each Active Employee and is comprised of hours in excess of 100 hours worked by the Active Employee, while in an eligible class, with one or more contributing Employers during a month.

Such hours credited to the reserve account of the Active Employee under the Fund shall be carried over to his credit for continued eligibility for benefits. The maximum number of hours credited to the Active Employee's reserve account at any time shall in no event exceed 600 hour after the deduction has been made for the current month's coverage.

All hours credited to an Active Employee's reserve account shall be cancelled if the Active Employee does not satisfy the requirements for becoming eligible for benefits under the Fund for four consecutive calendar months.

If when an Active Employee loses eligibility he or she has hours remaining in his or her reserve account and elects to self-pay for coverage through COBRA, the first month's self-pay amount will be prorated (reduced) by the hours remaining in the reserve account as outlined in Article II, Section 5(h).

- (3) An Active Employee's Dependent becomes eligible on the date the Active Employee's eligibility is effective, or on the date the Active Employee acquires the Dependent, whichever is later.
- (4) Individuals who are employed by an Employer as a supervisor or estimator, as well as shareholders or Corporate Officers who hold less than 100% of the shares in an incorporated Employer, may participate in the Fund, provided that their Employers pay current contributions to the Health and Welfare, Pension, Vacation and Apprentice Funds on their behalf on the greater of 160 hours or actual hours worked per month. The Employer(s) must notify the Fund of the individual's participation and sign a participation agreement with each of the above-listed

Funds. The individuals are subject to the same initial eligibility rules that apply to Active Employees as set forth in Article I, Section 1, Subsections (a)(1), (a)(2) and (a)(3). Sole proprietors are not eligible to participate in the Fund.

(b) Termination of Eligibility. An Active Employee's eligibility will terminate on whichever of the following dates is applicable:

- (1) on the last day of the calendar month for which he does not qualify under Section 1 of this Article II, except as provided in Sections 3, 5, or 6 of this Article;
- (2) on the date an Active Employee starts performing work that is not pursuant to a recognized Collective Bargaining Agreement in the area covered by the Plan. All contributions credited to the Employee's reserve account will be forfeited if eligibility is lost under this provision;
- (3) on the date of entrance into full-time active duty with the Armed Forces of the United States;
- (4) on the date the Plan is terminated by the Board of Trustees.

(c) Reinstatement of Eligibility

- (1) An Active Employee's eligibility will be reinstated if his reserved account reflects a total of at least 400 hours within the four month period following the termination of his previous eligibility. Such reinstatement will be effective on the first day of the second calendar month which follows the month in which this requirement is met.

If the Active Employee is not reinstated within a four month period, any hours remaining in his reserve account at the time of termination of his eligibility will be cancelled, and his eligibility can only be reinstated by satisfying the eligibility requirements as outlined in Section 1(a)(1)(ii) of this Article.

- (2) If an Active Employee enters full-time active duty with the Armed Forces of the United States, and subsequently returns to work for an Employer within 90 days from his discharge date, he will be eligible on the first day of such re-employment, and he is to be credited with any hours held in his reserve account at the time of entrance to active duty.

If work is not commenced for an Employer within 90 days after his discharge date, his eligibility can only be reinstated by satisfying the eligibility requirements as outlined in Section 1(a)(1)(ii) of this Article.

(d) Reciprocity. The Trust Fund is a party to the International Reciprocal Agreement. Under this agreement, if an Active Employee is working temporarily under the jurisdiction of another union local that is a party to the reciprocity agreement, any contributions made on the Active Employee's behalf to the Trust Fund covering that local will be transferred to the Active Employee's Home Trust Fund in order to maintain eligibility of benefits.

- (1) In order to participate in the reciprocity program, the Active Employee must, before he begins working in the jurisdiction of another union local, obtain a health and welfare transfer authorization.
- (2) The health and welfare transfer authorization must be submitted to the union local in whose jurisdiction the Active Employee is now working within thirty-five (35) days of the date he began work in that jurisdiction.
- (3) If an Active Employee has already established eligibility and incurred claims under this Trust Fund, he may not designate another Trust Fund as his Home Fund unless he transfers his union membership to a local not covered by the Home Fund.

Section 2. Dependents.

- (a) Eligible Dependents are defined in Article I, Section 8.
- (b) Termination of Eligibility for Dependents. The eligibility of a Dependent of an Active Employee will terminate on the earliest of the following dates:
 - (1) on the date the Active Employee's eligibility terminates, or in the event of the death of the Active Employee, on the date his eligibility would have terminated but for his death;
 - (2) on the date of entrance into full-time active duty with the Armed Forces of the United States;
 - (3) on the date he no longer qualifies as a Dependent, as defined in Section 8 of Article I;
 - (4) on the date the Plan ceases to provide Dependent coverage.
- (5) Domestic partner eligibility terminates on the date the domestic partner fails to meet the definition described in Section 8(a) of Article I, or the date shown on a signed Declaration Dissolution of the Partnership, which must be submitted to the Fund.

(c) Special Enrollment Rights.

- (1) Other Health Coverage. If a Covered Employee declines enrollment for an eligible Dependent(s) because the Dependent is covered under another group health plan, the Dependent may be eligible to be enrolled in this Plan in the future provided that enrollment in this Plan is requested within 30 days after the other coverage ends.
- (2) New Dependents. If a Covered Employee acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the new Dependent may be eligible to enroll in this Plan provided that enrollment in this Plan is requested

within 30 days after the marriage, birth, adoption, or placement for adoption. Coverage will become effective as of:

- (i) In the case of marriage, the first day of the month following the completed request for enrollment.
 - (ii) In the case of birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption.
 - a. The Covered Employee must pay any required contribution for a Dependent child's coverage.
 - b. A child is placed for adoption on the date the Covered Employee first becomes legally obligated to provide full or partial support of the child. A child who is placed for adoption with a Covered Employee within 30 days after the child was born will be covered from birth if the Covered Employee complies with the Plan's requirements for obtaining coverage for a newborn Dependent child. If the child is placed for adoption and the adoption does not become final, coverage for that child will terminate as of the date the Covered Employee no longer has a legal obligation to support the child.
- (d) Qualified Medical Child Support Orders. Dependent child(ren) will be recognized as eligible Dependent(s) if a divorce decree or other order of the court stipulates that the Covered Employee is responsible for the child's medical bills or must maintain health coverage for the child. The decree or order must satisfy the legal requirements pertaining to Qualified Medical Child Support Orders (QMSCO). The Plan has procedures to determine whether the order or other document is a QMSCO. A copy of the divorce decree and/or support order must be on file in the Trust Fund Office and the child must be enrolled as a Dependent in the Plan. Pursuant to the QMSCO, a child may be enrolled in the Plan by the non-Employee parent or the appropriate state agency.

Section 3. Non-Medicare Retired Employees.

- (a) A Non-Medicare individual who retires on or after May 1, 1988, and was eligible for benefits during all of the six months prior to his retirement, and receives a Regular Pension or Disability Pension, as defined in the Rules and Regulations of the Brick Masons' Pension Trust, or who retires on or after November 1, 2007 and is eligible for benefits under any retirement plan sponsored by the Union, may continue health care benefits as described in Section 5 of this Article, provided he was covered under the Active Plan as described in Section 3 (b) below. After the individual retires, upon the exhaustion of his reserve account, he will be asked to elect one of the aforementioned plans, once he has made his selection, he may not change to the other plan.
- (b) The Retiree Plan consists of the medical and prescription drug benefits described in Article VI, Section 1 and the hearing aid benefits described in Article XI only. It does not include life insurance, accidental death and dismemberment, loss of time, dental or vision benefits. If the individual selects the Retiree Plan, coverage will start as of the date pension benefits start, or after the number of hours in his reserve account falls below

100, whichever is later. The Retired Employee will maintain coverage under the Retiree Plan by remitting self-payment premiums by the 15th day of the month before the month for which coverage is desired. Individuals who select the Retiree Plan and have residual hours left in their reserve account, but not enough for a full month of eligibility under the Active Plan, will be able to use these residual hours to subsidize their first month of retiree self-payment premiums. The amount of the subsidy will be:

$$\frac{(\text{residual hours}) \times (\text{retiree monthly self-payment premium rate})}{(\text{monthly reserve account deduction})}$$

- (c) Coverage under the Retiree Plan will cease on the earliest of the following dates:
 - (1) The date the Retired Employee ceases to be eligible for pension benefits;
 - (2) The date the Fund ceases to provide such coverage;
 - (3) The date the Retired Employee ceases to pay premiums;
 - (4) The date the Retired Employee becomes covered under another group health plan;
 - (5) The date the Retired Employee becomes eligible for Medicare.
- (d) The Retired Employee may also continue his Dependents' benefits, if they are eligible under the Retiree Plan, or they may elect the special continuation coverage. Dependent benefits will terminate on the earliest of the following dates:
 - (1) The date the Fund ceases to provide such coverage.
 - (2) The date the Dependent becomes covered under another group health plan.
 - (3) The date the Dependent ceases to qualify as a Dependent.
 - (4) The date the Retired Employee's coverage terminates, except that when the Retired Employee becomes eligible for Medicare, the benefits for his eligible Dependent(s) may be continued until the earlier of (a) the date the Dependent becomes eligible for Medicare, or (b) the date the Dependent ceases to qualify as a Dependent.
- (e) If the benefits of a Dependent covered under the Retiree Plan terminate due to one of the qualifying events listed in Section 5(a) of this Article, that Dependent will then be eligible to continue Retiree Plan Benefits under the Special Continuation Coverage as described in Section 5.

Section 4. Mason Finisher.

A Mason Finisher, as defined under the Collective Bargaining Agreement, will be covered when he or she meets the eligibility requirements set forth in Section 1 of this Article II, above. The Mason Finisher's coverage, however, will be limited as follows:

- (a) Unlike Active Employees, a Mason Finisher may only enroll in the Fee-For-Service Medical Plan (i.e., Articles III, IV, V, VI) and Fee-For-Service Dental Plan (i.e., Article VIII); and
- (b) The Fund will not cover Dependents of Mason Finisher under any circumstances.

