CONSTRUCTION INDUSTRY
DRUG-FREE WORKPLACE PROGRAM
(DFW PROGRAM)

PLAN DOCUMENT

February 2, 2015

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JANUARY 2012

1. Purpose. The nature of the construction industry requires that all employees be in a condition to perform their job safely and efficiently, free from any impairment caused by alcohol or drugs. The AGC (Associated General Contractors), the MCA (Mason Contractors Association of America, Portland, Oregon, Chapter), the GCCA (General & Concrete Contractors Association), Cement Masons, Laborers, Carpenters, Bricklayers, and the Employer are firmly committed to eliminating all of the problems associated with employee alcohol and drug abuse.

   The Employer also recognizes the need to avoid unnecessary intrusion into employees' private lives and to assure employee privacy and confidentiality to the greatest extent possible, consistent with the goals of this Plan and Policy. In addition, the Employer acknowledges that some cases of substance abuse must also be dealt with as illnesses requiring medical treatment, not only as personnel problems. Lastly, the AGC, the MCA, the GCCA, Cement Masons, Laborers, Carpenters, Bricklayers and the Employers believe that the goals of its alcohol and drug policy should include education, prevention and rehabilitation. To achieve these objectives, all the Employers' employees must adhere to each of the following rules and regulations of the Construction Industry Drug-Free Workplace Program (DFW Program).

   This Plan, and the related Trust Fund, are established to provide and pay for the services and procedures needed to detect, diagnose at a medical facility, and refer for appropriate medical treatment any alcohol, drug or other substance abuse by any covered employee of a participating Employer.

2. Creators. The creators of the Plan are the following Employers and unions involved in the construction industry in Oregon and Southwest Washington: AGC, GCCA, Cement Masons, Carpenters, and Laborers. The MCA and the Bricklayers joined the Plan in 1998**.** They recognize that all employees must be in a condition to perform their job safely and efficiently, free from any impairment caused by alcohol or drugs.

3. Adoption and Amendment. Subject to the terms of applicable collective bargaining agreements and laws, the Trustees of Construction Industry Drug-Free Workplace Trust (DFW Trust) have adopted, and have the power to amend or terminate, this Plan and the related Trust Agreement.

4. Documents. The governing documents for administering this Plan are:

(a) This Plan Document.

(b) The Trust Agreement for the Construction Industry Drug-Free Workplace Trust.

(c) Such other policies, procedures and rules as the Trustees hereafter may adopt.

5. Covered Employees. Employees covered by this Plan include:

5.1 Bargaining Unit Employees (BU Employees) are those employees covered under a collective bargaining agreement in the construction industry in Oregon and Southwest Washington between the participating AGC, MCA, and GCCA Employers, and the Carpenters, Cement Masons, Bricklayers, and Laborers unions, which provide for contributions to fund benefits under this Plan and which are accepted by the Plan and the applicants for such employment. An Employer must also sign certain documents as required by the Plan before testing can begin, including the Employer Compliance Agreement and the Designated Representative form.

5.2 Non-Bargaining Unit Employees (NBU Employees) are those employees not covered by a CBA as described in Section 5.1 of a participating Employer who has signed the appropriate documents, including the Employer Compliance Agreement. The NBU Employees shall include all employees who work within the same geographical area as the Employer's BU Employees and the applicants for such employment.

6. Funding.

6.1 BU Employees. Testing and benefits for BU Employees are funded by contributions from Employers under the applicable collective bargaining agreements. The initial contribution rate is 10¢ ($.10) per hour for covered work hours during and after June 1997. Any change of such contribution rate made under any applicable collective bargaining agreement shall be the applicable rate for purposes of this Plan without further amendment hereto. Such contributions for each applicable work month shall be made to the administrative office of the Health and Welfare Plan for such BU employees, and that administrative office then shall forward the contribution to the administrative office of this DFW Trust, together with the names of all employees eligible for health plan benefit coverage for the benefit eligibility month.

6.2 NBU Employees. Testing and benefits for NBU Employees are funded by the Employer paying the designated amount directly to the administrative office of this Plan, in an amount as set from time to time by the Trustees.

6.3 Trust Fund. All sums paid to fund this Plan shall be held in the DFW Trust, which is intended to be tax-exempt under IRC § 501(c)(9), and disbursed as needed to cover Plan and Trust expenses and benefits for eligible employees. No funds held in trust shall revert to any Employer.

7. Administration.

7.1 Governance. The ERISA plan administrator and governing body shall be the Board of Trustees of the DFW Trust.

7.2 Administration. The Administrative Office for the DFW Plan and DFW Trust shall be Masonry Industry Trust Administration, 9848 E Burnside, Portland, Oregon 97216; telephone: (503) 261-0809; toll free: (877) 210-2654; facsimile: (503) 261-9973. The contact person is Kirt Haneberg.

7.3 Testing. Substance testing shall be done by a qualified medical facility approved by the Trustees. The testing facility is Legacy Laboratory Services/Metro Lab, 1225 NE Second Avenue, Portland, Oregon 97232; telephone: (503) 413-5295; facsimile: (503) 413-4856. The contact person is Lee Briney.

7.4 Medical Review Officer (MRO). The MRO approved by the Trustees shall interview each employee who tests positive and answer any questions about test procedures. The MRO is Dr. Kirby Griffin, M.D., of Northwest Occupational Health Associates, 9370 SW Greenburg Road, Suite 101, Portland, Oregon 97223; telephone: (503) 977-3225; facsimile: (503) 244-6790.

7.5 Employee Assistance Program (EAP). Initial confidential assessment of individuals with a positive test result or a repeat dilute result and recommendation for appropriate educational, counseling, or rehabilitation will be by the EAP approved by the Trustees. The EAP is Cascade Centers EAP, 7180 SW Fir Loop, Suite 1-A, Portland, Oregon 97223; telephone: (503) 639-3009; toll-free: (800) 433-2320; facsimile: (503) 620-3453.

7.6 Benefits and Health Plan. This Plan does not provide diagnostic or treatment benefits beyond the testing, detection, and treatment referral benefits described above. The Plan service providers will use their best efforts to inform and encourage any employee in need of further treatment to do so using the providers and benefits available under the employee's separate Health and Welfare Plan. **The only exception is that the Plan does pay for the first early intervention program, not to exceed $350.00 per participant, as approved by the Plan.**

8. Prohibited Use Affecting Employment. The Plan prohibits any use of alcohol or drugs that can impair a covered employee's ability to work safely or efficiently.

8.1 General Prohibition. The use of alcohol or drugs by employees during working hours or on a job site or on company property (including company vehicles) is absolutely prohibited. Any employee who violates this Plan may be required to undergo an educational or rehabilitation program and/or may be subject to discipline under the terms of this Plan up to and including termination.

8.2 Use. The term "use" means consuming, possessing, selling, transferring, concealing, distributing or arranging to buy or sell, being under the influence, or reporting for duty under the influence of alcohol or drugs to any degree, or having illegal drugs in one's possession or system.

8.3 Alcohol or Drugs. The term "alcohol or drugs" means any form of alcohol and/or other intoxicating substance, narcotic plant or similar substance whether illegal or not, including legal drugs obtained illegally.

8.4 Proper Medical Usage. Notwithstanding any other provision in this Plan, use of prescription and non-prescription medication is not a violation of this Plan if that medication is taken in accordance with a lawful prescription or standard medical dosage recommendation. The use of marijuana, which is a Schedule I controlled substance under federal law (Controlled Substances Act, 21 USC § 812), is expressly prohibited under this Plan even if its medical use is authorized under state law.

