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

FIFTH 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 8, 2018, amended the Northern California Tile Industry Health and Welfare Plan as follows, to be effective immediately, and authorized the Chairman and Secretary to authenticate the same by affixing their signatures thereto:

1. Amend Part I, Article III, C., to read as follows:

C. Eligibility Date

1. Your dependents who meet the Plan’s requirements will become eligible for benefits on the date that you become eligible, provided that they have been properly enrolled as dependents.

2. Newly-acquired dependents because of birth, adoption, or placement for adoption become eligible the date of the birth, adoption, or placement for adoption. Newly-acquired dependents because of marriage or registration of domestic partnership become eligible for benefits on the first day of the month after they are property enrolled as dependents.

2. Add a new section G. to Part I, Article III, that reads as follows:

G. Special Enrollment

If you decline enrollment for yourself or your Eligible Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself or your Eligible Dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Eligible Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Eligible Dependents may be enrolled in the Plan if they lose eligibility under Medicaid or a State Sponsored Children’s Health Insurance Plan and/or upon becoming eligible for a special premium assistance subsidy under Medicaid or a State Sponsored Children’s Health Insurance Plan. You must file your enrollment form with the Administration Office within 60 days of your Eligible Dependent losing coverage under Medicaid or a State Sponsored Children’s Health Insurance Plan or within 60 days of your Eligible Dependent becoming eligible for premium assistance under Medicaid or a State Sponsored Children’s Health Insurance Plan.
3. Amend Part 1, Article VI, 4. and 5., to read as follows:

4. NOTIFICATION OF CLAIM DECISION

(a) TIME LIMITS AND REQUESTS FOR ADDITIONAL INFORMATION

(i) Urgent Care Claims: If a claim is for urgent care, the Administration Office will notify the claimant of its determination as soon as possible, but no later than 72 hours after receipt of the claim by the Administration Office. The determination as to whether a claim involves urgent care is determined by the attending provider and the Plan defers to such determination.

If the claimant fails to provide sufficient information to determine whether benefits are payable under the plan, the Administration Office will notify the claimant what information is necessary as soon as possible, but no later than 24 hours after receipt of the claim by the Administration Office. The claimant will have 48 hours to provide the specified information. The Administration Office will notify the claimant of its decision as soon as possible, but no later than 48 hours after the Administration Office’s receipt of the specified information.

(ii) Pre-service claims: If a claimant makes a claim for benefits before care has been provided to the participant or family member, the Administration Office will notify the claimant of its decision as soon as reasonably possible, but no later than 15 days after the Administration Office received the claim.

The above 15-day time period may be extended for up to one additional 15-day period, but only due to matters beyond the Administration Office’s control. If the Administration Office needs a 15-day extension, it will notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.

(iii) Post-service claims: If a claimant makes a claim after care has been provided, the Administration Office will notify the claimant of its decision as soon as reasonably possible, but no later than 30 days after the Administration Office received the claim.

The 30-day time period may be extended for one additional 15-day period, but only due to matters beyond the Administration Office’s control. If the
Administration Office needs a 15-day extension, it will, before the end of the first 30-day period, notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.

(b) CONTENTS OF CLAIM DENIAL NOTICE: The Administration Office will provide the claimant with written notice if his or her claim for benefits is denied. If the claim involves urgent care, the information described below may be given orally, so long as a written notification is provided within three days after the oral notification. The notice will include the following information:

(i) a statement of the specific reason(s) for the denial;

(ii) reference to the specific Plan provision(s) on which the denial was based;

(iii) if the Administration Office’s decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;

(iv) a description of any additional information or documents that the claimant will need to submit if he or she wants the claim to be reconsidered, and an explanation of why that information is necessary;

(v) a description of the Plan’s appeal procedures, including any expedited appeal procedures available if it is a claim for urgent care benefits;

(vi) if the claim involves either 1) a rescission of coverage as defined in Part 1, Article I, Section D of these Rules, or 2) a medical judgment with respect to coverage under the Self-Funded PPO Plan, a statement of the claimant’s right to request an expedited external review, if the claim involves a medical condition for which the timeframe for completion of the Plan’s appeal procedures would seriously jeopardize the life or health of the claimant or would jeopardize the claimant’s ability to regain maximum function; and

(vii) a statement of the claimant’s right to bring a civil action under ERISA § 502(a), if the appeal is unsuccessful.

