Northern Nevada Laborers Health & Welfare Trust Fund

Mailing Address: Post Office Box 11337, Reno, NV 89510
Street Address: 445 Apple Street, Suite 109, Reno, NV 89502
Telephone: (775) 826-7200

Date **April 2023**

To: **All Active Employees and their Dependents of the Northern Nevada Laborers Health and Welfare Trust Fund**

Clarifications to Medical Benefits Pursuant to the end of the National Emergency and Public Health Emergency

This Participant Notice will advise you of certain material modifications that have been made to the Northern Nevada Laborers Health and Welfare Trust Fund. **This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully.

This SMM clarifies important changes in COVID-19 related benefits and administrative deadlines as a result of the declared end of the National Emergency ("NE") and Public Health Emergency ("PHE") on May 11, 2023.

The federal government has announced that both the National Emergency (NE) and Public Health Emergency (PHE) related to COVID-19 will terminate on May 11, 2023. Consequently, the plan rules concerning coverage of certain benefits related to COVID-19 will be changing. In general, all special rules in effect during the emergency will terminate and benefits will be covered under the usual cost-sharing provisions of the Fund.

Changes to COVID-19 Related Benefits

Below is a brief summary of changes to COVID-19 related medical and prescription drug coverage beginning May 12, 2023:

Benefit	During the Emergency Period	Effective May 12, 2023
COVID-19 vaccines, including boosters	No charge for the vaccine when received at either PPO or Non-PPO Providers.	COVID-19 vaccines and boosters for adults will NOT be covered. COVID-19 vaccines and boosters for children up to age 19 will be covered under the Well-Child benefits
COVID-19 diagnostic tests and related services	No charge for COVID-19 test related office visits or lab tests (including rapid diagnostic and swab-and-send tests) performed by either PPO or Non-PPO Providers.	COVID-19 test related office visits or lab tests will be covered in the same manner as any test or lab, based on whether the service is performed by PPO or Non-PPO Providers.

Benefit	During the Emergency Period	Effective May 12, 2023
COVID-19 at-home test kits, also known as over-the-counter, or OTC test kits	No charge for up to eight (8) over-the-counter (OTC) COVID-19 tests per month, both in and out of network. Reimbursement for out-of-network OTC COVID-19 tests is limited to $12 per test.	COVID-19 OTC tests are not covered.
Telehealth Services	Benefits for these Telehealth Services are covered by the Plan at the regular cost-sharing applicable to the office visit (that is, subject to deductible, copay, and/or coinsurance), depending on whether the provider is a P PO or Non-PPO Provider.	Telehealth Services for a mental health/ substance abuse diagnosis will be covered by the Plan at the regular cost sharing applicable to the office visit (that is, subject to deductible, copay, and/or coinsurance), depending on whether the provider is a PPO or Non-PPO Provider. All other Telehealth Services will be excluded.

Elimination of Extended Deadlines for Administrative Actions

In addition to the changes above, there are also certain administrative timeframes that will return to normal after the end of the NE and PHE.

Below is a brief summary of changes to administrative related deadlines beginning the earlier of 60 days after the announced end of the COVID-19 National Health Emergency, July 10, 2023 or one year from the deadline for your particular deadline, whichever is earlier.

Administrative Timeframe	During the Emergency Period	Return to Normal Timeframes
COBRA, HIPAA, special enrollment and benefit claims and appeals	During the National Emergency, deadlines for the following events were extended until the earlier of July 10, 2023 or one year from the original deadline: • COBRA elections • Paying COBRA premiums • Electing HIPAA special enrollment • Filing claims, appeals and requests for external review	Effective July 10, 2023, the deadlines for these events return to their normal timeframes. Please see your Summary Plan Description or contact the Fund Office for details on applicable timeframes.

You are still encouraged to use PPO facilities and PPO providers whenever possible. Please keep this important notice with your Plan Document/Summary Plan Description for easy reference to all Plan provisions. Please review these changes carefully and contact the Fund Office with any questions that you may have.

