NORTHERN CALIFORNIA TILE INDUSTRY HEALTH AND WELFARE PLAN
(As revised January 1, 2018)

THIRTEENTH AMENDMENT

Pursuant to the powers conferred upon them by Section 5.5 of Article V of the Restated Agreement and Declaration of Trust to adopt and from time to time amend, alter or otherwise change the Welfare Plan, the Board of Trustees, acting at its meeting of November 14, 2019, amended the Northern California Tile Industry Health and Welfare Plan as follows, to be effective January 1, 2020, and authorized the Chairman and Secretary to authenticate the same by affixing their signatures thereto:

1. Amended Part 2, Article I, to read in its entirety, as follows, effective for claims incurred between January 1, 2020 and March 31, 2021. This Amendment will sunset effective midnight March 31, 2021. Effective April 1, 2021, the benefits changed under this amendment will revert to as previously provided on December 31, 2019:

I. BENEFITS PAYABLE

A. USING THE PPO PLAN

Covered Plan participants and dependents have the right to obtain care from the physician, hospital or institution of their choice. However, when you use providers that belong to the Plan's contracted Preferred Provider Organization (PPO), the Plan pays a higher share of your provider's charges. The Plan currently contracts with Blue Shield of California as its PPO. (For a current list of preferred providers, visit www.blueshieldca.com/NetworkPPO or call the Plan Administration Office).

Covered charges for services or treatment rendered by hospitals, physicians and institutions belonging to the Preferred Provider Organization can be calculated with different Covered Percentages. Such differences occur when using a:

- PPO Hospital with a PPO Physician;
- PPO Hospital with a Non-PPO Physician;
- Non-PPO Hospital with a PPO Physician; and
- Non-PPO Hospital with a Non-PPO Physician.

The differences in the Covered Percentages payable for covered charges are shown in Part 2, Article I, Section C below.

Please note the following rules which apply to coverage under the Self-Funded PPO Plan:

Preferred Provider Discounts
The Plan has contracted with Blue Shield of California as its Preferred Provider Organization. Blue Shield of California has negotiated Contracted Rates with PPO physicians and hospitals. These rates are generally more favorable than the standard rates charged by similar providers for their services. Therefore, it is always to your advantage, and to the advantage of the Plan, if
you use PPO Providers when they are available.

Utilization Review Program
The Plan requires prior Utilization Review ("UR") for certain services, including all hospital admissions and overnight stays at any medical facility. Utilization Review has proven effective in helping patients avoid unnecessary effort and expense, while still getting quality medical services at the most appropriate level of care. Failure to obtain prior Utilization Review or to follow the recommendations of the Utilization Review Program may result in non-payment if the Utilization Review Program determines that the service is not covered. Please see Part 2, Article II, Cost Containment Rules, for further information.

The responsibility of notifying the UR Program lies with the covered person. Individuals are advised to contact the UR Program directly to verify that the admitting physician or hospital has made the required "notification." Utilization Review is provided by Blue Shield of California at (800) 541-6652.

Stop-Loss Limit
Another advantage to using PPO Providers is the lower stop-loss limit. The stop-loss limit works as follows:

When you use PPO Providers: After the out-of-pocket expenses for Covered Medical Charges incurred by each insured person reaches $1,250 ($3,750 per family), the Plan pays 100% of the Covered Medical Charges which that insured person incurs for Covered Services of PPO Providers for the rest of the calendar year.

When you use Non-PPO or Other Providers: After the out-of-pocket expenses for Covered Medical Charges incurred by each insured person reaches $8,500 ($25,500 per family), the Plan pays 100% of the Covered Medical Charges which that insured person incurs for Covered Services of Non-PPO and Other Providers for the rest of the calendar year.

Please see Section E below for complete rules on Stop Loss Limits.

Limitations and Exclusions
Certain covered medical charges are subject to limitations, and some procedures are excluded from coverage under the Plan. Please see Part 2, Article IV, Limitations and Exclusions, for further information.