Section 5. COBRA Continuation Coverage.

- (a) Under federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if a Covered Employee or his Dependent ceases to be eligible due to one of the following “Qualifying Events,” he may continue certain health care benefits through self-payment.
 - (1) Termination of employment (except for gross misconduct) or loss of eligibility due to reduced hours;
 - (2) The death of the Covered Employee;
 - (3) Divorce or legal separation;
 - (4) A dependent child loses Dependent status;
 - (5) A dependent loses coverage due to the Covered Employee eligibility for Medicare.

The Covered Employee or Dependent may continue medical and prescription drug benefits, or medical, prescription drug, dental and vision care benefit, if he was covered under the Plan for Active Employees. HMO coverage may also be continued. Life insurance and accidental death and dismemberment insurance benefits may not be continued.

- (b) If the Qualifying Event is that one described in Section 5(a)(1), coverage may be continued for 18 months. If a second Qualifying Event occurs, the continuation period for Dependents may be extended, but not beyond a total of 36 months.
- (c) If the Qualifying Event is that one described in Section 5(a)(2), (3), (4) or (5), coverage may be continued for 36 months.
- (d) If the Qualifying Event is the termination of employment, the reduction of work hours, or the death of an Employee, the Employer must advise the Plan Administrator of the event within 60 days.
- (e) If the Qualifying Event is a divorce, legal separation, a dependent child’s loss of Dependent status, or a dependent losing coverage due to the Covered Employee becoming eligible for Medicare, the Employee or family member must advise the Plan Administrator of the event within 60 days.
- (f) The Plan Administrator must provide the Employee with additional information about the continuation coverage. Election of continuation coverage must take place within 60 days

after such information is sent. All premiums must be paid within 45 days of the election. Subsequent payments must be received by the 15th day of the month before the month for which coverage is desired. No premium statements will be issued by the Fund.

- (g) The continuation coverage will cease on the earliest of the following dates:
 - (1) The date the maximum extension period has been reached;
 - (2) The date the Fund ceases to provide health care coverage;
 - (3) The date the individual ceases to pay premiums when due;
 - (4) The date the individual becomes covered under another health care plan;
 - (5) The date the individual becomes eligible for Medicare.
- (h) Employees who have residual hours left in their reserve account, but not enough for a full month of eligibility under the Active Plan, will be able to use these residual hours to subsidize their first month of COBRA self-payment premiums. The amount of the subsidy will be:
$$\frac{(\text{residual hours}) \times (\text{COBRA monthly self-payment premium rate})}{(\text{monthly reserve account deduction})}$$
- (i) If an Eligible Individual is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage as outlined in Section 5(b), the Eligible Individual and all Eligible Individuals in the family may be entitled to receive up to an additional 11 months of COBRA coverage. Eligible Individuals who become totally disabled, as determined by the Social Security Administration, while covered by the Plan and prior to the end of the first 60 days of eligibility for this continuation of coverage, and who provide a copy of the Social Security award before the end of the first eligibility period of 18 months, are entitled to extend this coverage for a total of 29 months, although the cost of the coverage may be greater in months 19 through 29.
- (j) If an Eligible Individual is enrolled in a Health Maintenance Organization plan and is receiving COBRA coverage, the Eligible Individual may be entitled to an 18-month extension of coverage under California law (Cal-COBRA), up to a total of 36 months from the date Plan coverage was lost as outlined in Section 5(a)(1). Premium payments for extended coverage (months 19 through 36) will be higher than standard COBRA coverage.
- (k) If while receiving COBRA coverage, a Covered Employee acquires a new Dependent through marriage, birth, adoption or placement for adoption, the Dependent(s) may be enrolled for the remainder of the Covered Employee's COBRA coverage period provided that notice is given to the Trust Fund Office within 30 days of acquiring the new Dependent.

- (l) If a Covered Employee becomes eligible for Trade Adjustment Assistance (TAA) pursuant to the Trade Adjustment Assistance Reform Act of 2002 or is an eligible alternative TAA recipient under the Act, and did not elect COBRA continuation coverage during the 60-day election period that was a direct consequence of the TAA-related loss of coverage, the Covered Employee may elect COBRA coverage (for him/herself and any eligible dependents) during a 60-day period that begins on the first day of the month in which the Covered Employee is determined to be a TAA-eligible individual. The election must be made no later than six months after the date of the TAA-related original loss of coverage. However, the maximum COBRA period is measured from the initial loss of coverage. TAA-eligible individuals can elect coverage for themselves and eligible family members may also elect COBRA continuation coverage.

COBRA continuation coverage elected during the second election period will begin on the first day of the second election period, and not on the date on which coverage originally lapsed. The time between the loss of coverage and the start of the second election period will not be counted for purposes of determining whether the individual has had a 63-day break in coverage (see Section 8 below).

Section 6. Continuation Coverage under USERRA.

If an Active Employee enters full-time active service in the Armed Forces and takes a military leave from work with an Employer, a federal law known as the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) governs eligibility under the Plan as follows:

- (a) If the Active Employee takes military leave for 30 days or less, the Active Employee and any eligible Dependents will continue to be eligible under this Plan.
- (b) If the Active Employee is on military leave for longer than 30 days:
 - (1) The Active Employee may self-pay for continuation coverage for himself or herself and any eligible Dependents for up to 24 months of coverage during active service provided:
 - (i) the Active Employee gives his or her Employer advanced notice of the military leave; and
 - (ii) when the total length of the military leave, when added to prior periods of military leave, does not exceed five years.
 - (2) The Active Employee's eligibility will be reinstated on the day he or she returns to work for a contributing Employer or registers for work with the Union, provided that this occurs within 90 days of discharge from active duty.

Section 7. Coverage During Family and Medical Leave.

- (a) Under a federal law known as the Family and Medical Leave Act (FMLA), a Covered Employee may continue medical, prescription drug, and dental, and vision coverage (but not life insurance, accidental death and dismemberment insurance, and loss of time

benefits) for the Covered Employee and any eligible Dependents subject to the terms of the law.

- (b) Eligibility will continue for the Covered Employee and eligible Dependents until the end of the leave, provided the contributing Employer properly grants the leave under the FMLA and makes payment of the required contributions to the Plan.
- (c) Whether or not the Covered Employee keeps coverage while on FMLA leave, if he or she returns to work promptly at the end of that leave, coverage will be reinstated without any additional limits or restrictions imposed on account of the leave. This is also true for any of Dependents who were covered by the Plan at the time of the leave.
- (d) Any changes in the Plan's terms, rules or practices that went into effect during a FMLA leave will apply to the Covered Employee and Dependents.

Section 8. Certificate of Creditable Coverage.

- (a) Under federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), when an Eligible Individual's coverage ends he or she is entitled by law to, and will be provided with, a certificate of creditable coverage. Certificates of creditable coverage indicate the period of time the Eligible Individual was covered under the Plan (including, if applicable, COBRA coverage), as well as certain additional information required by law. This certificate may be necessary if the Eligible Individual becomes eligible for coverage under another group health plan, or if he or she purchases a health insurance policy within 63 days after coverage under this Plan ends. The certificate is necessary because it may reduce any exclusion for pre-existing conditions that may apply under the new group health plan or health insurance policy.
- (b) This certificate will be provided shortly after this Plan knows, or has reason to know, that coverage (including COBRA coverage) for the Eligible Individual has ended. This certificate will also be provided once the Trust Fund Office receives a request for this certificate, provided that request is received within two years after the later of the date that coverage under this Plan ended or the date COBRA coverage ended.

ARTICLE III. FEE-FOR-SERVICE MAJOR MEDICAL BENEFIT PLAN

Section 1. Definitions.

- (a) **Covered Expenses** – The term “Covered Expenses” refers to the items of medical expense for which Fee-For-Service Medical Benefits may be payable.
- (b) **Contracted Rate** – The term “Contracted Rate” means the established rate paid by the Preferred Provider Organization to its network of PPO-Providers who have agreed to accept this established rate for services provided.
- (c) **Non-PPO Schedule** – The term “Non-PPO Schedule” means a fixed schedule of allowances the Plan will pay for Medically Necessary Covered Expenses received from a Non-PPO Provider. This schedule is based on the 1974 California Relative Value System (CRVS).

Section 2. Managed Care Programs.

The Trust contracts with a Health Management Organization to provide various managed care programs.

- (a) **Preferred Provider Organization (PPO).**
 - (1) The Fund’s Health Maintenance Organization has established a Preferred Provider Organization (PPO) network in which certain Hospitals, Physicians, and other health care providers have agreed to accept a discounted Contract Rate which is typically lower than what the provider would otherwise charge.
 - (2) If an Eligible Individual receives medical services from a PPO network provider, the billed charges will typically be lower than what the provider would otherwise charge.
 - (3) In no case will the Fund nor any Eligible Individual be liable for charges or fees for services in excess of the Contracted Rate charged by any provider in the PPO network for which an established Contracted Rate exists.
- (b) **Pre-admission Review.**
 - (1) If an Eligible Individual is going to schedule an elective, non-emergency hospitalization due to surgery or illness, including pregnancy and complications of pregnancy, the hospitalization must be approved by the Health Management Organization prior to admission.
 - (2) The Eligible Individual or his or her Physician will contact a Coordinator with the Health Management Organization to work out an appropriate treatment plan.

- (3) Emergency hospitalization does not require Pre-admission Review. However, the Health Management Organization must be notified within 48 hours of an emergency admission.
- (c) Concurrent Review and Discharge Planning.
 - (a) While an Eligible Individual is hospitalized, the Health Management Organization will monitor his or her progress.
 - (b) Requests for additional days of hospitalization and other types of services will be evaluated.
 - (c) In the event of catastrophic illness or Injury, the Health Management Organization will help to coordinate post-hospitalization care and suggest alternative treatment where appropriate.
- (d) Second Opinion Programs.
 - (a) If an elective surgery (surgery that is not Medically Necessary to save the life, or is not in response to an urgent medical condition of an Eligible Individual) is recommended by a Physician, a second opinion may be obtained through the Health Management Organization.
 - (b) The Plan will pay for all expenses incurred in connection with obtaining a second surgical opinion.
 - (c) No benefit reduction will apply if an Eligible Individual is hospitalized on a non-emergency basis without obtaining a second opinion.