NOTICE OF STATUS AS A GRANDFATHERED PLAN

Because this Plan is a "grandfathered health plan," we are required by law to provide this notice to you:

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administrative Office at (775) 826-7200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. Should you have any questions, please contact the Administrative Office.

Sincerely,

Board of Trustees

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding the Plan changes, please contact the Administrative Office.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.

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Northern Nevada Laborers Health & Welfare Trust Fund
Mail Claims to: Post Office Box 11337, Reno, NV 89510
Street Address: 445 Apple Street, Suite 109, Reno, NV 89502
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October 2022

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you

and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact the Department of Health and Human Services at 1-800-985-3059 to submit a complaint regarding potential violations of the No Surprises Act for enforcement issues related to federally regulated plans such as a self-funded group health plan (like this Plan). You may contact 1-888-466-2219 for enforcement issues related to state regulated plans.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

You can find information about your rights under your state's law at https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections. For the State of Nevada law information, please visit https://doi.nv.gov/Consumers/Health_and_Accident_Insurance/Balance_Billing_FAQs/ .

GRANDFATHERED HEALTH PLAN REMINDER

The Board of Trustees believes that the Northern Nevada Laborers Health & Welfare Trust Fund is a "grandfathered health plan" under the Affordable Care Act ("ACA"). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that ACA was enacted. Being a grandfathered health plan means that your Plan is not required to include certain

consumer protections of the ACA that apply to other plans (known as a Non-Grandfathered plan), for example, requiring the provision of preventive health services without any cost sharing. Grandfathered health plans must comply, however, with certain other consumer protections in the Act, such as the elimination of annual and lifetime limits on Plan's essential health benefits. (For a definition of what constitutes as Essential Health Benefits, please visit *www.healthcare.gov/glossary/essential-health-benefits*.)

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Office at (775) 826-7200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 1–866–444–3272 or *www.dol.gov/ebsa/healthreform.* This website has a table summarizing which protections do and do not apply to grandfathered health plans.

NORTHERN NEVADA LABORERS HEALTH & WELFARE TRUST FUND
445 Apple St., Ste. 109 * Reno, NV 89502 * P.O. Box 11337 * Reno, NV 89510
Telephone: (775) 826-7200 Fax: (775) 824-5080

July 2022

Important Notice to Plan Participants for the Northern Nevada Laborers Health & Welfare Trust Fund About Your Prescription Drug Coverage and Medicare

This Notice is for people who are eligible for Medicare and to inform you that your current prescription drug benefit program through the Northern Nevada Laborers Health & Welfare Trust Fund provides "Creditable Coverage," as defined below. It also includes answers to questions you may have regarding your current prescription drug program and how it relates to Medicare Part D coverage. If you or any of your eligible family members are now eligible for Medicare or will become eligible for Medicare in the next 12 months, please read this notice carefully and keep it where you can find it.

Medicare Part D prescription drug plans became available in 2006 to every person who is eligible for Medicare. You can obtain this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans will provide at least a standard level of coverage set by Medicare and some plans may offer more coverage for a higher monthly premium. (**Note that the Medicare Part D prescription drug program is NOT a benefit provided through the Northern Nevada Laborers Health & Welfare Trust Fund (Plan).** Medicare Part D plans are provided through Medicare and they are marketed by various Medicare-approved "Prescription Drug Providers" (PDPs). If you are eligible for Medicare, you will have a chance to enroll in a Medicare-approved Part D plan from October 15th through December 7th of each year. If you ever lose your current prescription drug coverage provided by the Plan, through no fault of your own, you will then be eligible for a two (2) month special enrollment period to enroll in a Part D plan.

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

The Board of Trustees of the Northern Nevada Laborers Health & Welfare Trust Fund hereby certifies that the prescription drug coverage it provides to Medicare-eligible participants is expected to pay out, on average for all such participants, at least as much as the standard Part D coverage would pay in calendar year 2019. It is therefore designated as providing "**creditable coverage**," meaning that any participant who later enrolls in a Medicare Part D plan will not be charged a late enrollment penalty (extra premium) for 2019.