B. DEDUCTIBLES AND ANNUAL MAXIMUM

Benefits are payable for Covered Medical Charges as follows:

a. For charges that are subject to a Deductible, benefits are payable for such charges that are more than the Deductible in each calendar year. The amount payable after the Deductible will equal the Covered Percentage times such charge in excess of the Deductible.
b. For such charges that are not subject to a Deductible, the amount payable is equal to the Covered Percentage times the amount of Covered Medical Charges.

c. Charges for Preventive Services, as defined in Part 2, Article III, Section Z of these Rules, that are provided by a PPO Provider are not subject to the Deductible and are payable at 100% of the amount of the PPO contracted rate.

**DEDUCTIBLES** (Per Calendar Year)

**Per Person:**
- When you use a PPO Provider.......................................................... $250
- When you use a Non-PPO Provider.................................................. $500

**Per Family:** *
- When you use a PPO Provider.......................................................... $750
- When you use a Non-PPO Provider.................................................. $1,500

(*Three family members must each separately satisfy the $250 deductible or the $500 deductible, as applicable.)

Additional Deductible for admission to any non-contracted facility or use of a non-contracted surgical facility.......................................................... $200

The Deductible Per Calendar Year applies to benefits for Covered Medical Charges provided by both PPO or Non-PPO Providers, in the applicable amounts, shown above.

The following rules govern the Deductibles listed above, and apply to each covered person:

a. **DEDUCTIBLE PER CALENDAR YEAR**
The Deductible per Calendar Year is the amount of Covered Medical Charges that each covered person must incur before benefits are payable each calendar year.

Charges incurred in the months of October, November and December that are used to meet this Deductible (in full or in part) for that calendar year will also be used to meet the Deductible per Calendar Year for the next year.

b. **DEDUCTIBLE FOR ACCIDENTS**
Your family is made up of you and your covered dependents. If two or more covered members of your family sustain injuries in the same accident, only one Deductible per Calendar Year must be met for all charges incurred due to these injuries during the rest of the calendar year in which the accident occurred.

c. **FAMILY DEDUCTIBLE**
Three members of your family must meet the Deductible per Calendar Year during any one year. Once the third family member meets that Deductible, no further Deductibles per Calendar Year must be met during the rest of that year for any charges incurred by any other members of your family.
C. COVERED PERCENTAGES (after deductible, where applicable)

Physician Charges-General Office Visits
When you use a PPO Provider.................................................................$10 copay
When you use a Non-PPO Provider..........................................................$20 copay
If a Preventive Service is provided by a PPO Provider during an office visit, and the primary purpose of the office visit is delivery of the preventive service, unless the preventive service is billed and tracked separately......................................................100%

Physician Charges-Specialist Office Visits
When you use a PPO Provider.................................................................$20 copay
When you use a Non-PPO Provider..........................................................$40 copay

Physician Charges-Hospital Visits
When you use a PPO Provider.................................................................80%
When you use a Non-PPO Provider..........................................................60%

Exceptions:
If you go to a PPO hospital, the Plan will pay the emergency room physician's fee at 80%, even if the physician is not a contracted provider.
If you go to a non-PPO hospital for emergency services, the Plan will pay the emergency room physician's fee at the greater of:
1. the amount that would be charged for such service if provided at a PPO-hospital;
2. 80% of the usual, customary and reasonable amount for the service; or
3. the amount that would be paid under Medicare for the service.

Preventive Services, as defined in Part 2, Article III, Section Z of these Rules
When you use a PPO Provider.................................................................100%
When you use a Non-PPO Provider..........................................................60%

Hospital Charges
When you use a PPO Provider.................................................................80%
When you use a Non-PPO Provider
(after additional $200 deductible)..............................................................60%

Exception: If you go to a non-PPO hospital for emergency services, the Plan will pay the greater of:
1. the amount that would be charged for such service if provided at a PPO-hospital;
2. 80% of the usual, customary and reasonable amount for the service; or
3. the amount that would be paid under Medicare for the service.