Section 3. Benefits.

If an Eligible Individual receives therapeutic treatment of an Injury or Sickness, the Plan will, subject to the terms and conditions hereafter stated, pay the following benefits:

- (a) Medically Necessary Covered Expenses: The Plan pays 80% of the Contracted Rate for Covered Expenses provided by a PPO Provider or 60% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider. Non-PPO Covered Expenses for anesthesiology claims are based on 85th percentile of HIAA.
- (b) Physical Therapy, Acupuncture, and Chiropractic Care: The Plan pays 80% of the Contracted Rate for Covered Expenses for physical therapy, acupuncture, and chiropractic care provided by a PPO Provider or 60% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider up to a maximum payable amount of \$35. Benefits are limited to 20 combined visits per year.
- (c) Outpatient Psychiatric Services: The Plan pays 50% of Covered Expenses for psychometric testing and psychotherapy when not confined in a Hospital as a registered bed patient. Covered Expenses for psychometric testing and psychotherapy when not

confined in a Hospital as a registered bed patient will not exceed a daily amount of 50% of covered charges up to a maximum of 50 visits per Calendar Year.

Section 4. Deductible.

The Deductible is the amount of Covered Expenses that must be paid by an Eligible Individual before the Plan will pay benefits.

- (a) The Deductible for each Eligible Individual is \$250. The Deductible must be satisfied each Calendar Year.
- (b) Any Covered Expenses applied to the Deductible in the last three months of the Calendar Year will be applied to the following Calendar Year's Deductible as well.
- (c) Common Accident. If two or more covered family members are injured in the same accident before the Deductible Amount has been satisfied, only one Deductible will apply to Covered Expense incurred for treatment received by all family members due to such accident for the remainder of the Calendar Year.

Section 5. Annual and Lifetime Maximum Benefits.

- (a) Annual Maximum. The annual maximum amount payable for each Eligible Individual for benefits under the Fee-For-Service Medical Plan is \$100,000.
- (b) Lifetime Maximum. The lifetime maximum amount payable for each Eligible Individual for benefits under the Fee-For-Service Medical Plan is \$500,000.

Section 6. Covered Expenses.

Covered Expenses include charges for the following services, supplies, and treatments which are certified by a licensed Doctor to be Medically Necessary:

- (a) Hospital Care:
 - (1) Daily room charge in a Hospital for:
 - (i) semi-private room;
 - (ii) private room, not to exceed the Hospital's average charge for semi-private room accommodations;
 - (iii) intensive care or coronary care unit, not to exceed two times the Hospital's most common charge for semi-private room accommodations; and
 - (2) General nursing care and charges for other Hospital services and supplies necessary for treatment of Injury or Sickness.
- (b) Extended Care Facility. Extended Care Facility room, board and general nursing care which commences within seven days after a period of at least five days confinement in a

Hospital, excluding that part of the Extended Care Facility's daily charge in excess of the charge for its most prevalent semi-private room rate and any charges incurred after the 60th day of confinement during any disability.

- (c) Treatment by a licensed Physician or podiatrist, including assistant surgeon and anesthetist; charges for the services of an assistant surgeon will be paid at a maximum of 20% of the amount paid to the primary Surgeon. An assistant surgeon is considered Medically Necessary when a procedure is at a level of technical surgical complexity that the assistance of another Surgeon is required. An assistant surgeon is not considered Medically Necessary when the assistance required is of a manual nature, and can be provided by non-Surgeon, paramedical personnel. Paramedical personnel include R.N.s, L.P.N.s, operating room technicians, and physician assistants. Services of surgical assistants (paramedical personnel) are included in the operating room facility charges and are not eligible for separate benefits.
- (d) Treatment by a licensed chiropractor, acupuncturist, or physical therapist paid at the appropriate PPO/Non-PPO percentage up to a maximum payable amount of \$35 per visit and limited to 20 combined visits per year.
- (e) Services of a Registered Nurse, provided that the services rendered require the skill or training of a Registered Nurse.
- (f) Services of a registered physiotherapist, licensed speech pathologist or laboratory technician.
- (g) Anesthesia and its administration.
- (h) Medical care by a Physician, Dentist, or dental Surgeon for a fractured jaw or for Injury to natural teeth, including replacement of such teeth within six months after the date of the accident.
- (i) X-ray or radium treatment, and X-ray and laboratory examinations.
- (j) Professional ambulance service to the Hospital for confinement therein and from the Hospital immediately following such confinement.
- (k) Medical supplies as follows:
 - (1) Drugs and medicines which can be obtained only by a numbered prescription for the specific accident or Sickness for which the patient is being treated (through the Prescription Drug Provider).
 - (2) Blood and blood plasma.
 - (3) Initial artificial limbs and eyes
 - (4) Surgical dressings.

- (5) Casts, splints, trusses, braces, and crutches.
 - (6) Rental of wheel chair, hospital bed, iron lung or other durable medical equipment used exclusively for treatment of Injury or Sickness, not to exceed the reasonable purchase price.
 - (7) Oxygen and rental of equipment for administration or oxygen.
 - (8) Insulin and diabetic supplies and diagnostics (through the Prescription Drug Provider).
- (l) Mental and Nervous disorders, as follows:
- (1) Inpatient treatment of Mental and Nervous Disorders, limited to a lifetime maximum of 28 days.
 - (2) Covered charges for convulsive therapy or shock treatment as a result of a mental or nervous disorder shall be paid in the same manner and subject to the same limitations and conditions as any other illness while Hospital confined.
 - (3) While not Hospital confined, covered charges will be paid at 50% of Covered Expenses for home, office, and Hospital visits.
- (m) Charges made by an alcoholism treatment unit, which is under the supervision of a legally qualified Physician. The alcoholism treatment unit must be able to provide medical detoxification, counseling and rehabilitative services. The maximum benefit for alcohol treatment will be limited to a lifetime maximum of 28 days.
- (n) Maternity care for female Employees and Dependent spouses only.
- (1) Covered Expenses will be covered as any other illness.
 - (2) Group health plans and health insurance issuers generally may not, under a federal law known as the Newborns' and Mothers' Health Protection Act of 1996, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarian section. However, federal law generally does not prohibit the Doctor from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Section 7. Limitations.

Major Medical Benefits are subject to the following limitations:

- (a) Charges for psychotherapy or psychometric testing when not confined in a Hospital as a bed patient shall be payable at an amount equal to 50% of Covered Expenses, up to 50 visits each Calendar Year per Eligible Individual.

- (b) Coverage for inpatient treatment of Mental and Nervous Disorders will be limited to 28 days of confinement during the lifetime of the Eligible Individual.
- (c) Coverage for physical therapy, acupuncture, and chiropractic care are paid at 80% of the Contracted Rate for PPO Providers and 60% of the Non-PPO Schedule for Non-PPO Providers up to a maximum of \$35 per visit and 20 combined visits per year.
- (d) Coverage for treatment of alcoholism shall be limited to treatment in an alcoholism treatment unit for a period not to exceed a total of 28 days during the lifetime of the Eligible Individual. The alcoholism treatment unit must be under the direct supervision of a legally qualified Physician, and must be able to provide medical detoxification, counseling and rehabilitative services.
- (e) Medical care by a Doctor, Dentist or oral Surgeon for a fractured jaw or an Injury to natural teeth (including replacement of such teeth) will be covered if the treatment occurs within six months after the date of the accident and the Eligible Individual was covered at the time of the accident.
- (f) Charges for the services of an assistant surgeon (Doctor) shall be limited to a maximum payment equal to 20% of the amount payable to the primary Surgeon (Doctor) performing the surgical procedure.
- (g) Charges in connection with pregnancy for Dependent children are limited to complications of pregnancy. Complications of pregnancy is defined as:
 - (1) Conditions, requiring Hospital confinements (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. Examples are acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. False labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy are not considered “complications”;
 - (2) Non-elective caesarian section;
 - (3) Ectopic pregnancy which is terminated; or
 - (4) Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.
- (h) Treatment of Temporomandibular Joint Dysfunction (TMJ) shall be limited to that which is Medically Necessary, according to accepted medical practices, to alleviate discomfort and/or restore function.

Section 8. Exclusions.