This is your Notice of creditable coverage. Be sure to read it carefully and keep it in a safe place where you can find it. If you lose this notice and need another copy, please call the Northern Nevada Laborers Health & Welfare Trust Fund administrator at (775) 826-7200, or request a copy in writing from Benefit Plan Administrators at 445 Apple Street, Reno, Nevada 89510.

Updated versions of this notice will be sent annually and you will be informed if the Northern Nevada Laborers Health & Welfare Trust Fund ever loses its Creditable Coverage status.

FREQUENTLY ASKED QUESTIONS

(1) Do I need to do anything now?

No, you can keep using the Northern Nevada Laborers Health & Welfare Trust Fund prescription drug program the same as you always have. When you first become eligible for Medicare[1], you will have the option to independently enroll in a Medicare Part D prescription drug plan. ***However, by enrolling in a Part D plan you may lose your prescription drug coverage under the*** Northern Nevada Laborers Health & Welfare Trust Fund***, you would likely gain little or no additional benefits, and you will not be reimbursed for your Part D premiums***. As mentioned above, the standard Part D benefit is not as good as the Northern Nevada Laborers Health & Welfare Trust Fund's own prescription drug program (as described in your Plan Booklet, also known as the Summary Plan Description and Plan Document).

You should compare your current prescription drug program, including which drugs are covered, with the benefits and costs of the Medicare Part D plans available in your area. To view the official summary of approved Medicare Part D plans in any U.S. state, visit http://www.medicare.gov/find-a-plan/questions/home.aspx. Note that a Part D plan might not include your regular prescription drugs on its formulary. The Northern Nevada Laborers Health & Welfare Trust Fund cannot provide you with a complete comparison of available Part D plans, but we urge you to carefully review any descriptions you may obtain.

(2) So why do I need to keep my Notice of Creditable Coverage?

In case you ever drop or lose your Northern Nevada Laborers Health & Welfare Trust Fund's (Plan) coverage, or in the unlikely event that the Plan's coverage becomes non-creditable, having this notice will allow you to immediately enroll in a Part D plan without having to pay a late enrollment penalty. Specifically, if you try to enroll after your initial eligibility period, you will be charged a permanent Part D premium surcharge of 1% for every month since your initial Medicare eligibility for which you cannot show that you had creditable coverage (if such non-creditable period exceeds 62 days). Also note that you may have to wait for the next regular annual Part D enrollment period, which will be **October 15th through December 7th** for coverage in the following calendar year.

(3) How can I get more information on Medicare Part D?

More detailed information about Medicare plans will be in the handbook "Medicare & You". You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare-approved Part D providers. At any time you can visit www.medicare.gov/ or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Every state has a State Health Insurance Assistance Program to help Medicare beneficiaries and their families with their health insurance choices and with problems that might arise. For the contact information of the program in your state of residence, please visit: https://www.medicare.gov/contacts/#resources/ships. Contact information for state programs will also be listed in your copy of the of the "Medicare & You" handbook.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration website at http://www.socialsecurity.gov/ or call them at 1-800-772-1213. TTY users should call 1-800-325-0778.

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[1] Your Medicare Initial Enrollment Period will be the month in which you become age 65, plus the preceding three months and the succeeding three months.

Creditable Prescription Drug Coverage

The Northern Nevada Laborers Health & Welfare Trust Fund provides prescription drug coverage through contract with Optum RX, Inc. For more information about prescription drug coverage, visit www.optumrx.com or call 1-800-797-9791.