Note: Prior approval of the Utilization Review Program is required before Inpatient non-emergency hospital benefits are payable. See Part 2, Article II.
Skilled Nursing Admission/Admission into an approved Hospice Program
The maximum covered charge is 50% of the most common semiprivate room and board charge of hospitals in the geographic area.

When you use a PPO Provider ................................................................. 80%
When you use a Non-PPO Provider
(after additional $200 deductible) .......................................................... 60%

Note: Prior approval of the Utilization Review Program is required before Skilled Nursing Admission/Admission into an approved Hospice Program benefits are payable. See Part 2, Article II.

Chiropractic Benefits (Manipulative Therapy of the Spine)
The Maximum Benefit is $1,000 per calendar year.

When you use a PPO Provider ................................................................. 80%
When you use a Non-PPO Provider .......................................................... 60%

Mental and Emotional Illness Benefits

Inpatient Treatment:
When you use a PPO Provider ................................................................. 80%
When you use a Non-PPO Provider .......................................................... 60%

Note: Prior approval of the Utilization Review Program is required before Inpatient Mental and Emotional Illness benefits are payable. See Part 2, Article II.

Outpatient Treatment (Other than Office Visits):
When you use a PPO Provider ................................................................. 80%
When you use a Non-PPO Provider .......................................................... 60%

Outpatient Treatment (Office Visits):
When you use a PPO Provider ................................................................. $10 copay
When you use a Non-PPO Provider .......................................................... $20 copay

Home Health Care/Private Nursing/Outpatient Hospice
When you use a PPO Provider ................................................................. 80%
When you use a Non-PPO Provider .......................................................... 60%

Note: Prior approval of the Utilization Review Program is required before non-PPO Provider Home Health Care/Private Nursing/Outpatient Hospice benefits are payable. See Part 2, Article II.
**Outpatient Surgery Charges**
Charges must be incurred on the day of surgery. Surgery must be done in: (a) a hospital; (b) an ambulatory surgical center; or (c) a physician's office.

**Facility Charges and Surgeon Charges:**
- When you use a PPO Provider ................................................................. 80%
- When you use a Non-PPO Provider (additional $200 deductible applies) .................. 60%
- Second Surgical Opinion (Deductible is waived) ........................................... 100%

*Note:* Prior approval of the Utilization Review Program is required before Outpatient Surgery benefits are payable. See Part 2, Article II.

**Inpatient Surgery Charges**

**Facility Charges:**
- When you use a PPO Provider ................................................................. 80%
- When you use a Non-PPO Provider (additional $200 deductible applies) .................. 60%

**Surgeon, Assistant Surgeon and Anesthesiologist Charges:**
- When you use a PPO Provider ................................................................. 80%
- When you use a Non-PPO Provider ........................................................... 60%

*Exception:* If you have surgery performed at a PPO hospital and your surgeon is a PPO provider, your anesthesiologist charges will be paid at 80%, even if the anesthesiologist is not contracted.

**Preadmission/Post-release Testing**
Preadmission tests must be made within four days prior to confinement as an inpatient. Preadmission and Post-release testing must be (a) related to the condition for which the insured person is or was confined; and (b) ordered by a physician.

- When you use a PPO Provider ................................................................. 80%
- When you use a Non-PPO Provider ........................................................... 60%

**Birthing Centers**

- When you use a PPO Provider ................................................................. 80%
- When you use a Non-PPO Provider ........................................................... 60%

*Note:* Prior approval of the Utilization Review Program is required before Birthing Center benefits are payable. See Part 2, Article II.
Podiatry Services

When you use a PPO Provider........................................................................... 80%
When you use a Non-PPO Provider................................................................. 60%

D. DAILY ROOM ALLOWANCES

Maximum Hospital Daily Room Allowance:
When you use a PPO Provider................................................................. Contracted Rate
When you use a Non-PPO Provider.................................................. Most Common Semiprivate Room Rate

The full cost of a private room is eligible if private room confinement is medically necessary.