8.5 Employees. This Plan applies to all employees of the Employer governed by the terms of any bargaining agreement with the Cement Masons, Laborers, Bricklayers, and Carpenters, as well as all applicants for any such position. Probationary employees who fail pre-employment testing are not eligible for employment unless they complete a state approved education or rehabilitation program at their own expense and then reapply. It also applies to non-bargaining unit employees of any Employer who signs an Employer Compliance Agreement with the Trust covering all employees who are within the geographic limits of the applicable bargaining agreement, including maintenance, sales, clerical, management, part-time, and applicants for any such position.

8.6 Working Hours. The term "working hours" means all the time during which employees are engaged in work duties or subject to the control of the Employer, and also includes scheduled breaks (including meal periods) and travel to work or from one workplace to another.

8.7 Employer Property. The term "Employer property" means all facilities, job sites, vehicles and equipment that are owned, leased, operated or utilized by the Employer or its employees for work-related purposes, including parking areas and driveways, as well as lockers, toolboxes or other storage areas used by the employees. It also includes other public or private property, facilities, vehicles and equipment located away from the Employer facility if the employee is present on such property for a

work-related purpose. Industry education and training assigned by the employer shall be considered a work-related purpose.

8.8 Private Property. An employee's private property may be inspected only for reasonable cause and shall include employee's lunch boxes, tool boxes, back packs, purses and the like that are brought by the employee onto Employer property or used for work-related purposes.

8.9 Voluntary Events. Events attended voluntarily are not considered to be covered under this Plan.

9. Privacy and Confidentiality.

9.1 Employer's Responsibilities. The Employer shall take reasonable measures to safeguard the privacy of employees in connection with this Plan and Policy, including maintaining the confidentiality of employees who come forward to discuss alcohol or drug abuse affecting them before any testing or disciplinary action. The Employer will be responsible to keep a locked file cabinet with results and information from Masonry Industry Trust Administration. The designated representatives shall be the only persons designated by the Employer to be responsible for receiving information from Masonry Industry Trust Administration or the local unions, notifying affected employees, and handling any paperwork related to a positive test.

9.2 Release of Test Results. The results of the drug test analysis will be sent to the Administrator by the MRO marked "Confidential". They will be opened only by the Administrator. All testing results of a positive test will only be made known to: the employee, the Employer (positive/negative/or other non-negative information only or such information as is required or permitted by law), and the treatment facilitator (Masonry Industry Trust Administration representatives). Upon request, the testing facility and/or Masonry Industry Trust Administration shall make available to employees and applicants the laboratory reports concerning his/her test results. The results of any positive test will not be released to any third party or outside agency unless required by law or with written permission of the employee. Notwithstanding anything herein, the Administrator or employer or any service provider may release such information to respond to a complaint, grievance, charge, lawsuit, or other proceeding initiated by the employee challenging a test, the results, testing program, administrative rules or disciplinary action. If an employee is an apprentice, the test results and any matter of non-compliance under this Program may be disclosed to the appropriate apprenticeship program if (1) the Trust approves this disclosure of such information and (2) the appropriate union approves this as the representative of the apprentices. If this is approved by the Trust, then the apprenticeship program must provide adequate information to the Trust in order to identify the apprentices.

10. Scope of Detection and Testing. An employee shall submit to testing for alcohol or other intoxicating substances for, and only for, a circumstance described below in 10.1, 10.2, 10.3, 10.4, 10.5, or 10.6:

10.1 Pre-Employment Testing. All applicants for employment will be required to submit to alcohol and drug testing under this Plan after a conditional offer of employment has been made unless the applicant has a current and valid verification card. Refusal to submit to a test or a continued positive shall be grounds for withdrawing a conditional offer of employment.

10.2 Systematic Computer Generated Testing. This Plan requires all employees to abide by the systematic computer generated employee drug testing program as part of this Plan. This computer drug testing selection procedure shall be administered by Masonry Industry Trust Administration. The systematic computer generated testing will test the pool 100% to 200% per year as determined in the sole discretion of the trustees; the goal of the system is to test an employee a minimum of one to two times but no more than three times per calendar year. The employee will be given an approved verification card indicating the date of the test. This limitation of three times does not apply to any other testing, such as reasonable suspicion testing, post-accident testing, follow-up testing, periodical testing, and testing by any treatment program. If a participant's name is drawn while he/she is unemployed or on vacation, or working outside the jurisdiction, he/she shall be required to take the test upon any return to employment. All new employees shall be tested if they have no verification card, or they must be tested if their verification card is more than one year old. If an employee's name is drawn, the Employer shall retrieve and destroy the employee's old verification card.

10.3 Reasonable Suspicion Testing. "Reasonable suspicion" means aberrant or unusual behavior of a person which:

10.3.1 is observed by the person's immediate supervisor or others and, if reasonably available, confirmed by the observation of another supervisory employee or managerial employee, which observations shall be documented by the observers; and

10.3.2 is the type of behavior which is a recognized and accepted symptom of intoxication or impairment caused by controlled substances or alcohol or addiction to or dependence upon said controlled substances; and

10.3.3 is not reasonably explained as resulting from causes other than the use of controlled substances (such as, but not by way of limitation, fatigue, lack of sleep, side effects of prescriptions or over-the-counter medications, reactions to noxious fumes or smoke, etc.).

The Employer must initiate the test for reasonable suspicion by notifying the Administrative Office of the circumstance and identity of the employee(s). The employee must report for testing as directed by the Employer, but no later than two (2) hours after being directed by the Employer. If the Employer has a reasonable basis for suspecting that prohibited drugs or alcohol have been used at a particular location (e.g., drug paraphernalia found on site), but the Employer cannot determine which employee(s) have used such prohibited drugs or alcohol, then the Employer has the right to request that all employees at that site be tested within a 24-hour period using an on-site mobile testing unit; if a mobile testing unit is not available, the Employer shall use a reasonable method for such testing, which includes the safe transportation of the employees to and from the lab.

10.4 Post-Accident Testing. Notwithstanding anything in this Plan, involvement in an on-the-job accident shall require testing where an employee is judged to have caused or contributed to an accident either (1) requiring off site medical attention to any employee or third-party or (2) resulting in any property damage that, at the time of the accident, is reasonably believed to exceed $500. The minimum level of injury for which a test shall be administered shall be the worker's need for off-site medical attention unless a supervisor trained in accordance with state requirements reasonably believes the injury was due to circumstances beyond the employee's control. Employer must initiate the test by notifying the Administrative Office of the circumstances and identity of the employee(s). The employee must report for testing as directed by the Employer within two (2) hours after receiving any needed medical treatment, but, if the employee does not need any medical treatment or the employee does not test within two (2) hours after receiving the medical treatment, then the employee must test no later then two (2) hours after being directed to test by the Employer.

10.5 Follow Up Testing. In addition to computer generated selection, employees who have returned to work following a prescribed program through the DFW Program's EAP shall be required to participate in follow-up testing at a minimum frequency of four times per year for two years. Employees do not receive a benefit payment of $50.00 for any follow-up testing. If the DFW Program's EAP recommends more frequent follow-up testing, those recommendations shall be followed.

10.6 Periodical Testing. The Employer has the right to request a periodical test if the employee's card is more than six months old, but less than one year old and the employee must comply.

10.7 Other Approved Testing. Testing is also authorized under this program if it is authorized under Section 11 or any other section, such as a test following a dilute under 11.5 or testing for a temperature failure or other invalid collection under 11.6.

11. Testing & Collection Procedures.

11.1 Testing. Any person shall be required to submit to drug or alcohol testing for any circumstance described in Section 10. Employees shall have reasonable notice that they have been selected to be tested and the date upon which the test is to be completed. Employees shall be given 24 hours to present themselves for testing after the employee is notified by the Employer of their selection to test under the systematic computer generated testing or periodical testing; otherwise the employee shall report to test in accordance with the applicable sections of 10.3 (reasonable suspicion testing), 10.4 (post-accident testing), 10.5 (follow up testing), and 10.7 (other testing). If a participant's name is drawn while he/she is unemployed, on the out of work list, on vacation, or working out of the jurisdiction, he/she shall be required to take the test upon returning to employment or upon returning to the jurisdiction.