	Contract Provider	Non-Contract Provider
Generic	You pay 100% of the discounted prescription cost and submit the proper receipt to the Trust Fund for reimbursement. Prescriptions filled at Contract Pharmacies are reimbursed at 80% of contract rate. You may fill your prescription up to a maximum of a 60 day supply. (Subject to deductible.)	You pay 100% of the prescription cost and submit the proper receipt to the Trust Fund for reimbursement. Prescriptions filled at Non-PPO Pharmacies are paid at 60% of the Plans non-contracted allowable. You may fill your prescription up to a maximum of a 60 day supply. (Subject to deductible.)
Preferred Brand	Brand drugs that have a generic equivalent will no longer be reimbursed at the applicable coinsurance (that is, 80% for Contract Pharmacies) of the brand contract rate. They will be reimbursed at the applicable coinsurance of the generic drug equivalent contract rate. (Subject to deductible.)	Brand drugs that have a generic equivalent will no longer be reimbursed at the applicable Plan allowable rate (that is, 60% for Contract Pharmacies) of the brand allowable. They will be reimbursed at the applicable Plan benefit of the generic drug equivalent. (Subject to deductible.)
Non-Preferred Brand	You pay 100% of the discounted prescription cost and submit the proper receipt to the Trust Fund for reimbursement. Prescriptions filled at Contract Pharmacies are reimbursed at 80% of contract rate. (Subject to deductible.)	You pay 100% of the prescription cost and submit the proper receipt to the Trust Fund for reimbursement. Prescriptions filled at Non-PPO Pharmacies at 60% of Plan allowable. You may fill your prescription up to a maximum of a 60 day supply. (Subject to deductible.)
Specialty (Pharmacy)	You pay 100% of the discounted prescription cost and submit the proper receipt to the Trust Fund for reimbursement. Prescriptions filled at Contract Pharmacies are reimbursed at 80% of contract rate. You may fill your prescription up to a maximum of a 30 day supply. (Subject to deductible.)	You pay 100% of the prescription cost and submit the proper receipt to the Trust Fund for reimbursement. Prescriptions filled at Non-PPO Pharmacies at 60% of Plan allowable. You may fill your prescription up to a maximum of a 30 day supply. (Subject to deductible.)
Originator Drugs	Not Covered	Not Covered

Deductible/Annual Limit	$250 or $350 depending on which coverage you have.

REMEMBER: Be sure to keep this notice. If you decide to enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to give a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (penalty).

Date: July 11, 2022
Plan Sponsor: Northern Nevada Laborers Health & Welfare Trust Fund
Contact/Position: James G. Mace, Fund Manager, Benefit Plan Administrators, Inc
Address: 445 Apple Street, Suite 102; Reno, Nevada 89502
Telephone: (775) 826-7200

As in all cases and situations, Northern Nevada Laborers Health & Welfare Trust Fund reserves the right to modify benefits at any time, in accordance with applicable law. As required by law, this document is intended to serve as your Medicare Notice of Creditable Coverage.

NORTHERN NEVADA LABORERS HEALTH & WELFARE TRUST FUND

445 APPLE STREET * P.O. BOX 11337 * RENO, NV 89510 * P. (775) 826-7200 * F. 775) 824-5080

July 2022

Dear Participants and Dependents,

This Notice includes annual notices the Plan is required to provide you under the Affordable Care Act and other Federal Laws. It also includes other reminders. This is for informational purposes only. No action is necessary.

GRANDFATHERED HEALTH PLAN REMINDER

The Board of Trustees believes that the Northern Nevada Laborers Health & Welfare Trust Fund is a "grandfathered health plan" under the Affordable Care Act ("ACA"). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that ACA was enacted. Being a grandfathered health plan means that your Plan is not required to include certain consumer protections of the ACA that apply to other plans (known as a Non-Grandfathered plan), for example, requiring the provision of preventive health services without any cost sharing. Grandfathered health plans must comply, however, with certain other consumer protections in the Act, such as the elimination of annual and lifetime limits on Plan's essential health benefits. (For a definition of what constitutes as Essential Health Benefits, please visit *www.healthcare.gov/glossary/essential-health-benefits.*)

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Office at (775) 826-7200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 1-866-444-3272 or *www.dol.gov/ebsa/healthreform.* This website has a table summarizing which protections do and do not apply to grandfathered health plans.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, in consultation with the attending physician and patient, including:

- all stages of reconstruction of the breast on which the mastectomy was performed (including coverage for nipple and areola reconstruction and regimentation to restore the physical appearance of the breast),
- reconstruction and surgery to achieve symmetry between the breasts,
- prostheses, and treatment of physical complications resulting from all stages of the mastectomy, including lymphedema (swelling that sometimes happens after treatment for breast cancer).