Intensive Care Unit Daily Allowance

When you use a PPO Provider................................................................. Contracted Rate
When you use a Non-PPO Provider................................................ The reasonable and customary charge of
........................................................................ an Intensive Care Unit (ICU) is eligible if
........................................................................ ICU confinement is medically necessary

E. STOP-LOSS LIMIT

Individual Stop-loss Limit:

When you use PPO Providers: After the out-of-pocket expense for allowable medical charges incurred by each insured person reaches $1,250 ($3,750 per family), the Plan pays 100% of the Allowable Expense which that insured person incurs for Covered Services of PPO Providers for the rest of the calendar year. After the out-of-pocket expense for allowable prescription charges incurred by each insured person reaches $6,250 ($10,700 per family), the Plan pays 100% of the Allowable Expense which that insured person incurs for Covered Services for the rest of the calendar year.

When you use Non-PPO or Other Providers: After the out-of-pocket expense for allowable charges incurred by each insured person reaches $8,500 ($25,500 per family), the Plan pays 100% of the Allowable Expense which that insured person incurs for Covered Services of Other Providers for the rest of the calendar year.

"Out-of-Pocket Expense" means expense which the insured person incurs for Covered Services during the calendar year and must pay out-of-pocket:

(a) to satisfy the Deductible; and

(b) as coinsurance (the percentage the insured person must pay in accord with the Covered Percentages provision).

The same out-of-pocket expense may be used to satisfy both the stop-loss limit for PPO Providers and the stop-loss limit for Non-PPO Providers.
The following benefits will not be paid at 100% even though the stop-loss limit has been reached: any additional Per Confinement Deductibles.

F. WELL CHILD CARE

Maximum Number of Exams
Benefits are limited to 31 periodic physical examinations at approximately each of the following age intervals: birth, 3-5 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 3 years, 4 years, 5 years, 6 years, 7 years, 8 years, 9 years, 10 years, 11 years, 12 years, 13 years, 14 years, 15 years, 16 years, 17 years, 18 years, 19 years, 20 years and 21 years.

Maximum Medical Benefit
$75 for each exam, except that an exam provided by a PPO Provider is not subject to this maximum.

Maximum Laboratory Benefit
$50 for laboratory services in connection with periodic physical examinations. A laboratory service that is a Preventive Service, as defined in Part 2, Article III, Section Z of these Rules, is not subject to this maximum if the service is provided by a PPO Provider.

Maximum Inoculation Benefit
$75 for all preventive inoculations with each periodic physical examination up to 30 months of age; and then $75 each calendar year thereafter up to age 19. An inoculation that is a Preventive Service, as defined in Part 2, Article III, Section Z of these Rules, is not subject to the maximum benefit described above if the inoculation is provided by a PPO Provider.

G. PREGNANCY BENEFITS

Expenses incurred for prenatal and delivery care, including termination of pregnancy, are paid in the same manner and subject to the same conditions as any other medically necessary service or supply. Pregnancy benefits that are Preventive Services, as defined in Part 2, Article III, Section Z of these Rules, are not subject to the Deductible and will be paid at 100% if provided by a PPO Provider.

The Plan will pay any bassinet or nursery charges made by the hospital for any day on which both mother and child are jointly confined in the hospital except that no benefits are provided to the grandchild of an insured person if that grandchild does not qualify under the eligibility rules of the Plan.