11.2 Forensic Laboratory. The employee's urine specimen is tested by a qualified medical laboratory under rules designed to assure the integrity of the specimen and provide an objective scientific analysis that is accurate and reliable. The forensic laboratory used by the DFW Program is Legacy Laboratory Services/Metro Lab. The purpose of the lab test is to determine a negative or positive result or other non-negative result (e.g. adulterated, substituted, invalid).

11.3 Testing Standards.

Type of Test: Enzyme immunoassay (EIA) or any other testing technology that the lab considers appropriate.

Confirmation Test: Gas Chromatography/Mass Spectrometry (GC/MS) or Liquid Chromatography Tandem Mass Spectroscopy (LC/MS/MS), or any testing technology the laboratory considers appropriate.

Drug testing and the chain of custody shall be conducted in accordance with the procedures of the U.S. Department of Health and Human Services Mandatory Guidelines for Federal Workplace Drug Testing Programs and the Department of Transportation, except as modified explicitly under this plan. The cutoff value shall change automatically upon change by such federal agency for those substances addressed by federal guidelines.

Effective July 1, 2014, the following substances will be tested at the indicated levels:

	Cutoff value	**Confirmation Cutoff Value**	**Units**
Amphetamines	**500**	**250**	**ng/mL**

Benzodiazepines	**200**	**100**	**ng/mL**
Cannabinoids	**50**	**15**	**ng/mL**
Cocaine	**150**	**100**	**ng/mL**
Ethanol	**50**	**50**	**mg/dL**
Opiates (Incl. Synthetics)	**300**	**150**	**ng/mL**
PCP	**25**	**25**	**ng/mL**
Heroin	**10**	**10**	**ng/mL**
Methadone	**300**	**150**	**ng/mL**
Ecstasy	**500**	**250**	**ng/mL**

Urine samples will be separated into two containers at the time of donation of the sample. One portion of the original urine sample shall be kept secure and chemically stable and made available for verification of laboratory testing results. Negative specimens are kept 5 business days (1 week). Positive and non-negative specimens are retained for 1 year in secure frozen storage unless the lab is notified in writing requesting a longer retention time.

11.4 Employee's Right to Independent Test. Any employee testing positive, adulterated or substituted shall have the right to have the secured portion of his/her urine sample independently examined by a laboratory at his/her expense. The laboratory selected shall meet the same certification and shall be able to provide the same quality and validity tests as the laboratory required under this Plan. The employee must request in writing a test of the secured portion within 30 days after being informed of the test results.

11.5 Dilute Specimens. Dilute specimens will be considered to be invalid for testing if the specific gravity is less than 1.003 and the creatinine is less than 20 mg/dL. If these two measurements are low, it means that a person has consumed too much water or other fluids, or is possibly taking a diuretic. The employee will be asked to refrain from excessive consumption of fluids and to return to the collection site for a second urine specimen within 24 hours. If the second specimen is also invalid / dilute, the employee will be referred to the MRO to discuss how to obtain a valid specimen and not be able to return to work until a valid specimen is provided that shows either a positive or negative or non-negative result and, if positive or non-negative, the employee takes the recommended steps to receive a return to work release.

Employees who have confirmed medical conditions that do not permit them to provide a valid urine specimen will be permitted to satisfy the testing requirements through alternative means of testing, such as blood or oral fluid testing. These arrangements will require medical documentation and will be considered on a case-by-case basis. Employees whose medical condition requires alternative testing procedures must contact the Administrator upon learning of the medical need, so that the request for alternative procedures may be evaluated in advance of any notification to be tested. An

employee who has a confirmed medical condition requiring regular or maintenance medication may notify the administrator; upon proper verification and providing the employee agrees, the administrator will notify the medical review officer so that delays in confirming a negative test result will be kept to a minimum.

11.6 Temperature Failure & Other Invalid Collection. A valid temperature for a collected specimen is within the range of 90 and 100 degrees Fahrenheit. In the event that the collector indicates that the specimen is outside of this range, the specimen will be considered invalid and the donor must remain at the collection site until he/she can provide another specimen. However, if the specimen is invalid because it does not contain appropriate amounts of uric acid or any other substance normally found in urine, then it is treated as an adulterated specimen subject to 12.3 and an observed collection is not required. Any collection following a temp-fail or any other invalid collection shall be directly observed by an employee of the collection site and the employee observing the collection will be of the same gender. However, if observation by an employee of the same gender is not possible, the collection site may undertake other reasonable methods to ensure the specimen is valid. If a specimen is invalid or suspicious for any other reason, then the collection site may also undertake any reasonable method to ensure the specimen is valid, including without limitation requiring the donor to remain at the collection site until he/she can provide another specimen.

11.7 Positive Test Levels. A positive drug test result shall mean test levels, on both the screening test and the confirmatory test, which are recognized as positive by the Laboratory according to the U.S. Department of Health and Human Services in its Mandatory Guidelines for Federal Workplace Drug Testing and the Department of Transportation and for federally regulated drugs and recognized as positive by the Laboratory according to CAP / FDT accrediting body. No action shall be taken, however, unless the result is verified by the MRO as provided in this Plan.

11.8 Notification of Test Results. The Administrative agent personnel shall contact the Employer only through its designated representative with the results of a positive test. In notifying an employee of a positive test, the Employer shall provide notification within five working days of receipt of the positive test result; utilize the written standard form of information which provides notice of the result, consequences, and options available to the employee; and shall make certain that the notification is given to the employee in privacy at a reasonable break in the work day, such as lunch and/or after work. Neither the results of the test nor the fact of notification shall be communicated to any person who does not have a bona fide need to know.

11.9 Reasonable Time to Contact EAP. The employee will be given reasonable time to contact the appropriate treatment facilitator as prescribed by the DFW Program's EAP to schedule counseling and may return to work with written approval from the DFW Program's EAP.

12. Test Results.

12.1 Negative Test. In the case of a negative test, the employee will continue to work, receive a verification card, and receive the appropriate maintenance benefit. A negative result means that no substance was detected in an amount equal to or above the cutoff value described in Section 11.3. The employee then will receive a **verification card** that should be retained and shown to the Employer upon request. Bargaining unit employees who are covered by a bargaining agreement that so provides will receive a $50 wellness check. **This is the only circumstance when the $50 check is issued.**

12.2 First or Second Positive Result. In the event of a **first or second positive result**, the positive test result shall not be the sole basis for termination, but the employee's verification card shall immediately become invalid. However, unless other cause for termination exists, the employee shall be suspended from employment and required to participate in education, counseling or rehabilitation as determined by the DFW Program's Employee Assistance Program. An employee who has been properly removed from the job **because of a positive result of their first or second time**, may resume working if he/she has received a work release from the DFW Program's EAP which is managing the employee's treatment. If the employee decided to return to the out of work list or be referred from the out of work list, the employee must also have a return to work release.

12.3 Other Non-Negative Specimens. Intentionally tampering with, or causing another person to tamper with, substituting for, or causing another person to substitute for a urine and/or blood specimen, whether the employee's specimen or another employee's specimen, shall constitute cause for the discharge of the employee who engages in such activity. If a specimen is reported as adulterated by the Collector or the Laboratory or is reported as Substituted by the Lab the test shall be treated as a positive result. See sections 12.2 and 15.6. If the testing facility determines that a specimen is invalid because it does not contain appropriate amounts of uric acid (e.g., synthetic urine) or any other substance normally found in urine, then the test will be treated as an adulterated specimen after review by the MRO.