This coverage may be subject to the Plan's deductibles, coinsurance, and/or co-payment provisions (consistent with those established for other benefits under the Plan). If you have any questions, please call the Plan administrator at 775-826-7200.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under Federal law, Group Health Plans and Insurers, may not generally restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours). The Plan and Insurers may not set level of benefits or out-of-pocket costs so that any portion of the 48-hour (96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan and Insurers cannot require that a physician or health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs you may be required to obtain precertification. Call the Plan Administrator at 775-826-7200 for more information.

HIPAA PRIVACY NOTICE REMINDER

This Notice is to remind you that, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan will only use or disclose your individual health information, known as protected health information, in accordance with the Plan's Notice of Privacy Practices. You may obtain a copy of the Plan's Notice of Privacy Practices at any time by calling the Plan

Administrator at 775-826-7200, to request that a copy be mailed to you. Within a reasonable period of time of your request, the Plan administrator's office will mail you a copy of the Notice. The Notice is also automatically provided to you at least once every three years or when there is a material change to the Notice.

COVID-19 Testing Reminders (During Public Health Emergency Period only)

As a reminder, you previously should have received notices regarding temporary coverage of COVID-19 diagnosis and antibody testing subject to federal guidelines during the public health emergency. Please note during the public health emergency period, at this stage, the Plan will cover at no cost-sharing to you only those COVID-19 tests (including antibody tests) that are approved, cleared or authorized by the FDA (or the FDA has authorized the test for emergency use) and a healthcare provider (licensed under applicable law) has determined there is a medical necessity for the test and orders the administration of such test for you and/or your eligible dependent. If the test does not meet federal guidance the Plan is allowed to deny reimbursement of the test or charge you the applicable cost-sharing for the non-covered test. Please also further note, the Plan is not required to cover any employer-return to work testing. Any questions about covered COVID-19 testing please contact the Plan Administrator for more information

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or the Children's Health Insurance Program ("CHIP") and you are eligible for health coverage from your employer, the State you reside in may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State that provides premium assistance, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **877/KIDS NOW** or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at *www.askebsa.dol.gov* or by calling toll-free 866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost- health-care/program-administration/premium-payment- program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.p df Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (327

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

AVAILABILITY OF SUMMARY OF BENEFITS & COVERAGE ("SBC")

Under the Affordable Care Act, Group health plans are responsible for providing a Summary of Benefits Coverage, also known as an SBC, to eligible new Participants and their dependents. The SBC provides a summary of what the Plan covers and what it costs. You also have the right to request and receive within seven (7) business days a SBC for the Plan. If you want a copy of the Plan's SBC and/or more details about your coverage and costs, please contact the Plan Administrator at (775) 826-7200.

MINIMUM ESSENTIAL COVERAGE

The Affordable Care Act establishes a minimum value standard of benefits for health plans. The minimum value standard is 60% (actuarial value) and eligible employer-sponsored plans (such as this Plan) are considered minimum essential coverage. (**Note:** Beginning in 2019, the individual penalty for failing to have adequate health coverage has been reduced to zero. This means there will no longer be a penalty assessed against individuals for failing to have health coverage. However, we believe there is little if any impact on you given that you have adequate coverage under this Plan.) **As such, the Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.**

RESCISSION OF COVERAGE RESTRICTIONS

Under the Affordable Care Act, the Plan and Insurers cannot retroactively cancel or terminate your coverage, except in cases of fraud, intentional misrepresentation of material fact, or failure to timely pay premiums. However, a retroactive cancellation of coverage is not considered a rescission if (1) it only has prospective effect, (2) is initiated by the covered individual, (3) due to delay in administrative record-keeping, (4) attributed to a failure to timely pay required premiums or contributions toward the cost of coverage, or (5) termination of coverage retroactive to the divorce, if the Plan does not cover former spouses. Plans and Insurers that rescind coverage must give affected individuals at least 30 days advance notice.

MEDICARE COORDINATION FOR RETIREES WHO ARE ELIGIBLE FOR MEDICARE– You are Required to Enroll

Medicare is our country's federal health insurance program for people who worked at least ten years in Medicare-covered employment who are age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income ("SSDI") benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin.