Benefits are not payable for:

- (a) Treatment of any Sickness or Injury for which the covered person is not under the care of a Physician;
- (b) Except in the case of an emergency, Hospital-related expenses which have not been preauthorized;
- (c) Medical examinations, services, or supplies not Medically Necessary for the treatment of an Injury or Sickness;
- (d) Expenses incurred for Experimental procedures; or treatment that is not within accepted medical practices;
- (e) Cosmetic surgery, except operations necessary to repair disfigurement due to an accident occurring while covered or surgical treatment after a mastectomy to assure a symmetrical appearance;
- (f) Any operation or treatment in connection with the fitting or wearing of dentures or for treatment of teeth or gums except (i) Tumors and (ii) treatment rendered within six months of accidental Injury to natural teeth (including their replacement), and (iii) fractures due to an accident occurring while covered under the Plan;
- (g) Charges in connection with pregnancy for other than the Covered Employee or Dependent spouse;
- (h) Charges for routine nursery care; however, any expenses incurred due to the confinement of a newborn dependent child that results from premature birth, abnormal congenital condition, or Sickness or Injury contracted or sustained after birth will be covered;
- (i) Expenses incurred for transplants;
- (j) No Plan benefits will be paid for any of the following Elective Surgeries:
 - (1) Uterine Suspension
 - (2) Sympathectomy (Thoracic or Lumbar)
 - (3) Omentopexy
 - (4) Renal Decapsulation
 - (5) Perirenal Insufflation
 - (6) Hypogastric or Pre-sacral Neurectomy
 - (7) Fascia Lata Stripping

- (8) Excision of Carotid Body
- (9) Ligation of Femoral Vein
- (10) Ligation of Internal Mammory Artery
- (11) Female Circumcision;
- (k) Treatment of drug addiction;
- (l) Charges in connection with acupressure or massage therapy;
- (m) Eye refractions, eye glasses, the fitting of eye glasses, and hearing aids;(See Article XI)
- (n) Vision therapy (orthoptics) unless it is in lieu of a surgical procedure;
- (o) Surgical procedures for the correction of visual refractive problems, including radial keratotomy;
- (p) Charges in connection with orthotics;
- (q) Transportation, except local ambulance services;
- (r) Orthopedic shoes and items which also serve as wearing apparel;
- (s) Charges for non-prescribed drugs and contraceptives;
- (t) Charges for services or supplies paid for under any other benefit provided by this Plan;
- (u) Custodial care, whether received at home, in a skilled nursing facility or Hospital;
- (v) Surgical procedures or treatment to alter a person's sex or reversals thereof;
- (w) Any supplies or services (a) for which no charge is made or the Eligible Individual is not required to pay, or (b) furnished by or payable under any plan or law of any Government or furnished by a Federal, State, County, Parish or Municipal Hospital where there is no legal requirement to pay for such supplies or services, except when this Trust Fund is required by Federal law to provide coverage;
- (x) Expenses incurred for services rendered by a person related by blood or marriage to the Eligible Individual or who ordinarily resides in that person's home;
- (y) Any Injury or Sickness arising out of or in the course of any occupation or employment for compensation, profit, or gain, or for which benefits are provided under any Workers' Compensation act or similar legislation;
- (z) Treatment of Injury or Sickness which is occasioned by war, or act of war, declared or undeclared.

Section 9. Extended Benefits During Total Disability.

If an Eligible Individual is Totally Disabled at the time his coverage terminates, medical benefits will be payable to the same extent as if the coverage had not been terminated, for expense incurred on account of the Sickness or Injury which caused such disability, until the earliest of:

- (a) the date on which the Total Disability ceases;
- (b) the date on which coverage for such person becomes effective, with no limitation as to the disabling condition, under any (i) group, blanket or franchise insurance coverage, (ii) service plan contracts, group practice, individual practice and other pre-payment coverage, (iii) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (iv) any coverage under governmental programs (such as Medicare, Medi-Cal and Medicaid) and (v) any coverage required or provided by any statute;
- (c) the end of the period of 12 months following the date on which coverage on account of the person ceases; or
- (d) upon reaching the annual or lifetime maximum benefit limits of the Plan.

Section 10. Women's Health and Cancer Rights Act of 1998.

In accordance with a federal law called the Women's Health and Cancer Rights Act of 1998, an Eligible Individual who is receiving benefits under the Plan in connection with a mastectomy will be provided coverage in a manner determined in consultation with the attending Physician and the patient for (subject to the terms and conditions of the Major Medical Plan as outlined in Article III):

- (a) All stages of reconstruction of the breast on which the mastectomy was performed;
- (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (c) Prostheses; and
- (d) Treatment of physical complications of the mastectomy, including lymphedemas.

ARTICLE IV. MEDICAL REHABILITATION BENEFIT

Section 1. Benefits.

If an Active Employee or a Dependent, while eligible, suffers any one of the following non-work incurred Injuries which require extensive Hospital and/or medical care the Plan will pay charges incurred for Covered Expenses, subject to the provisions of Article III:

- (a) Spinal Cord Injury: Damage to the spinal cord causing paralysis from waist or neck down;
- (b) Head Trauma: Injury to the head causing fracture of the skull, paralysis, or a long period of unconsciousness;
- (c) Major Burn Injury: Second and third degree burns over 20% or more of the body or on the face;

Section 2. Covered Expenses.

Covered Expenses include charges for the following types of treatment which are certified by the attending Doctor to be necessary for medical rehabilitation treatment, to the extent that the charges do not exceed Reasonable Charges:

- (a) treatment at a Neurological Training Center;
- (b) treatment at a Rehabilitation Center.

Section 3. Limitations.

Medical Rehabilitation Benefits are subject to the following:

- (a) The Eligible Individual must submit a Doctor's written opinion that he or she is totally disabled and unable to work.
- (b) Pre-authorization of treatment must be obtained from the Health Management Organization.

ARTICLE V. PHYSICAL EXAMINATION BENEFIT

Section 1. Benefits.

The Plan will pay benefits for routine physical examinations for an Active Employee and Dependent spouse performed by a licensed Physician as follows:

- (a) up to \$150 of Covered Expenses once per Calendar Year for a Covered Employee or spouse of a Covered Employee once every two years under the age of 35; and
- (b) up to \$150 of Covered Expenses once per Calendar Year for a Covered Employee or spouse of a Covered Employee age 35 and over.
- (c) If any abnormality is discovered as a result of a physical examination, the benefits outlined in Article III will be paid on the same basis as any illness.

Section 2. Covered Expenses.

Covered Expenses are as follows:

- (a) complete history and physical examination;
- (b) X-ray of chest;
- (c) electrocardiogram;
- (d) routine urine analysis;
- (e) CBC and differential;
- (f) blood chemistry screen profile (SMA-26);
- (g) serology and T4;
- (h) pap smears; and
- (i) sigmoidoscopy (if recommended by the Doctor for Eligible Individual over age 40).

Section 3. Limitations and Exclusions.

No benefits are payable for:

- (a) more than one examination per Calendar Year for Covered Employees or a Dependent spouse over the age of 35 or more than one examination every two years for Covered Employees or a Dependent spouse under the age of 35;
- (b) expenses incurred as a result of diagnosed Injury or Sickness;
- (c) any physical examination required for employment;
- (d) any examination for which the Eligible Individual's Employer is required to pay.

ARTICLE VI. FEE-FOR-SERVICE PRESCRIPTION DRUG BENEFIT

Section 1. Benefits.

The Plan contracts with a Pharmacy Benefit Manager to provide prescription drug benefits at network retail pharmacies and through a mail-order program. Benefits will be paid in accordance with the provisions of this Article for expenses (but not to exceed Reasonable Charges) incurred by an Eligible Individual for Medically Necessary drugs and medicines legally obtained from a licensed pharmacist upon the prescription of a currently licensed Doctor, exclusive of drugs or other medications that may be obtained without a prescription even though so prescribed.

Section 2. Copayments.

The Plan will pay the costs of prescription drugs purchased by a Participant through and in accordance with the rules of the provider network, subject to the following copayment amounts payable by the Eligible Individual:

- (a) Retail: Purchases at a participating retail pharmacy (up to a 30-day supply): \$10 for generic drugs, \$20 for formulary brand name drugs, 20% of retail cost for non-formulary brand name drugs.
- (b) Mail Order: Purchases through mail order service (up to a 90-day supply): \$15 for generic drugs, \$30 for formulary brand name drugs, \$45 for non-formulary brand name drugs.

Section 3. Limitations and Exclusions.

No benefits are payable for:

- (a) Any drugs not Medically Necessary to treat an Injury or Sickness;
- (b) Drugs or medicines purchased or received prior to the Covered Individual's initial eligibility or after the Covered Individual's eligibility for benefits terminates;
- (c) Medications received or consumed while in a licensed hospital or facility;
- (d) Medications prescribed for experimental or non-FDA approved indications;
- (e) Charges for non-prescription drugs;
- (f) Charges for services or supplies paid for under any other benefit provided by this Plan;
- (g) Any supplies or services (a) for which no charge is made or the Eligible Individual is not required to pay, or (b) furnished by or payable under any plan or law of any Government or furnished by a Federal, State, County, Parish or Municipal Hospital where there is no legal requirement to pay for such supplies or services, except when this Trust Fund is required by Federal law to provide coverage;

- (h) Any drugs for the treatment for an Injury or Sickness arising out of or in the course of any occupation or employment for compensation, profit, or gain, or for which benefits are provided under any Workers' Compensation act or similar legislation;
- (i) Drugs for the treatment of an Injury or Sickness which is occasioned by war, or act of war, declared or undeclared;
- (j) Cosmetic agents and photo-aged skin products;
- (k) Hair growth agents;
- (l) Injectable cosmetic agents;
- (m) Tretinoin agents used for treatment for acne;
- (n) Depigmentation or bleaching agents;
- (o) Contraceptives;
- (p) Fertility drugs;
- (q) Yohimbine for impotence;
- (r) Injectable drugs except impotence injectables, Remicade, Xolair, Humira;
- (s) Drugs for weight management;
- (t) Serums, toxoids, and vaccines;
- (u) Fluoride dental products;
- (v) Smoking cessation products;
- (w) Prescription drugs with equivalent over-the-counter products;
- (x) Non-insulin syringes;
- (y) Ostomy supplies;
- (z) Diagnostic tests (with exception of diabetic testing);
- (aa) Homeopathic medications;
- (bb) Durable Medical Equipment except respiratory therapy supplies and peak flow meters;
- (cc) Vitamins and dietary supplements (including vitamins with fluoride).

Section 4. Medicare Part D.

- (a) As of January 1, 2006, Medicare prescription drug coverage is available to everyone with Medicare. This coverage is known as Medicare Part D. Eligible Individuals who are Medicare-eligible and/or Dependents who are age 65 or older or are disabled and are receiving Social Security disability benefits may be eligible for this coverage.
- (b) The Fund has determined that the prescription drug coverage offered under this Article is, on average for all Plan participants, expected to pay out as much or more as the standard Medicare prescription drug coverage benefit, i.e., it is equivalent on a gross basis to Medicare Part D coverage. This means that an Eligible Individual can keep his or her coverage through the Fund and not pay extra if he or she later decides to enroll in Medicare Part D coverage.
- (c) If an Eligible Individual who is eligible for Medicare Part D chooses to enroll in a Medicare prescription drug plan in lieu of prescription drug coverage through the Fund, he or she will need to pay a monthly Medicare Part D premium to pay for similar benefits already provided by the Fund. Enrolling in a Medicare prescription drug plan will also cancel the Eligible Individual's medical, prescription drug, dental and vision benefits, since these benefits are offered under a combined basis.
- (d) If a Covered Employee retires or loses prescription drug coverage through the Fund, and does not enroll in Medicare prescription drug coverage after the Plan's coverage ends, the Eligible Individual may have to pay more to enroll in Medicare prescription drug coverage later. If an Eligible Individual goes for 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, the monthly Medicare Part D premium will increase by at least 1% per month for every month after that he or she did not have that coverage. This higher premium applies as long as the Eligible Individual is enrolled in Medicare.