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5. APPEAL PROCEDURES

(a) GROUNDS FOR APPEAL: The claimant may appeal any adverse action within the discretion of the Board of Trustees to the Board of Trustees. The Board of Trustees hears all appeals regarding self-funded PPO benefits, all appeals regarding eligibility under this Plan for any type of benefit, and appeals regarding medical and vision benefits when the claimant has made a specific claim for medical or vision care, and the HMO or other provider has denied the claim on the grounds that the claimant or family member is not eligible for the benefit under the terms of the Plan.

(b) SUBMISSION OF APPEAL: Appeals must be in writing, and state in detail the matter or matters involved. To submit an appeal, the claimant must send a letter with any documents and information that he or she wants the Board to consider, to the Administration Office. A claimant or claimant’s representative may submit evidence, including written testimony, as part of his or her appeal.

(c) TIME LIMITS: Claimants must submit an appeal within 180 days of receiving the denial of the original claim by the Administration Office. If a claimant does not submit an appeal within 180 days of receiving a denial, he or she will be deemed to have waived any objection to the denial.

(d) STANDARD FOR REVIEW: The Board of Trustees has full discretionary authority to decide upon Plan benefits, to interpret the Plan language conclusively and to make a final determination of the rights of any participant, beneficiary, assignee, or other person with respect to Plan benefits. The Board of Trustees will take into account everything that the claimant submitted, even material that was submitted or considered in the initial benefit determination. The Board of Trustees will not give deference to the initial determination. Neither a person who made the initial determination nor such a person’s subordinate shall have a vote in the decision on appeal.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment is medically necessary or appropriate, the Board of Trustees shall consult with a health care professional. The health care professional shall not have participated in making the initial benefit determination. The Board of Trustees shall, upon claimant’s request, identify the health care professional, regardless of whether the Board of Trustees relied on his or her advice in making the decision.

(e) FULL AND FAIR REVIEW

(i) A claimant will be provided, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with
the claim, prior to notification of the Board of Trustees’ determination of the appeal.

(ii) A claimant will be provided, free of charge, with any new or additional rationale on which the Board of Trustees’ determination of the appeal is based, prior to notification of the Board of Trustees’ determination of the appeal.

(f) NOTIFICATION

(i) TIME LIMITS FOR NOTIFICATION

(A) Urgent Care Claims: The Administration Office will notify the claimant of the Board of Trustees’ determination as soon as possible, but not more that 72 hours after receiving the claimant’s request for an appeal.

(B) Pre-Service Claims: The Administration Office will notify the claimant of Board of Trustees’ determination as soon as possible, but not more than 30 days after receiving claimant’s request for an appeal.

(C) Post-Service Claims: The Board of Trustees will render a decision on the appeal at the regularly scheduled meeting immediately following the filing of the appeal, unless the appeal is filed within 30 days of the meeting, in which case the decision may be made at the second meeting following the appeal.

If special circumstances require further extension, the decision will be made no later than the third meeting following the filing of the appeal. In such cases, the Administration Office will notify the claimant in writing of the extension, describing the special circumstances and the date the determination will be made, before the extension begins.

The Administration Office will notify the claimant of the Board of Trustees’ determination as soon as possible, but no later than 5 days after the decision is made. The Board of Trustees’ response period will be extended by any additional time it takes for the claimant to provide requested information.

(ii) CONTENTS OF NOTICE: The Administration Office will send the claimant written notice of the Board of Trustees’ decision on appeal. If the appeal has been denied, the notice will include the following information:

(A) the specific reason(s) for the denial;

(B) reference to the specific Plan provision(s) on which the denial is based;

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(C) if the decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;

(D) if the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the Plan’s terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(E) a statement that the claimant may view and receive copies of documents, records or other information relevant to the claim, upon request and free of charge;

(F) if the appeal involves either 1) a rescission of coverage as defined in Part 1, Article 1, Section D of these Rules, or 2) a medical judgment with respect to coverage under the Self-Funded PPO Plan, the claimant’s right to request external review, including the right to request expedited external review if the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant’s ability to regain maximum function, or if the appeal concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility;

(G) the claimant’s right to bring a civil action under ERISA § 502(a); and

(H) contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

IN WITNESS of the adoption of this amendment, the Chairman and Secretary hereby subscribe their names, on the dates indicated.

Chairman

Date: 11/8/18

Secretary

Date: 11/8/18

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