Under the Medicare program, the hospital insurance portion is called Medicare Part A, and the medical insurance portion, such as for the cost of physicians, is called Medicare Part B. Medicare Part A is financed by payroll taxes, and, if you are eligible to receive it based on your own or your spouse's employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage. Most working people are entitled to Medicare Part A when they reach age 65 because either they or a spouse paid Medicare taxes while working.

If you are retired, the Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A and Part B. **This means you and/or your spouse must enroll in both Medicare Part A and Part B, as soon as you and/or your spouse are eligible for Medicare. If you and/or your spouse do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid and failure to do so will resort in late enrollment penalties.**

Medicare's prescription drug plan (**Medicare Part D**) is available to Medicare beneficiaries and is part of your coverage if you are enrolled in the Plan. If you earn a higher income (above $85,000 for individuals or above $170,000 for married couples), Federal Law requires that you pay an additional premium for your Medicare Part D coverage to the Social Security Administration. This additional premium is called the Income-Related Monthly Adjustment Amount (also known as "IRMAA"). The premium is based on your modified adjusted gross income as reported on your IRS tax return from two years ago (thus, the fee in 2019 will be based on your adjusted gross income on your 2017 tax return). If you must pay a higher premium, Medicare will send you a letter with your premium amounts and the reason for their determination.

For more information on Medicare, please call Medicare at 800/MEDICARE (800/633-4227) or visit *www.medicare.gov*. TTY users should call 877/486-2048. If you have any questions, please contact the Plan Office at (775) 826-7200.

HIPAA SPECIAL ENROLLMENT RIGHTS

Under Federal Law, if you declined enrollment for yourself and/or your dependents because of having other sufficient group health coverage, you may be able to enroll yourself and/or your dependents in this Plan, if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement of adoption, you may be able to enroll yourself and your dependents within 30 days after the birth, adoption, placement for adoption, or marriage provided you complete and submit an Enrollment Form along with any other Plan required documentation (ex. marriage certificate, birth certificate, adoption papers) to the Trust Fund Office. To request special enrollment information, please contact the Plan Administrator at (775) 826-7200.

Option to Decline Dental and/or Vision Coverage

In accordance with Health Reform regulations, you have the option to decline/waive the Plan's dental and vision coverage and keep coverage under the Plan's medical and mental health benefits. If you do nothing, you will continue to have dental and vision health coverage through the Plan. To decline/waive coverage complete the portion of the Plan's enrollment form related to declining/waiving dental and/or vision coverage. Enrollment forms are available from the Trust Fund Office. Note that there is no additional compensation to you or you eligible dependent(s), if you choose to decline/waive dental and/or vision coverage. Please contact the Plan Administrator at (775) 826-7200 for more information.

Notice of Availability of Schedule of Allowances

As a reminder, the Plan's Schedule of Allowances Applicable to Non-Contract Providers is available to you and your eligible dependents from the Trust Fund Office. The Schedule of Allowances is the maximum amount allowed under the Plan for certain services for which you and/or your dependents receive from providers who are not contracted with the Plan. Please contact the Plan Administrator at (775) 826-7200 for more information.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is a federal law that prevents large group health plans and health insurers that provide mental health or substance abuse benefits from imposing less favorable benefit limitations, including financial requirements (e.g., deductibles, copayments, coinsurance and out of pocket limitations), treatment limitations (e.g., number of visits or days of coverage), and non-quantitative treatment limitations (e.g., preauthorization requirement, exclusion based on medical necessity) on those benefits than on medical and surgical benefits offered. As such, the limitations applicable to mental health or substance abuse benefits can be no more restrictive than the predominant limitations applied to substantially all medical and surgical benefits.

Pursuant to the Final MHPAEA rules, the Plan or Health Insurer will provide any current participants or potential participants (including dependents), upon request, the criteria for medical necessity determinations with respect to mental health/substance abuse benefits and the reason for any denial of reimbursement or payment for services with respect to mental health/substance abuse benefits.

It is the intention of the Board of Trustees that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more information on MHPAEA, please visit the Department of Labor website at *www.dol.gov/ebsa.*