ARTICLE VII. HEALTH MAINTENANCE ORGANIZATION (HMO) BENEFITS

Section 1. Kaiser Permanente.

Active and Retired Employees and their Dependents may enroll in the Kaiser Permanente HMO plan if they reside in the Kaiser service area. If a Covered Employee enrolls in the Kaiser Permanente plan, Kaiser Permanente will provide, subject to the terms and conditions of its agreement with the Fund, medical and prescription drug benefits and services as set forth in the aforementioned agreement. If a Covered Employee enrolls in the Kaiser Plan, benefit materials outlining the benefits and services, including the limitations and exclusions and claims and appeals procedures, will be furnished, free of charge, as a separate document.

Section 2. PacifiCare.

Active Employees and their Dependents may enroll in the PacifiCare HMO plan if they reside within 30 miles of the PacifiCare facility they wish to use (Retired Employees and their Dependents are not eligible for coverage in the PacifiCare plan). If a Covered Employee enrolls in the PacifiCare Plan, PacifiCare will provide, subject to the terms and conditions of its agreement with the Fund, medical and prescription drug benefits and services as set forth in the aforementioned agreement. If a Covered Employee enrolls in the PacifiCare plan, benefit materials outlining the benefits and services, including the limitations and exclusions and claims and appeals procedures, will be furnished, free of charge, as a separate document.

Section 3. Default Enrollment in Fee-For-Service Plan.

If no medical plan selection is made at the time of initial eligibility or reinstatement of eligibility, Covered Employees and their Dependents, if any, will be enrolled in the Fee-For-Service Medical Plan.

ARTICLE VIII. FEE-FOR-SERVICE DENTAL BENEFIT

Section 1. Definitions.

- (a) **Covered Dental Expense** – The term “Covered Dental Expense” means only expenses incurred for necessary treatment which is received by an Active Employee or his Dependent from a Dentist or a dental hygienist under the supervision of a Dentist and which, in the geographical area where treatment is rendered, is the usual and customary procedure for the condition being treated. However, the amount allowable as Covered Dental Expense will not exceed the amount specified in the Schedule of Dental Allowances for the procedure reported on any an attending Dentist’s statement. A Covered Dental Expense is deemed to be incurred on the date on which the service or supply which gives rise to the expense is rendered or obtained.

Section 2. Benefits.

If an Active Employee or his Dependent incurs Covered Dental Expense, the Plan will pay for the treatment, examination or procedure, but not more than 80% of the Covered Dental Expense or the Dentist’s Reasonable Charge, whichever is less.

The maximum amount payable hereunder for Covered Dental Expense incurred by each Active Employee or Dependent in any Calendar Year shall be \$1,000.

If benefits are payable under this benefit and the Fee-For-Service Medical Plan, payment will be made only under the plan which allows the greater payment.

Section 3. Schedule of Dental Allowances.

Subject to the Limitations and Exclusions hereinafter contained in Sections 5 and 6 of this Article, the Plan uses a Schedule of Dental Allowances which is updated periodically by the Board of Trustees. Copies of the current Schedule is available from the Trust Fund Office.

Section 4. Covered Expenses.

The following expenses are covered when rendered by a Dentist or a dental hygienist under the supervision of a Dentist, and when necessary and customary, as determined by the standards of generally accepted dental practice:

- (a) Routine examinations and/or prophylaxis, if performed by a Dentist or dental hygienist, once every six months.
- (b) Bitewing X-rays once every six months and complete mouth X-rays once every three years, unless additional X-rays are necessary.
- (c) Topical application of fluoride.
- (d) Space maintainers.
- (e) Restorative services:

- (1) Amalgam, synthetic porcelain and plastic fillings; or
 - (2) Gold restorations, crowns and jackets when teeth cannot be restored with the above materials.
- (f) Root canal therapy.
 - (g) Periodontal treatment (treatment of the tissues supporting the teeth).
 - (h) Extractions and other oral surgery, including anesthesia and pre- and post-operative care.
 - (i) Partial dentures and bridges.
 - (j) Initial complete dentures.
 - (k) Replacement of complete dentures.

Section 5. Limitations.

The benefits as outlined are subject to the following limitations:

- (a) Complete mouth X-rays are provided only once in a three year period, unless special need is shown. Supplementary bite-wing X-rays are provided only once in a six-month period, unless special need is shown.
- (b) Replacement of an existing prosthodontic appliance will be made only if it is unsatisfactory and cannot be made satisfactory. Partial crowns and bridges will be replaced only after three years have elapsed following any prior provision of such appliances for which a benefit was paid to the Eligible Individual by the Plan.
- (c) In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, the Plan will pay the applicable percentage of the lesser fee. The Eligible Individual shall be responsible for the remainder of the Dentist's fee.
 - (1) Partial Dentures. The Plan considers as Covered Dental Expense the Reasonable Charges for standard cast chrome or acrylic partial dentures. However, the Plan will allow the cost of such procedure to be applied toward a more complicated or precision appliance that the Eligible Individual and Dentist may choose to use. Any Denture for which a charge is made which exceeds the Reasonable Charges shall be considered an optional service and the provisions of (c), above, shall apply.
 - (2) Complete Dentures. If in the construction of a denture the Eligible Individual and Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the Plan will allow an appropriate amount for the standard denture toward such treatment and the Eligible Individual shall bear the difference in cost. Any denture for which a charge is made which exceeds the

customary fee shall be considered an optional service and the provisions of (c), above, shall apply.

- (3) Occlusion. The Plan will allow the cost of restorations required to replace missing teeth. Procedures, appliances, or restorations necessary to increase vertical dimension and/or restore or maintain the occlusion are considered optional, and the cost is the responsibility of the Eligible Individual. Such procedures include, but are not limited to: equilibration, periodontal splinting, restoration of tooth structure lost from attrition, and restoration for malalignment of the teeth.
- (4) Implants. If implants are utilized, the Plan will allow the cost of a standard complete or partial denture toward the cost of implants and appliances constructed in association therewith. The Plan will not allow the cost of surgical removal of implants.
- (d) Payment of Covered Dental Expense incurred as a result of tumors and accidental Injury occurring while covered under the Plan shall be made only for such expenses actually incurred in excess of all other benefits provided under the provisions of these Rules and Regulations.

Section 6. Exclusions.

In addition to the General Exclusions and Limitations contained in Article XIII, no benefits shall be provided for:

- (a) Services with respect to congenital or developmental malformations or cosmetic surgery or dentistry for cosmetic reasons, including but not limited to: cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, and anodontia;
- (b) Orthodontic services, including the correction of malocclusion; appliances or restoration necessary to increase vertical dimension;
- (c) Dietary planning, oral hygiene instruction or training in preventive dental care;
- (d) The replacement of any prothodontic appliance (including partial and complete dentures, crowns and bridges) which was covered under these Dental Benefit provisions, either as an initial complete denture or as a replacement, if such replacement occurs within three years from the date expense was incurred for such denture, unless the replacement is made because of the existing appliance is unsatisfactory and cannot be made satisfactory;
- (e) Services and supplies provided for the treatment of Temporomandibular Joint Dysfunction (TMJ);
- (f) Prescription Drugs;
- (g) Treatment of any condition for which the covered person is not under the care of a Dentist;

- (h) Any procedure which commenced before the date the person became eligible under this Dental Benefit;
- (i) Expenses incurred for Experimental procedures, or treatment that is not within accepted dental practice;
- (j) Expenses incurred for services rendered by a person related by blood or marriage to the Eligible Individual or who ordinarily resides in that person's home;
- (k) Any condition arising out of or in the course of any occupation or employment for compensation, profit, or gain, or for which benefits are provided under any Workers' Compensation act or similar legislation;
- (l) Treatment of any condition which is occasioned by war or act of war, declared or undeclared;
- (m) Any supplies or services (1) for which no charge is made or the Eligible Individual is not required to pay, or (2) furnished by or payable under any plan or law of any Government or furnished by a Federal, State, County, Parish or Municipal Hospital where there is no legal requirement to pay such supplies or services, except when this Trust Fund is required by Federal law to provide coverage.
- (n) Treatment of any condition that results from non-therapeutic release of nuclear energy.
- (o) Claims not submitted within one year of the date they were incurred, except in the absence of legal capacity. Additional information requested by the Administrative Office on behalf of the Board of Trustees that is not submitted in a timely manner may delay or deny payment.
- (p) Replacement of prosthesis, except a crown necessary for restorative purposes only, for which benefits were paid under this Plan if the replacement occurs within five years from the date the expense was incurred, unless (a) the replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural teeth, or (b) the prosthesis is a stayplate or similar temporary partial prosthesis, and is being replaced by a permanent prosthesis, while in the oral cavity, has been damaged beyond repair as a result of injury while covered.
- (q) Procedures which are necessary solely to increase vertical dimension, or restore the occlusion.

If benefits are also payable under the Fee-For Service Medical Benefit Plan, payment will be made only under the Plan that allows the greater payment.

Section 7. Extended Benefits.

If an Eligible Individual is receiving treatment for services required for the completion of a procedure which is considered a Covered Dental Expense at the time his coverage hereunder terminates, Dental Benefits will be payable for such expense, but not beyond 30 days after termination of coverage.

ARTICLE IX. PREPAID DENTAL BENEFITS

Section 1. United Concordia.