H. ALCOHOL AND DRUG DEPENDENCY TREATMENT

Benefits for alcohol and drug dependency detoxification and rehabilitation are provided only when preauthorized through Beat It!
Inpatient Benefits for Rehabilitation After Detoxification
First confinement, without prior outpatient treatment under the Beat It! program:
   Employee: ...................................................................................................... 100% of contracted rate

Other Inpatient Benefits:
When you use a PPO Provider........................................................................... 80%
When you use a Non-PPO Provider................................................................. 60%

Outpatient Benefits (Other than Office Visits)
When you use a PPO Provider........................................................................... 80%
When you use a Non-PPO Provider................................................................. 60%

Outpatient Benefits (Office Visits)
When you use a PPO Provider........................................................................... $10 copay
When you use a Non-PPO Provider................................................................. $20 copay

I. ANNUAL PHYSICAL EXAMINATIONS
Routine physical examinations for active employees................................. 100% of PPO contracted rate

J. ALL OTHER COVERED CHARGES
When you use a PPO Provider........................................................................... 80%
When you use a Non-PPO Provider................................................................. 60%

Exception: Preventive Services, as defined in Part 2, Article III, Section Z of these Rules, are not subject to the Deductible and will be paid at 100% if provided by a PPO Provider.

K. SMOKING CESSATION BENEFITS
When you use a PPO Provider........................................................................... 100%
When you use a Non-PPO Provider................................................................. 60%

The Plan covers the costs of smoking cessation programs, and of smoking cessation aids associated with qualified programs within the following quantity limits:
   1. Screening for tobacco use; and
   2. For those who use tobacco products, at least two tobacco cessation attempts per year.
For this purpose, covering a cessation attempt will include up to:
   (a) Four smoking cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
   (b) All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization. All tobacco cessation medications are provided under the Prescription Drug Program.
2. Amended Part 4, Article I in its entirety, as follows, effective for claims incurred between January 1, 2020 and March 31, 2021. This Amendment will sunset effective midnight March 31, 2021. Effective April 1, 2021, the benefits changed under this amendment will revert to as previously provided on December 31, 2019:

PART 4 - PRESCRIPTION DRUG BENEFITS
for Participants in the Self-Funded PPO Plan ONLY

I. BENEFITS PAYABLE

The Plan's prescription drug benefits for persons covered under the self-funded PPO Plan are administered by Sav-Rx. To receive these benefits, you must use your Sav-Rx card at a participating pharmacy, and pay the required co-payment as advised by your pharmacy.

(1) The co-payments are as follows:

Actives:  
- Generic drug: no charge
- $10 for formulary brand drug
- $40 for all other drugs

Retirees: 20% of the Sav-Rx rate, for all drugs

You may also use the Sav-Rx Mail Order system, and pay one co-payment for a 90-day supply, instead of the 30-day supply available from your pharmacist. The mail order co-payments are as follows:

Actives:  
- Generic drug: no charge
- $20 for formulary brand drug
- $80 for all other drugs

Retirees: 20% of the Sav-Rx rate, for all drugs

(2) Expenses for any prescription drug benefit that is a Preventive Service, as defined in Part 2, Article III, Section Z of these Rules, are not subject to the Deductible and will be paid at 100%.

(3) Specialty Drugs: Specialty drugs are prescription medications that require special handling, administration or monitoring. All specialty drugs are subject to prior authorization. Specialty drugs are only available through a Sav-Rx Specialty Pharmacy and are limited to a maximum of a 30 day supply.

Certain specialty drugs are eligible for manufacturer-sponsored coupon programs that significantly reduce the cost of the medication. Through Sav-Rx’s prior authorization process, Sav-Rx will identify specialty drugs that are eligible for a coupon program. Sav-Rx will then
facilitate covered individuals prescribed such a specialty drug in enrolling in the manufacturer-sponsored coupon program. Only the amount paid by the covered individual will be counted toward the stop-loss limit.

(4) **Prior Authorization Program:** Certain drug classes including, but not limited to, specialty drugs, oral and topical dermatologicals, oral and topical pain, erectile dysfunction, androgens for low testosterone, chemical dependency treatment, and stimulants for narcolepsy and attention deficit are subject to prior authorization by Sav-Rx.