12.4 Dilute Specimen. A "dilute specimen" means that the specific gravity or creatinine in the urine sample is below the minimum required level to be deemed a valid specimen, and is invalid for testing as described in Section 11.5. The employee will be asked to refrain from excessive consumption of fluids and to return to the collection site to provide a second urine specimen within 24 hours. The DFW Program pays for that second test, and will pay $50 to a bargaining unit employee who tests negative on the retest. If the second specimen is "dilute," it also is invalid, and **the employee cannot return to work until a valid specimen is provided, at the employee's expense, that produces either a negative or a positive test result and, if positive, the employee**

takes the recommended steps to receive a return to work release. If the employee fails to pay for the third or subsequent test, then the Administrative office may deduct the cost of the test, paid by the Administrative office, from the $50 Health Maintenance Benefit if any is owed.

13. Initial Employee Notification and Medical Review Officer (MRO) Review: The Administrator in consultation with MRO reviews all positive results. The Administrator checks its database to see if the employee has any medication positive records on file. This could include:

a) The employee listed a medication on the Custody and Control Form;

b) The lab states on the test result a medication that would cause the positive;

c) The employee has informed the Administrator of a medication using the Prescription or Release Authorization form;

d) There are previous results in the last year that were initially positive and the MRO then determined to be negative; or

e) The MRO has records of previous Medication Positives.

If one of these records are found, the MRO will be contacted. The MRO will attempt to verify the prescription with the pharmacy. If there is no release on file, the MRO will contact the employee to obtain a release to contact the pharmacy. If the prescription is verified, the MRO will notify the Administrator that the employee has a negative test.

If the MRO is not able to contact the employee within 24 hours, the MRO will contact the Administrator and the Administrator will use the "non-negative" test procedures to have the employer notify the employee about the test results. **The employee should not be removed from the job.** Once notified, the employee has 24 hours to contact the MRO. If the employee contacts the MRO and the prescription is verified, the MRO will notify the Administrator that the employee has a negative test.

If any of the following occurs, then the employer will be notified to remove the employee from the job while the procedures for verifying positive tests are being followed:

(a) The Administrator is not able to verify a prescription; or

(b) The Employee has not contacted the MRO within 24 hours of being notified of a non-negative result; or

(c) If the Administrator has no reason to suspect the positive result is due to a prescription medication, then the Administrator will notify the employer of a positive test result or invalid specimen.

An employee who has been notified by his/her employer of a positive test result is not eligible to return to work until the employee has submitted to his/her employer a "return to work" release issued by the EAP.

MRO Five (5) Day Review Period. An employee who has been notified by the Administrator of a positive test result may contest or explain the result to the employer through the MRO within five working days after receiving written notification of the positive test result. It shall be the employee's responsibility to contact the MRO upon receiving the notice. Failure to contact the MRO within five working dates after receiving notification shall constitute a waiver of the right to contest or explain. Unless the employee provides a medically satisfactory objection or explanation, the MRO shall provide the Administrator with a verified positive test result.

The MRO is Dr. Kirby Griffin, M.D., Northwest Occupational Health Associates (see Section 7.4). The MRO reviews the test results, interviews the employee on a confidential basis, and determines whether the positive test result should be confirmed or canceled. For example, the MRO can inquire about prescription and nonprescription drug usage, and determine if there is a legitimate reason to cancel the positive result. The MRO also determines if there has been an error in the custody and control of the urine specimen that would require cancellation.

14. Employee Assistance Program (EAP). For any positive result, the employee should contact the DFW Program's EAP (see Section 7.5). The EAP has a confidential interview with the employee, and recommends appropriate education, counseling, or rehabilitation. The DFWP Program requires that any employee that has tested positive or provided an invalid/adulterated specimen must complete the minimum of an education program. **An employee who refuses to participate in the EAP's recommended education, counseling or rehabilitation is subject to immediate termination pursuant to the requirements of Section 17. If an employee fails to attend the scheduled appointment with the EAP for the assessment appointment without notifying and rescheduling with the EAP at least 24 hours before the scheduled appointment time, then the employee must pay any rescheduling fee charged by the EAP before a new appointment will be set.**

15. Return to Work.

15.1 General. This section describes when an employee may return to work after testing. Regardless of whether an employee has tested negative and has a valid verification card, the Employer has the responsibility of ensuring compliance with this Plan and therefore has a responsibility of requesting when appropriate reasonable suspicion testing (Section 10.3) and post-accident testing (Section 10.4).

15.2 Return To Work After Testing. Following the test, the employee will return to work until notified of the results. However, the employee may be required to remain off work pending completion of any requirements imposed by the DFW Program's EAP if the EAP determines that an immediate return to work would present a safety risk.

15.3 Return to Work After First or Second Positive Test. **The EAP also determines when the employee can return to work and does so by issuing a return to work release**. The EAP will not issue a return to work release to any employee who, in the judgment of the EAP, is likely to be a safety risk in the work environment. The EAP or the employer can require that the employee provide a follow-up urine specimen for testing as a requirement for the employee to return to work. The DFW Program will pay for such follow-up test, but the employee will not receive a $50 check if the result is negative. If the employee decided to return to the out of work list or be referred from the out of work list, the employee must also have a return to work release. If the EAP determines an employee can return to work, an employer is not required to employ that employee if the employer does not have any work available for the employee and, even if an employer has work available, an employer is not required to provide a position to the employee if the employee does not return to work with a return to work release from the EAP within two (2) weeks from date of the positive test.

15.4 Testing Upon Completion of Treatment: If an employee completes the recommended level of treatment but has not provided a negative UA during the course of treatment, the employee is required to provide a negative UA within 5 days of completing his/her treatment. The date of completion will be set as the date upon which the negative UA is provided.

15.5 Compliance Agreement. The employee must participate in the EAP's recommended education, counseling, or rehabilitation. The Employer can require that the employee sign a compliance agreement as a condition to returning to work.

15.6 Employer's Responsibility. The Employer shall require that an employee who has tested positive **the first or second time for** alcohol or drugs shall return to work only after receiving a work release from, and subject to any educational, counseling, or rehabilitation program recommended by the DFW Program's EAP.

15.7 Termination After Third Positive Result. **If any employee has tested positive for a third time, the employee shall be immediately terminated and shall not be subject to future hire until the employee has satisfactorily completed an education, counseling, or rehabilitation program prescribed by the DFW Program's Employee Assistance Program.** For employment in the State of Washington, such rehabilitation program must be approved by the State. The cost of such education, counseling or rehabilitation shall be borne by the terminated employee and not by the DFW Program.

16. Benefits. The employee is responsible for obtaining any benefits that might be provided under his/her group health and welfare plan for such education, counseling, or rehabilitation. For any benefits not covered by the DFW Program, the employee should consult his/her summary plan description booklet for the group health and welfare, and direct all inquiries to the administrative office of that group health and welfare plan.

The DFW Program pays only the costs of testing, notices, MRO, DFW Program EAP, and the $50.00 wellness check for bargaining unit employees who test negative the first time after receiving the notice to test.

The DFW Program does **not** pay the costs of education, counseling or rehabilitation. **In addition, the Plan does pay for the first early intervention program, not to exceed $350 per participant, as approved by the Plan.**

17. Testing and Treatment Compliance - Refusal to Comply.

17.1 Employee Refusal to Comply. If an employee refuses to participate in the testing as outlined in the Plan or if an employee's test results are positive and the employee refuses to seek education, counseling, rehabilitation or the completion of a rehabilitation program as prescribed by the Program's EAP, that employee is subject to immediate termination and his/her verification card is immediately void, subject to the notice and opportunity to comply procedures of Sections 17.2, 17.3, 17.4, and 17.5, applicable to treatment compliance.

The term "refusal to comply" means any conduct by an employee that interferes with the testing process such as refusal or failure to appear at the collection site, refusing or failing to complete documentation properly and accurately, refusing to provide valid identification or signatures or initials where required, late arrival at the collection or test site, leaving the collection site when advised that a specimen must be re-collected, or having known adulterants on one's person when appearing for a collection or test, even if no adulterant is introduced into the specimen.