Active Employees and their Dependents may enroll in the United Concordia dental plan if they reside in the United Concordia service area. If a Covered Employee enrolls in the United Concordia plan, United Concordia will provide, subject to the terms and conditions of its agreement with the Fund, dental and orthodontic benefits and services as set forth in the aforementioned agreement. If a Covered Employee enrolls in the United Concordia plan, documents outlining the benefits and services, including the limitations and exclusions and claims and appeals procedures, will be furnished, free of charge, as a separate document.

Section 2. Default Enrollment in Fee-For-Service Dental Plan.

If no dental plan selection is made at the time of initial eligibility or reinstatement of eligibility, Covered Employees and their Dependents, if any, will be enrolled in the Fee-For-Service Dental Plan.

ARTICLE X. VISION CARE BENEFITS

Section 1. Benefits.

If an Active Employee or his Dependent obtains optometric services, Vision Service Plan (VSP) will provide, subject to the terms and conditions of its agreement with the Fund, benefits and services as set forth in the aforementioned agreement. If a Covered Employee enrolls in the VSP plan, documents outlining the benefits and services, including the limitations and exclusions and claims and appeals procedures, will be furnished, free of charge, as a separate document.

ARTICLE XI. HEARING AID BENEFIT

Section 1. Benefits.

If an Eligible Individual incurs expenses for one or more hearing aids that are certified by a Doctor to be necessary, the Fund will pay for the hearing aid(s), up to a maximum of \$1,200 per three-year period, with a \$50 deductible. The three-year period begins on the day a covered hearing aid claim is incurred.

Section 2. Exclusions.

No benefits are payable for (a) cleaning, repair and maintenance of a hearing aid; (b) batteries; and (c) replacement of a lost, stolen or broken hearing aid for which payment was made under this benefit.

ARTICLE XII. LOSS OF TIME BENEFIT

Section 1. Benefits.

If an Active Employee, while eligible, becomes totally disabled and unable to work as a result of Sickness or accidental Injury occurring on or off the job, the Plan will pay (subject to the provisions hereinafter stated) to the Active Employee a weekly benefit of \$25 (subject to federal and state taxes). The payment of such benefit is contingent upon the Employee's proof of entitlement to either California Unemployment Compensation Disability benefits or Workers' Compensation benefits, regardless of whether or not the Employee has insufficient earnings or has exhausted his U.C.D. or Workers' Compensation benefits.

Section 2. Payment of Benefits.

Payments begin with the first day of disability due to an accident and eighth day of disability due to Sickness. For each day during partial weeks of disability, payment will be one-fifth of the weekly benefit. The maximum number of weeks payable will be thirteen weeks per disability.

Section 3. Period of Disability.

For purposes of this Article XII only, successive periods of disability will be considered one period of disability unless the subsequent disability is due to an Injury or Sickness entirely unrelated to the causes of the previous disability and commences after return to active work for an Employer at least one full working day.

Section 4. Limitations.

- (a) The Loss of Time Benefit will not be provided unless the Active Employee is able to furnish proof of eligibility for Unemployment Compensation Disability or Workers' Compensation benefits, even if he has insufficient earnings or has previously exhausted these benefits.
- (b) A disability will be deemed to have begun on the date the Active Employee first became disabled, provided that treatment by a Doctor is received within three days of such date. If, however, treatment by a Doctor is not received in accordance with the foregoing, a disability will be deemed to have begun three days before such first treatment.

ARTICLE XIII. GENERAL EXCLUSIONS AND LIMITATIONS

Section 1. Exclusions.

The Fund shall not provide any benefits for:

- (a) any bodily Injury or Sickness for which the Eligible Individual is not under the care of a Physician or Dentist;
- (b) any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any workers' compensation or occupational disease law, even though the Eligible Individual fails to claim his or her right to such benefits. If the Fund has made payments for benefits prior to discovering any worker's compensation case, it shall have the right to file a lien for their reimbursement in such proceedings;
- (c) conditions caused by or arising out of an act of war, armed invasion or aggression;
- (d) any supplies or services (1) for which no charge is made; or (2) for which the Eligible Individual is not required to pay, or (3) furnished by a Hospital or facility operated by the United States Government or any authorized agency thereof or furnished at the expense of such Government or Agency; or (4) which are provided without cost by any municipal, county or other political subdivision;
- (e) charges for expenses incurred outside of the United States, unless such expenses are for emergency care received while traveling on business or vacation;
- (f) charges for services received by any Covered Employee or Dependent which are performed by the spouse, domestic partner, child, brother, sister or parent of the Covered Employee or of the Covered Employee's spouse;
- (g) care of treatment of a mentally abnormal or mental disordered sex offender or deviate in any Hospital or facility or any state or political subdivision;
- (h) care or treatment in any penal institution of any state or political subdivision;
- (i) court-ordered hospitalization or treatment;
- (j) conditions arising out of commission of a felony or engagement in an illegal activity;
- (k) conditions caused by or attributable to attempted suicide or intentionally self-inflicted Injury, whether sane or insane; and
- (l) conditions resulting from the non-therapeutic release of nuclear energy.
- (m) Claims not submitted within one year of the date they were incurred, except in the absence of legal capacity. Additional information requested by the Administrative Office

on behalf of the Board of Trustees that is not submitted in a timely manner may delay or deny payment.

Section 2. Limitations.

The Fund shall not be liable to provide benefits for medical services or supplies not reasonably necessary for the care or treatment of bodily Injuries or Sickness or for dental services or supplies not reasonably necessary for dental health. Furthermore, the Fund will not provide benefits for services, treatments or supplies for the care and treatment of bodily Injuries or Sickesses which are in excess of the Reasonable Charges.

ARTICLE XIV. COORDINATION OF BENEFITS

Section 1. Benefits Subject to the Provision.

All benefits provided under these Rules and Regulations, except benefits provided under Article X, XII, XVI, and XVII are subject to the following provisions and limitations.

Section 2. Definitions.

- (a) Plan – For purposes of this Article only, the term “Plan” means (1) group, blanket or franchise insurance, (2) service plan contracts, group practice, individual practice and other pre-payment coverage, (3) labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (4) any coverage under governmental programs, and any coverage required or provided by any statute, except Medicare, which provides benefits or services for medical, or dental care or treatment.
- (b) This Plan – For purposes of this Article only, the term “This Plan” means that portion of the Rules and Regulations which provides Medical, Hospital or Dental benefits.
- (c) Allowable Expense – The term “Allowable Expense” means any necessary, reasonable and customary item of medical or dental expense incurred, a portion of which is covered under one of the Plans covering the Eligible Individual for whom claim is made.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

The Fund shall not be required to determine the existence of any other Plan, or the amount of benefits payable under any Plan other than This Plan. The payment of benefits under This Plan shall be affected by the benefits payable under Plans only if the Fund is furnished with information concerning the existence of such other Plans by the Eligible Individual or insurance company, organization, agency or government or person.

Section 3. Effect on Benefits.

- (a) This provision shall apply in determining the benefits due an Eligible Individual under This Plan for any Claim Determination period if, for the Allowable Expenses incurred by such Eligible Individual during such period, the sum of the benefits that would be payable under This Plan in the absence of this provision, and the benefits that would be payable under all other Plans in the absence in them of similar provisions would exceed such Allowable Expenses.
- (b) When, in accordance with items (c) and (d) of this Section 3, This Plan would determine its benefits after the benefits of another Plan, then the benefits that would be payable under This Plan in the absence of this provision for the Allowable Expenses incurred as to such Eligible Individual shall be reduced to the extent necessary so that the sum of (1) such reduced benefits and (2) all the benefits payable for such Allowable Expenses under all other Plans, shall not exceed the total of such Allowable expenses.

When, in accordance with items (c) and (d) of this Section 3, This Plan would determine its benefits before the benefits of another Plan, then the benefits of This Plan shall not be reduced as provided in the preceding paragraph.

Benefits payable under another Plan include the benefits that would have been payable had claim been duly made for them.

(c) For the purpose of item (b) of this Section 3, the rules establishing the order of benefit determination are:

- (1) The benefits of a Plan which covers the person on whose expense claim is based as an Active, laid-off, or Retired Employee shall be determined before the benefits of a Plan which covers such a person as a dependent;
- (2) The benefits of a Plan which covers the person on whose expense claim is based as an Active Employee shall be determined before the benefits of a Plan which covers such person as a laid-off or Retired Employee;
- (3) The benefits of a Plan which covers the person on whose expense claim is based as a dependent of an Active Employee shall be determined before the benefits of a Plan which covers such person as a dependent of a laid-off or Retired Employee;
- (4) When both Plans cover the person on whose expense claim is based as a dependent child of an Active Employee, or when both Plans cover the person on whose expense claim is based as a dependent child of a laid-off or Retired Employee, the benefits of the Plan which covers the parent whose birthday (month and day only) occurs first during a Calendar Year shall be determined before the benefits of the Plan which covers the parent whose birthday (month and day only) occurs later in the year, except that in the event a father and mother are legally separated or divorced, the following rules shall apply:
 - (i) The benefits of a Plan which covers the person on whose expense claim is based as a dependent child of the parent with financial responsibility for the child's medical expenses by virtue of a court decree shall be determined first;
 - (ii) If there is no court decree, the benefits of a Plan which covers the person on whose expense claim is based as a dependent child of the parent with legal custody shall be determined first;
 - (iii) If there is no court decree and the parent with legal custody has remarried, the order of benefit determination shall be as follows:
 - a. the Plan which covers the parent with legal custody;
 - b. the Plan which covers the step-parent with legal custody; and

- c. the Plan which covers the parent without legal custody.
- (5) When This Plan and another Plan cover the person on whose expense claim is based as a dependent child and such other Plan does not contain the birthday rule as set forth in item (4) of this Section 3, but uses the benefit determination provision which provides that the Plan which covers such person as a dependent child of the father shall be determined before the benefits of a Plan which covers such person as a dependent child of the mother, then This Plan shall also use this benefit determination provision when applicable.
- (d) When the rules set forth in item (c) of this Section 3 do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expense claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.
- (e) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under This Plan, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of This Plan.