(5) **Mandatory Generic Program:** For any brand name prescription drug that has a generic equivalent drug, as determined by the U.S. Food and Drug Administration, the Plan will only cover the cost of the generic equivalent drug. If a covered individual chooses the brand name drug, he or she will be responsible for paying the difference between the generic equivalent drug and the brand name drug. This difference in cost will not be counted toward the covered individual’s annual stop-loss limit.

The Plan will waive the difference in cost between the brand name drug and the generic equivalent drug if a Letter of Medical Necessity from the prescribing physician is submitted to Sav-Rx.

(6) **Step Therapy Program:** For new medications prescribed on or after July 1, 2016, certain classes of prescription drugs are subject to the Step Therapy Program. The Step Therapy Program requires that cost effective therapeutically equivalent prescription drugs be tried before more expensive prescription drugs are authorized by Sav-Rx. Classes of prescription drugs requiring step therapy include, but are not limited to: Proton Pump Inhibitors, Statins for Cholesterol, ARB and Combination Antihypertensives, Beta and Calcium Channel Blockers, Triptans for Migraines, SSRI/SNRI Antidepressants, Cox 2 (Celebrex) and NSAID Anti-Inflammatory, Lyrica, Sleep Aids, Nasal Sprays, Glaucoma Eye Drops, and Osteoporosis Medications (Bisphosphonates). The classes falling within the Step Therapy Program are subject to change as more clinical and cost effective drugs become available.

Prescription drugs in one of the above-named classes prescribed before July 1, 2016 are not subject to the Step Therapy Program, however, they are eligible for the Therapeutic Interchange Program. The Therapeutic Interchange Program provides individuals receiving a brand name prescription drug, where a therapeutically equivalent generic drug is available, with information about the therapeutically equivalent generic prescription drugs available. If a covered individual elects to participate in the Therapeutic Interchange Program and switch from a brand name drug to a therapeutically equivalent generic drug, the covered individual shall receive the first two (2) fills at no cost.

(7) **Stop-loss Limit:** After the out-of-pocket expense for allowable prescription charges incurred by each insured person reaches $6,250 ($10,700 per family), the Plan pays 100% of the Allowable Expense which that insured person incurs for Covered Services for the rest of the calendar year.
(8) The Plan also participates in the following SavRx programs:

**SavRx TIP Program:** SavRx notifies you and your physician regarding the drugs you have been prescribed, making recommendations for generic or brand name equivalents which are lower in cost.

**SavRx Therapeutic Quantity Limitation Program (TOLP):** SavRx identifies potential overuse/abuse problems by limiting certain drugs issued on a therapeutic basis to a 30 day supply.

(9) Diabetes Benefits

If, while covered under the Plan, you or your dependent incurs Expense for the medically necessary treatment of:

(i) insulin-using diabetes;
(ii) non-insulin-using diabetes; or
(iii) gestational diabetes;

benefits will be payable as follows, even if the items are available without a prescription.

Benefits for the following items are payable in the same manner and subject to the same conditions and limitations as any other prescription drug:

(i) blood glucose monitors and blood glucose testing strips;
(ii) blood glucose monitors designed to assist the visually impaired;
(iii) pen delivery systems for the administration of insulin;
(iv) lancets and lancet puncture devices;
(v) insulin syringes;
(vi) insulin;
(vii) prescriptive medications for the treatment of diabetes; and
(viii) glucagon.

(10) Contraceptive Benefits

If you or your dependent receives outpatient Contraceptives, the Plan will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any covered drug.

Expenses for any contraceptive benefit that is a Preventive Service as defined in Part 2, Article III, Section Z of these Rules are not subject to the Deductible and will be paid at 100%.

"Contraceptives" means a variety of prescription methods, drugs or devices that are approved as contraceptives by the Federal Food and Drug Administration (FDA).

(11) Smoking Cessation Benefits

The Plan will pay 100% for all Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.
IN WITNESS of the adoption of this amendment, the Chairman and Secretary hereby subscribe their names, on the dates indicated.

Chairman  
Date: 11/14/2019  

Secretary  
Date: 11/20/2019