17.2 Opportunity to Comply. If an employee refused to take a drug test and was terminated for such, then the employee must test and follow any requirements if the test results are positive. If the employee had tested positive and was terminated for not following through with the requirements, then the employee must return to education, counseling, or rehabilitation in order to come back in compliance with the Program.

17.3 Treatment - First Notice of Opportunity to Comply. If an employee fails to comply with the treatment program for the first time as determined by the EAP, then the plan must first send a written notice to the employee of such failure before the Plan notifies the employee's employer and the local union. This notice of non-compliance must be sent at least five business days prior to the date that any notice is sent to the employee's employer and local union. The notice must state the following: (1) the

employee is not in compliance and that, if the employee does not get back into compliance within five business days, a notice of non-compliance will be sent to the employee's employer and local union, which will result in termination and ineligibility for work and (2) the employee may appeal this decision to the Claim Review Committee of the Board of Trustees for an expedited review under Section 28.1, and such review must occur before any notice is sent to the employee's employer or local union (but only so long as the appeal request is received by the Plan before the five business days has expired). Upon determination by the EAP, the Plan may in its discretion waive the five-business-day notice if the EAP determines there is a safety issue in waiting before removal of the employee. Furthermore, the Plan may in its discretion grant an employee more than five business days but no more than ten business days to get back into compliance under this section, if the EAP determines that the EAP cannot schedule the employee for the appropriate class or other appointment needed for the employee to be back into compliance.

17.4 Treatment-Second Notice of Opportunity to Comply. If an employee fails to comply with the treatment program for a second time as determined by the EAP, then the Plan must again send a written notice to the employee of such failure; however, upon the second non-compliance, the notice will be sent to the employee's employer and union at the same time it is sent to the employee. The notice must state the following: (1) the employee is not in compliance for a second time and that, if the employee does not get back into compliance within five business days, then a notice of non-compliance and a failure to correct the non-compliance will be sent to the employee's employer and local union, which will result in termination and ineligibility for work; (2) the employee may appeal this decision to the Claim Review Committee of the Board of Trustees for an expedited review under Section 28.1, and such review must occur before the notice of non-compliance and failure to correct the non-compliance is sent to the employee's employer and local union (but only so long as the appeal request is received by the Plan before the five business days have expired); and (3) if there is no appeal (or any appeal is rejected by the Claim Review Committee) and if the employee fails to comply with the treatment program for a third time, then (a) the Plan will send a letter of non-compliance, without prior notice to the employee, to the employee's employee and local union, (b) the third non-compliance will result in termination and ineligibility for work, and (c) furthermore, the employee will not be eligible for any benefits under this Plan and will not be eligible for rehire until the employee has completed a recommended education, counseling, or rehabilitation program as prescribed by the DFW Program's EAP at the employee's own expense and then reapply. Upon determination by the EAP, the Plan may in its discretion waive the five-business-day notice if the EAP determines there is a safety issue in waiting before removal of the employee. Furthermore, the Plan may in its discretion grant an employee more than five business days but no more than ten business days to get back into compliance under this section, if the EAP determines that the EAP cannot schedule the employee for the appropriate class or other appointment needed for the employee to be back into compliance.

17.5 Treatment - Third Notice of Non-Compliance. If an employee fails to comply with the treatment program for a third time as determined by the EAP, then the Plan will also send a written notice to the employee of such failure. This notice of non-compliance will also be sent at the same time to the employee's employer and local union. Upon receipt of this notice from the Plan, the employer may deliver this notice directly to the employee and terminate the employee. The notice must state the following: (1) the employee is not in compliance for a third time; (2) the employee may appeal this decision to the Claim Review Committee of the Board of Trustee for an expedited review under Section 28.1; and (3) because of the third violation, the employee is subject to immediate termination and ineligibility for work, unless and until the employee appeals the determination and the Claim Review Committee reverses the determination, and furthermore, absent reversal by the Claim Review Committee, the employee will not be eligible for any benefits under this Plan and will not be eligible for rehire until the employee has completed a recommended education, counseling, or rehabilitation program as prescribed by the DFW Program's EAP at the employee's own expense and then reapply.

17.6 Expedited Review. In the case of an appeal under Sections 17.3, 17.4, and 17.5, the plan administrator shall notify the employee of the Plan's determination as soon as possible, but not later than three business days after receipt of the appeal by the Plan, unless (1) the employee fails to provide sufficient information to review the appeal or provide the proper release forms to access the necessary information or (2) the employee requests a hearing. In the case of a failure to provide information or releases, the plan administrator shall notify the employee as soon as possible, but not later than 24 hours after receipt of the appeal by the Plan, of the specific information or releases necessary to complete the appeal. In the case of a request for a hearing, the hearing will be set as soon as possible, but no later than 30 days after receipt of the request for a hearing. The employee shall be afforded a reasonable amount of time, but not less than 48 hours, to provide the specified information. The plan administrator shall notify the employee of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information, (2) the end of the period afforded the employee to provide the specified additional information, or (3) the date of the hearing.

18. Termination.

18.1 Invalidation of Card. When an employee has been terminated as a result of the DFW Program, his/her verification card shall become immediately invalid.

18.2 First or Second Positive Result. The first or second positive result cannot be the **sole** basis for termination of employment. Unless other cause for termination exists, the employee with a positive result shall be **suspended** from employment and **must**

participate in the education, counseling, or rehabilitation prescribed by the DFW Program's EAP in order to obtain a return to work release.

18.3 Termination After Third Positive Result. **If any employee has tested positive for a third time, the employee shall be immediately terminated and not subject to future hire, until the employee has satisfactorily completed an education, counseling, or rehabilitation program prescribed by the DFW Program's EAP.** For employment in the State of Washington, such rehabilitation program must be approved by the State. The cost of such education, counseling or rehabilitation shall be borne by the terminated employee and not by the DFW Program.

18.4 Probationary Employees. Probationary employees will be terminated and are not eligible for rehire until they have completed a recommended education, counseling, or rehabilitation program as prescribed by the DFW Program's EAP at their own expense and then reapply. A probationary employee is an employee who has worked less than 250 hours as a craftsperson under a collective bargaining agreement with one of the unions participating in this program (including hours as a journeyperson and an apprentice) prior to the date of testing.

19. Last Chance Agreement. Upon submission of a work release from the program administrator of the EAP, the Employer and the employee may enter into a return to work or last chance agreement. Employees who successfully complete a prescribed education, counseling, or rehabilitation shall be returned to the group of employees subject to computer generated selection for testing. **The return to work or last chance agreement, which will be prepared by the Employer in conjunction with the Employee Assistance Program, will require the employee to adhere to all education, treatment and rehabilitation recommendations, and will require the employee to authorize the program to notify the Employer should he/she not remain in substantial compliance with the recommendations**.

20. Notice By Employees of Drug Related Offenses. All employees must notify management of any criminal conviction for any drug-related offense occurring in the workplace, no later than five (5) days after such conviction.

21. Employee Self Help. If an employee suspects that he/she has a substance abuse problem, the employee is expected to seek assistance for that problem, either from the DFW Program's Employee Assistance Program, the health and welfare plan or another competent source. The EAP is a private and confidential service that provides information and referral services to covered individuals and their dependents for drug and alcohol problems. Covered employees can obtain assistance by calling in the Portland area (503) 215-3561, or outside of the Portland area at (800) 255-5255. Any person employed by the Employer who voluntarily seeks assistance or rehabilitation for alcohol or drug related problems before disciplinary action has commenced will not be subject to discipline so long as the person continues to participate satisfactorily in the education, rehabilitation, or counseling program and continues to perform and behave satisfactorily and does not create any safety risk on the jobsite as determined by

the EAP. However, a probationary employee is not eligible for benefits under this plan even though the probationary employee voluntarily submits to treatment under this self-help provision, and the probationary employee is also not eligible for employment until the probationary employee completes a state approved education or rehabilitation program prescribed by the DFW Program's EAP at the probationary employee's own expense and then reapplies (see Section 8.5 and Section 18.4).