Section 4. Right to Receive and Release Necessary Information.

For the purpose of determining the applicability of and implementing the terms of this provision of This Plan or any provision of similar purpose of any other Plan the Fund may, with the consent of the Eligible Individual, release to or obtain from an insurance company or other organization or person any information with respect to any person, which the Fund deems to be necessary for such purposes. Any Eligible Individual claiming benefits under This Plan shall furnish to the Fund such information as may be necessary to implement this provision.

Section 5. Facility of Payment.

Whenever payments which should have been made under This Plan in accordance with this provision have been made under any other Plan, the Fund shall have the right in its sole discretion to pay to any organization making such payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under This Plan and to the extent of such payments, the Fund shall be fully discharged from liability under This Plan.

Section 6. Right of Recovery.

When payments have been made by the Fund with respect to Allowable Expense in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Fund shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Fund shall determine: (1) any persons to or for or with respect to whom such payments were made, or (2) insurance companies, service plans or any other organizations.

Section 7. Coordination with Pre-Paid Plans (Medical and Dental).

If an Eligible Individual is covered under the Fee-For-Service Medical or Dental Plan provided by the Fund in addition to being covered as a dependent under a prepaid plan sponsored by (1) the employer of his or her spouse if the Eligible Individual is the Covered Employee, or (2) the employer of the parent who is the spouse of a Covered Employee if the Eligible Individual is a Dependent under this Plan, the Eligible Individual may receive treatment either from a provider or privately selected Hospital as part of the Fee-For-Service plan or from a provider or Hospital in the prepaid plan. If the Eligible Individual receives treatment through the prepaid plan, the primary coverage under the Fee-For-Service Plan provided by the Fund will pay for all copayments that the individual is legally obligated to pay, not to exceed this Plan's normal benefit.

ARTICLE XV. GENERAL PROVISIONS

Section 1. Proof of Claim.

All Hospital Expense Benefits will be paid by the Fund to the Hospital, or to the Covered Employee upon receipt of proof that the Hospital has been paid, and all other benefits will be paid by the Fund to the Covered Employee as they accrue upon receipt of written proof, satisfactory to the Fund, covering the occurrence, character, and extent of the event for which claim is made.

Section 2. Benefits Not Assignable.

Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person; however, any Covered Employee may direct that benefits due him be paid to an institution in which he or his Dependent is hospitalized, to any provider of medical or dental services and supplies in consideration for medical, dental or Hospital services rendered or to be rendered, or supplies furnished or to be furnished, or to any other person or agency that may have provided or paid for, or agreed to provide or pay for, any benefits payable hereunder.

Section 3. Claim Filing Period.

Benefits will be paid by the Fund only if notice of claim is made within ninety (90) days from the date on which covered expenses were first incurred unless it shall be shown by the Covered Employee not to have been reasonably possible to file a claim within such time limit, but in no event shall benefits be allowed if notice of claim is made beyond one year after the end of the 90-day period.

Section 4. Payment in Absentia.

In the event the Fund determines that the Covered Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Covered Employee has not provided the Fund with an address at which he can be located for payment, the Fund may, during the lifetime of the Covered Employee, pay any amount otherwise payable to the Covered Employee to the husband or wife or relative by blood of the Covered Employee, or to any other person or institution determined by the Fund to be equitably entitled thereto; or in the case of the death of the Covered Employee before all amounts payable under Articles III, IV, V, VI, VIII, X, XI and XII have been paid, the Fund may pay any such amount to any person or institution determined by the Fund to be equitably entitled thereto. The remainder of such amount shall be paid to one or more of the following surviving relatives of the Covered Employee: lawful spouse, child or children, mother, father, brothers or sisters, or to the Covered Employee's estate, as the Board of Trustees in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Fund hereunder to the extent of such payment.

Section 5. Claims and Appeals Procedures.

These claims and appeals procedures apply to new claims filed on or after January 1, 2003.

(a) Applicability.

- (1) These claims and appeals procedures apply to claims for the following benefits provided directly by the Fund (referred to herein as a “claim(s)”):
 - (i) Fee-For-Service Major Medical Benefits (Article III)
 - (iii) Medical Rehabilitation Benefit (Article IV)
 - (iii) Physical Examination Benefit (Article V)
 - (iv) Fee-For-Service Prescription Drug Benefit (Article VI)
 - (v) Fee-for-Service Dental Benefits (Article VIII)
 - (vi) Loss of Time Benefit (Article XII)
 - (vii) Hearing Aid Benefit (Article XI)
 - (2) These claims and appeals procedures are not applicable to the following benefits:
 - (i) HMO Benefits (Article VII)
 - (ii) Vision Care Benefits (Article X)
 - (iii) Prepaid Dental Benefits (Article IX)
 - (iv) Life Insurance Benefits (Article XVI)
 - (v) Accidental Death & Dismemberment Benefits (Article XVII)
- (b) Use of an Authorized Representative. An Eligible Individual, or the authorized representative of an Eligible Individual (collectively referred to herein as the “claimant”), may file a claim or appeal a denied claim. An Eligible Individual may be required to furnish documentation showing that a person is, in fact, an authorized representative.
- (c) Failure to Follow Procedures. If the Fund fails to follow these claims and appeals procedures, and it does not correct the error without prejudice to the Eligible Individual, such individual will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedies under ERISA Section 502(a).
- (d) Types of Claims
- (1) Group Health Claims. A group health claim is a request for medical or dental benefits under Articles III, IV, V, VI, and VIII the Plan or hearing aid benefits under Article XI. There are three subcategories of Group Health Claims:
 - (i) Post-Service Claim. A Post-Service Claim is a claim for which Plan

approval is not required prior to obtaining services and payment is being requested for care already rendered to the Eligible Individual.

- (ii) Pre-Service Claim. A Pre-Service Claim is a claim for which the Plan conditions receipt of the benefit on approval of the benefit in advance of obtaining care (e.g., Medical Rehabilitation Benefit under Article IV and Pre-Admission Review for elective Hospital stays under Article III, Section 2(b)).
 - (ii) Concurrent Claim. A Concurrent Claim is when the Plan has approved an ongoing course of treatment to be provided over a period or a number of treatments, for example, approval of a hospitalization for 3 days (e.g., Concurrent Review under Article III, Section 2(c)).
- (2) Loss of Time Claim. A Loss of Time Claim is a claim for the Loss of Time Benefits described in Article XII of this Plan.

Requests for information about Plan benefits or eligibility are not considered claims unless prior approval is required by the Plan.

- (e) Filing a Claim. All claims must be filed in writing on forms provided by the Plan. Payment of benefits will be made only to the extent provided in the Plan and in accordance with the terms and conditions of the Plan. A claim is considered “filed” when it is received by the Trust Fund Office, regardless of whether it contains all the information necessary to render a decision.

For Pre-Service Claims only: If a claimant fails to properly file a Pre-Service Claim, the claimant must be notified of the failure and the proper procedures for filing the claim within 5 days following the failure. Notification may be oral, unless the claimant requests written notice.

- (f) Review of Claim: Time Frames.

- (1) Post-Service Claim. The claimant must be notified in writing of a denial within 30 days after a claim is filed, unless an extension of time for processing the claim is necessary due to matters beyond the control of the Plan. If such an extension is necessary, the claimant must be notified in writing, prior to the commencement of the extension, of the circumstances requiring the extension and the date by which the Plan expects to render a decision, which will not be more than 45 days from the date the claim was filed.

If the extension is due to the claimant’s failure to submit the information necessary to decide the claim, and the extension notice specifically describes the required information, the claimant must be given at least 45 days from receipt of the extension notice within which to provide such information. The time period for making the decision will be suspended from the date on which the extension notice is sent to the claimant to the earlier of: (i) the date on which the Plan receives the claimant’s response; or (ii) the due date established by the Plan for

the furnishing of the requested information.

- (2) Pre-Service Claim. The claimant must be notified of the decision, whether adverse or not, within 15 days after a claim is filed, unless an extension of time for processing the claim is necessary due to matters beyond the control of the Plan. If such an extension is necessary, the claimant must be notified, prior to the commencement of the extension, of the circumstances requiring the extension and the date by which the Plan expects to render a decision, which will not be more than 30 days from the date the claim was filed.

If the extension is due to the claimant's failure to submit the information necessary to decide the claim, and the extension notice specifically describes the required information, the claimant must be given at least 45 days from receipt of the extension notice within which to provide such information. The time period for making the decision will be suspended from the date on which the extension notice is sent to the claimant to the earlier of: (i) the date on which the Plan receives the claimant's response; or (ii) the due date established by the Plan for the furnishing of the requested information.

- (3) Concurrent Care Decisions. Any reduction or termination by the Plan of an ongoing course of treatment (other than by Plan amendment or termination) before the end of the approved period or number of treatments constitutes a claim denial, and the claimant must be notified of the denial sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a decision on appeal before the benefit is reduced or terminated.
- (4) Loss of Time Claim. The claimant must be notified in writing of a denial within 90 days after the claim is filed, unless special circumstances require an extension of time for processing the claim. If such an extension is required, the claimant must be notified in writing, prior to the commencement of the extension, of the special circumstances requiring the extension and the date by which the Plan expects to render a decision, which will not be more than 180 days from the date the claim was filed.

- (g) Claim Denial Notice. If a claim is denied, in whole or in part, the claimant must be notified of the denial in writing. Such written notice of denial must contain the following:

- (1) The specific reason(s) for the denial;
- (2) Reference to the specific Plan provision(s) on which the denial is based;
- (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (4) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an denial of a claim on appeal.

(5) For Group Health Claims only:

- (i) If applicable, a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of such rule, guideline, protocol, or other criterion will be provided to the claimant, free of charge and upon request.
- (ii) If the denial is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the decision will be provided to the claimant, free of charge and upon request.

(h) Filing an Appeal. Any claimant whose claim is denied, in whole or in part, may file a written appeal with the Board of Trustees within 180 days (60 days for a Loss of Time Claim) after the claimant receives the written notice of denial. An appeal is considered “filed” when it is received by the Trust Fund Office, regardless of whether it contains all the information necessary to render a decision.

The appeal must state in clear and concise terms the reasons for disputing the denial and must be accompanied by any supporting documentary material.

As part of the appeals procedure, the claimant must be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. Furthermore, the claimant must be given the opportunity to submit written comments, documents, records, and other information relating to the claim, which must be considered by the Board, regardless of whether such information was submitted or considered in the initial claims review.

Upon good cause shown, the Board of Trustees shall permit the appeal to be amended or supplemented and shall grant a hearing on the appeal before the Board of Trustees to receive and hear any evidence or argument which cannot be presented satisfactorily by correspondence.

For Group Health Claims only: The Board must not afford deference to the initial review. If a denial was based in whole or in part on a medical judgment, the Board must consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional must not be the individual who was consulted in connection with the initial claim denial, nor the subordinate of any such individual. Furthermore, the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of the claim must be identified, even if the advice was not relied upon in denying the claim.

(i) Review of Appeals: Time Frames

- (1) Post-Service Claims. The Board, which meets quarterly, must make a decision no later than the date of the first such meeting which occurs at least 30 days after an appeal is filed, unless special circumstances require an extension of time for

review. If such an extension is required, the claimant must be notified in writing, prior to the commencement of the extension, of the special circumstances requiring the extension and the date as of which the decision will be rendered, which will be no later than the third meeting of the Board after the appeal is filed. If, however, the extension is due to the claimant's failure to submit the information necessary to decide the appeal, and the extension notice specifically describes the required information, the claimant must be given at least 45 days from receipt of the extension notice within which to provide such information. The time period for making the decision will be suspended from the date on which the extension notice is sent to the claimant to the earlier of: (i) the date on which the Fund receives the claimant's response; or (ii) the due date established by the Plan for the furnishing of the requested information, which must be specified by the Plan, and be at least 45 days from the date of the notification.

The claimant must be notified within 5 days after the Board makes its decision.

- (3) Pre-Service Claims. The claimant must be notified of the decision, whether adverse or not, within 30 days after the appeal is filed.
- (4) Loss of Time Claims. The Board, which meets quarterly, must make a decision no later than the date of the first such meeting which occurs at least 30 days after an appeal is filed, unless special circumstances require an extension of time for processing. If such an extension is required, the claimant shall be notified in writing, prior to the commencement of the extension, of the special circumstances requiring the extension and the date by which the decision will be rendered, which shall be no later than the third regular meeting following the date the appeal was filed.

If the reason for taking the extension is to obtain additional information from a claimant, the decision will be made by the later of: (1) the third regular meeting following the date the appeal was filed; or (2) the first regular meeting that is at least 30 days after the claimant responds. If, after a reasonable period of time, but not less than 90 days, the claimant has not responded to a request for additional information, the Board may decide the appeal, provided the claimant is notified in writing at least 60 days before the decision on review is made that such decision will be made regardless of whether the claimant responds.

The claimant shall be notified of the decision on review within five (5) days after it is made.

- (j) Appeal Denial Notice. If a claim is denied on appeal, in whole or in part, the claimant must be notified of the denial in writing. Such written notice of denial must contain the following:
 - (1) The specific reason(s) for the denial of the claim on appeal.
 - (2) Reference to the specific Plan provision(s) on which the denial on appeal is based.

- (3) 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 claim.
- (4) A statement of the claimant's right to bring an action under ERISA Section 502(a).
- (5) For Group Health Claims only:
 - (i) If applicable, a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of such specific rule, guideline, protocol, or other criterion will be provided to the claimant, free of charge and upon request.
 - (ii) If the denial is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the decision will be provided to the claimant, free of charge and upon request.
- (k) The claimant's failure to timely file a claim or an appeal within the appropriate time periods shall constitute a waiver of the claimant's right to file a claim or appeal a denied claim, as the case may be, provided that the Board of Trustees may relieve a claimant of any such waiver for good cause if application for such relief is made within one year after the date shown on the notice of action on his claim or appeal.
- (l) No claimant or other person shall have any right or claim to benefits under this Plan, or any right or claim to payments from the Fund, other than as specified herein. The denial of a claim as to which the right to review has been waived, or the decision of the Board of Trustees with respect to an appeal, shall be final and binding upon all parties, subject only to judicial review as provided under ERISA. No action may be brought for benefits provided by the Plan, or to enforce any right under the Plan, until after a claimant has exhausted the administrative remedies available under the Plan, and thereafter, the only action that may be brought is one to dispute the decision of the Board. The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a participant or beneficiary of the Plan within the meaning of those terms as defined in ERISA.

Section 6. Physical Examination and Autopsy.

The Fund, at its own expense, shall have the right and opportunity to examine the person of any Eligible Individual when and so often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law. Proof of claim forms, as well as other forms, and methods of administration and procedure will be solely determined by the Fund.

Section 7. 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 Law or similar legislation.

Section 8. Relationship to Trust Agreement.

The provisions of these Rules and Regulations are subject to and controlled by the provisions of the Trust Agreement, and 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 shall prevail.

Section 9. Subrogation and Third Party Reimbursement

If an Eligible Individual is injured through the act or omission of another, other than his Employer, under the Plan's subrogation policy, the Plan has the legal right to be reimbursed in full for all medical and other benefits paid by it to, or on behalf of, any Eligible Individual to the extent the Eligible Individual has recovered or has a legal right to recover proceeds in connection with any judgment, compromise, settlement or other wise from:

- (a) a person responsible for the Injury, Sickness or condition;
- (b) an insurance company of the responsible person;
- (c) the Eligible Individual's own liability insurance carrier.

When a claim is filed for medical or other benefits in connection with an Injury, Sickness, or condition arising from an accident, the Plan will pay all benefits provided by the Plan. However, those benefits will be paid only after the Eligible Individual has signed, notarized and returned a Reimbursement Agreement giving the Plan full rights if recovery against all persons who, or insurance companies which may, be liable for the same expenses.

The Trustees expect full compliance with the Plan's reimbursement policy and with the Reimbursement Agreement. Therefore, the Trustees reserve the right to withhold future medical payments from an Eligible Individual where the Eligible Individual has obtained a recovery from another source, as described above, but has not reimbursed the Plan as required. Future benefits will be withheld in an amount equal to the amount previously owed the Plan until such time as the Plan's claim for reimbursement has been completely satisfied. The Trustees also reserve the right to file suit against any Eligible Individual who fails to comply with the terms of the Plan or of the Reimbursement Agreement.

ARTICLE XVI. LIFE INSURANCE BENEFITS

Section 1. If an Active Employee or Dependent dies from any cause, the life insurance company will pay, subject to the terms and conditions of the group policy and as amended from time to time, an amount equal to the amount set forth in the aforementioned policy.

ARTICLE XVII. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Section 1. If an Active Employee dies or loses one or more hands or feet, or eyesight in one or both eyes, as the result of accidental means and within 90 days of the accident, the accidental death and dismemberment insurance company will pay, subject to the terms and conditions of the group policy and as amended from time to time, an amount equal to the amount set forth in the aforementioned policy.

ARTICLE XVIII. AMENDMENT AND TERMINATION

Section 1. In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Eligible Individuals, the Board of Trustees expressly reserve the right, in its sole discretion at any time and from time to time, but upon a non-discriminatory basis:

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

Section 2. In accordance with Article VI, Section 11 of the Brick Masons' Health & Welfare Trust Fund Trust Agreement, the Trustees, by a unanimous vote, may modify the eligibility and reserve account rules in conjunction with the signing of a new Employer to the Collective Bargaining Agreement who becomes obligated to this Trust Fund.

ARTICLE XIX. DISCLAIMER

Section 1. None of the benefits provided in these Rules and Regulations, except benefits provided under Article VII, IX, X, XVI, and XVII, are insured by any contract of insurance and there is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amounts in the Trust Fund collected and available for such purpose.

Section 2. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. If there is a material modification or reduction in covered services or benefits provided by the Plan, a summary description of such modification or change will be furnished to participants and beneficiaries not later than 60 days after the date of the adoption of the modification or change. In the event of termination of the Plan, any assets remaining after satisfaction of all liabilities shall be applied to provide, either directly or through the purchase of insurance, life, sick, accident or other benefits as required by Treasury Regulations issued under Internal Revenue Code § 501(c)(9).

ARTICLE XX. PROTECTED HEALTH INFORMATION

Section 1. The Plan will use protected health information (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996, Pub.L. No.104-191 (HIPAA) and the HIPAA Privacy Regulations, 45 Code of Federal Regulations, Parts 160 and 164, Subparts A through E. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations, as defined in the HIPAA Privacy Regulations.

Section 2. The Plan will use and disclose PHI as required or permitted by the HIPAA Privacy Regulations and pursuant to a written authorization of the Participant or Beneficiary.

Section 3. For purposes of this Article XX, the Board of Trustees 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 documents have been amended to incorporate the following provisions.

Section 4. With respect to PHI, the Plan Sponsor agrees to:

- (a) Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law;
- (b) Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to Plan Sponsor with respect to such information;
- (c) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- (e) Make PHI available to an individual based on access requirements in accordance with 45 C.F.R. § 164.524;
- (f) Make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;
- (g) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- (h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan’s compliance with HIPAA;
- (i) If feasible, return or destroy all PHI received from the Plan that Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not

feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- (j) Ensure that the adequate separation between the group health plan and the Plan Sponsor is established as required in accordance with 45 C.F.R. § 164.504(f)(2)(iii).

Section 5. There shall at all times be adequate separation between the Plan and the Plan Sponsor. For this purpose, only the Trustees acting on behalf of the Board of Trustees may be given access to PHI.

Section 6. The persons described in Section 5 above may only have access to and use and disclose PHI for Plan administration functions.

Section 7. If the persons described in Section 5 above do not comply with this Article XX, the Plan Sponsor shall take appropriate action for resolving such issues of noncompliance, including disciplinary action if appropriate.