22. Third party Testing. If an employee violates a separate substance abuse policy required by another contractor or owner while the employee is working for a participating employer, then the employee must submit himself or herself for evaluation if he or she is required by the participating employer to do so, subject to the following: (1) the positive test result will be submitted by the employee to the Program, (2) the positive test result will be treated as a positive test result under the Program if the result violates the testing standards of this Program, and (3) treatment and compliance with treatment will be in accordance with the Program, including without limitation that the participating employer will be advised of treatment compliance problems in accordance with Section 17.

23. Consistent with Law. Nothing in this Plan and Policy is intended, nor shall it be construed, to authorize any action that is unlawful under federal or state law.

24. Other Substance Abuse Policies. This Plan and Policy is in addition to and separate from any substance abuse policies and procedures required by federal, state and local government organization.

25. Project Waiver. The Trustees may waive the Program on a project basis if there is already a drug and alcohol program in place which the Trustees determine to be substantially equivalent to this program.

26. Controlling Documents. In the event of any conflict between any summary of this Plan and any of the controlling plan documents, which includes this Plan, Trust Agreement, and any other rules approved by the Trustees, the plan documents shall control and be enforced.

27. Construction and Determinations by Trustees. The Trustees shall have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters, and to construe the provisions of the Plan, Trust Agreement, and the rules, regulations, and resolutions issued thereunder. Any such determination and any such construction adopted by the Trustees in good faith shall be binding upon all the parties hereto and the Participants, and shall be given the fullest deference allowed by law.

28. Claim Review.

    28.1 Expedited Review. The DFW Program is designed to answer all questions as soon as possible to minimize disruption of work. A claimant should seek expedited review

before initiating the ERISA claim review under 28.2. If the claim involves a benefit issue, then the appeal procedures in Appendix I shall apply.

28.1.1 Procedures. Questions about drug and alcohol test procedures can be answered by referring to the Plan Document explaining the DFW Program, or by contacting the Administrative Office specified above in 7.2.

28.1.2 Test Results and Treatment. Questions about individual test results and treatment will be addressed on a confidential basis by contacting the DFW Program's MRO or EAP specified above in 7.4 and 7.5.

28.2 ERISA Claim Procedure. To assure confidentiality to the employee and handling by the persons who best know the specialized needs of the DFW Program, all reviews of disputed or denied claims regarding test procedures, results and recommended treatment must be handled by the Claim Review Committee established by the Board of Trustees, and not by anyone involved in review of denied claims under the employee's separate health and welfare plan. The health and welfare plan's review procedure should be used for all claims involving treatments that are handled outside the services provided by the DFW Program. If the claim involves a benefit issue, then the appeal procedures in Appendix I shall apply.

28.2.1 Notice of Denial. The Administrative Office must notify the employee of the denial of any claim within a reasonable time, not to exceed 30 days after the claim is filed with the Administrative Office. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The denial will state the reason(s) for denial, explain the applicable Plan provision(s), explain this review procedure, and state if claimant needs to submit any additional material information.

28.2.2 Request for Review. Claimant, or claimant's representative, must file with the Administrative Office within 60 days after receiving the denial notice under section 28.2.1, a written request to have the denial reviewed by the Trustees' Claim Review Committee. Failure to make such request by the 60th day ends claimant's right to review by the Committee or a Court.

28.2.3 Review. The Trustees' Claim Review Committee will conduct its review and issue its decision within 60 days after the request under section 28.2.2 is received by the Administrative Office. Claimant and his/her representative will be notified of the time and place and may in the sole discretion of the committee attend and present evidence and argument. The Committee decision

will be written, and set forth the reasons and Plan provision(s). That decision is final and binding. A copy will be provided to Claimant and his/her representative.

28.2.4 Court Action. A claimant is not entitled to file a court action unless and until the foregoing review process has been completed.

28.2.5 Exclusive Remedy. The claim review process of sections 28.1 and 28.2 is the exclusive means to resolve claims and disputes involving the DFW Program and its benefits. Claims and disputes involving conduct of the Employer are subject to dispute resolution procedures set forth in the applicable labor agreement.

29. Statement of ERISA Rights.

Each Participant in this Program is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Approved 10/2010 _____ Board Chair

_____ Board Secretary

Appendix I

THE CONSTRUCTION INDUSTRY DRUG-FREE WORKPLACE PROGRAM

CLAIMS REVIEW PROCEDURES

1. Introduction. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. § 1133, and § 1135, this policy sets forth the requirements for procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as "claimants").

2. General Obligation to Establish and Maintain Reasonable Claims Procedures. These procedures shall at all times be maintained and shall be interpreted and applied in a reasonable manner consistent with the requirements of the Department of Labor (hereafter collectively referred to as "claims procedures"), including without limitation the following:

2.1 General Requirements. The claims procedures shall comply with the requirements of sections 3, 4, 5, 6, 7, 8, 9, and 10 of this policy, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to DOL regulations.

2.2 Summary Plan Description. A description of all claims procedures (including, in the case of a group health plan within the meaning of section 13.6 of this policy, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames are included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3.

2.3 No Fees or Costs. The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits, and therefore no fees or costs are charged under this policy. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant (e.g., in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim.

2.4 Authorized Representative. The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, within the meaning of section 13.1 of this policy, a

health care professional, within the meaning of section 13.7 of this policy, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant.

2.5 Consistent Decisions. The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

2.6 Telephone Calls. In their discretion, the administrator may respond to general telephone calls regarding benefit coverage. However, the response is not binding until a claim is filed as set forth in section 5 unless: (1) preauthorization is required by the plan, (2) the claim is an urgent claim under the group health plan, (3) the response by the administrator is in writing, or (4) a binding response is otherwise required by this policy or the DOL regulations. The response is also not binding if the claimant or his/her representative fails to disclose any relevant information affecting the claim.

3. Group Health Plans. The claims procedures for the group health plan shall be reasonable shall comply with the requirements of section 2 above and the following additional requirements:

3.1 Notification of Procedures for Pre-Service Claims. The claims procedures provide that, in the case of a failure by a claimant or an authorized representative of a claimant to follow the plan's procedures for filing a pre-service claim, within the meaning of section 13.2, the claimant or representative shall be notified of the failure and the proper procedures to be following in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative. Section 3.1 shall apply only in the case of a failure that:

(A) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

3.2 Required Appeal. The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act, and therefore only one appeal is required. A claimant is required to make an appeal to the Plan's Appeals Committee, which is the Board's standing subcommittee of Trustees. A claimant has a voluntary right to appeal any decision of the Appeals Committee to the Full Board of Trustees.

3.3 Voluntary Appeal. To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by section 3.2 of this policy, the claims procedures provide that:

3.3.1 The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

3.3.2 The plan agrees that any statute limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

3.3.3 The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by section 3.2 of this policy;

3.3.4 The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

3.3.5 No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

3.4 No Mandatory Arbitration. The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations, except to the extent that the plan or procedures provide that:

3.4.1 The arbitration is conducted as one of the two appeals described in section 3.2 of this policy and in accordance with the requirements applicable to such appeals; and

3.4.2 The claimant is not precluded from challenging the decision under section 502(a) of the Act or other applicable law.

4. Disability Benefits. The claims procedures for disability benefits shall be reasonable and shall comply with the requirements of sections 2, 3.2, 3.3, and 3.4 above.

5. Definition of Claims for Benefits. For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with the plan's reasonable procedure for filing benefit claims as set forth in this policy. In the case of the group health plan, a claim for benefits includes any pre-service claims within the meaning of section 13.2 and any post-

service claims within the meaning of section 13.3. The claim for benefits must be made in writing unless (1) it is an urgent claim as required under this policy or (2) it is otherwise required by this policy or the DOL regulations. A claim for benefits must include all information needed to determine whether a claim is covered or not covered by the plan, and such other information as required by the plan administrator.

6. Timing of Notification of Initial Benefit Determination.

6.1 General. Except as provided in sections 6.2 and 6.3, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with section 7 of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

6.2 Group Health Plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination in accordance with sections 6.2.1, 6.2.2, or 6.2.3, as appropriate.

6.2.1 Urgent Care Claims - Initial Benefit Determinations. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later that 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this section 6.2.1 shall be made in accordance with section 7. The plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of --

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

6.2.2 Concurrent Care Decisions - Initial Benefit Determinations. If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then the following applies:

(A) Any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The plan administrator shall notify the claimant, in accordance with section 7, of the adverse benefit determination at a time sufficient in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with section 7, and appeal shall be governed by sections 9.2.1, 9.2.2, or 9.2.3, as appropriate.

6.2.3 Other Claims - Initial Benefit Determinations. In the case of a claim not described in sections 6.2.1 or 6.2.2, the plan administrator shall notify the claimant of the plan's benefit determination in accordance with either sections 6.2.3(A) or 6.2.3(B), as appropriate.

(A) Pre-Service Claims - Initial Benefit Determinations. In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this section 6.2.3(A) shall be made in accordance with section 7.

(B) Post-Service Claims - Initial Benefit Determinations. In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with section 7, of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required

information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

6.3 Disability Claims - Initial Benefit Determinations. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with section 7, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this section 6.3, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

6.4 Calculating Time Periods - Initial Benefit Determinations. For purposes of section 6, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to section 6.2.3 or 6.3 due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

7. Manner and Content of Notification of Initial Benefit Determination.

7.1 General Requirements. Except as provided in section 7.2, the plan administrator shall provide a claimant with written or electronic notification of any adverse initial benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104(b)-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant, the following information:

7.1.1 The specific reason or reasons for the adverse determination;

7.1.2 Reference to the specific plan provisions on which the determination is based;

7.1.3 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;

7.1.4 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 section 502(a) of the Act following an adverse benefit determination on review;

7.1.5 In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment of similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

7.1.6 In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

7.2 Oral and Written Notification on Urgent Claims - Initial Benefit Determinations. In the case of an adverse initial benefit determination by a group health plan concerning a claim involving urgent care, the information described in section 7.1 may be provided to the claimant orally within the time frame prescribed in section 6.2.1, provided that a written or electronic notification in accordance with section 7.1 is furnished to the claimant not later than 3 days after the oral notification.

8. Appeal of Adverse Benefit Determinations.

8.1 General Requirements - Appeals. The plans have established a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination. A claimant may file an initial appeal with the plan, which shall be heard by the Appeals Committee of Trustees. This appeal is required. A claimant may request, but is not required to appeal, the decision of the Appeals Committee to the Full Board of Trustees.

8.2 Full and Fair Review - Appeals. Except as provided in sections 8.3 and 8.4 of this policy, the claims procedures of the plan shall provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination and shall provide the following:

8.2.1 Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

8.2.2 Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

8.2.3 Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to section 13.8;

8.2.4 Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

8.3 Group Health Plans - Appeals. The claims procedures of a group health plan shall provide the following, in addition to complying with the requirements of sections 8.2.2 through 8.2.4 of this policy:

8.3.1 Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination.

8.3.2 Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

8.3.3 Provide that, 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, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

8.3.4 Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

8.3.5 Provide that the health care professional engaged for purposes of a consultation under section 8.3.3 of this policy shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

8.3.6 Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which:

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

8.4 Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of sections 8.2.2 through 8.2.4 and 8.3.1 through 8.3.5 of this policy.

9. Timing of Notification of Benefit Determination on Review - Appeals.

9.1 General Requirements - Appeals.

9.1.1 Except as provided in sections 9.1.2, 9.2, and 9.3 of this policy, the plan administrator shall notify a claimant in accordance with section 10 of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

9.1.2 In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, section 9.1.1 shall not apply, and, except as provided in sections 9.2 and 9.3, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in

accordance with section 10, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

9.2 Group Health Plans - Appeals. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with sections 9.2.1 through 9.2.3, as appropriate.

9.2.1 Urgent Care Claims - Appeals. In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with section 10 of this policy, of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

9.2.2 Pre-Service Claims - Appeals. In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with section 10 of this policy, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination.

9.2.3 Post-Service Claims - Appeals.

(A) In the case of a post-service claim, except as provided in section 9.2.3(B) of this policy, the plan administrator shall notify the claimant, in accordance with section 10, of the plan's benefit determination on review within a reasonable period of time. In the case of a group health plan that requires one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. (If the group health plan requires two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination.)

(B) In the case of a multiemployer plan with a committee or board of trustees designated a the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, section 9.2.3(A) shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for

review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with section 10, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

9.3 Disability Claims - Appeals.

9.3.1 Except as provided in section 9.3.2 of this policy, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by section 9.1 of this policy, except that a period of 45 days shall apply instead of 60 days for purposes of that section.

9.3.2 In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, section 9.3.1 shall not apply, and the appropriate named fiduciary shall instead made a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with section 10, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

9.4 Calculating Time Periods – Appeals. For the purpose of section 9 of this policy, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to section 9.1, 9.2.3(B), or 9.3 of this policy due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

9.5 Furnishing Documents – Appeals. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in sections 10.3, 10.4, and 10.5 of this policy as is appropriate.

10. Manner and Content of Notification of Benefit Determination on Review - Appeals.

The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(l)(i),(iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

10.1 The specific reason or reasons for the adverse determination;

10.2 Reference to the specific plan provisions on which the benefit determination is based;

10.3 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 claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to section 13.8 of this policy;

10.4 A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in section 3.3.4, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

10.5 In the case of a group health plan or a plan providing disability benefits--

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

10.5.2 If the adverse benefit determination 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 determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

10.5.3 The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

11. Preemption of State Law.

11.1 Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

11.2.1 For purposes of section 11.1, a State law regulating insurance shall not be considered to prevent the application of a requirement of this policy merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under

group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the forgoing.

11.2.2 The State law procedures described in section 11.2.1 are not part of the full and fair review required by section 503 of the Act. Claimants therefore need not exhaust such State law procedures prior to bringing suit under section 502(a) of the Act.

12. Failure to Establish and Follow Reasonable Claims Procedures. In the case of the failure of the plan to establish or follow claims procedures consistent with the requirements of the DOL regulations, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act. If a suit is filed, the standard of review shall be whether the plan acted arbitrary or capriciously.

13. Definitions. The following terms shall have the meaning ascribed to such terms in this section 13 whenever such term is used in this section:

13.1.1 A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations--

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

13.1.2 Except as provided in section 13.1.3, whether a claim is a "claim involving urgent care" within the meaning of section 13.1.1(A) is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

13.1.3 Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" within the meaning of section 13.1.1 shall be treated as a "claim involving urgent care" for purposes of this section.

13.2 The term "pre-service claim" mans any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

13.3 The term "post-service claim" means any claim for a benefit under a group health plan that is not a pre-service claim within the meaning of section 13.2.

13.4 The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a

benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

13.5 The term "notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1)(b) as appropriate with respect to material required to be furnished or made available to an individual.

13.6 The term "group health plan" means an employee welfare benefit plan within the meaning of section 3(1) of the Act to the extent that such plan provides "medical care" within the meaning of section 733(a) of the Act.

13.7 The term "health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

13.8 A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information.

13.8.1 Was relied upon in making the benefit determination;

13.8.2 Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

13.8.3 Demonstrates compliance with the administrative processes and safeguards required pursuant to section 2.5 of this policy in making the benefit determination; or

13.8.4 In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

14. Apprenticeship Plans. This section does not apply to employee benefit plans that solely provide apprenticeship training benefits.

15. Applicability Dates. This policy shall apply to claims filed under the plan on or after January 1, 2002, except this policy shall apply to claims filed under a group health plan beginning on or after January 1, 2003. This policy is incorporated as part of the applicable plan documents, and shall control and supersede any inconsistent provisions.

Appendix II

CONSTRUCTION INDUSTRY DRUG FREE WORKPLACE PROGRAM

PRIVACY NOTICE

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully.

This Notice describes the medical information practices of the Construction Industry Drug Free Workplace Program (the "Program") and that of any third party that assists in the administration of Program claims. The Program is required by law to maintain the privacy of protected health information. The Health Insurance Portability and Accountability Act of 1996 governs protection of private health information. If you have medical and prescription drug coverage through another health plan, that plan has its own Privacy Practices to protect your health information.

If you have any questions about this Notice, please contact the Program's administrative agent, Masonry Industry Trust Administration, Inc.

I. Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. The Program maintains a record of the health care claims reimbursed under the Program for Program administration purposes. This Notice applies to all of the medical records and private health information we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This Notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information. We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the Notice that is currently in effect.

II. How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. Disclosure of private medical information shall be the minimum necessary to satisfy the purpose of the disclosure. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

A. To Facilitate Treatment. The Program may use and disclose your health information to facilitate treatment or services by providers, including coordination or management of health carrier related services. For example, the Program may disclose health information about you with physicians who are treating you.

B. For Payment (as described in applicable regulations). We may use and disclose medical information about you to determine eligibility for Program benefits, to facilitate payment for treatment and services you received from health care providers, to determine benefit responsibility under the Program, or to coordinate Program coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Program will cover the treatment. We may also share medical information with a utilization review or pre-certification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or with another health plan to coordinate benefit payments.

C. For Health Care Operations (as described in applicable regulations). We may use and disclose medical information about you for Program operations. These uses and disclosures are necessary to run the Program. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Program coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, claims appeals, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Program administrative activities.

D. As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

E. To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

F. Special Situations.

1. Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

2. Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

3. Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

4. Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

5. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

6. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

7. Law Enforcement. We may release medical information if asked to do so by a law enforcement official; in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about a victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct at the hospital; and in emergency circumstances to report a crime; the location of the crime or victims; or the identify, description or location of the person who committed the crime.

8. Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

9. National Security and Intelligence Activities. We may release medical information about you to authorize federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

10. Research. The Program may disclose your health information to researchers when (1) their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information, or (2) the research involves a limited data set which includes no unique identifiers (information such as name, address, social security number, etc., that can identify you).

11. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

12. For Treatment Alternatives. The Program may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

13. For Distribution of Health Related Benefits and Services. The Program may use and disclose your health information to provide information on health-related benefits and services that may be of interest to you.

14. For Disclosure to the Board of Trustees. The Program may disclose your health information to another health plan maintained by the Construction Industry Drug Free Workplace Program or to the Board of Trustees for Program administration functions performed by the Board of Trustees on behalf of the Program. In addition, the Program may provide summary health information to the Board of Trustees so that the Board of Trustees may solicit premium bids from health insurers or modify, amend or terminate one or more of the Programs. The Program may also disclose to the Board of Trustees information whether you are participating in the Program.

15. A Family Member or Close Personal Friend Involved in Your Health Care. The Program may make your health information known to a family member or close personal friend. Disclosure of your health information will be determined based on how involved the person is in your health care or payment of your health care claims. For example, the Programs would normally provide information to a family member confirming eligibility for health coverage or if a claim was paid but not the specific treatment or diagnosis provided or the reason the provider was consulted. The Program may release health information to parents or guardians, if allowed by law. The Program also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you are not present or able to agree to these disclosures of you health information, the Program, through its third party administrator may use its professional judgment to determine whether the disclosure is in your best interest. **If you do not want your health information disclosed to a family member or close personal friend as outlined in this section, you must notify the Program as described in the Right to Request Restrictions on page 4.**

16. Personal Representative. The Program will disclose your health information to an

individual who has been designated as your personal representative and has qualified for such designation in accordance with relevant state law. However, before the Program will disclose health information to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualifications, such as a power of attorney.

Even if you designate a personal representative, federal law permits the Program to elect not to treat the person as your personal representative if the Program has a reasonable belief that: (1) you have been, or may be, subject to domestic violence, abuse or neglect by such person; (2) treating such a person as your personal representative could endanger you; or (3) the Program determines, in their professional judgment, that it is not in your best interest to treat the person as your personal representative.

17. Business Associates. Business Associates perform various functions and services on behalf of the Program. For example, the third party Administrator, Masonry Industry Trust Administration, Inc., will be handling many of the functions in connection with the operation of the Program. To perform these functions, or provide the services, the Programs' Business Associates may receive, create, maintain, use or disclose your health information, but only after agreeing, in writing, to appropriate safeguards concerning your health information.

18. Other Covered Entities. The Program may use or disclose your health information to administer the Program, including all disclosures authorized by the Program to Employers, Unions, Medical Review Officer, Employee Assistance Program, Treatment Facilities, and other entities.

III. Your Rights Regarding Your Medical Information

You have the following rights regarding medical information we maintain about you:

A. Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Program benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Masonry Industry Trust Administration, Inc. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Note that under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. In some, but not all, circumstances, you may have a right to have this decision reviewed.

B. Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment

for as long as the information is kept by or for the Program. To request an amendment, your request must be made in writing and submitted to Masonry Industry Trust Administration, Inc. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Program;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If the Program denies your request, you have the right to file a statement of disagreement. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure of your medical information was made for any purpose other than treatment, payment, or health care operations.

To request this accounting of disclosures, you must submit your request in writing to Masonry Industry Trust Administration, Inc. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request in a 12 month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request.

To request restrictions, you must make your request in writing to the Trust Administrative Agent, Masonry Industry Trust Administration, Inc. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Masonry Industry Trust Administration, Inc. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your written request must specify how or where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. To obtain a paper copy of this Notice, contact Masonry Industry Trust Administration, Inc.

G. Right to Complain/Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Program or with the Secretary of the Department of Health and Human Services. To file a complaint with the Program, contact Masonry Industry Trust Administration, Inc. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

IV. Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

V. Minimum Necessary Disclosure of Health Information

The amount of health information the Program will use or disclose will be limited to the "minimum necessary" as defined in the HIPAA Privacy Rule.

VI. Potential Impact of State Laws

The HIPAA Privacy Rule generally does not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which the Program may be required to operate. For example, where such laws have been enacted, the Program will follow more stringent state privacy laws that relate to uses and disclosures of health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproduction rights, and so on.

VII. Effective Date/Changes to This Notice

This Notice is effective April 14, 2004. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about

you as well as any information we receive in the future. If the Program makes a material change to this Notice, it will provide a revised Notice to you at the address that the Program has on record for the participant enrolled in the Program within 60 days of the change.

HOW TO CONTACT THE ADMINISTRATIVE AGENT, MASONRY INDUSTRY TRUST ADMINISTRATION, INC.:

Address: **Masonry Industry Trust Administration, Inc.**
9848 E. Burnside Street
Portland, OR 97216

Telephone: **(503) 254-4022 or (800) 591-8326**

HOW TO CONTACT THE PRIVACY OFFICIAL:

Address: **Administrator**
Construction Industry Drug Free Workplace Program
9848 East Burnside
Portland, OR 97216

Telephone: **(503) 254-4022 or (800) 591-8326**

HOW TO CONTACT U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF CIVIL RIGHTS:

Address: **200 Independence Ave., S.W.**
Washington, DC 20201

Telephone: **(202) 619-0257 Toll Free: (877) 696-6775**